blue california
Promise Health Plan

Policy Title: Community Based Adult Services (CBAS)		POLICY #: 10.02.23 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 9/12	**Effective Date** 11/22	**Revision Date** 12/18, 3/22, 10/22, 2/23, 3/23, 3/24
VP Approval: Tracy Alvarez, VP, Medical Care Solutions			**Date of Approval: 3/12/2024**
Medical Services/P&T Committee: (If Applicable) Jennifer Nuovo, MD			**Date of Committee Review: 3/12/2024**

A. PURPOSE

To provide guidance on how Blue Shield of California Promise Health Plan's (Blue Shield Promise) Utilization Management (UM) will coordinate and/or authorize medically necessary covered services to Community Based Adult Services (CBAS)-eligible adult individuals with intensive health care needs.

B. DEFINITIONS

1. **Community Based Adult Services (CBAS)** – CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.

2. **CBAS Eligibility Determination Tool (CEDT)** – an assessment tool used in determining eligibility for CBAS Services.

3. **Enhanced Care Management (ECM)** – a service, consisting of "complex case management" and "person-centered planning," that includes the coordination of supports, including medical, social, educational, and other services, whether covered or not under the Medicaid program, and periodic in-person consultation with the enrollees and/or designees.

4. **Individualized Plan of Care (IPC)** – a written plan designed to provide the CBAS beneficiary with appropriate treatment and level of service in accordance with the assessed needs of the individual. The IPC is prepared by the CBAS Center's multi-disciplinary team.

C. POLICY

I. Blue Shield Promise provide members with access to CBAS as set forth in the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9 Special Terms and Conditions, amended December 29, 2020, or as set forth in any subsequent demonstration amendment or renewal, or successor demonstration, waiver, or other Medicaid authority. Without limitation, Blue Shield Promise shall do the following:

a. Provide and coordinate the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS provider capacity in a county within the service area relative to the capacity that existed on April 1, 2012; and

b. Arrange medically necessary covered services for members with similar clinical conditions as CBAS recipients if there is insufficient CBAS provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.

II. In addition to the BSCPHP DHCS Contract, Exhibit A, Attachment III, Subsection 5.3 (Scope of Services), Blue Shield Promise shall cover CBAS in accordance with the California CalAIM 1115(a) Demonstration, Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs), including §VIII.A.49 and 51, or in accordance with any subsequent Demonstration amendment or renewal or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS. Blue Shield Promise shall:

a. Arrange for the provision of CBAS to members determined eligible to receive CBAS in accordance with the CalAIM STCs Section VIII.A.48.d, and the BSCPHP DHCS Contract, Exhibit A, Attachment III, Subsection 5.4.2.C (Coordination of Care);

b. Consider a member's relationship with a previous provider of services similar to CBAS when referring a member to a CBAS Provider;

c. Cover CBAS as a bundled service through a CBAS provider or arrange for the provision of unbundled CBAS based on the assessed needs of members eligible for CBAS if a certified CBAS provider is not available or not contracted, or there is insufficient CBAS provider capacity in the area, as required by BSCPHP DHCS Contract, Exhibit A, Attachment III, Subsection 5.2.8.J, (Community Based Adult Services). Arranging for unbundled CBAS services includes authorizing covered services and coordinating with community resources to assist members whose CBAS providers have closed, and members who have similar clinical conditions as CBAS members, to remain in the community, in accordance with the following requirements:

i. Unbundled CBAS covered services are limited to the following:

1. Professional nursing services
2. Nutrition

3. Physical therapy
4. Occupational therapy
5. Speech and language pathology services
6. Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the member's home and the CBAS unbundled service provider
7. Non-specialty mental health services (NSMHS) and substance use disorder (SUD) services that are covered services

d. Blue Shield Promise shall coordinate care for unbundled CBAS services that are not covered services based on the assessed needs of the member eligible for CBAS, including:
   i. Personal care services
   ii. Social services
   iii. Physical and occupational maintenance therapy
   iv. Meals
   v. Specialty mental health services (SMHS)
   vi. SUD services

e. Ensure continuity of care, in accordance with the BSCPHP DHCS Contract, Exhibit A, Attachment III, Section 4.3 (Population Health Management and Coordination of Care), when Members switch and/or transfer from one CBAS Provider to another.

D. PROCEDURE

I. Blue Shield Promise Referral Workflow and Timeframes for Community Based Adult Services:
   a. Initial, Standard Process:
      i. A potential need for CBAS services is identified and a referral is submitted to the Blue Shield Promise CBAS Team. Any of the following may refer a member for CBAS services:
         1. Community based organizations
         2. Physicians
         3. Nursing facilities
         4. Hospitals
         5. Individuals family members
         6. CBAS providers
      ii. For new referrals, Blue Shield Promise will require a current history and physical or other supporting medical record from a physician to be attached for review.
      iii. Blue Shield Promise CBAS department/CBAS coordinators reviews the referral and applies CBAS pre-screen criteria:
         1. Medi-Cal eligible
         2. ≥ 18 years old
         3. Medi-Cal coverage is assigned to Blue Shield Promise

iv. If the member does not meet pre-screening criteria, Blue Shield Promise CBAS department/CBAS coordinators will notify the requesting party and the member of ineligible status by mail within 5 business days.
v. If the member does meet the pre-screening criteria, a letter acknowledging receipt of the inquiry and eligibility for the face-to-face assessment (F2F) will be mailed to the requesting party and the member within 5 business days.
vi. Blue Shield Promise /contracted home health schedules a F2F assessment with the member:
    1. Blue Shield Promise CBAS coordinators send the contracted home health agency referrals to begin the F2F process. The contracted home health agency makes the first attempt to contact the member or family within five (5) business days of the initial referral. The contracted home health nurse coordinates and schedules the F2F meeting with member, family member, or caregiver.
    2. If unable to reach the member during the first attempt, the contracted home health nurse shall make two additional attempts via telephone between five (5) and eight (8) business days of the initial referral to schedule the F2F.
    3. If still unable to reach the member after the three telephonic attempts, Blue Shield Promise CBAS coordinators will make a final attempt in writing. A notification/unable to reach letter, giving the member until the 14th calendar day from when the request was received to schedule the F2F, shall be mailed to the member's primary residence.
    4. If the member does not respond or schedule the F2F within 14 days of the initial referral, Blue Shield Promise shall send a notification letter (same letter as unable to reach) or referral closure to the member and requestor. The notice shall also indicate that if CBAS services are still being requested, then a new referral must be submitted to begin the process again.
    5. If the member or the caregiver/family member is contacted on the first attempt, the F2F meeting is scheduled within 14 days from when the request was received.
vii. The F2F eligibility assessment is completed using the CEDT tool within 30 calendar days from the date of the initial referral, utilizing the following:
    1. DHCS Community Based Adult Services (CBAS) CBAS Eligibility Determination Tool – CEDT Version 2.0
    2. DHCS Community Based Adult Services (CBAS) CBAS Eligibility Determination Tool- CEDT: Patient Health Record Quick Guide
    3. Other documentation required to determine eligibility may include:
        a) Current history and physical signed by a physician or other licensed medical staff
        b) Current medication record signed by a physician or a nursing med sheet
        c) Evidence of confirmed chronic mental illness in one or more diagnoses as set forth in the Diagnostic and Statistical Manual of

Mental Disorders, Fifth Edition, Text Revision (DSM V TR (2022), published by the American Psychiatric Association

d) Evidence of a physicianconfirmed diagnosis of Alzheimer's Disease, Dementia, Traumatic Brain Injury or Organic Brain Injury

viii. At Blue Shield Promise, the determination of eligibility and approval for services shall involve:
1. Quality Assurance (QA)/CBAS case manager reviewer conducts the initial review of the completed CEDT assessment tool.
2. QA reviewer may require a current history and physical or other supporting medical record for review.
3. 2nd level reviewer (physical reviewer) shall conduct the final review of the decision for the CBAS service request.
4. Approval or denial of authorization for the CBAS provider to conduct the individualized plan of care (IPC) is sent to the CBAS provider by facsimile (fax) within one (1) business day of decision.
5. If approved for services, the member retains the right to remain or to choose another center at a later time.

ix. If approved, the CBAS provider shall receive an authorization by fax from Blue Shield Promise to conduct the IPC/Level of Service (LOS) assessment.
1. The CBAS Multidisciplinary Team (MDT) shall perform the IPC assessment
2. The CBAS provider shall then submit the prior authorization request to Blue Shield Promise along with the completed IPC as well as the LOS recommendation.

x. Blue Shield Promise/CBAS department adjudicates the prior authorization request from the CBAS provider through the following processes:
1. Blue Shield Promise shall approve, modify, or deny the prior authorization request within five (5) days, in accordance with Health and Safety Code, §1367.01.
2. If Blue Shield Promise cannot make a determination within five (5) business days, a 14-day delay letter shall be mailed to the member and the CBAS provider.
3. Blue Shield Promise shall notify the CBAS provider by fax within one (1) business day of the decision. Blue Shield Promise CBAS department/CBAS Coordinators will mail a deferral letter of notification to the member within two (2) business days of the decision. CBAS provider may begin services upon receiving the fax authorization.

II. Initial, Expedited Process:

a. Nursing facility staff or hospital staff identifies a potential need for expedited CBAS services within the discharge plan and submits a request for inquiry to begin CBAS Assessment process.

b. Blue Shield Promise 's contracted home health nurse makes an attempt to schedule a F2F assessment at the nursing facility or hospital with member/facility

or facility or hospital with member/facility within 1 business day of receiving the referral.
   i. Member has the right to choose the center. Member may choose a CBAS center based upon personal preferences, geographic location, and cultural and linguistic needs.
   ii. The F2F assessment is completed using the CEDT tool within 72 hours from the initial inquiry.
   iii. Approval or denial of authorization for the CBAS provider to conduct the IPC is sent to the Center by FAX within 1 business day of decision.

c. At Blue Shield Promise, the determination of eligibility and approval for services shall involve:
   i. QA reviewer conducts the initial review of the completed CEDT assessment tool.
   ii. QA reviewer may require a current history and physical or other supporting medical record for review.
   iii. 2nd level reviewer (physician reviewer) shall conduct the final review of the decision for the CBAS service request.

d. If approved, the CBAS provider shall receive an authorization by fax from Blue Shield Promise's CBAS team to conduct the IPC/LOS assessment.
   i. The CBAS Multidisciplinary Team (MDT) shall perform the IPC assessment
   ii. The CBAS provider shall then submit the prior authorization request to Blue Shield Promise along with the completed IPC as well as the LOS recommendation.

e. Blue Shield Promise shall approve, modify, or deny the prior authorization request within 3 business days, in accordance with H & S Code, §1367.01 (h) (2).

f. Blue Shield Promise shall notify the CBAS provider by fax within one (1) business day of the decision. Blue Shield Promise will mail a letter of notification to the member within two (2) business days of the decision.

III. Existing CBAS Participants:
a. CBAS provider reassesses the participant and submits to Blue Shield Promise: a prior authorization request, the participant's attendance records, for the past two (2) months, along with an updated IPC and the LOS recommendation.

b. Blue Shield Promise / CBAS case manager receives the prior authorization request from the CBAS provider and reviews the authorization request and the LOS recommendation through the existing authorization process.
   i. Blue Shield Promise shall approve, modify, or deny the prior authorization request within 5 business days, in accordance with H&S Code, Section 1367.01.

ii. If Blue Shield Promise cannot make a determination within five (5) business days, a 14-day delay letter shall be mailed to the member and the CBAS provider.
iii. Blue Shield Promise shall notify the CBAS provider by fax within one (1) business day of the decision. Blue Shield Promise shall send a letter of notification to the member within two (2) business days of the decision.

c. A F2F assessment prior to the determination of the reauthorization is not required for existing participants. However, Blue Shield Promise may request the F2F for reauthorization requests that lack sufficient supporting information for a determination to be made.

d. A F2F assessment shall be conducted for requests whereby Blue Shield Promise has determined that the LOS for the prior authorization request is to be decreased or denied.

e. CBAS services continue upon receipt of fax authorization.

IV. Continuity of Care

a. Blue Shield Promise will provide continuity of care to members through continued access to a CBAS provider with whom there is an existing relationship for up to twelve (12) months after member enrollment. This requirement shall include out-of-network providers if there are no quality-of-care issues and the provider will accept Blue Shield Promise's rate or the Medi-Cal Fee-For-Service (FFS) rate, whichever is higher, as set forth in the BSCPHP DHCS Contract, Exhibit A, Attachment III, §5.2.12 (Continuity of Care).
b. Blue Shield Promise will ensure that CBAS Individual Plans of Care (IPCs) are consistent with the member’s overall care plans and goals.
c. Blue Shield Promise will conduct the initial assessment and subsequent reassessments for Members requesting CBAS in accordance with the CalAIM STCs, §VIII.A.48.e.and VIII.A.51.b. In addition, Blue Shield Promise will:
    i. Conduct the CBAS eligibility determination using a DHCS-approved assessment tool. A registered nurse with level of care determination experience must perform the member's CBAS eligibility determination. Blue Shield Promise will not deny, defer, or reduce a requested level of CBAS for a member without a face-to-face review.
    ii. Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a member in a hospital or skilled nursing facility (SNF) whose discharge plan includes CBAS, or who is at high risk of admission to a hospital or SNF or faces an imminent and serious threat to their health.
    iii. Conduct a reassessment, with family involvement, when appropriate, and redetermination of the member’s eligibility for CBAS at least every six (6) months after the initial assessment or up to every twelve (12) months when determined by Blue Shield Promise to be clinically appropriate. When a member requests that services remain at the same level or requests an

increase in services due to a change in their level of need, Blue Shield Promise may conduct the reassessment using only the member's CBAS IPC, including any supporting documentation supplied by the CBAS provider.

iv. Notify members in writing of their CBAS assessment determination in accordance with the timeframes identified in the CalAIM STCs, Section VIII.A.51.b. Blue Shield Promise's template written notice shall be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in the BSCPHP DHCS Contract, Exhibit A, Attachment III, Section 4.6 (Member Grievance and Appeal System).

v. Require that CBAS providers update a member's CBAS discharge plan of care and provide a copy to the member and to Blue Shield Promise whenever a member's CBAS services are terminated. The CBAS discharge plan of care must include:
   1. The member's name and ID number
   2. The name(s) of the member's physician(s)
   3. If applicable, the date the Notice of Action denying authorization for CBAS was issued
   4. If applicable, the date the CBAS benefit will be terminated
   5. Specific information about the member's current medical condition, treatments, and medications
   6. Potential referrals for medically necessary services and other services or community resources that the member may need upon discharge
   7. Contact information for the member's case manager
   8. A space for the member or the member's representative to sign and date the discharge plan of care

d. Blue Shield Promise will coordinate with the CBAS provider to ensure timely exchange of the following coordination of care information:
   i. Member's discharge plan of care
   ii. Reports of incidents that threaten the member's welfare
   iii. Health and safety of the member
   iv. Significant changes in the member's condition
   v. Clear communication pathways between the appropriate CBAS provider staff and Blue Shield Promise staff responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for members who have a care team
   vi. The CBAS provider receives advance written notification and training prior to any substantive changes in Blue Shield Promise's policies and procedures related to CBAS

V. Reassessment of Established CBAS Participant:

a. Every six (6) months or when there is a change in the member's LOS, the CBAS provider shall update the IPC.

b. The CBAS provider submits an updated IPC, the participant's attendance records, for the past two months, along with the authorization request for a

change in the approved LOS to Blue Shield Promise.

c. Blue Shield Promise reviews the prior authorization request and the IPC against established CBAS criteria.

d. If LOS criteria are met, Blue Shield Promise shall approve the authorization request within 5 business days.

e. If Blue Shield Promise cannot make a determination within five (5) business days a 14-day delay/deferral letter shall be mailed by the CBAS department to the member and the CBAS provider and saved in the department folder.

f. Once a notice gets automatically triggered by MHC, Blue Shield Promise shall notify the CBAS provider by fax within one (1) business day of the decision. Blue Shield Promise shall mail a letter of notification to the member within two (2) business days of the decision.

g. CBAS services begin.

h. If the request no longer meets eligibility criteria, the member has the option of being enrolled in other Blue Shield Promise eligible programs.

i. If the member agrees to participate in other Blue Shield Promise eligible programs, Blue Shield Promise Social Services Staff will conduct an ongoing assessment for changes in the members functioning status and health condition.
j. If determined to be appropriate, the Blue Shield Promise staff will refer the member for a new F2F assessment to determine eligibility for CBAS.

VI. CORE Services:

The following are examples of each of the core services that CBAS centers are required to provide to each participant during each day of the participant's attendance at the center:

a. One or more of the following (5) professional nursing services:
    i. Observation, assessment, and monitoring of the participant's general health status and changes in condition, risk factors, and the participant's specific medical, cognitive, or mental health condition/s upon which admission to the CBAS Center was based.
    ii. Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medications and interventions, as needed.
    iii. Oral or written communication with the participant's personal health care provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs, or symptoms.
    iv. Supervision of the provision of personal care services for the participant and assistance, as needed.

v. Provision of skilled nursing care and intervention, within scope of practice to participant, as needed.

b. One or both of the following personal care services:
   i. Protective group supervision and interventions to assure participant's safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering.
   ii. Supervision of, or assistance with activities of daily living or instrumental activities of daily living.

c. One or more of the following social services provided by the social worker or social worker assistant:
   i. Observation, assessment, and monitoring of the participant's psychosocial status
   ii. Group work to address psychosocial issues
   iii. Care coordination

d. At least one of the following therapeutic activities provided by the CBAS center activity coordinator or other trained personnel:
   i. Group or individual activities to enhance the social interaction, encourage physical exercise, or improve cognitive functioning of the participant to prevent deterioration.
   ii. Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.

e. One meal per day of attendance, unless the participant declines or medical contraindications exist.

VII. Additional services are provided as specified:
a. Rehabilitation Therapy – physical therapy, occupational therapy, speech therapy
b. Mental health services
c. Nutrition services – registered dietician for dietary counseling and nutritional education for the participant and/or family
d. Podiatry services
e. Optometry screening by a licensed ophthalmologist or optometrist
f. Dental screening
g. Transportation services
h. Other services, as approved by the department
i. Blue Shield Promise will ensure that any Medicare services are coordinated timely for dually eligible members

VIII. Determining Eligibility for CBAS Services: Eligibility determinations for the CBAS benefit will be performed as follows:

a. 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 unless criteria under STC 19 (e)(ii) are met.

b. Blue Shield Promise will perform the eligibility determination for managed care members. DHCS or its contractor(s) will perform the eligibility determination for beneficiaries exempt from managed care. An initial face-to-face review is not required when Blue Shield Promise, the DHCS, or its contractor(s) determines that the individual is eligible to receive CBAS based on available medical information or history.

c. 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 individuals determined by the managed care plan to be clinically appropriate.

IX. CBAS Program Eligibility: The CBAS benefit will be available to all beneficiaries who meet the requirements of STC 19(a) and for whom CBAS is available based on STC 19(b) who meet medical necessity criteria as established in state law and who qualify based on at least one of the medical criteria in (i) through (v) below:

a. Meet or exceed the “Nursing Facility Level of Care A” (NF-A) criteria as set forth in the California Code of Regulations; OR

b. Have a diagnosed organic, acquired, or traumatic brain injury, and/or chronic mental disorder. “Chronic mental disorder” means the enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (e) Schizophrenia and Other Psychiatric Disorders, (f) Mood Disorders, (g) Anxiety Disorders, (h) Somatoform Disorders, (i) Factitious Disorders, (j) Dissociative Disorders, (k) Paraphilia, (l) Eating Disorders, (m) Impulse Control Disorders Not Elsewhere Classified, (n) Adjustment Disorders, (o) Personality Disorders, or (p) Medication-Induced Movement Disorders. In addition to the presence of a chronic mental disorder or acquired, organic, or traumatic brain injury, the enrollee shall need assistance or supervision with either:
    i. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
    ii. One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation; or

c. Have moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's disease; or

d. Have a mild cognitive impairment including Alzheimer's disease or other dementias, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's disease, defined as mild or early-stage Alzheimer's disease AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

e. Have a developmental disability. "Developmental disability" means a disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

X. Levels of Medical Necessity Criteria:

a. Medical Necessity Level 1 – Assess needs for chronic qualifying conditions. The participant has one or more chronic or post-acute medical, cognitive, or mental health conditions that are identified as requiring one or more of the following, without which the participant's condition will likely deteriorate:
   i. Monitoring
   ii. Treatment
   iii. Intervention

b. Medical Necessity Level 2 – Identify ADL/IADL compromises (for category 2 or 4 only)
   i. Limitations in the performance of 2 or more activities of daily living or instrumental activities of daily living or one or more from either ADLs or IADLs.
   ii. A need for assistance or supervision in performing the activities identified as related to the condition or conditions that qualify the participant for ADHC. The assistance or supervision shall be in addition to other non-adult day health care support the participant is currently receiving in his or her place of residence.

c. Medical Necessity Level 3 – Identify Community Supports. The participant's network of non-adult day health care center supports is insufficient to maintain the individual in the community, as demonstrated by at least one of the following:
   i. Participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
   ii. 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.
   iii. 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. Medical Necessity Level 4 – Identify Risk for Institutionalization
    i. A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner that if adult day health care services are not provided, would likely result in ER visits, hospitalization, or another institutionalization.
e. Medical Necessity Level 5 – Identify need for daily CBAS services
f. Medical Necessity Level 6 – Determine Eligibility Outcome

XI. Individual Plan of Care (IPC):

a. The IPC should include
    i. Medical diagnoses
    ii. Prescribed medications
    iii. Scheduled days at the CBAS center
    iv. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis
    v. Elements of the services which need to be linked to individual objectives, therapeutic goals, and duration of services
    vi. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities
    vii. Participation in specific group activities
    viii. Transportation needs, including special transportation
    ix. Special diet requirements, dietary counseling, and education, if needed
    x. A plan for any other necessary services that the CBAS center will coordinate.

b. IPCs shall be reviewed and updated no less than every six months by the CBA staff, the enrollee, and his/her support team. Review shall include review of progress, goals, objectives, and the IPC itself.

XII. Level of Service (LOS) Adjudication:

Blue Shield Promise's adjudication process for the level of service considers the following factors:

a. Overall health condition of the participant, relative to the participant's ability and willingness to attend the number of days.

b. Frequency of services needed.

c. The extent to which other services currently being received by the recipient meet the recipient's needs.

d. For existing participants, the attendance record for the previous authorization period.
    i. If the personal healthcare provider or CBAS physician has requested a specific number of days. When requesting the number of days per calendar month, the provider must ensure the request is related to the participant's problems and the number of days needed to carry out the individualized plan

of care (IPC).

e. Treatment needs of the participant shall determine the frequency and duration of attendance. The number of days scheduled shall be governed by the least time needed to carry out an individual plan of care related to the needs of the participant and his or her family 22 CCR §54223 (a).

f. Participants shall not be encouraged to attend more frequently than necessary for achievement of individual goals and objectives. 22 CCR §54223 (b).

g. Initial and subsequent treatment authorization requests may be granted for up to six (6) calendar months.

h. Participation in an adult day health care program is voluntary. The participant may end the participation at any time; however, an adult day health care center shall not otherwise terminate the provision if services to any participant unless approved by the State Department.

XIII. Enhanced Case Management:
Members who are not eligible for CBAS will be assisted with obtaining Enhanced Case Management Services. These are services that may be available in the member's community or provided under the member's health plan benefits. Members deemed as no longer eligible for CBAS services will be transitioned from the CBAS services by referring them to a Blue Shield Promise ambulatory case manager. The case manager will perform an individual assessment of the member's needs and coordinate any arrangements the member may be eligible for. Services may include:

- Mental health services
- Home delivered meals
- Personal care
- Medications
- Nurse Advice Line
- In Home Support Services
- Help finding Wheelchairs, Walkers, Blood Pressure Monitors, and Scales
- Physical or Occupational Therapy
- Urgent Care Needs
- Behavioral Health Services
- Non-Emergency Transportation

E. MONITORING:
N/A

F. REPORTING:

Blue Shield Promise will submit to DHCS the following reports 30 calendar days following the end of each reporting period as specified by DHCS:

1. On a quarterly basis, how many members have been assessed for CBAS and the total number of members currently receiving CBAS, either as a bundled or unbundled service;
2. Identification of CBAS providers added to or deleted from Blue Shield Promise's network, and when there is a 5% drop in capacity in the quarterly network changes submission required in BSCPHP DHCS Contract, Exhibit A, Attachment III, Subsection 5.2.13.C (See Network Management policy 415344 Accessibility and Availability of Services);
3. A summary of any complaints surrounding the provision of CBAS (See Member Appeals and Grievances policy 10.19.5 Beneficiary Grievance Management System).
4. Any reports pertaining to the health and welfare of the members utilizing CBAS.
5. On an annual basis, a list of Blue Shield Promise contracted CBAS providers and CBAS accessibility standards.

G. REFERENCES & ATTACHMENTS:

1. 10.19.5 Beneficiary Grievance Management System
2. 22 CCR §54223 (a)
3. 22 CCR §54223 (b)
4. 415344 Accessibility and Availability of Services
5. Agency for Healthcare Research and Quality
6. American Academy of Neurology: Detection, Diagnosis and Management of Dementia
7. BSCPHP DHCS Contract, Exhibit A, Attachment III, Section 5.3
8. BSCPHP DHCS Contract, Exhibit A, Attachment III, Subsection 5.4.2.C
9. BSCPHP DHCS Contract, Exhibit A, Attachment III, Subsection 5.2.8.J
10. BSCPHP DHCS Contract, Exhibit A, Attachment III, Section 4.3
11. BSCPHP DHCS Contract, Exhibit A, Attachment III, Subsection 5.2.12
12. BSCPHP DHCS Contract, Exhibit A, Attachment III, Section 4.6
13. BSCPHP DHCS Contract, Exhibit A, Attachment III, Subsection 5.2.13.C
14. BSCPHP Provider Manual
15. California CalAIM 1115(a) Demonstration, Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs)
16. Darling, et al. vs Douglas Settlement Agreement, Care # C-09-03798 SBA
17. DSM-V
18. H & S Code, §1367.01 (h) (2)
19. P&P 10.4.3 Complex Case Management
20. Welfare and Institutions Code
    - §14184.201(d)(4),
    - §14527
    - §14525(a), (c), (d) and (e)
    - §14526.1 9(d)(1), (3), (4), (5) and (e)
    - §14550-14551

H. REVISION HISTORY

Date	Modification (Reviewed and/or revised)	E-Filing Number
3/2024	2024 Annual Review • Reviewed regulatory requirements per DHCS • Updated references	
3/2023	Updated reporting per DHCS contract Amendment 32 Requirements	
2/2023	Updated Regulatory Requirements DHCS	