PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3115</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Community Based Adult Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 10/17/2012
(Effective 07/01/2012)</td><td colspan="4">Next Review Date: 10/14/2027
Last Review Date: 10/14/2026</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 10/14/2026</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
C. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
D. CGA024 – Medi-Cal Member Grievance System
E. MPCR700 – Assessment of Organizational Providers
F. MPCR500 – Ongoing Monitoring of Sanctions

II. IMPACTED DEPTS:

A. Care Coordination
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Community Based Adult Services (CBAS): An outpatient facility-based program that delivers skilled nursing care, social services, therapeutic activities, personal care, family/caregiver training and support, nutrition services and transportation to qualified beneficiaries.
B. Developmentally Disabled (DD): Throughout this document, the term "developmentally disabled" is used to match current California Code of Regulations (CCR) language. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as "people with intellectual and other developmental disabilities."
C. Emergency Remote Services (ERS): Temporary provision of CBAS services in a care setting other than the CBAS center, such as an alternative location in the community, at the doorstep of the participant's home, or via telehealth, including telephone and virtual video conferencing, as clinically appropriate, to allow for immediate response to a Member's need when an emergency restricts or prevents them from receiving services at their CBAS center.
D. Intermediate Care Facilities (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
E. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative

IV. ATTACHMENTS:

A. CBAS Individual Plan of Care (IPC) Form (DHCS 0020)

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Applies to:	☒ Medi-Cal	☐ Employees

V. PURPOSE:

Effective July 1, 2012, Partnership HealthPlan of California assumed responsibility to provide benefits for the services provided at Community Based Adult Service (CBAS) agencies. Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDPH licenses Adult Day Health Care (ADHC) centers and CDA certifies them for participation in the Medi-Cal Program. The purpose of this policy is to define the process required to access CBAS services.

VI. POLICY / PROCEDURE:

A. CBAS Objectives
   1. The primary objectives of the CBAS program are to:
      a. Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and
      b. Delay or prevent inappropriate or personally undesirable institutionalization
      c. The program stresses partnership with the participant, the family and/or caregiver, the primary care provider (PCP), and the community in working toward maintaining personal independence.

B. Eligibility Criteria
   1. To be eligible for CBAS services through Partnership HealthPlan of California, the person must be at least 18 years of age. They must be an eligible Member of Partnership's Medi-Cal program.
   2. The Member must also meet all the following criteria:
      a. Must have one or more chronic or post-acute medical, cognitive, or mental health conditions.
      b. A physician, physician assistant, nurse practitioner or other health care provider has, within his/her scope of practice, requested CBAS services for the person.
      c. The person requires ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health provider to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive or mental health condition.
      d. The person requires CBAS services that are individualized and planned to support the individual and his or her family or caregiver in the living arrangement of his/her choice and to avoid or delay the use of institutional services, including but not limited to, hospital services, inpatient mental health services or placement in a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.
      e. Any person who is a resident of an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) shall be eligible for CBAS care services if that resident has disabilities and a level of functioning that are of such a nature that without supplemental intervention through CBAS care, placement to a more costly institutional level of care would likely occur.
   3. Medical Necessity Criteria
      a. Except for participants residing in an ICF/DD-H, authorization or reauthorization of a CBAS Treatment Authorization Request (TAR) shall be approved only if the participant meets all of the following medical criteria:
         1) The participant has one or more chronic or post-acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization:
            a) Monitoring
            b) Treatment

c) Intervention

2) The participant's network of daytime health care support is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
   a) Participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision
   b) Participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant
   c) Participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.
   d) A high potential exists for the deterioration of the Participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if CBAS services are not provided.
3) The Member meets the criteria for Emergency Remote Services (ERS) as defined in Section VI.F below.

C. CBAS Authorization Process
1. Initial Request: A request for initiation of CBAS services may come from one of the following sources:
   a. Community Based Adult Services Center
   b. A licensed physician, physician assistant, nurse practitioner or other health care provider within their scope of practice and board certification
   c. Nursing Facility
   d. Hospital
   e. Individual Member
   f. Family member
   g. Community Based Organization
   h. Partnership's internal report with CBAS indicator
   i. Partnership's Care Coordination staff
2. To recommend a Member for CBAS services, all other requesting entities besides the CBAS center itself must refer to the CBAS center. This inquiry may be done verbally or in writing. The following information should be included at the time of the request:
   a. Member's Name
   b. Identification Number
   c. Date of Birth
   d. Contact Information of Member, caregiver and referring agent. (Name, address, phone number)
   e. Reason the Member needs CBAS services
   (Specific information may vary by the requesting entity)

D. TAR Submission
1. The CBAS agency will begin their Multidisciplinary Team assessment process and complete the Individualized Plan of Care (IPC), (see Attachment A). When the evaluation and IPC is complete and CBAS staff determines the Member to be appropriate for services, the CBAS agency must electronically submit a TAR to Partnership. The TAR must include the codes and description of the services to be provided and a copy of the IPC, with anticipated level of service, as well as any other clinical documentation available (i.e. History and Physical).
2. An initial face-to-face review is not required when Partnership or DHCS or its contractor(s) determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses. Partnership determines that a Member is

eligible to receive CBAS, and that the receipt of CBAS is clinically appropriate, based on review of the IPC and clinical information submitted with the TAR.

a. If Partnership or DHCS or its contractor(s) cannot determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses, then the initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by DHCS.

3. Partnership will approve, modify or deny the requested CBAS services within seven (7) calendar days of receipt of the TAR, in accordance with Health and Safety Code 1367.01. Decisions for requests on behalf of Members in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who are at high risk for admission to a hospital or SNF (e.g., an expedited or urgent request) will be made within 72 hours of receipt of the TAR, in accordance with CMS Letter Number 11-W100193/9 (CalAIM) Special Terms and Conditions (STCs). If the TAR is approved, the facility will be notified via copy of the authorization.
4. If the TAR is modified or denied, a Notice of Action (NOA) letter will be sent to the Member and CBAS provider.
5. If the plan does not have sufficient information to make a determination, Partnership will extend the time frame one time by up to 14 calendar days. The Member and the CBAS provider are notified immediately in writing of the extension and what additional information is required to complete the review. If no additional requested information is received, the TAR may be denied via the NOA letter. The letter will include appeal rights and responsibilities.
6. CBAS providers can contact Partnership at (800) 863-4155 with all inquiries related to CBAS eligibility determinations, authorization requests, and care planning. The call will be triaged to the appropriate department, where the appropriate assigned Case Manager/Care Team will be identified and notified for follow-up. Partnership will coordinate with CBAS providers, treating practitioners, and other appropriate care team participants for the timely exchange of coordination of care information, including but not limited to:
   a. Updates to Member's IPC and/or discharge plan
   b. Reports of incidents that threaten the welfare, health, and safety of the Member
   c. Significant changes in the Member's condition

E. Reassessment and Reauthorization

1. Eligibility for ongoing receipt of CBAS is determined at least every six (6) months through the reauthorization process, or up to every twelve (12) months for Members determined by Partnership to be clinically appropriate based on medical necessity and clinical stability.
2. A CBAS center initiates the reassessment process by submitting a request for continued CBAS services, including an updated IPC and any supporting clinical documentation.
   a. Examples:
      1) Prior authorization end date is approaching
      2) Due to a change in level of service
3. A TAR is created and sent to Partnership with an IPC and a Level of Service recommendation.
4. Partnership receives the prior authorization request from the CBAS center, which includes a completed IPC and level of service recommendation. Partnership will handle the recommendation through existing TAR process which includes:
   a. Partnership will approve, modify or deny prior authorization request within seven (7) calendar days, in accordance with Health and Safety Code 1367.01.
   b. If Partnership cannot make a decision within seven (7) calendar days, a 14-day pend letter will be sent to the Member and center.
   c. Partnership notifies the CBAS center of the authorization determination within 24 hours of the decision. The plan notifies the Member within 48 hours of the decision.

5. Any denial of ongoing CBAS services or reduction in the requested level, frequency, or duration of services by DHCS or by Partnership requires a face-to-face review.
    a. Process must be completed in accordance with the Health and Safety Code 1367.01 and ensure timelines are met.
6. CBAS services continue.

F. Emergency Remote Services (ERS)
1. Pursuant to the CalAIM 1115 waiver authorized by Centers for Medicare and Medicaid Services (CMS) in January of 2022, CBAS Emergency Remote Services (ERS) are available to Members who are approved and participate in services delivered by a CBAS center.
    a. ERS are defined as the temporary provision of CBAS services in a care setting other than the CBAS center, such as an alternative location in the community, at the doorstep of the participant's home, or via telehealth, including telephone and virtual video conferencing, as clinically appropriate, to allow for immediate response to a Member's needs when an emergency restricts or prevents them from receiving services at their CBAS center.
2. Prior to delivery or approval of ERS services, CBAS centers are required to complete the necessary two-step process for obtaining approval from the California Department of Aging (CDA).
    a. Prior to authorizing CBAS ERS services, Partnership shall track and ensure contracted CBAS providers have completed the approval process as required.
    b. Partnership shall regularly check the CDA website for updated CBAS and ERS letters.
3. Effective October 1, 2022, CBAS providers are required to provide ERS when Members experience unique circumstances as defined below:
    a. Public Emergency: The CBAS center is located in a region that is impacted by State or local disaster(s) as determined by DHCS or Partnership, regardless of whether formally declared. Partnership will allow for the provision of ERS prior or subsequent to an official public health emergency declaration, as determined by DHCS or Partnership. These public emergencies may include, but are not limited to: earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc.
    b. Personal Emergency: The Member enrolled in CBAS is experiencing a time-limited serious illness or injury, crisis or care transition, which temporarily prevents or restricts their ability to receive CBAS services in-person at the CBAS center location, subject to approval by Partnership. For the purposes of ERS, DHCS has defined this as:
        1) Serious illness or injury that prevents the Member from receiving CBAS services within the facility and that providing medically necessary services/supports to the Member would protect life, address or prevent significant illness or disability, and/or alleviate pain.
        2) Crisis means that the Member is experiencing or threatened with intense difficulty, trouble or danger. Examples of personal crises include the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
        3) Care transitions occur when the Member is moving to or from care settings such as returning to home or another community setting after a hospital or nursing facility stay.
4. Members who are hospitalized or admitted to a skilled nursing facility (SNF) are not eligible for ERS services while they are admitted or in those facilities.
5. ERS provided during a care transition shall address service gaps and Member/caregiver needs but should not duplicate responsibilities assigned to intake or discharging entities.
6. To request ERS services:
    a. The Registered Nurse and Social Worker at the CBAS center must first assess the emergency and make updates to the Member's IPC above (Attachment A).
    b. If there is no active TAR on file for CBAS services, the CBAS provider must submit a new TAR to Partnership requesting ERS services along with:
        1) A copy of the Member's IPC

2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services
3) Anticipated time/duration of ERS services

c. If there is already an active TAR on file for CBAS services, the CBAS provider must submit a TAR modification request to Partnership requesting ERS services along with:
1) An updated copy of the Member's IPC
2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services
3) Anticipated time/duration of the ERS services

d. During the TAR review process for ERS services, Partnership staff shall work collaboratively with contracted CBAS providers regarding the method of ERS services.

7. ERS services are time-limited and may be authorized for up to three (3) consecutive months for Members who are experiencing a public or personal emergency.
a. Members may choose to cease ERS services at any time.
b. For Members who may require ERS beyond the initial three (3) consecutive months:
1) The CBAS center shall complete a new assessment documenting the continued need for remote/telehealth delivery of CBAS services and supports at least every three (3) months. A TAR modification request shall be submitted to Partnership requesting a continuation of ERS along with the Member's updated IPC for review.

8. Through the TAR review process for ERS services, Partnership shall coordinate with the CBAS center(s) to ensure that Members have their service and support needs met throughout the duration of ERS services.

G. CBAS Facility Selection
1. Members may choose any contracted CBAS Center that is available and capable of meeting the Member's needs and is within the selected facility's time, access, transportation, and distance requirements.

H. Reduction in Services or Discharge from CBAS Services
1. If a Member is going to experience a reduction in CBAS or ERS services, the CBAS center must submit an updated IPC to Partnership.
2. If the Member will be discharged from a CBAS center, the CBAS center must update the Member's IPC and/or complete a discharge plan for the Member. A copy of the revised IPC and/or discharge plan must be submitted to Partnership for review. The discharge plan must include the following:
a. The Member's name and ID number
b. The name(s) of the Member's physician(s)
c. If applicable, the date the NOA denying authorization for CBAS was issued
d. If applicable, the date the CBAS benefit will be terminated
e. Specific information about the Member's current medical condition, treatments, and medications
f. Potential referrals for medically necessary services and other services or community resources that the Member may need upon discharge
g. Contact information for the Member's case manager
h. A space for the Member or the Member's representative to sign and date the discharge plan or IPC
3. If a Member has already been discharged, the CBAS center must submit the updated IPC and/or discharge plan to Partnership within 30 days.
4. Partnership shall review the IPC and/or discharge plan to determine whether the Member has ongoing health, behavioral health, LTSS, social service, or care coordination needs requiring additional intervention or referral.
a. For Members that possess additional needs, Partnership shall make a referral to appropriate care coordination or case management services.
b. Members who are discharged from a CBAS program involuntarily may file a grievance with

Partnership or request a fair state hearing or independent medical review within 180 calendar days of the date of the involuntarily discharge.

1) A Member who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.
2) A CBAS participant may file a grievance with Partnership as a written or oral complaint as described in Partnership policy CGA024 Medi-Cal Member Grievance System. The Member or their authorized representative may file a grievance at any time that they experience dissatisfaction with the services or quality of care provided to them.

I. Unbundled Services
   1. If a Member is determined to be eligible for CBAS services but there is no CBAS facility in the Member's service area, the Member may choose to attend a CBAS facility of their choice. If there is no CBAS facility available, Partnership will assist in arranging for those individual services that are Partnership benefits and make appropriate referrals to other agencies for the unbundled services that are not Partnership benefits.
   2. Unbundled CBAS covered services are limited to the following:
      a. Professional Nursing Services
      b. Nutrition
      c. Physical Therapy
      d. Occupational Therapy
      e. Speech and Language Pathology Services
      f. Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service Provider; and
      g. Non-specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are covered services

J. Quality and Monitoring
   1. Licensing & Program Oversight: Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDA certifies licensed Adult Day Health Care (ADHC) centers as Medi-Cal CBAS providers. CDA is responsible for initial certification of new CBAS centers as Medi-Cal providers, certification renewal, providing on-going training and technical assistance to centers, and initiating adverse certification actions against centers that are substantially out of compliance with program requirements.
      a. Partnership's Provider Relations department shall review All Center Letters (ACL) issued by the CDA and ensure that contracted CBAS providers are meeting all requirements issued in those letters.
   2. Credentialing: Partnership's Provider Relations department is responsible for ensuring that all CBAS providers are licensed pursuant to CDA and DHCS regulations, and verifying center credentials (see policy MPCR700 Assessment of Organizational Providers). Pursuant to Partnership policy MPCR500 - Ongoing Monitoring of Sanctions, Partnership's CBAS providers shall be monitored monthly to ensure they remain free of Medi-Cal and Medicare sanctions and maintain a valid and unrestricted license.
      a. In addition, Partnership's Network Services department shall review and monitor the CDA website for updates to contracted CBAS providers licensing and/or ERS approval status.
      b. Partnership's Network Services department shall update Partnership Health Services staff when or if a CBAS provider loses their license(s) or ERS approval(s).
      c. Partnership Provider Relations and Health Services departments will be responsible for providing written notification and training (if necessary) when substantive updates to CBAS-related policies and procedures are made.
   3. In collaboration with Health Services (HS) staff, Partnership's Network Services department

shall monitor the documentation and reporting requirements of CBAS providers, including but not limited to IPCs, discharge plans, on-going assessments, progress notes, discharge plans, timely completion of the CBAS Emergency Remote Services Initiation Form (CEIF or CDA 4000), etc.

4. Reporting: CBAS centers shall remit to Partnership all DHCS and/or CDA required reporting pursuant to the templates and frequencies requested by Partnership.
5. In addition to DHCS quarterly reporting requirements, Partnership Health Services staff shall monitor and track available performance and/or quality measures published by the CDA, such as the CBAS dashboard, to track, trend and/or evaluate CBAS provider performance and outcomes.

VII. REFERENCES:

A. Welfare and Institutions Code, Sections 14525 and 14526.1
B. California Health and Safety Code Section 1367.01
C. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) #19-02 Implementation of New CBAS Individual Plan of Care (IPC) (*Amended* 03/19/2019)
D. Medi-Cal Provider Manual/ Guidelines: Community-Based Adult Services (CBAS) *(community)*
E. DHCS APL 22-020 *Revised* Community-Based Adult Services Emergency Remote Services (11/02/2022)
F. DHCS APL 21-011 *Revised* Grievance and Appeal Requirements, Notice And "Your Rights" Templates (08/31/2022)
G. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) 22-04 *Revised* Launch of New CBAS Emergency Remote Services (ERS) (10/03/2023)
H. Centers for Medicare and Medicaid Services (CMS) Letter Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs) (*Amended* 11/28/2014)
I. Centers for Medicare & Medicaid Services (CMS), California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration, Project No. 11-W-00193/9, Special Terms and Conditions (STCs).

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

08/20/14; 01/20/16; 11/16/16; 04/19/17; *06/13/18; 06/12/19; 05/13/20; 05/12/21; 05/11/22; 05/10/23; 10/11/23; 10/09/24; 11/12/25; 09/16/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

REGULATOR APPROVAL:
DHCS approved on 11/12/2025 for MOR.0254
DHCS approved on 11/07/2025 for MOR.0253
DHCS approved on 8/9/2023 for R.0218
DHCS approved on 4/4/2023 for R.0215
DHCS approved on 3/30/2023 for R.0216

DHCS approved on 3/14/2023 for R.0217
DHCS approved on 2/6/2023 for APL 22-020

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.