# CBAS Managed Care Cutover Webinar
# Frequently Asked Questions (FAQs)

## Community-Based Adult Services (CBAS) Eligibility Determination Tool (CEDT)

**1. Who is responsible for completing the CEDT Tool?**

A – The CEDT is completed by staff of the Medi-Cal managed care plan (MC Plan) or Medi-Cal Field Office (MCFO) to assess and determine if an individual meets the eligibility criteria for community-based adult services (CBAS).

**2. Will MC Plans provide a copy of the completed CEDT to CBAS centers for the participants they assess?**

A – Within the contractual agreements between the MC Plans and CBAS providers, both parties may agree to what information needs to be shared and when, including the CEDT upon completion.

## Authorization for CBAS Services

**3. Who can request an assessment for CBAS eligibility?**

A – Requests for CBAS assessment can come from a number of sources, including but not limited to: community-based organizations, physicians, family members, CBAS participants, discharge planners at hospitals or nursing facilities, and the staff of CBAS centers.

**4. What is the process for enrolling potential new CBAS participants in MC Plans?**

A – **After October 1, 2012,** When a CBAS provider identifies that an individual is in need of CBAS, the CBAS provider must confirm Medi-Cal eligibility and follow one of the following options.

- ✓ For participant enrolled in a managed care plan, as identified through an Automated Eligibility Verification System (AEVS) or Medi-Cal Point of Service (POS) eligibility check – submit a request for inquiry to begin the CBAS assessment process to the managed care plan identified. This process will start the CBAS eligibility process. (Note: the process is identified within the Plan and Center training slides presented in September 5, and 14, 2012 CBAS Phase 2 Managed Care Cutover Webinars)

- ✓ For participant identified through an AEVS or POS eligibility check as fee-for-service – submit TAR to LA MCFO following the existing process.

**For the period of October 1, 2012 through November 31, 2012, DHCS will remain responsible for determining eligibility for new CBAS participants. Providers should submit a TAR to LA MCFO following the existing process.** This process only applies to prospective CBAS participants.

**After December 1, 2012**, all new CBAS participants must be enrolled in the MC plans, unless the beneficiary is exempt from MC Plan enrollment. Further guidance on this process will be shared prior to December 1, 2012.

**5. Do CBAS centers need authorization from a MC Plan even for "Assessment" days?**

A – Yes. MC Plans are responsible for determining CBAS eligibility for their members prior to authorizing the services. If an individual is determined eligible to receive CBAS, the MC Plan will authorize the CBAS center to conduct initial multidisciplinary team assessments and develop the individual's plan of care (IPC). The CBAS center then submits the completed IPC to the MC Plan for authorization/approval of the IPC and the number of service days.

**Managed Care Enrollment**

**6. If a dual-eligible beneficiary (covered by both Medicare and Medi-cal) enrolled in Medi-Cal Managed Care wants to disenroll and go back to fee-for-service Medi-Cal, when will the beneficiary disenrollment or fee-for-service status become effective?**

A – Until implementation of the Coordinated Care Initiative (June 2013), dual-eligible beneficiaries who are not otherwise exempt from enrollment in Medi-Cal Managed Care may choose to enroll in a MC Plan or return to fee-for-service Medi-Cal at any time. Changes become effective in the month following the beneficiary's choice.

**7. Dual-eligible participants received a letter from DHCS that the deadline to communicate their choice to enroll in managed care or remain in fee-for-service Medi-Cal was Sept 18, 2012. They were told that if they did not make a choice, the State would enroll them in a MC Plan. With the new "Confirmation Period," is this deadline extended?**

A – The deadline for all managed care eligible CBAS participants to:

1) Make a choice of a MC Plan or to remain in fee-for-service Medi-Cal; or
2) Be passively enrolled in a MC Plan by the State was September 18, 2012.

The "Confirmation Period" allows those CBAS participants who are not exempt from enrollment in Medi-Cal Managed Care and chose to remain in fee-for-service Medi-Cal, to continue receiving CBAS services until October 31, 2012. CBAS services will be discontinued for these individuals, effective November 1, 2012, if they are not enrolled in Medi-Cal Managed Care by that date.

**8. The "Confirmation Period" allows CBAS-eligible participants who have affirmatively opted to remain in fee-for-service Medi-Cal, to continue the CBAS benefit until October 31, 2012. Can these people change their minds and enroll in Medi-Cal Managed Care in mid-October?**

A – Yes. Also, these persons should be informed that unless they are exempt from enrollment in a MC Plan, they will lose their CBAS as of November 1, 2012.

**9. Are CBAS-eligible persons who are in the Veteran's Administration (VA) system for their health care exempt from enrollment in Medi-Cal Managed Care?**

A – If by "VA system" you mean one of the health plans administered through the VA, then yes. There is no Medi-Cal managed care plan that matches with these VA health plans, so a CBAS-eligible person who is enrolled in a VA health plan is exempt from enrollment in Medi-Cal Managed Care.

**10. Some of our participants have enrolled in a Medicare special needs plan (SNP) with Central Health, an HMO not on the Choice Enrollment Form. I understand these participants are exempt from enrolling in Medi-Cal managed care. Therefore, where do I submit the TARs/IPCs after October 1, 2012, for these participants and the claims for payment?**

A – Continue submitting TARs and IPCs as you have through fee-for-service Medi-Cal. Yes, Central Health Medicare Plan does not match with any Medi-Cal managed care plan in Los Angeles County; therefore, CBAS participants enrolled in a SNP through Central Health Medicare Plan are exempt from enrolling in a Medi-Cal managed care plan. The list of health plans on the Choice Enrollment Form is of Medi-Cal managed care plans that match with Medicare health plans. During this first phase of dual-eligibles enrollment, the absence of Central Health Medicare Plan from the list means your participants are exempt from Medi-Cal Managed Care enrollment.

**11. Some of our dual-eligible participants chose not to enroll in a MC Plan because their Medicare primary care and specialist doctors have told them not to or they will not see them anymore. Is it legal for these doctors to do that?**

A – Yes, it is legal; however, they may be misinformed. These doctors and specialists may continue to bill Medicare for their services. Enrollment in a MC Plan only improves the care coordination available to their patients and does not affect their existing Medicare benefits.

**Medi-Cal Managed Care Plans (MC Plans)**

**12. Many CBAS participants are very concerned about limitations of medical specialists and hospitals under Medi-Cal managed care. Can you explain more about the difference they may experience after joining a MC Plan?**

A – Enrollment in a MC Plan does not alter their Medicare benefits or providers. Therefore the MC Plan has no ability to limit physician or hospital visits provided by Medicare. Enrollment in a MC Plan merely provides care coordination for all enrollees, including CBAS participants.

**13. Will each MC Plan have a CBAS department/contact person? How can we obtain contact names/numbers from managed care plans?**

A – DHCS does not have a complete list of phone contacts for MC Plans. Please contact the MC Plan through its main phone line. If you have difficulty contacting the MC Plan, please contact the MMCD Ombudsman Unit at 1-888-452-8609 or MMCDOmbudsmanOffice@dhcs.ca.gov.

**14. What if a participant switches from one contractor of a MC Plan to another contractor also covered by the MC Plan. Is another IPC needed? What happens if they switch from one MC Plan to another MC Plan during the middle of a care plan, without telling anyone? Is a new IPC needed, including chest x-ray?**

A – Not necessarily, but maybe. This depends on the MC Plan. IPCs must be renewed periodically, so MC Plans may exercise some judgment. Contact the new managed care plan to inform them you have a CBAS participant and work with them as soon as you can.

**15. Some Medicare doctors are telling their patients that if they join a MC Plan they will be charged a 20% copay and deductibles. Is this allowed?**

A – Section 51002(a) of Title 22 of the California Code of Regulations states:

> A provider of service under the Medi-Cal program shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service.

It is not legal for a Medicare doctor to charge for a Medicare copayment today, and they must not charge a copayment if participants enroll in Medi-Cal Managed Care. All Medicare services stay the same because Medicare is the primary health insurance. If doctors bill Medi-Cal today for a copayment, they will continue to bill Medi-Cal through the MC Plan and be reimbursed according to existing rules about how much Medi-Cal is authorized to pay toward the co-payment. The doctor does not have to belong to a MC Plan provider network.

**Assessment/Reassessment**

**16. Who should be initiating the 6-month reassessment process, the MC Plans or the CBAS center?**

A – For all MC Plan participants, CBAS centers will continue to submit reauthorization requests for continued participation in the CBAS program to each participant's MC Plan.

**17. At what point do we request the history and physical from a prospective participant's personal health care provider, before the request for inquiry to begin CBAS services is submitted to the MC Plan?**

A – CBAS providers are required by State regulation to obtain a history and physical from a prospective participant's physician as part of their multidisciplinary team assessment (MDT) (Section 54207, Title 22 California Code of Regulations). The MDT assessment and care plan development for managed care participants will be authorized by the MC Plan after a face-to-face assessment is complete and a beneficiary is determined eligible. MC Plans may establish a process for obtaining a history and physical from the personal physician as part of the face-to-face assessment, and coordinating this with the CBAS provider.

**18. What data (e.g., history and physical, MEDS profile) does the CBAS center need to collect before a face-to-face assessment will be conducted by the MC Plan?**

A – Any information required by a MC Plan for a CBAS face-to-face assessment request will be specified by the MC Plan. CBAS providers with questions regarding plan requirements for assessment that are not specified in the CBAS center's managed care contracts should call the plan's provider services department.

**19. Please clarify, after the face-to-face assessments are conducted, the CBAS centers will have to do their own 3-day assessments?**

A – Yes. After the managed care plan determines that an individual is eligible for CBAS, the CBAS center will be notified of the assessment results and requested to conduct all required initial multidisciplinary team assessments and develop the individual's plan of care (IPC), including the recommended number of service days. The CBAS center will submit the IPC to the managed care plan for adjudication (decision).

**20. Where does the face-to-face assessment for new candidates for CBAS take place? At the center, the participant's home, or another site?**

A – For managed care participants, the MC Plan will coordinate with the member to identify the best location to conduct the CBAS face-to-face assessment. The assessment may be conducted in the participant's home, at a CBAS center, or other location agreed upon between the member and plan. For fee-for service

participants, the MCFO will continue to coordinate face-to-face assessments with the CBAS center.

## Reimbursement

**21. The State has allowed a one-month extension (Confirmation Period) for individuals who have chosen fee-for-service Medi-Cal to continue to receive CBAS services. Do CBAS centers bill all of their participants to fee-for service Medi-Cal for the month of October or only participants who have chosen not to enroll in a MC Plan?**

A – Claims for fee-for-service participants should be sent through the Medi-Cal fee-for-service system as usual. Claims for services delivered to MC Plan participants from October 1, 2012, and after, should be sent to the participant's MC Plan.

## Treatment Authorization Requests (TARs)

**22. Where do I send TARS for new and continuing participants?**

| *Tar Type* | *Where to Submit TAR* |
|---|---|
| 1. New CBAS participant TAR for services beginning in September 2012 | ✓ Los Angeles Medi-Cal Field Office (LA MCFO) |
| 2. Reauthorization TAR – Submitted in September for services beginning on or after October 1, 2012 (e.g., TARs expiring in September 2012) | ✓ Los Angeles Medi-Cal Field Office (LA MCFO) |
| 3. Reauthorization TAR – Submitted in October for services on or after October 1, 2012 (e.g., TARs expiring in October 2012 or later) | ✓ For participant enrolled in a managed care plan, as identified through an AEVS or POS eligibility check-submit to the managed care plan identified.<br><br>✓ For participant identified through an AEVS or POS eligibility check as fee-for-service-submit TAR to LA MCFO |

**Please Note:**

- ✓ Participants making a choice to enroll in managed care during September 2012 will not be identified in a Medi-Cal eligibility check as being in a plan. They will appear as fee-for-service. All TARs submitted during September 2012 for individuals identified as fee-for-service should be submitted to the LA MCFO for adjudication

- ✓ Since an individual's Medi-Cal eligibility and plan choice may change from month-to-month, providers must verify Medi-Cal eligibility prior to rendering services each calendar month. Access the following link to obtain information about checking Medi-Cal eligibility: http://files.medi-cal.ca.gov/pubsdoco/userguides.asp.

**23. How will MC Plans know that a CBAS TAR for one of their new members is due to expire?**

A – DHCS sends updated TAR data to each of the plans every two weeks. Those data include TAR effective dates and expiration dates for each of their members.