



TOBY DOUGLAS
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

June 13, 2014

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**RE: California "Bridge to Reform" Demonstration (Waiver No. 11-W-00193/9)
Amendment Request for Community-Based Adult Services (CBAS)**

Dear Mr. Boben, Ms. Garner, and Dr. Nagle:

The State of California proposes to amend the Special Terms and Conditions (STCs) of Waiver 11-W-00193/9, California Section 1115 "Bridge to Reform" Demonstration (Demonstration Waiver), pursuant to STC paragraphs 98 through 101, relating to Community-Based Adult Services (CBAS). This amendment will assure continuation of the services being received by approximately 28,000 current CBAS recipients.

California is fully committed to the ideals of health care reform and continuing CBAS as a managed care benefit beyond August 31, 2014. This amendment would allow for a seamless transition of CBAS to continue beyond the initial Waiver implementation and transitional phase from Adult Day Health Care that was effective on April 1, 2012.

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The State is requesting that this Demonstration Waiver amendment be approved prior to the end of the current CBAS STCs, to allow for ongoing services that begin on September 1, 2014. DHCS is prepared to collaborate in the coming months with the Centers for Medicare and Medicaid Services (CMS) in order to secure prompt approval of this amendment.

BACKGROUND

The CBAS program was developed when the Adult Day Health Care (ADHC) program was being eliminated from the Medi-Cal program as an Optional State Plan benefit under Assembly Bill 97 (Chapter 3, Statutes of 2011). A class action lawsuit, *Esther Darling, et al. v. Toby Douglas, et al.*, (Case No. C-09-0798-SBA) challenged the elimination, and a Settlement Agreement was reached in March 2012. The ADHC benefit being eliminated under the Medi-Cal program was replaced with a new CBAS program and CMS granted authority for the amendment as part of the BTR Waiver beginning April 1, 2012 through August 31, 2014 (which is also the end date of the Settlement Agreement).

The Waiver amendment included CBAS as a managed care benefit with transitional services for moving participants from ADHC services to a higher level of medical eligibility criteria in the CBAS program. Transitional services were also approved for enhanced case management for those participants that did not meet the medical eligibility for CBAS, but needed assistance with community connections, socialization services, and/or care management.

During this Waiver period, the CBAS program has rolled out as a viable managed care benefit. This was a three-phase transition consisted of Phase 1 (in July 1, 2012), with approximately 10 percent of CBAS recipients participating into a County Organized Health System (COHS) managed care county; then, Phase 2 (in December 1, 2012) with approximately 90 percent of the CBAS eligible population transitioned to the Geographic Managed Care (GMC) plan or the Two-Plan Model counties. Phase-three occurred in 2014, with the 28 remaining Rural counties transition to managed care with CBAS as a benefit in four of those counties.

Given the medical eligibility criteria and available services and supports to this vulnerable population, the State is seeking to continue CBAS in the BTR Waiver as an ongoing managed care benefit beyond the August 2014 end date. CBAS has matured into a functional and key part of the Coordinated Care Initiative (CCI) and Managed Long-Term Services and Supports (MLTSS), with CBAS benefits continuing to be offered as a managed care benefit under the BTR Waiver.

IMPACT TO SERVICES

Eliminated:

- Enhanced Case Management due it being transitional services for ADHC to CBAS, as part of the Settlement Agreement. Participants that did not qualify for CBAS at the time of the transition from ADHC, or any time after that, were able to receive case management for connecting to other viable community services in their local area.
- Unbundled Services as these services are available as part of the Managed Care plan's oversight of their participants. Services are coordinated if CBAS is not an option due to a site closure, assisting individuals either with getting into another Center or providing the needed services and care under their managed care benefits.

WAIVER AUTHORITY

DHCS believes the existing waiver of freedom of choice, statewideness, and comparability encompasses this proposed Demonstration Waiver amendment. To the extent necessary, DHCS requests that its authority to operate under this waiver extends to the amendments contained in this request.

EXPENDITURE AUTHORITY

This proposed Demonstration Waiver amendment will not impact the existing Waiver Expenditure Authority.

BUDGET NEUTRALITY

Budget Neutrality for CBAS remains consistent with the 1115 Demonstration Waiver.

PUBLIC NOTICE AND TRIBAL NOTICE

As required by STC Paragraph 7 and STC Paragraph 14, Tribal Notice on the Demonstration Waiver amendment took place as follows:

- DHCS' Primary, Rural, and Indian Health Division submitted a request to CMS and received approval on March 27, 2014, for no Tribal Notice.

DHCS provided, and continues to provide, Public Notice and input through the following:

- Stakeholder Meetings beginning in October 2013, including Stakeholder Workgroup meetings, through April 2014. Meetings conducted were in-person meetings, webinars, and teleconferences. All information and PowerPoints have been posted on the CDA website, available at:
www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Stakeholder_Process/

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- A two-week Public Comment period was available for comments on the draft STCs and SOPs from April 24 through May 8, 2014. A summary of comments is also posted on the CDA website at the above link.
- June 10, 2014, a webinar review of updates made from Public Comment period was presented, with a public posting of all submitted Amendment draft documents available after being submitted to CMS.

Thank you for your assistance and continued support of California's commitment to improving health care delivery and innovation. DHCS is happy to assist CMS in any way as the proposed CBAS Demonstration Waiver amendment is reviewed. If you have any questions, please contact: Danielle Stumpf, at (916) 440-7400.

Sincerely,

/s/

Toby Douglas
Director

Enclosures:

- Special Terms and Conditions language
- Standards of Participation language

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A. General Provider Requirements

To become a Medi-Cal Community-Based Adult Services (CBAS) provider, the prospective provider must first obtain an Adult Day Health Care (ADHC) center license, issued by the California Department of Public Health and apply for certification for enrollment in Medi-Cal to the Department of Health Care Services (DHCS) or its designee*. Upon meeting the criteria for certification and Medi-Cal provider enrollment, the ADHC center licensee will be certified as a CBAS provider. This specific waiver provider designation will afford CBAS providers the opportunity to deliver outpatient CBAS center services to eligible Medi-Cal beneficiaries (referred to as CBAS participants) in a community setting.

CBAS providers shall:

1. Meet all applicable licensing and certification, as well as Medi-Cal and waiver program standards, as described or referenced in this document;
2. Adhere to these waiver Standards of Participation (SOPs);
3. Enter into contracts with Medi-Cal managed care plans within the provider's geographic area to provide CBAS center services to Medi-Cal plan members;
4. Provide services in accordance with the CBAS participant's Individual Plan of Care (IPC);
5. Adhere to the documentation, training, and quality assurance requirements identified in the Centers for Medicare and Medicaid Services (CMS)-approved 1115 waiver (#11-W-00193/9), inclusive of all the Special Terms and Conditions (STCs) contained therein; and
6. Demonstrate ongoing compliance with the requirements specified in these SOPs.

*The California Department of Aging (CDA) is DHCS' designated representative for the certification of CBAS providers. . Future reference in these SOPs will specify CDA.

B. CBAS Center Services

A CBAS provider shall provide services at the ADHC center, pursuant to a CBAS participant's IPC, developed by the center's multidisciplinary team. These services shall include all of the following, as specified in a CBAS participant's IPC, during a minimum of a four-hour stay at the center. Any length of stay under four hours will not be reimbursed. The CBAS provider is responsible for documenting the provision of at least four hours of CBAS to each participant at the center

1. Core services: each CBAS participant shall receive ALL of these services on each day of attendance at the center:
 - a. Professional nursing.
 - b. Therapeutic activities.
 - c. Social services and/or personal care services.
 - d. One meal offered per day.

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2. Additional services: each CBAS participant shall receive the following services as needed and as specified in his/her IPC:
 - a. Physical therapy.
 - b. Occupational therapy.
 - c. Speech therapy.
 - d. Mental health services
 - e. Registered dietitian services.
3. Transportation to and from the center and the participant's place of residence, shall be arranged or provided as needed.

C. Legal Authority and Requirements.

1. CBAS providers shall:
 - a. Deliver services in licensed ADHC centers in accordance with Health and Safety (H&S) Codes under Division 2, Chapter 3.3 and shall provide services in accordance with the California Code of Regulations (CCR), Title 22 under Division 5, Chapter 10 and with the CMS-approved waiver document(s).
 - b. Be certified and enrolled as Medi-Cal providers and shall meet the standards specified in the Welfare and Institutions Codes under Division 9, Chapter 8.7; in the CCR, Title 22 under Division 3, Chapter 5; and as set forth in these SOPs.
 - c. Apply for certification. The application review includes, but is not limited to, evaluation of the provider legal entity and associated individuals to ensure there are no restrictions on their Medi-Cal/Medicaid enrollment status.
 - d. Apply for recertification as Medi-Cal providers at least every 24 months and be subject to an application review as specified in Subsection C.1.c. and an onsite review. The onsite review includes, but is not limited to, evaluation of administrative systems and processes, staffing, and the appropriateness and quality of services delivered. Recertification is contingent upon the provider's demonstration of continuing compliance with standards for participation in the Medi-Cal program.
2. If there is a change in adopted laws or regulations governing the licensing of ADHC centers, certification of CBAS providers, and/or updates to the CBAS program as issued through DHCS Provider Bulletins, these SOPs shall be interpreted in such a manner as to be in conformance with such laws or regulations.

D. Physical Plant and Health and Safety Requirements.

To ensure the health and safety of the CBAS participants, the physical plant of each center shall conform to the requirements of applicable sections of Title 22 of the CCR as described in part by the following:

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1. Physical accommodations – Designed, equipped, and maintained to provide for a safe and healthful environment. Each center shall:
 - a. Comply with state and local building requirements and codes.
 - b. Be maintained in conformity with the regulations adopted by the State Fire Marshal.
 - c. Have a working, listed telephone number.
 - d. Have a working FAX number.
 - e. Have a working email address.
 - f. Have electronic equipment, including computers and software, adequate to comply with State CBAS reporting requirements.
 - g. Have a working heating and cooling system.
 - h. Have adequate lighting.
 - i. Have appropriate water supply and plumbing.
2. Space Requirements – Demonstrate all of the following, to include but not be limited to:
 - a. Available space sufficient to accommodate both indoor and outdoor activities and store equipment and supplies.
 - b. A multipurpose room large enough for all participants to gather for large group activities and for meals.
 - c. A secluded area that is set aside for participants who require bed rest and privacy during medical treatments or social service interventions.
 - d. Appropriate office area(s).
3. Maintenance and Housekeeping – Be clean, safe, and in good repair at all times; maintenance shall include provisions for cleaning and repair services.
4. Safety – Have appropriate protective devices to guard against hazards by means of supervision, instruction, and installation.
5. Supplies – Maintain sufficient supplies for functional operation and meeting the needs of the participants.
6. Solid Waste – Provide for the storage and disposal of solid waste according to the standards set forth in Title 22.

E. CBAS Eligibility Determination and Authorization

Eligibility determination and authorization for CBAS shall be determined as specified in the CBAS STCs and as follows:

1. A Treatment Authorization Request (TAR) or other agreed upon authorization document shall be prepared by the CBAS provider and submitted to the managed care plan, or to DHCS for beneficiaries exempt from enrolling in a

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managed care plan, for each beneficiary seeking CBAS. TARs for CBAS must be supported by the participant's IPC.

2. Reauthorization TARs for CBAS must be submitted to the appropriate reviewer at least every six months, or up to 12 months as specified in the STCs, and must continue to be supported by the participant's IPC.
3. Authorization timeframes shall be in accordance with H&S Code 1367.01 and State Medi-Cal regulations and policy.

F. Individual Plan of Care (IPC)

The participant's IPC shall:

1. Be developed by the CBAS center's multidisciplinary team and signed by representatives of each discipline required to participate in the multidisciplinary team assessment.
2. Be the result of a collaborative process among the CBAS provider, the participant, and if applicable, the participant's authorized representative(s) and/or managed care plan.
3. Be signed by either the CBAS provider's physician or the participant's personal health care provider. "Personal health care provider" may include a physician assistant or nurse practitioner within their scope of practice under the appropriate supervision of the physician.
4. Be based on a person-centered planning process and meet the requirements specified in the CBAS STCs.
5. Be based on assessment or reassessment conducted no more than 30 days prior to the start date of the IPC. If the CBAS participant is a Medi-Cal managed care member and the participant's plan requires submission more than 30 days prior to the IPC effective date, the CBAS provider must identify any change in condition requiring IPC amendment prior to implementation and amend it accordingly if a change to the IPC is needed.

G. CBAS Staffing

1. A CBAS provider shall employ or contract with a variety of staff and render required services as described in these SOPs. The staff providing CBAS center services shall meet all licensing requirements as specified in the California Business and Professions Code, as well as these SOPs, as appropriate to the individual staff person. A CBAS provider's staffing requirements shall be based on the provider's hours of service and the average daily attendance (ADA) from the previous three consecutive months. The ADA can also be tied to ADA levels on various days of the week so long as the CBAS provider can demonstrate that the ADA for those days are consistent.

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- a. "Hours of service" means the program hours for the provision of CBAS, which shall be no less than 4 hours excluding transportation. The hours of service shall be defined and posted by the adult day health care center.
2. Professional nursing coverage of the center shall include Registered Nurse (RN) staffing at a ratio of one RN for every 40 participants in ADA, or one RN for the first 40 participants and a half-time Licensed Vocational Nurse (LVN) for every increment of 10 in ADA exceeding 40 participants.
 - a. There shall be at least one licensed nurse physically present and performing nursing duties at the center at all times during the center's hours of service during which participants are present. The licensed nurse physically present may be an LVN, providing the LVN is under the supervision of the RN, is working within scope of practice, and the RN is immediately available by phone if needed.
3. Social services staffing must include social workers at a ratio of one medical social worker for every 40 participants in ADA, or one medical social worker for the first 40 participants and a half-time social worker assistant for every increment of 10 in ADA exceeding 40 participants.
4. The program aide staffing shall be at a ratio of one program aide on duty for up to and including 16 participants
 - a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
 - b. Any number of participants up to the next 16 shall require an additional program aide (for example, 17 participants require two program aides).
5. Participants' needs supersede the minimum staffing requirements specified in these SOPs. The CBAS provider shall be responsible for increasing staffing levels as necessary to maintain the health and safety of all participants and to ensure that services are provided to all participants according to their IPCs.
6. Physical, occupational, and speech therapy, and mental health services shall be provided at a minimum monthly rate of 20 total therapy hours for each increment of five participants in ADA.

H. Organization and Administration

The CBAS center shall be organized and staffed to carry out the services and other requirements specified in the waiver. Such organization shall include:

1. An administrator and full-time program director. An administrator or program director must be on duty at all times
 - a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.

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- b. The CBAS provider shall have a written policy for coverage of the administrator and program director during times of absence.
2. Sufficient supportive staff to conduct the CBAS provider's daily business in an orderly manner.
3. CBAS staffing that meets the individual professional requirements specified in relevant state laws and regulations and in these SOPs.
4. Financial and accounting records that fully disclose the disposition of all funds.
5. The maintenance of appropriate personnel and CBAS participant health records and personnel records.
6. Ability to comply with State reporting requirements as specified through Provider Bulletins, these SOPs, and as applicable, Medi-Cal managed care plan contract requirements. CBAS providers must report the following:
 - a. Discharge plan at time of disenrollment from the CBAS center:
 - i. Must be reported to CDA for fee-for-service CBAS participants and to the responsible managed care plan for managed care plan members.
 - b. Incident reports:
 - i. All incidents that threaten the welfare, safety, or health of the participant(s) shall be reported to CDA, and, if applicable, the CBAS participant's managed care plan within 48 hours of the incident and documented in writing in the required format. Such documentation shall be available to appropriate CDA/managed care plan staff at all times.
7. Written policies and procedures for center operations and the provision of services to CBAS participants.
8. Emergency Services – Maintenance of updated written procedures for dealing with emergency situations. Such procedures shall include, at a minimum all of the following:
 - a. Use of the local 911 system.
 - b. Appropriately trained personnel; at a minimum, all direct care staff shall be trained in first aid and certified in basic life support.
 - c. Written permission from all CBAS participants for transfer to and treatment by local hospitals or other treatment facilities as needed, which can be provided for in the participation agreement.
9. Grievance Procedures – A written grievance process whereby participants and family/caregivers can report and receive feedback regarding CBAS services.

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10. Civil Rights and Confidentiality – Adherence to all laws and regulations regarding civil rights and confidentiality of both participants and CBAS staff. CBAS providers are subject to Federal and State laws regarding discrimination and abuse and the reporting of such, inclusive of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Information Practices Act (IPA).
11. Quality Control/Quality Assurance – Quality control/quality assurance reviews that are in accordance with the Quality Assurance Plan, as described in the CMS-approved 1115 waiver (#11-W-00193/9).
12. Training Requirements – Training of all direct care CBAS staff regarding the care appropriate to each participant's diagnoses and his/her individual care needs.

Provision of training to CBAS staff is a requirement to be enrolled in Medi-Cal as a CBAS provider and is not separately reimbursable outside of the CBAS provider's rate by either Medi-Cal or the Medi-Cal managed care plans.

- A Training of CBAS staff shall include an initial orientation for new staff; review of all updated policies and procedures; hands-on instruction for new equipment and procedures; and regular updates on State and Federal requirements, such as abuse reporting and fire safety.
 - b. Training shall be conducted and documented on a quarterly basis and shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor(s).
13. Documentation – Maintenance of a health record for each CBAS participant that shall be available to appropriate DHCS/CDA and managed care plan staff for any scheduled or unscheduled visits.
 - a. This health record shall include documentation of all services provided and refused, the current IPC, referral requests and outcomes of said referral(s).
 - b. Health record documentation shall be maintained in compliance with applicable Federal and State laws and shall be retained by the CBAS provider for a minimum of seven years. Health records shall be stored so as to protect against loss, destruction, or unauthorized use.
 - c. The CBAS provider shall maintain administrative records that document compliance with these SOPs.

C. Community- Based Adult Services (CBAS)

95. Community-Based Adult Services (CBAS) Eligibility and Delivery System.

“Community Based Adult Services” 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.

a. CBAS Recipients are those persons who:

- i. Are age 18 years and older;
- ii. Derive their Medicaid eligibility from the State Plan and are either aged, blind, or disabled; including those who are recipients of Medicare.
- iii. Are Medi-Cal managed care plan members or are exempt from enrollment in Medi-Cal managed care.
- iv. Reside within a geographic services area in which the CBAS benefit was available as of April 1, 2012, as more fully described in STC 95(b), or are determined eligible for the CBAS benefit by managed care plans that contract with CBAS providers pursuant to STC 95(b) and STC 98(a)(ii).

b. Delivery System.

CBAS is a Medi-Cal managed care benefit in counties where CBAS existed on April 1, 2012. To the extent that the provision of CBAS is determined by DHCS to be both cost-effective and necessary to prevent avoidable institutionalization of plan enrollees within a plan's service area in which CBAS was not available as of April 1, 2012, CBAS may be a Medi-Cal managed care benefit pursuant to STC 98(a)(ii) available to that plan's enrollees at the discretion of the plan when it contracts with a CBAS provider that has been certified as such by DHCS. CBAS shall be available as a Medi-Cal fee-for-service benefit for individuals who do not qualify for, or are exempt from enrollment in, Medi-Cal managed care as long as the individual resides within the geographic service area where CBAS services are provided.

c. CBAS Program Eligibility Criteria. The CBAS benefit shall be available to all beneficiaries who meet the requirements of STC 95(a) and for whom CBAS is available based on STC 95(b) and who qualify based on the medical criteria in (i) through (vi):

- i. Meet medical necessity criteria as established in State law; and
- ii. Meet or exceed the “Nursing Facility Level of Care A” (NF-A) criteria as set forth in the California Code of Regulations; or
- iii. 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

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Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (f) Schizophrenia and Other Psychiatric Disorders, (g) Mood Disorders, (h) Anxiety Disorders, (i) Somatoform Disorders, (j) Factitious Disorders, (k), Dissociative Disorders, (l) Paraphilia, (m) Eating Disorders, (n) Impulse Control Disorders Not Elsewhere Classified (o) Adjustment Disorders, (p) Personality Disorders, or (q) 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:

- A. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
 - B. One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation.
- iv. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 of the Alzheimer's Type; or
 - v. Have a mild cognitive disorder such as dementia, including Dementia of the Alzheimer's Type, AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
 - vi. 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.
- d. CBAS Eligibility Determination.
Eligibility determination for the CBAS benefit will be performed as follows:
- i. 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 the State Medicaid Agency unless criteria under 95 (d)(ii) are met. The eligibility determination will be conducted by the beneficiary's managed care plan or the State Medicaid Agency or its contractor(s) for beneficiaries exempt from managed care.
 - ii. An initial face-to-face review is not required when a managed care plan 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.
 - iii. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by the managed care plan to be clinically appropriate.

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Denial or reduction of CBAS by DHCS or by a managed care plan requires a face-to-face review.

e. Grievances and Appeals

- i. A beneficiary who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.

96. CBAS Benefit and Individual Plan of Care (IPC).

CBAS benefits include the following:

- a. Core Services: Professional nursing care, personal care and/or social services, therapeutic activities, and a meal shall be provided to all eligible CBAS beneficiaries on each day of service as follows.
 - i. Professional nursing services provided by an RN or LVN, which includes one or more of the following, consistent with scope of practice: observation, assessment, and monitoring of the beneficiary's general health status; monitoring and assessment of the participant's medication regimen; communication with the beneficiary's personal health care provider; supervision of personal care services; and provision of skilled nursing care and interventions.
 - ii. Personal care services provided primarily by program aides which include one or more of the following: supervision or assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs); protective group supervision and interventions to assure participant safety and to minimize risk of injury, accident, inappropriate behavior, or wandering.
 - iii. Social services provided by social work staff, which include one or more of the following: observation, assessment, and monitoring of the participant's psychosocial status; group work to address psychosocial issues; care coordination.
 - iv. Therapeutic activities organized by the CBAS center activity coordinator, which include group or individual activities to enhance social, physical, or cognitive functioning; facilitated participation in group or individual activities for CBAS beneficiaries whose physical frailty or cognitive function precludes them from independent participation in activities.
 - v. A meal offered each day of attendance that is balanced, safe, and appetizing, and meets the nutritional needs of the individual, including a beverage and/or other hydration. Special meals will be provided when prescribed by the participant's personal health care provider.
- b. Additional Services. The following additional services shall be provided to all eligible CBAS beneficiaries as needed:
 - i. Physical therapy provided by a licensed, certified, or recognized physical therapist within his/her scope of practice.
 - ii. Occupational therapy provided by a licensed, certified, or recognized occupational therapist within his/her scope of practice.

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- iii. Speech therapy provided by a licensed, certified, or recognized speech therapist within his/her scope of practice.
- iv. Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by a licensed, certified, or recognized mental health professional within his/her scope of practice. Individuals experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning shall be referred by CBAS staff to the identified managed care plan, County Mental Health programs, or appropriate behavioral health professionals or services.
- v. Registered dietician services provided by a registered dietician for the purpose of assisting the CBAS beneficiary and caregivers with proper nutrition and good nutritional habits.
- vi. Transportation, provided or arranged, to and from the CBAS beneficiary's place of residence and the CBAS center, when needed.

c. Individual Plan of Care (IPC).

The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request.

The IPC is prepared by the CBAS center's multidisciplinary team based on the team's assessment of the beneficiary's medical, functional, and psychosocial status, and includes standardized components approved by the State Medicaid Agency. Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports. Person-Centered Planning includes consideration of the current and unique bio-psycho-social-cultural and medical needs and history of the individual, as well as the person's functional level, support systems, and continuum of care needs. CBAS center staff, the beneficiary, and his/her support team shall review and update the beneficiary's IPC at least every six months. Such review and updates must include an evaluation of progress toward treatment goals and objectives, and reflect changes in the beneficiary's status or needs. The IPC shall include at a minimum:

- 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 that need to be linked to individual objectives, therapeutic goals, and duration of service(s).

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- 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.
- xi. IPCs will be reviewed and updated no less than every six months by the CBAS staff, the enrollee, and his/her support team. Such review must include a review of the participant's progress, goals, and objectives, as well as the IPC itself.

97. CBAS Provider Specifications.

CBAS center staff shall include licensed and registered nurses; licensed physical, occupational, and speech therapists; licensed behavioral health specialists; registered dietitians; social workers; activity coordinators; and a variety of other non-licensed staff such as program aides who assist in providing services.

- a. Licensed, registered, certified, or recognized staff under California State scope of practice statutes shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.
- b. All staff shall have necessary experience and receive appropriate on-site orientation and training prior to performing assigned duties. All staff will be supervised by CBAS center or administrative staff.
- c. The State Medicaid Agency maintains Standards of Participation for all CBAS providers. These Standards of Participation are hereby incorporated by reference and can be found on the Department of Health Care Services and California Department of Aging (CDA) websites. Any changes in the CBAS Provider Standards of Participation must be submitted to CMS.

98. Responsibilities of Managed Care Plans for CBAS Benefits

The responsibilities of managed care plans for the CBAS benefit shall be consistent with each individual managed care plan's contract with DHCS and shall include that plans do the following.

- a. Contract Requirements for Managed Care Plans:
 - i. Contract with sufficient available CBAS providers in the managed care plans' covered geographic areas to address in a timely way the needs of their members who meet the CBAS eligibility criteria in 95(c). Sufficient means: providers that are adequate in number to meet the expected utilization of the enrolled population without a waitlist; geographically located within one hour's transportation time and appropriate for and proficient in addressing enrollees' specialized health needs and acuity, communication, cultural and language needs and preferences.
 - ii. Plans may, but are not obligated to, contract for CBAS with providers licensed as ADHCs and authorized by the Department to provide CBAS on

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- or after April 1, 2012. Plans are not obligated to develop new CBAS networks or capacity in geographical areas where CBAS capacity is limited or where ADHC was not available prior to April 1, 2012;
- iii. Where there is insufficient or non-existent CBAS capacity in the plan's covered geographic area and ADHC had been available prior to April 1, 2012, the plan shall arrange for the delivery of appropriate plan-covered benefits and coordinate with community resources to assist members, who have similar clinical conditions as CBAS recipients, to remain in the community.
 - iv. Confirm that every contracted CBAS provider is licensed, certified, operating, and meets the managed care plan's credentialing and quality standards.
 - A. The managed care plan may exclude any CBAS provider, to the extent that the managed care plan and CBAS provider cannot agree to terms, the CBAS provider does not meet the plan's credentialing or quality standards, is terminated pursuant to the terms of the CBAS provider's contract with the managed care plan, or otherwise ceases its operations as a CBAS provider.
 - B. The managed care plan shall provide the State Medicaid Agency a list of its contracted CBAS providers and its CBAS accessibility standards on an annual basis.
- b. Eligibility and Authorization: Develop and implement policies and procedures for CBAS eligibility determination and authorization that address the eligibility criteria set forth in STC 95, the processes and timelines in State law, and all of the following:
- i. Face-to-face eligibility determination (F2F) review requirements: the minimum standard is that the managed care plan will conduct an F2F eligibility determination for those beneficiaries who have not previously received CBAS through the plan, provided that the managed care plan has not already determined through another process that the member is clinically eligible for CBAS and in need for the start of CBAS to be expedited.
 - ii. Timeline for eligibility determination: the plan shall complete the F2F eligibility determination using the standard State-approved tool, as soon as feasible but no more than 30 calendar days from the initial eligibility inquiry request. The plan shall send approval or denial of eligibility for CBAS to the CBAS provider within one business day of the decision and notify the member in writing of his/her CBAS eligibility determination within two business days of the decision.
 - iii. Timeline for service authorization: After the CBAS eligibility determination and upon receipt of the CBAS treatment authorization request and individual plan of care (IPC), the plan shall:

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- A. Approve, modify or deny the authorization request within five business days of receipt of the authorization request, in accordance with State law.
 - B. Determine level of service authorization (i.e., days per week authorized) based on the plan's review of the IPC submitted by the CBAS provider, consideration of the days per week recommended by the CBAS multidisciplinary team, and the medical necessity of the member.
 - C. Notify the provider within one business day of the authorization decision. Notify the member within two business days of the authorization decision, including informing the member of his/her right to appeal and grievance processes in accordance with 95.e.
 - iv. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that an F2F will not be performed. At a minimum, expedited authorization shall occur within 72 hours of receipt of a CBAS authorization request for individuals in a hospital or nursing facility whose discharge plan includes CBAS, or when the individual faces imminent and serious threat to his or her health.
 - v. Written notices to the beneficiary shall include procedures and contacts for grievances and appeals.
 - vi. Guidelines for level of service authorization, including for the number of days per week and duration of authorization up to 12 months.
 - vii. Continuity of care: The managed care plan shall ensure continuity of care when members switch health plans and/or transfer from one CBAS center to another.
- c. Coordination with CBAS Providers: Coordinate member care with CBAS providers to ensure the following:
- i. CBAS IPCs are consistent with members' overall care plans and goals developed by the managed care plan.
 - ii. Exchange of participant discharge plan information, reports of incidents that threaten the welfare, health and safety of the participant,, and significant changes in participant condition are conducted in a timely manner and facilitate care coordination.
 - iii. Clear communication pathways to appropriate plan personnel having responsibility for member eligibility determination, authorization, care planning, including identification of the lead care coordinator for members who have a care team, and utilization management.
 - iv. Written notification of plan policy and procedure changes, and a process to provide education and training for providers regarding any substantive changes that may be implemented, prior to the policy and procedure changes taking effect.

99. CBAS Center Provider Oversight, Monitoring, and Reporting.

The State shall maintain a plan for oversight and monitoring of CBAS providers to ensure compliance and corrective action with provider standards, access, and

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delivery of quality care and services. Reporting of activity associated with the plan must be consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section IV, General Reporting Requirements. Such oversight, monitoring and reporting shall include all of the following:

- a. Enrollment Information: to include the number of CBAS beneficiaries served in the CBAS program, total determined eligible and ineligible quarterly, and explanation of probable cause of any negative change from quarter to quarter of more than five percent and description of any steps taken to address such variances.
- b. Summary of operational/policy development/issues, including complaints, grievances and appeals. The State shall also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.
- c. Summary of all quality assurance/monitoring activity undertaken in compliance with STC 100, inclusive of all amendments.

100. CBAS Quality Assurance and Improvement Strategy.

Quality assurance and monitoring of CBAS shall be consistent with that the managed care Quality Strategy required by 42 CFR Part 438 Subpart D which is integrated into the DHCS contracts with managed care plans statewide. Such a Quality Assurance and Improvement strategy shall assure the health and safety of Medi-Cal beneficiaries receiving CBAS services and shall address, at a minimum, all of the following:

- a. The quality and implementation of the CBAS beneficiary's person-centered IPC.
- b. The provider's adherence to State licensure and certification requirements.
- c. Financial oversight by the State Medicaid Agency, and
- d. Administrative oversight of the managed care plans by the State Medicaid Agency.

101. CBAS Provider Reimbursement.

- a. DHCS shall reimburse CBAS providers serving eligible Medi-Cal beneficiaries who are exempt from enrollment in Medi-Cal managed care at an all-inclusive rate per day of attendance per beneficiary. DHCS shall publish such rates.
- b. Managed care plans shall reimburse contracted CBAS providers pursuant to a rate structure that shall include an all-inclusive rate per day of attendance per plan beneficiary, or be otherwise reflective of the acuity and/or level of care of the plan beneficiary population served by the CBAS providers. Managed care plans may include incentive payment adjustments and performance and/or quality standards in their rate structure in paying CBAS providers.