

business enrollees or Medicaid fee-for-service participants, if the provider accepts only Medicaid patients. Contracted services must be made available 24 hours per day, seven days per week when medically necessary. The State, through the health plan contracts must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.

- d. **Credentialing** - The State through its health plans must demonstrate that the health plan providers are credentialed. The State must also require these health plans to participate in efforts to promote culturally competent service delivery.
  - e. **Demonstrating Network Adequacy** - Annually the State must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area.
    - i. The State must provide supporting documentation that must show that the health plan offers an adequate range of preventive, primary, and specialty services care for the anticipated number of enrollees in the service area. The network must contain providers who are sufficient in number, mix, and geographic distribution to meet the anticipated needs of enrollees.
    - ii. The State through its health plans must submit this documentation when it enters into a contract.
    - iii. The State must submit this documentation any time that a significant change occurs in the health plan's operations that would affect adequate capacity and services.
    - iv. Significant changes include changes in services, benefits, geographic service area, or payments or the entity's enrollment of a new population.
- 42. Certification** – Prior to enrollment and annually, the State is required to certify to CMS that each health plan has complied with State standards for service availability and must make all documentation available to CMS upon request.
- 43. Concurrent Operation of the Multipurpose Senior Services Program (MSSP) 1915 (c) Home and Community Based Services (HCBS) program (CA 0141).** Payment for the MSSP 1915 (c) waiver services will be included in the plan capitation payments from the State starting July 1, 2014. Eligible beneficiaries in the seven CCI counties who are participating in the MSSP waiver will be allowed to join the Cal MediConnect program, if eligible, or mandatorily enrolled in a plan. The Cal MediConnect plans and Medi-Cal only managed care plans will be required to contract with MSSP providers to ensure on-going access to MSSP waiver services for MSSP enrolled beneficiaries at the time of transition through December 31, 2017. MSSP waiver providers will continue to provide the same services to MSSP Waiver participants/clients; however, they will receive payment for Medi-Cal managed care members from the plans. These requirements shall be outlined in the plan and MSSP Waiver provider contracts

## VIII. CONTINUING OPERATION OF DEMONSTRATION PROGRAMS

### Community-Based Adult Services (CBAS) for Medi-Cal State Plan Populations

- 44. 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 45, or are determined eligible for the CBAS benefit by managed care plans that contract with CBAS providers pursuant to STC 44(b) and STC 47(a)(ii).
  
- b. Delivery System.
  - i. 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 47(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. The State must ensure that plans have mechanisms to provide care coordination, person-centered planning continuity-of-care, out-of-network care, and other provisions related to newly enrolled managed care beneficiaries as described in STC 58
  
  - ii. 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 is provided.
  
  - iii. If there is insufficient CBAS Center capacity due to Center closure(s) to satisfy demand in counties where CBAS centers existed as of April 1, 2012, the State Medicaid Agency must assure that eligible CBAS beneficiaries that had received CBAS at the closed Center(s) have access to unbundled CBAS as needed for continuity of care and subject to the following general procedures:
    1. Managed care beneficiaries: For managed care beneficiaries who are eligible for CBAS and there is a 5% change from County capacity as of April 1, 2012, in the area, the MCO will authorize unbundled services and facilitate utilization through care coordination.
  
    2. Fee-for-Service beneficiaries: For FFS beneficiaries who are eligible for CBAS and there a 5% change from County capacity as of April 1, 2012, in the area, the following procedures will apply:

- DHCS will work with the local CBAS Center network and beneficiary’s physician to identify other available CBAS Centers, and the type, scope and duration of the CBAS the beneficiary needs.
- DHCS will work with the beneficiary’s physician to arrange for
  - needed nursing services,
  - referral to, or reassessment of, In-Home Supportive Services as needed for personal care services (or authorization of waiver personal care services needed in excess of the IHSS cap).
- If the beneficiary needs therapeutic services, DHCS will work with the beneficiary’s physician to coordinate the authorization of needed services.
- If the beneficiary needs mental health services, DHCS will work with the beneficiary’s physician to refer the beneficiary to the local mental health services program.

iv. In the event of a negative change in capacity of 5% or greater in any county for any reason, DHCS shall identify in the quarterly report for the same quarter as the negative change the provider capacity in that county for providing all core and additional CBAS services (as listed in STCs 45(a) and 45(b)) on an unbundled basis.

c. Home and Community-Based Settings. The state must ensure that home and community-based settings have all of the qualities required by 42 CFR 441.301(c)(4), and other such qualities as the secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by CFR 441.301(c)(4)(vi) must be met. The state will engage in a CBAS stakeholder process to amend the HCB settings statewide transition plan to ensure that all home and community-based settings found in the 1115 Demonstration have all of the qualities required by 42 CFR 441.301(c)(4). The state will amend the statewide transition plan to include all HCBS settings used by individuals in the 1115 Demonstration and submit to CMS no later than September 1, 2015, to ensure complete compliance with HCB Settings by March 17, 2019.

d. CBAS Program Eligibility Criteria. The CBAS benefit shall be available to all beneficiaries who meet the requirements of STC 44 and for whom CBAS is available based on STC 44 who meet medical necessity criteria as established in state law and who qualify based on at least one of the medical criteria in (i) through (v):

- i. Meet or exceed the “Nursing Facility Level of Care A” (NF-A) criteria as set forth in the California Code of Regulations; OR
- ii. 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 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; OR.

iii. 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

iv. 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

v. 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.

e. 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 (e)(ii) are met. The eligibility determination will be conducted by the beneficiary's managed care plan, or by 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.

iv. Denial in services or reduction in the requested number of days for services of ongoing CBAS by DHCS or by a managed care plan requires a face-to-face review.

f. 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.

ii. A CBAS participant may file a grievance with their Managed Care Organization as a written or oral complaint. The participant or their authorized representative may file a grievance with the participant's Managed Care Organization at any time they experience dissatisfaction with the services or quality of care provided to them, and as further instructed by the MCO.

#### 45. **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 and as specified on the person's IPC:
  - 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.
  - 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 whole person-centered project will comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying: 1) How the IPC will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

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 or when there is a change in circumstance that may require a change in benefits. 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).
- 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.

**46. 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 are found in Attachment W to these STCs. 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 approved by CMS.

**47. 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 with these STCs 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(d). 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 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 44, 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:
    - 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(f).
  - 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.

**48. 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 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 and reported to CMS on a quarterly basis. Such oversight, monitoring and reporting shall include all of the following:

- a. Enrollment Information: to include the number of CBAS FFS and MCO beneficiaries in each county the capacity of each county -, total determined eligible and

ineligible beneficiaries per county 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. The quarterly CBAS provider-reported data submitted to the CDA, identifying participant statistics, average daily attendance utilization at Centers, and capacity data.

c. 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.

d. Summary of all quality assurance/monitoring activity undertaken in compliance with STC 100, inclusive of all amendments.

e. CBAS FFS and Managed Care Access Monitoring. The State Medicaid Agency will assure sufficient CBAS access/capacity, through the mechanisms listed below, in every county where CBAS existed as of April 1, 2012.

- i. Review the total number of individuals receiving a new assessment for CBAS vs. the total number of individuals obtaining ongoing CBAS and the number of participants obtaining unbundled services. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.
- ii. Review of overall utilization of CBAS, including newly opened or closed Centers. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.
- iii. Review of FFS and MCO grievances and appeals by CBAS enrollees for areas including but not limited to: appeals related to requesting services and not able to receive services or receiving more limited services than requested, excessive drive/ride times to access CBAS, grievances around CBAS providers, grievances around FFS or MCO staff in assessment, any reports pertaining to health and welfare of individuals utilizing CBAS, and any reports pertaining to requesting a particular CBAS provider and unable to access that provider. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plans that addresses such variances.
- iv. A review of any other beneficiary or provider call center/line for complaints surrounding the provision of CBAS benefits through FFS or the MCOs. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plans that addresses such variances.
- v. Review the CBAS provider capacity per county vs. the total number of beneficiaries enrolled for CBAS each quarter. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

- vi. Evidence of sufficient access monitoring and corrective action plans must be provided to the regional office annually and at any other time a significant impact to the MCO's operations are administered
- vii. If it is found that the State did not meet the monitoring mechanisms listed above, CMS reserves the right to withhold a portion or all of FFP related to CBAS until which time the State provides adequate documentation assuring sufficient access.

**49. CBAS Quality Assurance and Improvement Strategy.** Quality assurance and monitoring of CBAS shall be consistent with 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 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.

**50. 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. Plan payments must be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. Managed care plans may include incentive payment adjustments and performance and/or quality standards in their rate structure in paying CBAS providers.

**51. CBAS Program Integrity**

- a. Following a determination that a credible allegation of fraud exists involving a CBAS provider, the state shall notify managed care plans promptly of the finding. The state must require managed care plans to report, in a timeframe and manner as specified by the state, but no less frequently than quarterly, to the state all payments made to the applicable CBAS provider for CBAS services provided after the date of notification; the state must disclose this information to CMS beginning with payments made on or after April 1, 2016.
- b. If the credible allegation of fraud is proven:
  - i. For purposes of claiming FFP, the state must adjust its claiming associated with payments to a managed care plan to account for an amount equal to what the managed care plan has paid to an applicable CBAS provider for dates of services occurring after the state has notified the managed care

plan that the CBAS provider has been referred for investigation. The state shall refund the federal share associated with such payments in accordance with Attachment OO.

- ii. The state may recoup from its payment to a managed care plan an amount equal to what the managed care plan has paid to the applicable CBAS provider for dates of service after the state has notified the managed care plan that the CBAS provider has been referred for investigation.
- iii. Additional specifications pertaining to these requirements including information about how payments and claiming will be adjusted and MCPs will be notified are set forth in Attachment OO in accordance with the Medicaid Managed Care proposed rule at 80 FR 31097 or the finalized 42 CFR 438. The state must submit Attachment OO by June 30, 2016.

### California Children's Services (CCS)

52. **CCS Demonstration Project Approval.** The demonstration project will test two health care delivery models for children enrolled in the California Children's Services (CCS) Program. The two demonstration models include provisions to ensure adequate protections for the population served, including a sufficient network of appropriate providers and timely access to out of network care when necessary. The plan shall also include specific criteria for evaluating the models. These CCS pilot models shall be eligible for FFP from the Date of CMS approval through the term of the demonstration. In addition, the pilot programs are limited to the two current counties that are authorized as of the date of this approval.
53. **CCS Demonstration Project Protocol.** The overarching goal of the CCS pilot project is for the State to test two models of health care delivery for the CCS population that results in achieving the desired outcomes related to timely access to care, improved coordination of care, promotion of community-based services, improved satisfaction with care, improved health outcomes and greater cost-effectiveness. The demonstration will be analyzed on the following:
  - a. A Program Description – inclusive of eligibility, benefits, cost sharing;
  - b. Demonstration Program Requirements - inclusive of eligibility, enrollment, benefits, and cost-sharing;
  - c. Budget/Allotment Neutrality projections
  - d. Outcomes for:
    - i. Ensuring that the CCS population has access to timely and appropriate, high quality and well-coordinated medical and supportive services that are likely to maintain and enhance their health and functioning and meet their developmental needs.
    - ii. Increasing patient and family satisfaction with the delivery of services provided through the CCS program.
    - iii. Increasing satisfaction with both the delivery of and the reimbursement of services.
    - iv. The State's ability to measure and assess those strategies that are most and least effective in improving the cost-effectiveness of delivering high-