Community Based Adult Services (CBAS) - Utilization Management (UM) Criteria-Medi-Cal, Including Members Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit Under the Age of 21

Utilization Management Criteria Statement

This document includes criteria that supports utilization review of Community-Based Adult Services (CBAS). Refer to the NCAL UM Criteria List.

The clinical recommendations of clinicians that are in a treatment relationship with a Member are not subject to these criteria. Their treatment recommendations are guided by their professional judgment and influenced, where applicable, by clinical practice guidelines.

Utilization review for CBAS occurs when a second qualified licensed clinician, other than the treating clinician, reviews the assessment and recommendation of an initial qualified licensed clinician against utilization review criteria. By California Department of Health Care Services (DHCS) regulation, as outlined in the CA section 1115 Medicaid demonstration, entitled CA Advancing and Innovating Medi-Cal, Project Number 11-W-00193/9, CBAS authorizations for CBAS Three-Day Multi-Disciplinary Evaluations and Day Treatment can be approved through a two Registered Nurse (RN) review and approval process. A designated NCAL Regional MD reviewer serves to approve, deny, delay, or modify the service request based on a determination of medical necessity. All RN recommendations for denials are deferred to the MD reviewer for final assessment and decision. These criteria are consistent with criteria included in the CA DHCS CBAS developed and required assessment tools, entitled CBAS Eligibility Determination Tool (CEDT) and Individual Plan of Care (IPC).

Principles

The purpose of CBAS is to offer services to eligible adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. The program stresses partnerships with the participant, the family and/or caregiver, the primary care physician, and the community in working toward maintaining personal independence.

Core services of CBAS include:

- Professional nursing (observation, assessment, and monitoring of general health status, medication regimen, communication with primary care provider, supervision of personal care services, and provision of skilled nursing care and interventions)
- Social services
- Personal care services
- Therapeutic activities (group and/or individual activities)
- At least one meal offered each day of attendance (special meals provided when prescribed by the primary care provider)

Additional services based on IPC include:

- Restorative physical therapy
- Restorative occupational therapy
- Speech therapy
- Registered dietician services
- Behavioral health services
- Transportation, provided or arranged, to and from the CBAS participant's place of residence and the CBAS center, when needed.

Kaiser Foundation Health Plan, Inc. covers Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, as required by law for Medi-Cal Managed Care Plan (MCP) Members under 21, when determined to be medically necessary based upon the standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396(r)(6)) and the Member's current clinical condition. The EPSDT medical necessity criteria indicate services must be covered to correct or ameliorate defects and physical and mental illnesses or conditions. Services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.

Service/s need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the Member's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Additional services must be provided if determined to be medically necessary for a Member.

Medical necessity decisions are individualized. Flat limits or hard limits based on a monetary cap, or budgetary constraints are not consistent with EPSDT requirements. Therefore, MCPs are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity. The

determination of whether a service is medically necessary or a medical necessity for a Member must be made on a case-by-case basis, taking into account the particular needs of the Member.

Note: COVID-19 Public Health Emergency

On April 13, 2020, DHCS issued an All Plan Letter (APL 20-007 POLICY GUIDANCE FOR COMMUNITY-BASED ADULT SERVICES IN RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY) to Medi-Cal Managed Care Plans (MCPs) to provide policy guidance regarding temporary authorization of Community-Based Adult Services (CBAS) provided telephonically, in participants' homes, and individually in centers, in lieu of congregate services provided at CBAS centers.. Effective October 1, 2022, APL 20-007 was superseded by APL 22-020, Community Based Adult Services Emergency Remote Services, authorized under CalAIM 1115 Demonstration Waiver. This is to allow for immediate response to address the continuity of care needs of Members participating in CBAS when an emergency restricts or prevents them from receiving services at their center.

The health plan designated RN completes the CEDT tool, by interviewing the Member and/or through corroborative sources, such as but not limited to, Provider and caregiver interviews, health and utilization data reviews, and information possessed by KFHP to determine if the Member is eligible for CBAS. If eligible, an authorization is issued for a Three-Day Assessment. The three-Day Assessment is conducted by a multi-disciplinary CBAS Center treatment team and the Member. The assessment findings and requested CBAS core services are documented in the Individual Plan of Care (IPC) and submitted to the health plan for authorization. CBAS services are approved based on KFHP's authorization process. Members can be approved for services for up to 7 days/week.

Clinical Review Criteria

Eligible Recipients: To be eligible for CBAS services, a recipient must meet the following eligibility and medical necessity criteria:

- The individual must be Medi-Cal eligible and 18 years of age or older
    - Apply EPSDT medical necessity criteria if the Medi-Cal managed Member is under 21 years old, as outlined above.
- The individual must be enrolled in a Medi-Cal managed care plan (MCP) unless the individual is not eligible to enroll in managed care
- The individual must meet the specified medical criteria of any one or more of the following categories

Category 1: Nursing Facility-A (NF-A) Level of Care or above

1. Has been determined by DHCS to meet the NF-A level of care or above; and
2. Meets eligibility and medical necessity criteria contained in sections 14525(a), (c), (d) and (e); 14526.1(d)(1), (3), (4) and (5); and 14526(e) of the W&I Code (summarized in a. through e. below):
    1. The individual is 18 years of age or older and has one or more chronic or post-acute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or

other health care provider has, within their scope of practice, requested CBAS services for the person.

2. The individual requires ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.
3. The individual requires CBAS services, as defined in W&I Code, Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the CBAS program to support the individual and their family or caregiver in the living arrangement of their choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing nursing or continuous nursing care.
4. Any individual who is a resident of an intermediate care facility for the Developmentally Disabled-Habilitative (ICF/DD-H) shall be eligible for CBAS services if that member has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through CBAS, placement to a more costly institutional level of care would be likely to occur.
5. Except for individuals residing in an ICF/DD-H, the individual must meet all the following:
    1. The individual has one or more chronic or post-acute medical, cognitive, or mental health conditions that are identified by the individual's personal health care provider as requiring one or more of the following: monitoring, treatment, or intervention, without which the individual's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization.
    2. The individuals' network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by a least one of the following:
        1. The individual lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
        2. The individual 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 individual.
        3. The individual has family or caregivers available, but those individuals require respite to continue providing sufficient and necessary care or supervision to the individual.
    3. A high potential exists for the deterioration of the individual's medical, cognitive, or mental health condition or condition(s) in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if CBAS services are not provided.
    4. The individual's condition(s) require CBAS services, on each day of attendance, that are individualized and designed to maintain the ability of the individual to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalizations.

Category 2: Organic, acquired, or traumatic brain injury, and/or chronic mental illness:

1. Has been diagnosed by a physician as having an organic, acquired, or traumatic brain injury, and/or has a chronic mental illness; AND
2. Meets CBAS eligibility and medical necessity criteria, as listed in Category 1 above, AND
3. Demonstrates need for assistance or supervision with at least:
    1. Two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene; OR
    2. One ADL/IADL listed above, and one of the following: money management, accessing resources, meal preparation, or transportation.

Category 3: Alzheimer's disease or other dementia:

1. Individuals have been diagnosed with moderate to severe Alzheimer's disease or other dementia, characterized by the descriptors of, or comparable to, Stages 5, 6, or 7 Alzheimer's disease (Refer to guide below for descriptors of stages):
    1. Stage 5: Moderately severe cognitive decline. Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential.
    2. Stage 6: Severe cognitive decline. Memory difficulties continue to worsen, significant personality changes may emerge, and affected individuals need extensive help with daily activities.
    3. Stage 7: Very severe cognitive decline. This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak, and, ultimately, the ability to control movement; AND, ultimately, the ability to control movement; AND,
2. Meets CBAS eligibility and medical necessity criteria, as listed in Category 1 above.

Category 4: Mild Cognitive Impairment including Alzheimer's disease or other Dementias:

1. Individuals have been diagnosed with 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, characterized by one or more of the following:
    1. Decreased knowledge of recent events
    2. Impaired ability to perform challenging mental arithmetic
    3. Decreased capacity to perform complex tasks
    4. Reduced memory of personal history
    5. The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations; AND
2. Meets CBAS eligibility and medical necessity criteria, as listed in Category 1 above; AND
3. The individual must demonstrate a need for assistance or supervision with two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene.

Category 5: Individuals who have Developmental Disabilities:

1. Meets the definitions and requirements set forth in title 17, section 54001(a) of the California Code of Regulations, as determined by a Regional Center under contract with the Department of Developmental Services; AND

2. Meets CBAS eligibility and medical necessity criteria, as listed in Category 1 above.

CBAS Eligibility Determination:

Determination of eligibility for CBAS includes all the following:

- An initial face-to-face (F2F) review by a registered nurse with a level of care determination experience. The eligibility determination shall be performed by the individual's MCP, or by DHCS or its contractor(s) for individuals exempt from managed care.
- The initial F2F review is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses
- Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every 12 months for individuals determined by the MCP as clinically appropriate.
- Reauthorization of CBAS services shall be granted when the eligibility and medical necessity criteria specified above have been met and the individual's condition would likely deteriorate if the CBAS services were denied.
- Denial in services or reduction in the requested number of days for services of ongoing CBAS by DHCS or by an MCP requires a F2F review.

Provision of Emergency Remote Services (ERS):

These services are meant to be temporary and time-limited, as outlined below, specifically either:

1. **Short-term**: Members may receive ERS for an emergency occurrence for up to three consecutive months. The plan will coordinate to ensure duration of ERS is appropriate during the Member's current authorized period and, as necessary, for reauthorization into a new period; or
2. **Beyond Three Consecutive Months:** ERS for an emergency occurrence may not exceed three consecutive months, either within or crossing over an authorized period, without assessment and review for possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan. The plan will coordinate on requests for authorization of ERS that exceed three consecutive months. Participants may need and/or be appropriate for ERS beyond three months.

Two types of 'unique circumstances' listed in the 1115 Waiver Special Terms and Conditions which may result in the need for ERS are as outlined below.

1. **Public Emergencies**, such as state or local disasters, regardless of whether formally declared. These may include, but are not limited to earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc.
2. **Personal Emergencies**, such as serious illness or injury, crises, or care transitions, as defined below. Specific personal emergencies may include serious illness or injury, crises, care transitions such as to/from a nursing facility, hospital, and home.
    1. "Serious Illness or Injury" means that the illness or injury is preventing the Member from receiving CBAS within the facility and providing medically necessary services

and supports that are required to protect life, address or prevent significant illness or disability, and/or to alleviate pain.
2. "Crises" means that the Member is experiencing, or threatened with, intense difficulty, trouble, or danger.
3. "Care Transitions" means transitions to or from care settings, such as returning to home or another community setting from a nursing facility or hospital.

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References

California Department of Health Care Services, CBAS DHCS Provider Manual, February, 2023, reference link: Community-Based Adult Services (CBAS): Billing Codes and Reimbursement Rates (community cd) (ca.gov).

APL 22-020 (supersedes APL 20-007) Community-Based Adult Services Emergency Remote Services, reference link: APL 22-020 (ca.gov).

CalAIM 1115 Waiver and STC(s), reference link: California TC Approval Letter and STCs