

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

California's Bridge to Reform 1115 Demonstration Waiver (11-W-00193/9)
Community-Based Adult Services (CBAS) Amendment
Draft Special Terms and Conditions
June 10, 2014

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.

California's Bridge to Reform 1115 Demonstration Waiver (11-W-00193/9)
Community-Based Adult Services (CBAS) Amendment
Draft Special Terms and Conditions
June 10, 2014

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.

California's Bridge to Reform 1115 Demonstration Waiver (11-W-00193/9)
Community-Based Adult Services (CBAS) Amendment
Draft Special Terms and Conditions
June 10, 2014

- 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).

California's Bridge to Reform 1115 Demonstration Waiver (11-W-00193/9)
Community-Based Adult Services (CBAS) Amendment
Draft Special Terms and Conditions
June 10, 2014

- 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

California's Bridge to Reform 1115 Demonstration Waiver (11-W-00193/9)
Community-Based Adult Services (CBAS) Amendment
Draft Special Terms and Conditions
June 10, 2014

- 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:

California's Bridge to Reform 1115 Demonstration Waiver (11-W-00193/9)
Community-Based Adult Services (CBAS) Amendment
Draft Special Terms and Conditions
June 10, 2014

- 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

California's Bridge to Reform 1115 Demonstration Waiver (11-W-00193/9)
Community-Based Adult Services (CBAS) Amendment
Draft Special Terms and Conditions
June 10, 2014

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.