Molina Healthcare of California

Community-Based Adult Services (CBAS) Toolkit

July 2025

Community-Based Adult Services (CBAS) provide essential support to older adults and individuals with chronic conditions or disabilities, enabling them to live independently while maintaining their quality of life. Molina of California (MHC) has developed the CBAS Toolkit as a valuable resource to address frequently asked questions and provide comprehensive support to our CBAS Centers. This toolkit is designed to assist our centers in delivering high-quality services to our members, ensuring they have the necessary information and tools to meet their needs effectively. It serves as a helpful guide for navigating the various aspects of CBAS services, promoting consistency and efficiency in care delivery.

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Prior Authorizations Requests

1. What documents are required for initial CBAS Services?

I. Before a request for CBAS services can be submitted, the member must first go to the CBAS center of their choice. The CBAS center must be located within the member's area, as it will be responsible for providing transportation to and from the center. Once this is done, the member must visit their PCP to obtain approval to attend the CBAS center.

II. The CBAS center must submit the CBAS Prior Authorization Request Form and select INITIAL CBAS SERVICES; they must include the H&P.

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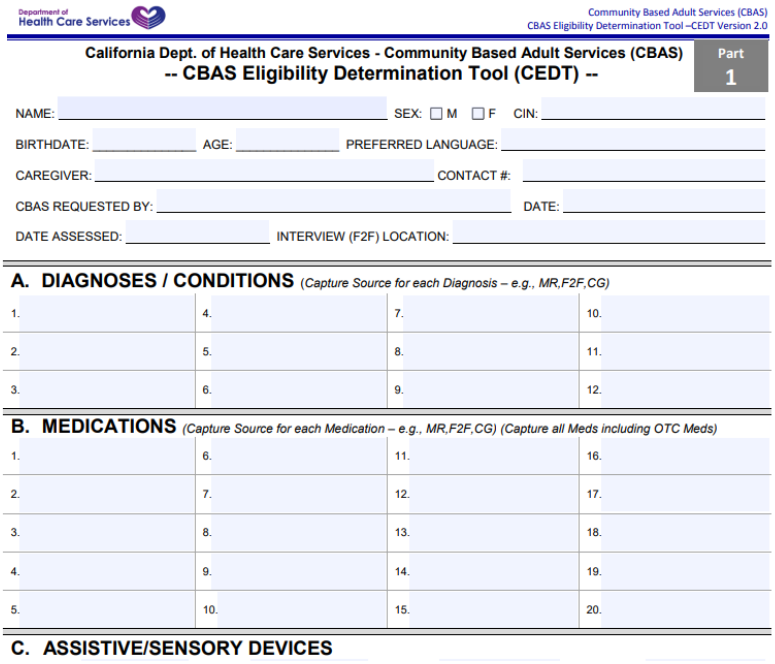
Molina Healthcare of California
COMMUNITY BASED ADULT SERVICES (CBAS) REQUEST FOR SERVICES

*Please fax the completed form to **Molina Healthcare of California CBAS at 1-800-811-4804**, if you have questions may call our Molina Utilization Management Department (844) 557-8434*

DATE:	**PCP:**			
REFERRING PHYSICIAN INFORMATION				
REFERRING PHYSICIAN:	**REFERRING PHYSICIAN NPI NUMBER:**			**REFERRING PHYSICIAN PHONE NUMBER:**
REFERRING PHYSICIAN ADDRESS:				**REFERRING PHYSICIAN FAX NUMBER:**
PATIENT INFORMATION				
MEMBER NAME:	**GENDER:**	**DOB:**	**AGE:**	**MEMBER ID (Medi-Cal/CIN):**
ADDRESS:	**PHONE NUMBER:**			**ALTERNATE NUMBER:**
PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) Enter Name and Address	**Preferred Language:**			
REFERRAL - SERVICE TYPE REQUESTED				
☐ **Expedited Referral for Post Hospitalization/SNF stay**	☐ **Initial CBAS Services** ☐ **Continued CBAS Services for 6 months (Must include IPC & Last TAR Number)**			☐ **Modification of Days for IPC**
CBAS CENTER SUBMITTING THIS REQUEST				
PROVIDER NAME or Specify DBA:	**PROVIDER NPI NUMBER:**			**PHONE NUMBER:**

III. Once Molina receives the initial request as outlined in Step I, the Molina CBAS team will fax the request to Partners in Care to schedule the Face-to-Face interview.

IV. After Partners in Care completes the Face-to-Face interview, they will complete the CBAS Eligibility Determination Tool (CEDT). They will then fax the completed CEDT or a denial notification letter to Molina. If the CEDT indicates approval, Molina will issue an authorization for a comprehensive assessment to the selected CBAS center.



Department of Health Care Services

Community Based Adult Services (CBAS)
CBAS Eligibility Determination Tool –CEDT Version 2.0

California Dept. of Health Care Services - Community Based Adult Services (CBAS)
-- CBAS Eligibility Determination Tool (CEDT) --

Part 1

NAME: _____ SEX: ☐ M ☐ F CIN: _____

BIRTHDATE: _____ AGE: _____ PREFERRED LANGUAGE: _____

CAREGIVER: _____ CONTACT #: _____

CBAS REQUESTED BY: _____ DATE: _____

DATE ASSESSED: _____ INTERVIEW (F2F) LOCATION: _____

A. DIAGNOSES / CONDITIONS *(Capture Source for each Diagnosis – e.g., MR,F2F,CG)*

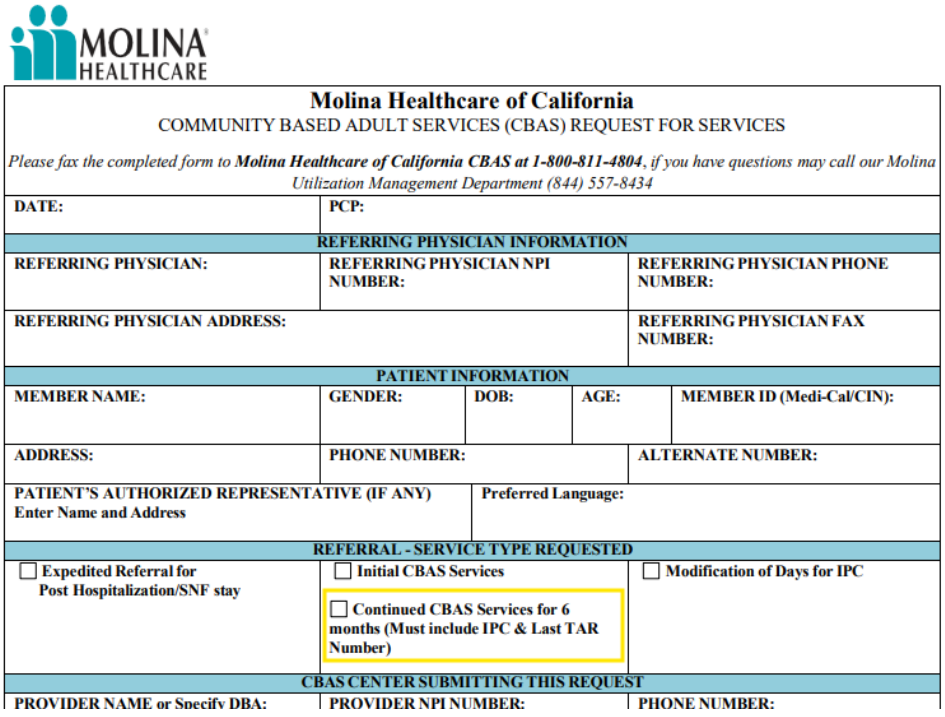
1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

B. MEDICATIONS *(Capture Source for each Medication – e.g., MR,F2F,CG) (Capture all Meds including OTC Meds)*

1.	6.	11.	16.
2.	7.	12.	17.
3.	8.	13.	18.
4.	9.	14.	19.
5.	10.	15.	20.

C. ASSISTIVE/SENSORY DEVICES

V. After completing the comprehensive assessment, the CBAS center must submit a request for ongoing services. This includes the CBAS Service Request Form indicating Continued CBAS Services for up to 6 months, along with the IPC (Individual Plan of Care).



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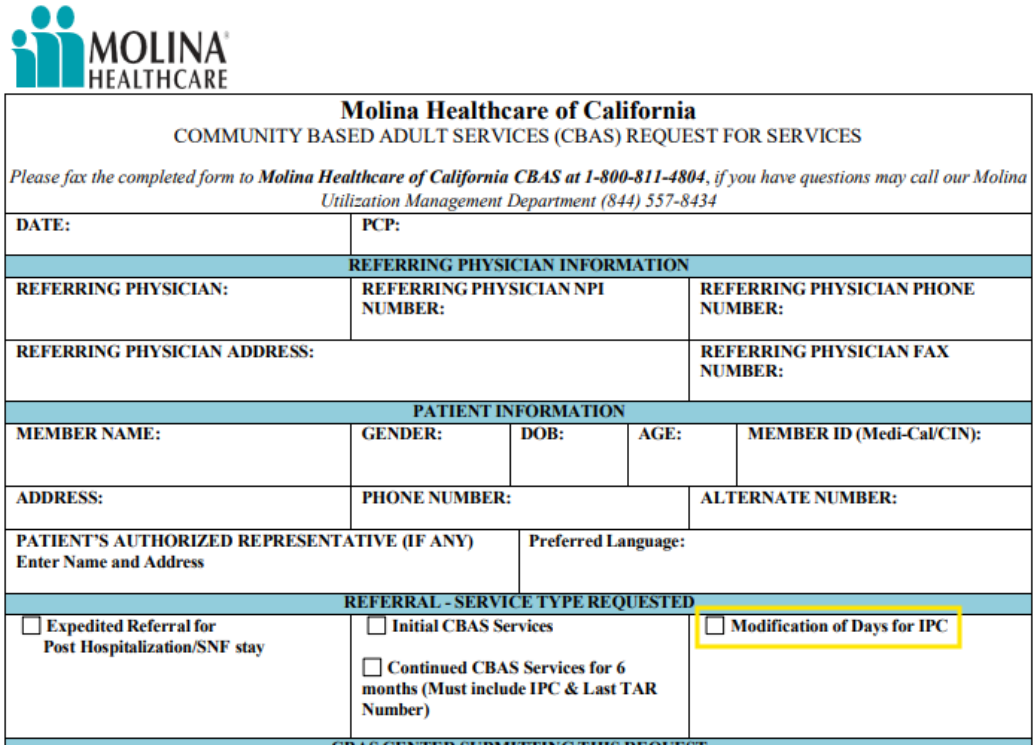
CBAS CENTER SUBMITTING THIS REQUEST				
PROVIDER NAME or Specify DBA:	**PROVIDER NPI NUMBER:**			**PHONE NUMBER:**

2. When would I request a Modification of Days for IPC and what documents are required?

Modification requests should be submitted when CBAS centers need to request additional service units (days). The CBAS center must submit the CBAS Services Request Form along with the revised IPC that provides justification for the requested modification.

If there are existing claims for current open authorizations, the CBAS center must submit a request covering the remaining TAR period for which the modification is being made, along with the current IPC.



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3. Who do I call to follow up on an authorization submitted

To check the status of a request, please call the Provider Line at (844) 557-8434.

4. What is the turnaround time for authorizations

The turnaround time for all routine CBAS-related requests is 5 business days.

- Once approved:
    - CEDT assessment is approved for 1 month (T1023)
    - Assessment is approved for 3 months (H2000)
    - Ongoing Service is approved for 6 months (S5102)

5. Where can I look up the status of an authorization submitted?

You can check the status on our Provider Portal, Availity: availity.com/

6. How do I submit a retro authorization when a member is not in your system or there is an eligibility concern?

Molina does not retroactively authorize services that require PA unless extenuating circumstances are present and provided with the authorization request. An extenuating circumstance is defined as: Provider did not know nor reasonably could have known the patient was a Molina Member at the time service was rendered, or the Provider did not know nor reasonably could have known that the patient needed a service that required authorization prior to the service being rendered, or Molina error, or Special Provider contractual requirements.

Retro-authorization with extenuating circumstances can be evaluated by the Utilization Management (UM) Department when the request is received within ten (10) business days of the provider becoming aware of the extenuating circumstance. Request should be accompanied by evidence of eligibility verification performed by the provider.

For detailed information on the Provider Dispute process, please visit the MHC website: molinahealthcare.com/providers/ca/medicaid/policies/provider-dispute.aspx

Assessments

1. Who do I contact to schedule a CEDT assessment for potential CBAS candidates?

Molina utilizes Partners in Care to coordinate the face-to-face assessment with the CBAS center.

2. Will MHC use the Treatment Authorization Request (TAR) CBAS Centers already have for a participant?

Yes – The TAR period on the IPC must correspond with the date span indicated on the Service Request Form.

3. How long will it take MHC to approve a TAR?

Routine CBAS-related requests are processed within 5 business days.

Claims

1. How do CBAS Centers get paid for an IPC assessment?

CBAS Centers may send the completed IPC assessment and claim to MHC.

2. How do CBAS Centers submit a claim to MHC?

CBAS Centers can submit claims directly to MHC using one of the following methods:

- **Online:** Submit claims directly through the Availity Portal.
- **EDI Clearinghouse:** Submit claims via your clearinghouse using Payer ID: 38333.

- To register, complete the EDI Registration Form.

- **Paper Claims:**
  Mail to:
  Molina Healthcare of California
  P.O. Box 22702
  Long Beach, CA 90801

3. What are the paper claim guidelines?

Paper claims are required to be submitted on original red and white CMS-1500 and CMS1450 (UB04) Claim forms. Paper claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include claims with handwriting. Claims must be typed with either 10-point or 12-point Times New Roman font, using black ink.

4. Where can I find the timely filing guidelines for submitting a claim?

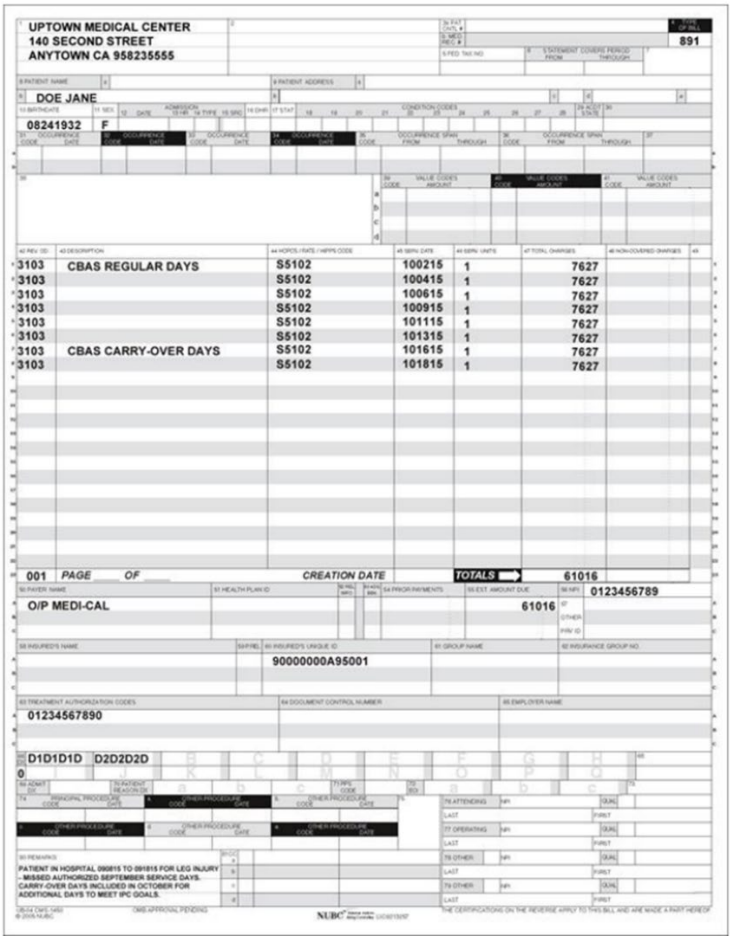
Timely filing guidelines can be found in the Medi-Cal Provider Manual, under the Claims and Compensation Chapter.

5. Are we required to bill on a UB-04 or an HCFA form?

UB-04 Form

6. What fields are required on the UB-04 form?

- Rendering Provider Name, Address, and Zip code
  - The name and service location of the provider submitting the bill.
- Billing Provider Name, Address, and Zip code
  - Enter the address that the provider submitting the bill intends the payment to be sent if different than field 1.


UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 958235555

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3103	CBAS REGULAR DAYS	S5102	100215	1	7627	
3103		S5102	100415	1	7627	
3103		S5102	100615	1	7627	
3103		S5102	100915	1	7627	
3103		S5102	101115	1	7627	
3103		S5102	101315	1	7627	
3103	CBAS CARRY-OVER DAYS	S5102	101615	1	7627	
3103		S5102	101815	1	7627	

001 PAGE OF CREATION DATE TOTALS 61016

O/P MEDI-CAL 61016 0123456789

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PATIENT IN HOSPITAL 090815 TO 091015 FOR LEG INJURY - MISSED AUTHORIZED SEPTEMBER SERVICE DAYS. CARRY-OVER DAYS INCLUDED IN OCTOBER FOR ADDITIONAL DAYS TO MEET IPC GOALS.

7. How can I register for EFT and to view ERAs?

Molina uses a third-party vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery. Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, to provide searchable ERAs, and allows Providers to receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll.

Additional information about EFT/ERA is available at MolinaHealthcare.com or by contacting the Molina Provider Contact Center.

Benefits and Services

1. What's the difference between a "benefit" and a "service?"

A benefit is something MHC provides because the state or federal government requires it. For example, doctor visits are a benefit, as are medications and durable medical equipment. The CBAS Program is also a benefit. A service is something that MHC offers beyond the benefits. Services include a 24/7 nurse advice line, 24/7 Member Services department and programs for people with diabetes or asthma.

2. Is CBAS a Medi-Cal or Medicare benefit?

The CBAS Program is a Medi-Cal benefit, not a Medicare benefit. For members who have both Medicare and Medi-Cal, the service is provided under their Medi-Cal coverage.

3. Who can request CBAS benefits for health plan members?

Any provider (hospital or physician) can identify a potential need for CBAS services and submit a request to begin the CBAS assessment process. The provider does not have to be contracted with MHC. The provider should call MHC's Member Services department at (888) 665-4621. MHC will then review the request for CBAS benefits and authorize the request if it is medically necessary. The services must be provided by an MHC contracted CBAS Center.

4. If a participant joins a Medi-Cal health plan, will their In-Home Supportive Services (IHSS) be affected?

No, the In-Home Supportive Services (IHSS) program provides in-home assistance to eligible aged, blind, and disabled individuals as an alternative to out-of-home care and enables recipients to remain safely in their own homes. Enrolling in a Medi-Cal managed care plan in California will not cause members to lose their In-Home Supportive Services (IHSS) benefits; IHSS remains a Medi-Cal entitlement even when managed care is involved.

5. In addition to CBAS, what other benefits will participants get through MHC?

MHC provides certain incontinence supplies, some medical equipment not covered by Medicare, hearing aids, non-emergency transportation to medical appointments, two months of skilled nursing facility admissions and certain medications not covered by Medicare.

6. Are CBAS Centers responsible for transporting CBAS beneficiaries to and from the Centers?

Yes, CBAS Centers are responsible for transporting approved CBAS beneficiaries to and from the CBAS Centers to receive their services.

7. Can my Medi-Cal patients use any transportation vendor for their Non-Emergency Medical Transportation (NEMT) to and from their doctor?

- Medi-Cal: The Transportation Vendor for Molina Medi-Cal members is American Logistics for both NEMT and NMT mode of transportation. For NEMT, a Physician Certification Statement (PCS) form must be completed by a Provider if the members transportation needs cannot be met by a private or public vehicle (uber, taxi, etc.). The PCS form can be found and completed here: Vasion
- To Schedule Transportation (schedule transportation at least 72 hours in advance):
    - By Phone: (844) 292-2688 – American Logistics Call Center
    - By Web: Molina.AmericanLogistics.com

8. How is Continuity of Care (COC) administered for a non-par CBAS provider?

MHC will redirect the CBAS participant to the nearest In-Network CBAS provider.

CBAS Provider Contracts

1. Who do I contact if I have questions regarding my contract?

Contact the Contracting Team:

- Inland Empire: IEContracting@MolinaHealthcare.com
- Los Angeles: LAContracting@MolinaHealthcare.com
- San Diego: MHCSanDiegoContracts@MolinaHealthcare.com
- Sacramento: MHCSacramentoContracts@MolinaHealthcare.com

2. Will MHC contract with ADHC centers not approved as a CBAS Centers?

No.

3. Does MHC have a different network of CBAS Center providers than Health Net?

Yes, MHC and Health Net may have different CBAS Center provider networks. While the health plans were required to offer contracts to all certified CBAS Centers in their service areas, the CBAS Centers were not required to contract with the health plans. Each health plan can provide you with a list of their contracted CBAS Centers.

Molina Healthcare Care Management

At Molina Healthcare, our Care Management team is made up of experienced professionals, including Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), and Licensed Social Workers (MSWs and LCSWs), as well as other healthcare professionals. These individuals serve as Care Managers and Transition of Care (ToC) Coaches, playing a vital role in supporting our members throughout their healthcare journey.

1. What Do Care Managers and Transition of Care Coaches (ToC) Do?

Molina's Care Managers and ToC Coaches are dedicated to helping members manage complex health needs and navigate the healthcare system. Transition of Care Coaches specifically focus on supporting members who are moving between care settings or levels of care. This includes, but is not limited to, transitions such as:

- Discharge from hospitals
- Transfer from inpatient facilities
- Movement from skilled nursing facilities (SNFs) to home
- Transition to community-based care environments

These coaches ensure that care plans are followed, necessary services are in place, and members have the resources they need to remain safe in their home or community setting.

2. What is the role of the Molina Care Manager and Transition of Care Coach (ToC)?

Once assigned, the Molina Care Manager or ToC Coach will serve as the member's primary point of contact for coordinating care. They can assist with:

- Developing and updating personalized care plans
- Scheduling follow-up appointments or services
- Coordinating with healthcare providers and support services
- Identifying community resources to support health and wellness

Please keep in mind that while Care Managers and ToC Coaches are a valuable resource for clinical and care coordination needs, they may not have direct access to information related to authorizations, claims, billing, or provider contracting. However, they can help connect you with the appropriate department or representative to address those concerns.

3. What is the purpose of Care Management for members receiving Long-Term Services & Supports (LTSS) such as CBAS?

Care Management plays a critical role in supporting Molina Healthcare members who receive Long-Term Services and Supports (LTSS), including Community-Based Adult Services (CBAS). The primary goal is to ensure that members receive coordinated, person-centered care that supports their health, independence, and overall well-being.

Benefits of Care Management for Members receiving LTSS:

- **Individualized Care Planning:** Care Managers work with members to create a customized care plan that reflects their unique medical, social, and functional needs. This ensures that services are tailored to support the member's goals and preferences.
- **Coordinated Service Delivery:** Care Managers help coordinate services across multiple providers and care settings. This includes working with CBAS centers, home health agencies, personal care providers, and other community-based organizations to ensure continuity and quality of care.
- **Support During Transitions:** Whether transitioning from a hospital to home, or between community programs, Care Managers help navigate changes in care settings and ensure that services are in place to support a safe and successful transition.
- **Advocacy and Education:** Care Managers advocate for members by helping them understand their benefits, identify available services, and access the right level of care. They also provide education on chronic condition management, wellness strategies, and how to maximize available supports.

- **Monitoring and Follow-Up:** Ongoing monitoring allows Care Managers to assess changes in a member's condition or circumstances and adjust the care plan as needed. Regular follow-up helps ensure that services remain appropriate and effective.

Ultimately, the purpose of Care Management for members receiving LTSS is to empower individuals to live safely and independently in the setting of their choice—whether at home or in the community—while maintaining the highest possible quality of life.

4. How can a CBAS Center find out if the member is working with a Care Manager?

To find out if a Molina member has an assigned Care Manager or Transition of Care Coach, please contact us with the member's name and date of birth via one of the methods below:

- Phone: (833) 234-1258
- Fax: (562) 499-6105
- Email: MHCCaseManagement@MolinaHealthcare.com

Our staff will check if a Care Manager or Transition of Care Coach has already been assigned. If so, we will connect you with that person or share their contact information. If no Care Manager is currently assigned and the member has identified needs, one will be assigned to provide support.

5. When should a CBAS Center contact Care Management or the LTSS Liaison?

Questions related to the Health Risk Assessment, Care Plan, changes or decline in the members health or physical status which require our assistance.

LTSS Liaison	Contact Number	Email Address
Blanca Martinez Director Healthcare Services	562-485-4966	blanca.martinez@molinahealthcare.com
Trista Friemoth, Manager Healthcare Services	1-414-293-0133	trista.friemoth@molinahealthcare.com
LTSS Mailbox	N/A	caltss@molinahealthcare.com

CBAS Critical Incidents (CI) Reporting

1. What is the purpose of the Critical Incident (CI) reporting requirement for Molina Health Care?

To identify, analyze, and address adverse events that occur at or in transit to/from CBAS centers to improve the quality and safety of care and prevent recurrence. The CBAS incident Report (CDA 4009) is used by CBAS Centers to provide summary information on adverse events that occur at or in transit to or from CBAS Centers. The Department of Health Care Services requires Molina to collect Critical Incident (CI) reports from Community-Based Adult Services (CBAS).

2. What types of incidents are considered Critical Incidents (CIs)?

CI reporting focuses on unusual incidents, adverse events, or incidents that could potentially harm participant. Unusual occurrences are generally widespread in their effect, threaten the welfare, safety, or health of center participant, and are largely those that happen:

- In the environment- such as earthquake or flood; or
- In the facility- such as fire or explosion
- Incidents that require reporting may include, but are not limited to:
- Death, Serious Injury, and unusual incidents
- Participant missing from the Center- Participant arrives at the Center and goes missing during the program day
- Abuse, neglect, or exploitation allegations
- Incidents involving law enforcement, emergency room visits, or medication errors
- Falls or other environmental events
- Unexplained absence with inability to contact- unplanned absence from the Center on scheduled days of attendance, coupled with the inability to contact the participant/caregiver, using all available contact information, within a reasonable period, to determine the reason for the absence.

3. How should CBAS Centers report Critical Incidents to Molina Health Care?

CBAS Centers must follow the California Department of Aging (CDA) Incident Report instructions, complete the CDA 4009 form, and submit the completed form to Molina Health Care via the email address: CBAS@molinahealthcare.com

4. Where can CBAS Centers find the instructions for filling out the CDA Incident Report form?

The instructions for filling out the CDA Incident Report form can be found on the California Department of Aging's website at the following link: aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Forms_and_Instructions/

5. What form must CBAS Centers complete to report a Critical Incident to Molina Health Care?

CBAS Centers must complete the CDA 4009 form, which can be found on the California Department of Aging website at: aging.ca.gov/download.ashx?lE0rcNUV0zaqMET2XrTCdw%3d%3d

CBAS Emergency Remote Services (ERS) APL 22-020

1. What is the new requirement for CBAS providers regarding ERS starting October 1, 2022?

Starting October 1, 2022, CBAS providers are required to offer Emergency Response Services (ERS) to CBAS participants when all ERS policy criteria are met. ERS must be available during emergencies, with temporary and time-limited support.

2. What is the Purpose of ERS?

The purpose of ERS 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.

3. What are the two types of “unique circumstances” that may require ERS?

The two types of unique circumstances are:

- **Public Emergencies:** such as state or local disasters (e.g., earthquakes, floods, fires, epidemic outbreaks like COVID-19).
- **Personal Emergencies:** such as serious illness or injury, crises (e.g., loss of caregiver, neglect), or care transitions (e.g., moving from a hospital or nursing facility to home).

4. How is "serious illness or injury" defined in the context of ERS?

"Serious illness or injury" means a condition that prevents a member from attending CBAS within the facility and requires medically necessary services to protect life, address or prevent significant illness, disability, or alleviate pain.

5. How long can a member receive ERS for a short-term emergency?

A member can receive ERS for up to three consecutive months for a short-term emergency. CBAS providers and Molina must work together to ensure the duration is appropriate and reauthorize if necessary.

6. What happens if ERS is needed for more than three consecutive months?

CBAS providers and MCPs must coordinate requests for authorization of ERS that exceed three consecutive months. Instances of ERS that go beyond three months must be authorized by Molina. If ERS is needed beyond three consecutive months, it requires an assessment and review to determine

the continued need for remote/telehealth services. Authorization for ERS beyond three months must be obtained from Molina.

7. Do CBAS providers need to submit a separate prior authorization for ERS?

No, CBAS providers do not need to submit a separate prior authorization for ERS as long as the member's current CBAS authorization is active. However, if ERS is needed beyond three consecutive months, a prior authorization request must be submitted to Molina.

8. What are the Care Coordination Requirements?

Within 30 days of a discharge, Molina receives a copy of the member's discharge plan from the CBAS provider. Molina reviews the discharge plan to determine if further service coordination is required for the member.

For participants who remain enrolled in the CBAS program but have a reduction in the number of days they attend the program, the participant's IPC must be updated to reflect the change in services provided.

For More Information

1. Is MHC available to provide educational presentations to CBAS Center staff and clients?

Yes.

2. Who can we contact at MHC for answers or guidance?

Please contact your Provider Relations Facility Representative, see below:

Relations	Contact Number	Email Address
Laura Gonzalez, Mgr., Provider Relations Los Angeles, Orange Counties	562-325-0368	Laura.Gonzalez3@molinahealthcare.com
MiMi Howard, Provider Relations Rep. Riverside and San Bernardino Counties	562-455-3754	SMiMi.Howard@molinahealthcare.com
For San Diego, Sacramento, and Imperial Counties Please send to both MiMi Howard and Laura Gonzalez		