CALIFORNIA
DEPARTMENT OF AGING (CDA)

ACL #14-02

FAX Cover

TO:	**All Community-Based Adult Services (CBAS) Providers**
FROM:	**CBAS Branch**
DATE:	**March 25, 2014**
SUBJECT:	**New Policy and Procedure For CBAS Participant Change From Managed Care to Fee-For-Service**

This fax is being sent on behalf of the Department of Health Care Services to update CBAS providers on a new policy and procedure for authorization of services that will ensure continuity of care when Medi-Cal beneficiaries move from managed care to fee-for-service.

For More Information:
Access the CDA CBAS website at:

www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Default.asp

Contact CDA at:
- ✓ Email – CBAScda@aging.ca.gov
- ✓ Phone – (916) 419-7545

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State of California—Health and Human Services Agency

Department of Health Care Services

CBAS Fee-for-Service Procedure for Continuity of Care

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

Authorization for Community-Base Adult Services (CBAS) Participants Moving Between Managed Care Plans and Fee-for-Services Medi-Cal

OVERVIEW: To ensure **continuity of care** for active CBAS participants that move between a Managed Care Plan (MC Plan) and Fee-For-Service (FFS) Medi-Cal, DHCS has authorized an updated procedure providing faster, continual coverage for those recipients and Centers.
When a participant is continuing with on-going services at a CBAS Center and **only their payment source is changing** from a MC Plan to FFS Medi-Cal, the participant's continuity of care is of foremost importance.

PROCEDURE: Ensures that CBAS Centers can continue to serve the participant without a break-in-service or payment by following these simple steps:

1. CBAS Center routinely checks the participant's eligibility, noting a change from their prior authorized MC Plan, and seeing the participant is now in FFS Medi-Cal.

2. CBAS Center submits a FFS Treatment Authorization Request (TAR) notifying the Los Angeles Medi-Cal Field Office (LAMFO) of this payment source change for the remaining authorized months of service. The TAR is submitted with:

   a. The MC Plan's notice of authorization for services that the Center received for the participant's current CBAS (***MUST BE ATTACHED**);

   b. The IPC (***MUST BE ATTACHED**) that was completed for the authorization for services, that the Center is currently performing, and

   c. The CEDT ("CBAS Eligibility Determination Tool") if available at the Center.

   d. The Center types a note in the "Miscellaneous" text box on the TAR stating:
      - "*Payment Source Change – Prior authorization for continuing CBAS from '**Fill in MONTH**' to '**fill in MONTH**'.*"

3. The LAMFO receives the TAR and above attached materials, indicating the previously authorized months of service for the participant. The LAMFO will review the documents and can approve the remaining duration of services, as indicated on the Authorization for Services from the MC Plan, without the need for a face-to-face at that time. The LAMFO's TAR adjudication will be for the same number of days per week approved by the MC Plan. If a change in days of service is being requested, a face-to-face will need to be performed.

   If/when a new TAR for the participant is submitted for another six months of authorized services, and if the participant is still under FFS Medi-Cal, the LAMFO will authorize the TAR or schedule a face-to-face, if necessary (i.e.; request for change in service days).

   This Procedure does not change the process for participants that move from one CBAS Center to another (when the new Center performs an MDT assessment and develops an IPC). **This is ONLY for a change in payment source at the same CBAS Center**.

QUESTIONS: Please contact the LAMFO for CBAS at 213-897-0745.