

**Community-Based Adult Services (CBAS) Providers  
Special Terms and Conditions  
August 29, 2013**

|   | # | Terms and Conditions   | Recommended Actions |     |        |              | Amendments/<br>Comments/Questions                       | Meeting Feedback/Discussion  |
|---|---|--|---------------------|-----|--------|--------------|---|--|
|   |   |  | Delete              | Add | Change | No<br>Change |   |  |
|   | 1 | 95. Community-Based Adult Services (CBAS) Eligibility and Enrollment.<br><br>"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, and transportation to certain State Plan beneficiaries. |                     |     |        |              | how to get flexibility non-institutional licensed ADL/C | Flexibility in the model to be facility and community based to engage in other settings. Issues to consider: If take out facility, unclear where services will be provided. If want to provide services in the home, need to get a separate license. |
| 1 | 2 | a. <u>CBAS Program</u> must be operational for the period from April 1, 2012, through August 31, 2014 for CBAS Beneficiaries who :   |                     |     | x      |              |   | Has to change to reflect new time frame – to be done in the future.  |
| 2 | 3 | i. Are those persons who are age 18 years and older;   |                     |     |        | x            |   |  |
| 2 | 4 | ii. Derive their Medicaid eligibility from the State Plan and are either aged, blind, or disabled; including those who are recipients of Medicare.   |                     |     |        | x            |   |  |
| 2 | 5 | b. <u>CBAS Program Enrollment Criteria</u> . The CBAS benefit will be available to all CBAS beneficiaries who qualify based on the medical criteria in (i) through (vi) and comply with the requirement in (vii) to enroll in managed care for CBAS services:  |                     |     |        | x            |   |  |
| 2 | 6 | i. Meet medical necessity criteria as established by the State, and <i>law</i>   |                     |     |        | x            |   | Make it explicit where it's established - W & I Code.  |
| 2 | 7 | ii. Meet "Nursing Facility Level of Care A"  |                     |     |        | x            | Firm language to say per W & I code                     |  |

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|   |    | (NF-A) criteria as set forth in the California Code of Regulations, or above NF-A Level of Care; or  |                     |     |        |           |   |                             |
| 2 | 8  | 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  |                     |     |        | x         | Like to see the language in criteria firmly state diagnosis of ... (Some centers / plans base categorical info. on IDT assessments or use language of as characterized by.) |                             |
| 2 | 9  | iv. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer's Type, AND needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene, or;   |                     |     |        | x         |   |                             |
| 2 | 10 | 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, or; |                     |     |        | x         |   |                             |
| 2 | 11 | vi. Have a chronic mental disorder or acquired, organic, or traumatic brain injury. "Chronic mental disorder" means the enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the  |                     |     |        | x         |   |                             |

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|   |    |   | Delete              | Add | Change | No<br>Change |                                   |                             |
|   |    | 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) Paraphilias, (m) Gender Identity Disorders, (n) Eating Disorders, (o) Impulse Control Disorders Not Elsewhere Classified (p) Adjustment Disorders, (q) Personality Disorders, or (r) 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: |                     |     |        |              |                                   |                             |
| 2 | 12 | 1. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or  |                     |     |        | x            |                                   |                             |
| 2 | 13 | 2. One need from the above list and one of the following: money management;   |                     |     |        | x            |                                   |                             |

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|   |    | accessing community and health resources; meal preparation, or transportation.   |                     |     |        |           |   |   |
| 1 | 14 | vii. <i>Enrollment for Non-CBAS services.</i> No sooner than July 1, 2012, if the CBAS beneficiary is eligible to enroll in a managed health care plan in the counties specified in Attachment O, the CBAS beneficiary must be enrolled in the managed care plan to receive the CBAS benefit. This requirement does not apply to otherwise eligible CBAS beneficiaries residing in a county that is not listed in Attachment O or who are exempted from or ineligible for enrollment in a managed care plan. | x                   |     | x      |           | No longer applicable<br><i>ADD Enrollment for CBAS services</i>   | Have definition for enrollment, but current language no longer needed.  |
| 2 |    |  |                     |     |        |           |   |   |
| 1 | 15 | c. <u>CBAS Patient Protections.</u><br>i. <i>No Disruptions in Care.</i> State Plan Beneficiaries who previously received Adult Day Health Care Services between July 1, 2011 and February 29, 2012 must have a <u>face to face assessment to determine CBAS enrollment qualification</u> , but there will be no disruption in care until the face to face assessment has been conducted.  | x                   |     | x      |           | Within the current new environment of CCI and CMC, the plans have a more complete picture of their members and should have the choice of conducting F2F or not, depending on the degree of confidence they have that a referral to CBAS will yield an enrollment after the 3-day assessment.<br><br>There needs to be an agreed upon pathway for communication between the plan and the CBAS centers to | With CCI it may not be necessary to do a F2F because plans will already have necessary client assessments. Beneficiaries will have identified risk level. Could allow quicker enrollment. Talk about this in the IPC section. |
| 2 |    |  |                     |     |        |           |   |   |

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|  |   |                      |                     |     |        |           | <p>share assessment findings and make adjustments as indicated.</p> <p>Specifically if there is a change in status or newly identified problem as part of the CBAS quarterly assessment or ongoing observation, how to ensure that the Plan has a built in system to respond to a specific change in status for that client.</p> <p>If there is a change in status – which “Care Coordinator” should follow Cal Medi Connect may have the option to provide Care Coordination, but how to ensure a warm hand off to another program if necessary for the client.</p> <p>No longer applicable</p> |                             |

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| 1 | 16 | ii. <i>Second Level Review.</i> State Plan Beneficiaries who previously received Adult Day Care Services between July 1, 2011, and February 29, 2012 and have been determined not to meet the level of care for CBAS by the Department or a managed health care organization may request a second level review. The second level review may be requested by the beneficiary, their family or guardian. An individual must continue to receive CBAS services if the individual was receiving CBAS prior to being determined ineligible for CBAS until the second level review has been completed. The second level of review must not be conducted by the same individual that conducted the initial face to face review. Individuals determined not eligible must have a Discharge Plan of Care completed and provided in writing to the individual, family member or guardian. Individuals determined ineligible for CBAS through a second level review shall retain the right to all Medicaid due process provisions including aid pending the outcome of a hearing or appeal. | x                   |     | x      |           | No longer applicable              | No further comments.                 |
| 2 |    |  |                     |     |        |           |                                   |                                      |
| 4 | 17 | On a yearly basis in the report required by  | x                   |     |        |           |                                   | Part of state negotiations with CMS. |

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|   |    | paragraph 0, the State must report the number of second level of reviews requested, including but not limited to the number of second level of reviews which resulted in a reversal of the initial decision. If the data reveal that there are issues with the second level of reviews, CMS reserves the right to require that the second level of review be completed by an entity/agency independent of the initial assessment reviewer. |                     |     |        |           | <p><i>State Reporting to CMS</i></p> <p>This requirement was specific to the eligibility reviews conducted as part of the settlement.</p>  | Propose deletion.  |
| 1 | 18 | iii. <i>Continuity of Care.</i> In referring a beneficiary for CBAS services under paragraph <b>Error! Reference source not found.</b> (d)(iii) to a CBAS Center, consideration will be given to the CBAS beneficiary's relationship with previous <u>providers of similar services</u>  |                     |     | x      |           | <p><i>Person-centered</i></p> <p><i>Keep concept</i></p> <p><i>Quality metrics</i></p> <p>"Continuity of Care" is not a good title for this category, but we could not think of a better overall one. But should refer to maintaining continuity of services beyond that of CBAS and maintaining relationships with those other providers.</p> | Keep the concept, but change the title. Person-centered. Need quality metrics associated with this. Possibly add to SOPs.  |
| 1 | 19 | iv. <i>Discharge Plan of Care.</i> State Plan and CBAS beneficiaries determined not in need of CBAS services will be provided a written Discharge Plan of care to be completed by a CBAS center. The Discharge Plan of care must contain:  |                     |     | x      |           | <p><i>SOP</i></p> <p>Discharge in this category should apply specifically to <u>discharge from the program</u> and not <u>"discharge planning"</u> for care plans.</p> <p><i>Written discharge</i></p>   | <p>Keep the concept. Contractual piece between centers and plans. Might be better placed in SOPs.</p> <p>Suggestion to add a section regarding relationship between managed care plans and providers – to include items such as discharge, eligibility/authorization</p> |

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|   |    |   |                     |     |        |           |  | processes and timelines, etc.                                  |     |
| 1 | 20 | 1. The name(s) of the patient's physician(s) and the patient's ID number.   |                     |     |        | X         | SOP<br>timeline for completion<br>ADD section re HP + CBAS   |  |     |
| 1 | 21 | 2. The date the Notice was issued.  |                     |     |        | X         |  | SOP  |     |
| 1 | 22 | 3. The date the CBAS services are to end.   |                     |     |        | X         |  | SOP  |     |
| 1 | 23 | 4. Specific information about the patient's current medical condition, treatments and medication regime.  |                     |     | X      |           |  | SOP  |     |
| 1 | 24 | 5. A statement about Enhanced Case Management Services and how they will be provided to those eligible State plan beneficiaries   |                     |     | X      | SOPs      | We assume that anyone is eligible to ask for Plan case management services, but the level of care management could be lower or greater than "enhanced" which seems to be a definition specific to CBAS transition. | SOP  |     |
| 1 | 25 | 6. A statement of the right to file a Grievance or Appeal, or to request a second level review.   |                     |     |        |           | X  |  | SOP |
| 1 | 26 | 7. A space for the beneficiary or representative to sign and date the document.   |                     |     |        |           | X  |  | SOP |
|   | 27 | v. <i>Grievances and Appeals.</i> Individuals who receive a notice of adverse action are entitled to file a Grievance or Appeal as they are entitled under State and Federal law. |                     |     |        |           | Both FFS / M Care  | Should retain somewhere for FFS and Managed Care participants. |     |

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| 4 | 28 | vi. The State must submit to CMS for review the notices of adverse action that will be sent to CBAS beneficiaries outlining their new services and due process rights, before they are sent to the beneficiaries.  | x                   |     |        |           | This was specific to the settlement agreement.  | State to negotiate with CMS.  |
| 1 | 29 | <p>d. <u>CBAS Assessment</u>. Assessment for the CBAS benefit will be performed as follows:</p> <p>i. The initial assessment for the CBAS benefit will be performed through a <u>face-to face review</u> by a registered nurse with level of care experience, using a standardized tool and protocol approved by the State Medicaid Agency. The assessment may be conducted by the State Medicaid Agency or its contractor(s), including a CBAS beneficiaries' Managed Care Plan.</p> <p><i>Eligibility Determination- STC</i></p> |                     | x   | x      |           | <p>Overarching concern that this process is taking 2 months or more in some regions and should be streamlined.</p> <p>This conforms to the idea in #15 that some Plan Members will not require a F2F because the Plan has already screened them as appropriate for referral to CBAS based on HRA data etc.</p> <ul style="list-style-type: none"> <li>Consider how to improve current requirement of F2F and eligibility determination prior to 3-day CBAS assessment.</li> </ul> <p>Also, build in expedited assessment and/or presumptive or retroactive eligibility when certain criteria are met.</p> <p>Refer to F2F time guidelines from Medi-cal contract to add the detail here</p> | <p>Different reassessment for returning participants. Plans open to being lenient on this. Decisions should be driven by beneficiary clinical status. Look at this issue in more detail in SOPs, include timelines for eligibility determination and authorization that are currently in contract but not specified in STCs or SOPs. Still needs to be included here, at least generally, for CMS purposes.</p> <p>Centers assume risk when taking clients before authorization given by plans – can be discussed during SOPs as well. What can we streamline to expedite this process? It takes a long time to just get the health record from PHCP before plans will come in to do an assessment. Workgroup agreed there's a need to change the process to make it easier to enroll participants.</p> |

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| 2 |    |  |                     |     |        |           |   |  |
| 2 | 30 | ii. CBAS beneficiaries' <u>eligibility must be re-determined at least every six months</u> , or whenever a change in circumstances occurs that may require a change in the individual's CBAS benefit.  |                     |     |        | x         | <i>as determined by needs of client</i> | CBAS centers are required by law/reg to conduct quarterly and 6 month reassessment, but Workgroup should consider reauthorization annually for select participants. Talk about this during the SOP discussion. |
| 2 | 31 | iii. CBAS will be provided:<br>a. To CBAS beneficiaries who have been referred for an assessment, are assessed, and are determined to meet the eligibility criteria in STC <b>Error! Reference source not found.</b> ;                                     |                     |     | x      |           |   |  |
| 1 | 32 | b. State Plan Beneficiaries who previously received Adult Day Health Care (ADHC) services between July 1, 2011, and February 29, 2012, and are assessed and determined to meet the eligibility criteria in STC <b>Error! Reference source not found.</b> ; | x                   |     |        |           | PER ...clean up reference               | No further comments for 32-34  |
| 2 |    |  | x                   |     |        |           |   |  |
| 1 | 33 | c. State Plan Beneficiaries who previously received ADHC services  | x                   |     |        |           |   |  |

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| 2  |    | between July 1, 2011, and February 29, 2012, and who have not yet been assessed by the State Medicaid Agency for eligibility for CBAS; or  |                     |     |        |           |   |  |
| 1  | 34 | d. State Plan Beneficiaries who previously received ADHC services between July 1, 2011, and February 29, 2012 and who have been determined to be ineligible for CBAS, but for whom a care plan has not been developed and/or acted upon.                               | X                   |     |        |           |   |  |
| 2  |    |  |                     |     |        |           |   |  |
| 10 | 35 | e. <u>CBAS Individual Plan of Care (IPC)</u> . "Individualized Plan of Care" is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual.  |                     |     | X      |           | Governing Statute: H&S 1570.7(i), defines IPC.                                      | Plan/CBAS provider collaboration in developing IPC as part of larger care plan required for all Plan members. How can the CBAS IPC be retooled to better reflect the larger care plan and its goals, not just CBAS. Update and streamline this section for items until 48. |
| 10 | 36 | The IPC is prepared by the CBAS Center's multidisciplinary team and will include an element of Person-Centered Planning, which is a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. |                     |     | X      |           | Governing Statute: WIC 14529 (d)(2)<br>Cross reference SOP, CBAS Services, item 15. |  |
| 10 | 37 | Person-Centered Planning includes consideration of the current and unique bio-psycho-social and medical needs and history of the individual, as well   |                     |     | X      |           |   |  |

*ans*  
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*one IPA*

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|    |    | as the person's functional level, support systems, and continuum of care needs.  |                     |     |        |           |  |                             |
| 10 | 38 | The IPC will include:  |                     |     | x      |           | <i>np will work with CBAS access to all dental in to</i> |                             |
| 10 | 39 | i. Medical diagnoses.  |                     |     |        |           |  |                             |
| 10 | 40 | ii. Prescribed medications.  |                     |     |        |           |  |                             |
| 10 | 41 | iii. Scheduled days at the CBAS center.  |                     |     |        |           |  |                             |
| 10 | 42 | iv. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis.  |                     |     |        |           |  |                             |
| 10 | 43 | v. Elements of the services which need to be linked to individual objectives, therapeutic goals, and duration of service(s).   |                     |     |        |           |  |                             |
| 10 | 44 | vi. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities.   |                     |     |        |           |  |                             |
| 10 | 45 | vii. Participation in specific group activities.   |                     |     |        |           |  |                             |
| 10 | 46 | viii. Transportation needs, including special transportation.  |                     |     |        |           |  |                             |
| 10 | 47 | ix. Special diet requirements, dietary counseling and education, if needed.  |                     |     |        |           |  |                             |
| 10 | 48 | x. A plan for any other necessary services that the CBAS center will coordinate.   |                     |     |        |           |  |                             |
| 10 | 48 | xi. IPCs will be reviewed and updated on no less than every six months by the CBAS staff, the enrollee and his/her support team. Such review must include a review of progress, goals, and objectives, and the IPC itself. |                     |     |        |           |  |                             |

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| 9 | 49 | f. <u>Basic CBAS Benefits.</u> The following services will be provided to all eligible CBAS beneficiaries:<br>i. Nutrition service – one balanced, safe, and appetizing meal that meets the nutritional needs of the individual including beverage and/or other hydration. Special meals will be provided by the CBAS Center when required by the enrollee’s physician. |                     |     |        | X            | Governing Statutes: WIC 14550 (d)(1)(2); 14550.5(d).<br><br>Cross reference SOP CBAS Services, items 20 & 21.   |   |
| 9 | 50 | ii. Professional nursing care, including RN and LVN services. Professional nursing will be organized, appropriately staffed, and equipped to provide skilled nursing care to CBAS Beneficiaries receiving CBAS services.  |                     | X   | X      | X            | Add care coordination; consider flexibility with nurses going out into community; medication reconciliation<br><br>Governing Statutes: WIC 14550c)(1)(2); 14550.5(a)(1-5) | Difference between care coordination and communication. Define in contractual relationships between plans and centers as needed. CBAS centers required by law/reg to coordinate care with other medical service providers, the caregivers, and community organizations. |
| 9 | 51 | iii. Therapeutic activities aimed at enhancement of the social, physical, or cognitive functioning of the CBAS Beneficiary.   |                     |     |        | X            |   |   |
| 9 | 52 | iv. Facilitated participation in group or individual activities for CBAS Beneficiaries whose physical frailty or cognitive function precludes them from independent participation in activities.  |                     |     |        | X            | Governing Statutes: WIC 14550(g); 14550.5(c)(1)   |   |
| 9 | 53 | v. Social services provided by a social worker to facilitate and assist the CBAS Beneficiary and his/her family and/or caregivers in providing  |                     | X   | X      | X            | Add care <del>coordination</del> <i>nursing social SW</i> consider flexibility for SW going out into the community.   | CBAS centers required by law/reg to coordinate care with other medical service providers, the caregivers, and   |

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|   |    | necessary home care and to cope with issues related to aging and disability.  |                     |     |        |              | Governing Statutes: WIC 14550(f); 14550.5(b)(2)   | community organizations.    |
| 9 | 54 | vi. Personal care services provided primarily by program aides to assist the CBAS Beneficiary with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). |                     |     |        | x            | Governing Statutes: WIC 14550(c)(2); 14550.5(b)(1)  |                             |
| 9 | 55 | g. <u>Additional CBAS Benefits.</u> The following additional benefits will be provided to all eligible CBAS beneficiaries when specified on the person's IPC:                           |                     |     |        |              | Cross reference SOP CBAS Services, item 22 & 23.  |                             |
| 9 | 56 | i. Physical therapy provided by a licensed, certified, or recognized physical therapist within his/her scope of practice.   |                     | x   | x      |              | Physical Therapy "skilled services" inside of the CBAS center are always provided under the supervision of PT but not necessarily by the PT (may an assistant or aide).<br>.Guidelines for what constitutes individual versus group have already been placed via SBS guidelines. Regulatory guidelines are already in place for the Maintenance program<br>Governing Statute: WIC 14550(a)(2)<br><i>Should there be something included to differentiate whether the level of care is actually on an individual basis with a physical therapist or in a group setting without?</i> | <i>Might belong in SOPs</i> |

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| 9 | 57 | ii. Occupational therapy provided by a licensed, certified, or recognized occupational therapist within his/her scope of practice. |                     | x   | x      |           | <p>Governing Statute: WIC 14550(a)(2)</p> <p>Occupational Therapy “skilled services” inside of the CBAS center are always provided under the supervision of OT but not necessarily by the OT (may be an assistant or aide).</p> <p>Important to maintain integrity and IDT approach of CBAS model while increasing flexibility.</p> <p><i>Can we indicate if this could be done in an outpatient setting vs CBAS setting and if there are barriers to getting this service in an outpatient setting what are those barriers? Transportation?</i></p> <p>Governing Statute: WIC 14550(a)(1)</p> |                             |
| 9 | 58 | iii. Speech therapy provided by a licensed, certified, or recognized speech therapist within his/her scope of practice.            |                     | x   | x      |           | <p>Speech Therapy “skilled services” inside of the CBAS center are always provided under the supervision of ST but not necessarily by the ST (may be an assistant or aide).</p> <p><i>Can we indicate if this could be done in an outpatient setting vs CBAS setting and if there are barriers to getting this service in an outpatient setting what are those barriers? Transportation? And what is the</i></p>   |                             |

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|   |    |   | Delete              | Add | Change | No Change |   |   |
|   |    |   |                     |     |        |           | <i>anticipated duration of treatment and treatment goals?</i><br>Governing Statute: WIC 14550(a)(3)   |   |
| 9 | 59 | iv. Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by licensed, certified, or recognized mental health specialist under scope of practice statutes. Individuals experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning will be referred by CBAS staff to County Mental Health programs, or psychiatrists or psychologists, other mental health specialists, or emergency mental health services. |                     | x   | x      |           | <i>Would like to see something about how frequently medication review and reconciliation are done and some clarification as to what will be done by CBAS facilities that have BH capability vs CMH. CBAS could perform additional services with a value added rate. Community MH has limited capacity Nurses perform medication reconciliation. Might consider embracing some of the ADCRC model guidelines as dementia patients are excluded from county</i><br><br>Governing Statute: WIC 14550(e). | Change wording to include health plan. May not need to have this much detail. |
| 9 | 60 | v. Registered dietician services provided by a registered dietician for the purpose of assisting the CBAS Beneficiary and/or family caregivers in assuring proper nutrition and good nutritional habits in the CBAS center and in the recipient's home.   |                     | x   | X      |           | Registered dietician consults on as needed basis (i.e. specialized diet, physician's request). RD oversees CBAS diet/menu. RN used for ongoing dietary teaching within scope of practice.<br><br><i>Would like to assess frequency of this service per client as I do not seeing a dietary recommendation being a service that needs to be done on a weekly basis – more like once a</i>  |   |

less detail

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|   |    |   | Delete              | Add                            | Change | No Change |   |  |
|   |    |   |                     |                                |        |           | <i>month and as needed.</i>   |  |
| 9 | 61 | vi. Transportation to and from the CBAS Beneficiary's place of residence and the CBAS center through its transportation, or via a transportation service in vehicles accessible to the CBAS Beneficiary that are properly licensed and maintained pursuant to applicable laws. Drivers will be appropriately licensed and maintain a good driving record which will be verified by the CBAS administrative staff at least annually. |                     | x                              | x      | x         | Governing Statute: WIC 14550(d)(2)<br><i>Add language about paratransit use.</i><br>Governing Statute: WIC 14550(h) | Add language to clarify center responsibilities and to be consistent with regulations. |
|   |    |   |                     | <i>change consistent w reg</i> |        |           |   |  |
| 1 | 62 | <del>h. Delivery System. CBAS will be provided on a fee-for-service basis from April 1, 2012 through at least June 30, 2012. No sooner than July 1, 2012, CBAS services will be provided as follows:</del>  |                     |                                | x      |           |   | Leave only: "CBAS services will be provided as follows"                                |
| 1 | 63 | i. Counties that have implemented managed care: CBAS will only be available to eligible individuals enrolled in managed care for non-CBAS care, and CBAS will be furnished through the same managed care entity, except as set forth in (iii) below.  | x                   |                                | x      |           | <i>This reference to "non CBAS care" is no longer needed because of CCI</i>   | How does the state ensure all beneficiaries have the same opportunity – Parking Lot    |
| 2 |    |   |                     |                                |        |           |   |  |
| 1 | 64 | ii. <del>Counties that have not yet implemented managed care.</del> CBAS will be provided, bundled (through CBAS centers) and   |                     |                                |        | x         | <i>This may be a moot point by August 2014.</i>   |  |

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|   |    | unbundled (i.e., component parts of CBAS center services delivered outside of centers – made available per (v) below), as a fee-for-service benefit to all eligible CBAS Beneficiaries.  |                          |     |        |           |  |  |
| 1 | 65 | iii. Individuals who qualify for CBAS but do not qualify for managed care, or who have been exempted from, managed care based on a Medical Exemption Request: CBAS will be provided as a fee-for-service benefit.  | x                        |     |        | x         | Is MER going to be available only in the CCI counties? Because otherwise they have a choice to not enroll in MCMC. MERs were not given to CBAS.                    | Medical exemptions not applicable to duals. But language needed for medically eligible individuals who have a MER so they can still have access to CBAS. Keep in STCs. |
| 2 |    |  |                          |     |        |           |  |  |
|   | 66 | iv. Nothing in this section exempts the State from managed care requirements of 42 CFR 438.  |                          |     |        |           |  |  |
| 1 | 67 | v. If there is insufficient CBAS Center capacity to satisfy demand in counties with ADHC centers as of December 1, 2011, the State Medicaid Agency must assure that CBAS beneficiaries have access to the unbundled CBAS services as needed and subject to the following general procedures: |                          |     |        | ?x        | Need a mechanism to permit expansion.<br>Need ability to have room for innovative programs including possible ADCRC, Social Day or other specialized need programs | Programmatic issue for the future. Parking lot.  |
| 3 |    |  | * Capacity - parking lot |     |        |           | Need to define capacity in a better manner than licensed capacity because does not take into account functional capacity, nor language and cultural needs.         |  |
|   |    |  | Capacity - not STCs      |     |        |           | Ensuring access continues to be critical. Even if it is not part of the  |  |

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|   |    |  |                     |     |        |           | <p>Special Terms &amp; Conditions, but instead included in the Standards of Participation or elsewhere, the State should take steps should to encourage identify access issues to this important service. Steps should also be taken to develop new CBAS programs in areas where there is no center, or restarting services at sites that have closed.</p> <p>In addition, DHCS and health plans should promote increased utilization of current programs and services by taking active steps to link members to local programs. NOTE: time is often of the essence for beneficiaries in determining eligibility and initiating services. Standards for prompt processing of eligibility should be maintained in the Standards of Participation.</p> |   |
| 1 | 68 | 1. Managed care beneficiaries: For managed care beneficiaries, if the MCO assessed a beneficiary and | x                   |     |        | x         | <p>Unbundled services are still very much needed in areas where a CBAS center closed or one is not currently available, especially rural areas that</p>  | <p>Modify concepts (68-74) to fit current requirements for FFS/managed care beneficiaries? Some beneficiaries still receive unbundled services. Don't</p> |

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|   |    | determines that he or she is eligible for CBAS services and the MCO/CBAS Center determines that there is insufficient CBAS center capacity in the area, the MCO would authorize unbundled services and facilitate utilization through care coordination. |                     |     |        |           | are too distant from the nearest center to be served, or when transportation is not available. Unbundled services should continue.  | specify what services are needed, as long as they help keep individual in the community. Leave in as covered benefit, not as prescriptive as currently defined, until CCI in effect in all counties. To be discussed at 2/4 Workgroup meeting. |
| 2 |    |  |                     |     |        |           |   |  |
| 3 |    |  |                     |     |        |           |   |  |
| 1 | 69 | 2. Fee-for-Service beneficiaries: For FFS beneficiaries who are CBAS eligible but who do not have access to a CBAS center, the following procedures will apply:  | x                   |     |        | x         | Should this section be eliminated? Or does the ability to provide fee for service provide a degree of flexibility for those programs in rural regions or others not yet in the managed care program? We want to allow flexibility, but not add a layer of bureaucracy. This area will also influence section 90 and beyond. |  |
| 2 |    |  |                     |     |        |           |   |  |
| 3 |    |  |                     |     |        |           | These services should continue.   |  |
| 1 | 70 | • DHCS will identify the type, scope and duration of the CBAS services   | x                   |     |        | x         | These unbundled services should continue.   |  |
| 2 |    |  |                     |     |        |           |   |  |

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|   |    |   | Delete              | Add | Change | No Change |  |                             |
| 3 |    | the beneficiary needs.  |                     |     |        |           |  |                             |
| 1 | 71 | <ul style="list-style-type: none"> <li>• DHCS will arrange for               <ul style="list-style-type: none"> <li>○ needed nursing services,</li> </ul> </li> </ul>   | x                   |     |        | x         | These unbundled services should continue |                             |
| 2 |    |   |                     |     |        |           |  |                             |
| 3 |    |   |                     |     |        |           |  |                             |
| 1 | 72 | <ul style="list-style-type: none"> <li>○ referral to In-Home Supportive Services for additionally needed personal care services (or authorization of waiver personal care services needed in excess of the IHSS cap).</li> </ul>  | x                   |     |        | x         | These unbundled services should continue |                             |
| 2 |    |   |                     |     |        |           |  |                             |
| 3 |    |   |                     |     |        |           |  |                             |
| 1 | 73 | <ul style="list-style-type: none"> <li>• If the beneficiary needs therapeutic services, DHCS will internally coordinate with the Medi-Cal Field Office having jurisdiction for the authorization of these services.</li> </ul>  | x                   |     |        | x         | These unbundled services should continue |                             |
| 2 |    |   |                     |     |        |           |  |                             |
| 3 |    |   |                     |     |        |           |  |                             |
| 1 | 74 | <ul style="list-style-type: none"> <li>• If the beneficiary needs mental health services, DHCS will refer the beneficiary to the local mental health services program.</li> </ul>   | x                   |     |        | x         | These unbundled services should continue |                             |
| 2 |    |   |                     |     |        |           |  |                             |
| 3 |    |   |                     |     |        |           |  |                             |
| 1 | 75 | vi. The State must ensure that plans have mechanisms to provide care coordination, person centered planning continuity of care, out of network care, etc to newly enrolled managed care beneficiaries as described in STC <b>Error! Reference source not found.</b> .f. |                     |     |        | x         |  | No further comments         |
| 3 |    |   |                     |     |        |           |  |                             |

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|   |    |   | Delete              | Add | Change | No Change |  |                             |
| 4 | 76 | vii. The State must submit to CMS for review the informing notices that will be sent to CBAS beneficiaries outlining their new services and due process rights, before they are sent to the beneficiaries.  | x                   |     |        |           | This was specific to the settlement, no longer necessary.  | State negotiation with CMS  |
| 9 | 77 | <u>i. CBAS Provider Specifications.</u><br>i. CBAS Center staff includes licensed and registered nurses; licensed physical, occupational, and speech therapists; behavioral health specialists; registered dietitians; social workers; and a variety of non-professional staff that assist in the provision of services such as program aides and transportation drivers. |                     |     |        | x         | Cross reference SOP:<br>3. Organization and Administration, items 35-37;<br>7. CBAS Waiver Services, items 48-60   | No further comments 77-84.  |
| 9 | 78 | ii. Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff will provide services within their individual scope of practice and receive supervision required under scope of practice laws.  |                     |     |        | x         | Cross reference SOPs:<br>3. Organization and Administration, d, item 39, and<br>7. CBAS Waiver Services, items 49. |                             |
| 9 | 79 | iii. Non-professional staff will receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by CBAS center professional and/or administrative staff.   |                     |     |        | x         | Cross reference SOP 10. Training Requirements, b, item 74.   |                             |
| 9 | 80 | iv. Professional and non-professional staff are required to have appropriate experience and   |                     |     |        | x         |  |                             |

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|   |    |  | Delete              | Add | Change | No Change |  |  |
|   |    | training at the time of hiring.  |                     |     |        |           |  |  |
| 4 | 81 | v. Any changes in the CBAS Providers Standards of Participation must be submitted to CMS. The STCs are the terms of the CBAS amendment, not the Settlement Agreement or Standards of Participation.  |                     |     |        | x         |  | State to negotiate with CMS items 81-86.   |
| 4 | 82 | <u>j. CBAS Center Provider Oversight and Monitoring.</u> Within 90 days of the effective date of these STCs, the State must submit a plan for CMS approval for oversight and monitoring of CBAS providers to ensure compliance and corrective action with provider standards, access and delivery of quality care and services.      |                     |     |        |           |  |  |
| 4 | 83 | The plan must detail a process whereby the State will notify CMS about the number of CBAS providers determined eligible and ineligible for participation under the Demonstration. Reporting of activity associated with the plan must be consistent with paragraph <b>Error! Reference source not found.</b> on Quarterly reporting. |                     |     |        |           |  |  |
| 4 | 84 | i. <b>No later than April 16, 2012, the State will submit to</b> CMS the total number of CBAS-eligible beneficiaries, the number of enrollees in each center, the capacity of each center, and the number of enrollees in each plan as of April 1, 2012. CMS   |                     |     | x      |           | This should still be tracked to ensure access to services/centers. Delete the highlighted phrase only. | State to negotiate with CMS – need to report what they want reported. Date is obsolete, but an important access issue. Hard for the state to report and doesn't reflect anything worthwhile. Still need some kind of a dashboard to indicate where things stand in the |

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|   |    |  | Delete              | Add | Change | No Change |   |   |
|   |    | 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.  |                     |     |        |           |   | state. Blends with items 87-95.State Action for these items – come to 2/4 Workgroup meeting with a recommendation for streamlining.   |
| 3 | 85 | vii. No later than April 16, 2012, the State will submit to CMS the geographic demarcation of CBAS centers and the radii (i.e., zip codes, counties, cities) within which beneficiaries will be eligible to receive CBAS services.   |                     |     | x      |           | Access reporting (tracking of centers, services) that is reasonable and useful should continue.   |   |
| 4 |    |  |                     |     |        |           | 85 95   |   |
| 1 | 86 | viii. No later than May 1, 2012, and quarterly thereafter, the State will identify provider capacity for providing unbundled services, if needed, within the geographic demonstrations identified in section ii above.   |                     |     |        | x         | State<br>No communication   | No further comment  |
| 4 |    |  |                     |     |        |           | A   |   |
| 3 | 87 | k. <u>CBAS FFS Access Monitoring.</u> The State must monitor the availability of sufficient access to CBAS services that continue to be delivered on a fee-for-service basis (in geographic areas (i.e., counties) where ADHC centers existed on December 1, 2011) using the “A Plan to Monitor Healthcare Access for Medi-Cal Beneficiaries”, as approved by CMS. The |                     | X   |        |           | Monitor or access actively.<br><br>*More explanation is needed and access should be actively monitored.<br><br>If this has to do with the 10% rate reduction exemption, the Dept should | <u>STC 85-95: Monitoring &amp; Reporting Requirements</u><br>Decide where to put streamline reporting section in STCs. Determine what is included/excluded in reporting requirement. Incorporate into 95J Section. Add language on specific |

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|   |    |  | Delete              | Add | Change | No Change |   |   |
|   |    | <p>plan is available at: <a href="http://www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%20092811.pdf">http://www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%20092811.pdf</a> (Department of Health Care Services, September 2011).</p> |                     |     |        |           | <p>ensure that further exemption does not need to be provided, given the level of Center closures.</p> <p><i>AK</i></p> | <p>reporting activity consistent with 1115 waiver. Bring into alignment with Quarterly Reporting.</p> <p>CDA developed a Dashboard (draft) to address need to inform community about CBAS. To be posted on CDA website, updated monthly. (Refer to Dashboard regarding data proposed.) Graphic will be sent to CMS quarterly.</p> <p><u>Recommendations:</u> Ask Plans what info they need to know. Establish another workgroup focusing on data. Determine capacity relative to population characteristics. Capture what happens to people when centers close. Develop outcome measures (consider pilot.) Determine how long it takes to get admitted to program (access.) Help people in community improve access. Utilize Plan data to inform data collection and outcome measures/methodology. Need to know location/distribution of CBAS centers: where there are no centers, &lt;1, &gt; 5.</p> |
| 3 | 88 | <p><u>1. CBAS Managed Care Access Monitoring.</u></p> <p>i. The State Medicaid Agency will assure sufficient CBAS access/capacity, through</p>   |                     |     |        |           |   |   |

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|   |    | the mechanism listed below, in every county except: Del Norte, Siskiyou, Modoc, Trinity, Lassen, Mendocino, Tehama, Plumas, Glenn, Lake, Colusa, Sutter, Yuba, Nevada, Sierra, Placer, El Dorado, Amador, Alpine, San Joaquin, Calaveras, Tuolumne, Mariposa, Mono, Madera, Inyo, Tulare, Kings, San Benito, and San Luis Obispo.   |                     |     |        |              |  |                             |
| 1 | 89 | 1. Review the total number of individuals receiving an assessment for CBAS services vs. the total number of individuals obtaining CBAS services or unbundled services. Breakout the number of people receiving bundled vs. unbundled CBAS 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 a corrective action plans that addresses such variances. |                     |     | x      |              | Clarify by plan and/or by county<br><br>*Note that some of these counties are served by CBAS centers in neighboring counties<br>*The past reports should be reviewed and used to assess the impact today of changes to ensure effective monitoring of access, as part of the Waiver Workgroup process. Changes should not just be looked at qtr to qtr, but over the long term.<br>*It is critical that the 10% rate reduction be restored, given the loss of CBAS providers |                             |
| 3 |    |   |                     |     | x      |              |  |                             |
| 4 |    |   |                     |     |        |              |  |                             |

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|   |    |  | Delete              | Add | Change | No Change |  |                             |
| 1 | 90 | 2. Review of overall utilization of CBAS or 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 a corrective action plans that addresses such variances.  |                     |     | x      |           | Clarify by plan and/or by county<br><br>Again, what has the longer term amount of change been?   |                             |
| 3 |    |  |                     |     | x      |           |  |                             |
| 4 |    |  |                     |     |        |           |  |                             |
| 3 | 91 | 3. Review of MCO grievance 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 services, grievances around the CBAS providers, grievances around MCO staff in assessment, any reports pertaining to health and welfare of individuals utilizing |                     |     | x      |           | *Has this process been helpful? Have grievances and appeals emerged?<br>*This list does not seem very clear or helpful, and we feel a better process could be designed that would yield useful information; there should be an end goal related to quality and access. |                             |

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|   |    |   | Delete              | Add | Change | No<br>Change |   |                             |
| 4 |    | CBAS services, 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.                        |                     |     |        |              |   |                             |
| 3 | 92 | 4. A review of any other beneficiary or provider call center/line for complaints surrounding the provision of CBAS benefits through 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. |                     |     |        | x            | *Same thing as prior item.<br>*Access issues should be distilled from complaint records<br>*Since the transition to managed care is still going on in the rural counties, this is still needed. |                             |
| 4 |    |   |                     |     |        |              |   |                             |

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|   |    |  | Delete              | Add | Change | No Change |   |                             |
| 1 | 93 | 5. Review the CBAS provider capacity vs. the total number of beneficiaries seen for bundled and unbundled CBAS 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 a corrective action plans that addresses such variances. |                     |     | x      | x         | Need better definition of capacity. Percent of licensed capacity based on national CDC findings? 68% is the national number. CDC uses utilization per 1,000 population over 65 years old for comparison purposes.<br><br>This needs to be made meaningful and studied. Many CBAS Centers are at a low census due to the impact of the confusion created by the transition period, which reduced referrals. Constructive followup action should be linked to this process, which should be public information and used to facilitate better utilization. In areas where programs have closed, it should be determined whether all pts were able to move to other programs. |                             |
| 3 |    |  |                     |     |        |           |   |                             |
| 4 |    |  |                     |     |        |           |   |                             |
| 3 | 94 | ii. Evidence of sufficient access monitoring and corrective action plans must be provided to the regional office in conjunction with the submission of MCO contracts at least annually and at any other time a significant impact to the MCO's operations are administered.  |                     |     | x      |           | We need more information to clarify what this means.  |                             |
| 4 |    |  |                     |     |        |           |   |                             |
| 3 | 95 | iii. 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 services until which  | x                   |     |        |           | It isn't constructive to lose funding for programs based on whether the state meets the monitoring mechanisms.  |                             |

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|   |    |  | Delete              | Add | Change | No Change |  |  |
|   |    | time the State provides adequate documentation assuring sufficient access.   |                     |     |        |           |  |  |
| 1 | 96 | <p><u>m. CBAS Provider Reimbursement.</u> Payment for CBAS will be as follows:</p> <p>i. CBAS will be treated as a carved out service from current managed care contracts and rates. The State Medicaid Agency will be responsible for payment of the CBAS service claims directly to CBAS providers on a fee-for-service basis until the CBAS program is transitioned to a managed care system.</p> |                     |     | x      |           | <p>The rate needs to be increased: the 10% reduction needs to be restored, and a higher rate is needed given that A) there has been no rate increase in years, while all costs – including utilities, transportation, staffing, and meals – have increased. B) The transition of almost all participants confirmed that CBAS pts meet a high level of medical necessity – i.e., they are confirmed as having a high level of acuity, requiring more staffing etc to serve them. C) A number of programs have had to close due to the inadequate rate, and access has been impacted. D) Given the cost of SNF placement, placement in CBAS would provide cost savings to warrant the increased rate. E) In rural areas, there should be rural factor to address the increased cost of transportation.</p> | <p><u>STC 96-102 Provider Reimbursement</u></p> <p>Language should be retained but with changes. Combine STC 96(m) with STC 97. DHCS has methodology to set rate. CMS approves the methodology. DHCS identifies covered services. Recommend looking at formula/methodology for determining reimbursement. The established rates for Plans and Providers are different. The actuarial capitation rate was based on ADHC prior to the Settlement. The acuity of center participants is higher now and a different level of staffing is required. Rural rate should incorporate transportation.</p> |
| 5 |    |  |                     |     |        |           |  |  |
| 5 | 97 | <p>ii. Under the fee-for-service payment system, CBAS providers will be reimbursed for</p>   |                     |     | x      |           | <p>Again, this should be restudied to ensure access.</p>   |  |

*Handwritten notes in red:*  
 rate ↑  
 needs re-statement  
 rural rate to incorporate transportation

*Handwritten notes in red:*  
 rural rate to incorporate transportation  
 actuarial set rate

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|   |    |  | Delete              | Add | Change | No<br>Change |  |  |
|   |    | <p>providing the CBAS benefit at least at the rate described below, minus ten percent, except in exempted Medical Service Study Areas (MSSA)<sup>1</sup>, which will receive the rates below.</p> <p>a) Comprehensive multidisciplinary evaluation - \$80.08 per evaluation.</p> <p>b) Community-Based Adult Services, adult - \$76.27 per day.</p> <p>c. Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter - \$64.83 per encounter.</p> |                     |     |        |              |  |  |
| 1 | 98 | <p>iii. The State must develop an actuarially sound capitation rate for CBAS, but not implement the rate before July 1, 2012. That rate will include both service costs and administrative and reporting costs, and will be paid to existing managed care entities for a standard package of CBAS services furnished to CBAS enrollees who are also enrolled with the managed care entities for non-CBAS services.</p>   |                     |     | x      |              | <p>If CBAS is currently paid at an actuarially sound rate set by the State, how was that done?</p> | <p>Discussion regarding how the actuarial rate is set, with the historical fee-for-service rate as the starting point. More discussion regarding how higher acuity individuals are served now and that ADHC historical spending does not account for this.</p> |
| 1 | 99 | <p>iv. Non-State plan services offered though the demonstration as unbundled services per (h)(v) are paid at a fee-for service rate basis as established by DHCS.</p>  |                     |     |        | x            |  |  |

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|   |     |   | Delete              | Add | Change | No Change |                                     |   |
| 1 | 100 | v. Reimbursement methodologies are detailed as follows:<br><b>(See page 36 below)</b>   |                     |     |        |           |                                     |   |
| 5 | 101 | vi. Contracts with the managed care entities will require payment to CBAS providers no less than the rates detailed in (ii), above.   |                     |     |        |           |                                     |   |
| 4 | 102 | vii. Any separate contract, or amendment to existing managed care plan contracts to include this service must be submitted to CMS for review and approval according to the requirements of 42 CFR Part 438.   |                     |     |        |           |                                     |   |
| 1 | 103 | <b>1. Enhanced Case Management (ECM).</b> “Enhanced Case Management” is a service consisting of “Complex Case Management” and “Person-Centered Planning” services including the coordination of eligible Medi-Cal beneficiaries’ individual needs for the full array of necessary long-term services and supports including medical, social, educational, and other services, whether covered or not under the Medicaid program, and periodic in-person consultation with the enrollees and/or his designees. | x                   |     |        |           | CCI likely supercedes this section. | <u>STC 103-123</u><br>ECM is provided through August 2014 for class members who are not CBAS eligible. The ECM term disappears in August. CCI requires Plans to provide care management services. |
| 1 | 104 | a. <u>ECM Eligibility.</u> From April 1, 2012, through August 31, 2014, the ECM benefit will be available to all Medi-Cal beneficiaries who:  | X                   |     |        |           |                                     |   |
| 1 | 105 | i. Received ADHC services through the California Medicaid program at any time from July 1,  | x                   |     |        |           |                                     |   |

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|   |     |  | Delete              | Add | Change | No Change |                                   |                             |
|   |     | 2011 through February 29, 2012.  |                     |     |        |           |                                   |                             |
| 1 | 106 | ii. Have been determined to be ineligible for CBAS or who are eligible for CBAS but exempted from enrolling in managed care and choose to receive ECM as a fee-for-service benefit rather than the CBAS benefit through a managed care plan.   | X<br>X              |     |        |           |                                   |                             |
| 2 |     |  |                     |     |        |           |                                   |                             |
| 1 | 107 | iii. A Medi-Cal beneficiary determined to be eligible for ECM may, at a later date, be determined eligible for CBAS. If the enrollee then receives CBAS, he/she will no longer receive ECM. If at a later time the enrollee no longer receives CBAS, he/she will be eligible to receive ECM. | X<br>X              |     |        |           |                                   |                             |
| 2 |     |  |                     |     |        |           |                                   |                             |
| 1 | 108 | iv. An ECM-eligible enrollee who receives CBAS at some time between April 1, 2012, and August 31, 2014, is eligible to receive ECM for any time period during which they do not receive the CBAS benefit. A beneficiary shall not receive ECM and CBAS concurrently.                         | X<br>X              |     |        |           |                                   |                             |
| 2 |     |  |                     |     |        |           |                                   |                             |
| 1 | 109 | <u>b. ECM Benefits.</u> The following services will be provided as ECM to all eligible state plan beneficiaries:<br>i.<br>ii. Complex Case Management Services means the systematic coordination and   | X                   |     |        |           |                                   |                             |

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|   |     |  | Delete              | Add | Change | No<br>Change |                                   |                             |
|   |     | assessment of care and services to enrollees who require the extensive use of resources and who need assistance navigating the services system to facilitate the appropriate delivery of care and services,  |                     |     |        |              |                                   |                             |
| 1 | 110 | iii. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services;   | X                   |     |        |              |                                   |                             |
| 1 | 111 | iv. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the individual, includes; | X                   |     |        |              |                                   |                             |
| 1 | 112 | 1. activities such as ensuring the active participation of the eligible individual, and  | X                   |     |        |              |                                   |                             |
| 1 | 113 | 2. working with the individual (or the individual's authorized health care decision maker) and others to develop those goals and indentify a course of action to respond to the assessed needs of the eligible individual  | X                   |     |        |              |                                   |                             |
| 1 | 114 | v. Referral and related activities (such as  | X                   |     |        |              |                                   |                             |

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|   |     |  | Delete              | Add | Change | No Change |                                   |                             |
|   |     | scheduling appointments for the individual) to help the eligible individual obtain needed services;  |                     |     |        |           |                                   |                             |
| 1 | 115 | vi. Monitoring and follow-up activities; and   | X                   |     |        |           |                                   |                             |
| 1 | 116 | vii. Person-Centered Planning means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of Complex Case Management and Discharge Planning. In compliance with STC <b>Error! Reference source not found.</b> .f.iv. | X                   |     |        |           |                                   |                             |
| 1 | 117 | c. <u>ECM Delivery System.</u> ECM will be provided through fee-for-service for individuals who are not enrolled in a managed care plan, and through managed care plans for individuals who are enrolled in a managed care plan.   | X                   |     |        |           |                                   |                             |
| 1 | 118 | d. <u>ECM Provider Specifications.</u> Managed care plans and the Department's fee-for-service ECM contractor(s) shall assure that their ECM functions are supervised by persons with appropriate clinical training and experience. Such training and experience may be demonstrated by:   | X                   |     |        |           |                                   |                             |
| 1 | 119 | i. A baccalaureate degree in a human services area and at least one year's experience  | X                   |     |        |           |                                   |                             |

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|   |     |  | Delete              | Add | Change | No Change |   |                             |
|   |     | working with populations with special needs (e.g. older adults, developmental disabilities, medically fragile, etc.), or   |                     |     |        |           |   |                             |
| 1 | 120 | ii. A RN license issued by the State and one year's experience working with populations with special needs, or.  | x                   |     |        |           |   |                             |
| 1 | 121 | iii. A master's degree in a human services area without one year's experience performing case management.  | x                   |     |        |           |   |                             |
| 1 | 122 | e. <u>ECM Reimbursement</u> . Payment for ECM will be as follows:<br>i.<br>ii. ECM provided by the State Medicaid Agency's fee-for-service contractor(s) must be paid for through a per-member, per-month rate to be set through contract between the State Medicaid Agency and the contractor(s). | x                   |     |        |           | CROSSwalk on quality<br>plans<br>strategies |                             |
| 1 | 123 | iii. ECM provided by managed care plans will be paid for through an actuarially sound capitation rate. Any amendment to the managed care plan contracts to include this service must be submitted to CMS for review and approval according to the requirements of 42 CFR Part 438.                 | x                   |     |        |           | · CMS<br>· CBAS Health Home                 |                             |

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|        |     |  | Delete              | Add | Change | No<br>Change |                                   |  |
| 1<br>4 | 124 | <b>2. CBAS/ECM Quality Strategy.</b><br>a. <u>Amendment to the Quality Strategy.</u> The State will amend the managed care Quality Strategy required in 42 CFR section 438 Subpart D no later than July 1, 2012 to include the Home and Community Based Services, as well as any time additional HCBS are added to the Demonstration, which are considered a significant change. |                     |     |        | x            | • 1175 www-00                     | Need a Quality Strategy in STCs and to align quality strategies. Look at CCI requirements and the CMS LTSS Quality Strategy Report. Determine what CMS requires of CCI, what Managed Care Plans expect of CBAS providers, and what managed care requirements are for managing a network of providers. Focus on outcomes of CBAS. Propose formation of workgroup to cross-walk what Plans need, what CBAS can offer, what CMS wants. Identify key outcome indicators. |
| 1<br>4 | 125 | b. <u>Quality Strategy Design Elements.</u> An overarching Quality Assurance and Improvement (QAI) strategy must assure the health and welfare of enrollees receiving HCBS and must address the:   |                     |     |        | x            |                                   |  |
| 1<br>4 | 126 | i. Enrollee's person-centered IPC development and monitoring,  |                     |     |        | x            |                                   |  |
| 1<br>4 | 127 | ii. Specific eligibility criteria for particular HCBS,   |                     |     |        | x            |                                   |  |
| 1<br>4 | 128 | iii. Adherence to provider qualifications and/or licensure,  |                     |     |        | x            |                                   |  |

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|        |     |  | Delete              | Add | Change | No<br>Change |                                   |                             |
| 1<br>4 | 129 | iv. Assurance of health and safety of Medi-Cal beneficiaries,  |                     |     |        | X            |                                   |                             |
| 1<br>4 | 130 | v. Financial oversight by the State Medicaid Agency, and   |                     |     |        | X            |                                   |                             |
| 1<br>4 | 131 | vi. Administrative oversight of the managed care plans by the State Medicaid Agency  |                     |     |        | X            |                                   |                             |
| 1      | 132 | <b>3. CBAS/ECM Fair Hearing and Appeal Rights.</b><br>a. Enrollees who have received CBAS and are then found to be ineligible for CBAS must be provided with a Discharge Plan prepared by the CBAS center. A copy of the Discharge Plan will be provided to the enrollee and the managed care plan or the State Medicaid Agency, where applicable. |                     |     |        | X            |                                   |                             |
| 1      | 133 | b. The provision of CBAS and ECM through the Demonstration does not negatively impact the right of enrollees to written notice of adverse actions, an opportunity for a hearing, and the right to file appeals and grievances.   |                     |     |        | X            |                                   |                             |
| 1      | 134 | <b>4. CBAS/ECM Annual Report.</b> The State must provide the CMS with a draft annual CBAS report as part of the annual report requirement for the Demonstration  |                     |     |        | X            |                                   |                             |

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| 4 |     | as stipulated in STC <b>Error! Reference source not found.</b> The first draft CBAS report will be due no later than October 1, 2012. The CBAS report will at a minimum include:  |                     |     |        |           |                                   |                             |
| 1 | 135 | a. An introduction;   |                     |     |        |           |                                   |                             |
| 1 | 136 | b. A description of each HCBS in the approved Demonstration including Community Based Adult Services and Enhanced Case Management.  |                     |     |        |           |                                   |                             |
| 1 | 137 | c. An overarching Quality Assurance and Improvement (QAI) strategy that assures the health and welfare of enrollees receiving HCBS that addresses the a) enrollee's person-centered IPC development and monitoring, b) specific eligibility criteria for particular HCBS, c) adherence to provider qualifications and/or licensure, d) assurance of health and safety of Medi-Cal beneficiaries, d) financial oversight by the State Medicaid Agency, and e) administrative oversight of the managed care plans by the State Medicaid Agency; |                     |     |        |           |                                   |                             |
| 1 | 138 | d. An update on service use by enrollees;   |                     |     |        |           |                                   |                             |
| 1 | 139 | e. A general update on managed care and FFS CBAS including the collection, analysis and reporting of data at the aggregate level;   |                     |     |        |           |                                   |                             |
| 1 | 140 | f. Monitoring of the quality and accuracy of screening and assessment of enrollees who qualify for CBAS and ECM;  |                     |     |        |           |                                   |                             |
| 1 | 141 | g. CBAS provider capacity to ensure sufficient  |                     |     |        |           |                                   |                             |

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|   |     |  | Delete              | Add | Change | No Change |                                   |                             |
|   |     | access, barriers, and possible solutions;  |                     |     |        |           |                                   |                             |
| 1 | 142 | h. An update on the use of the ECM benefit;  | X                   |     |        |           |                                   |                             |
| 1 | 143 | i. The various service modalities employed by the State, including updated service models, opportunities for self-direction, etc.;   |                     |     |        |           |                                   |                             |
| 1 | 144 | j. Specific examples of how HCBS have been used to assist Medi-Cal enrollees;  |                     |     |        |           |                                   |                             |
| 1 | 145 | k. A description of the intersection between Demonstration HCBS and any other State programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. California's Money Follows the Person Demonstration, Duals Demonstration, optional Health Home benefit, etc.);                                 |                     |     |        |           |                                   |                             |
| 1 | 146 | l. Contract requirements for provider capacity and service availability;   |                     |     |        |           |                                   |                             |
| 1 | 147 | m. Other topics of mutual interest between CMS and the State related to the HCBS included in the Demonstration;  |                     |     |        |           |                                   |                             |
| 1 | 148 | n. The Report may also address such topics workforce development, certification activity, self-direction opportunities and structure, capacity in the State to meet needs of specific populations receiving the services (older adults, people with disabilities, people with multiple chronic conditions), and rebalancing goals related to HCBS; |                     |     |        |           |                                   |                             |
| 1 | 149 | o. Additionally, the Report will also summarize the  |                     |     |        |           |                                   |                             |

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|   |     | outcomes of the State’s QAI for HCBS as outlined above;   |                     |     |        |              |   |   |
| 1 | 150 | p. The State may also choose to provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the Demonstration, including innovative practices, access to services, the intersection between CBAS and Medicaid behavioral health services, cost-effectiveness, and short and long-term outcomes.  |                     |     |        |              |   |   |
| 4 |     |   |                     |     |        |              |   |   |
| 1 | 151 | <b>5. CBAS /ECM Research Study Design.</b> At least annually the State will research, test and measure whether individuals enrolled in CBAS improve the status of their health. The CBAS recipient functionality will be based on the perceptions of their by their primary caregivers whether the individual is enrolled in a CBAS center or receive CBAS services unbundled because of limited availability at the CBAS Center. The annual measures must include but are not limited to the enrollees ability to: |                     |     |        | x            | ID common measures using TOPS tools, for example, Quality of Life measures, Satisfaction tools. | Items in STC 151 should be considered by the Quality Workgroup. |
| 4 |     |   |                     |     |        |              |   |   |
| 1 | 152 | a. Maintain or expand conversation or communication;  |                     |     |        |              | Add reduce social isolation, which is an evidence-based risk factor                             |   |
| 1 | 153 | b. Maintain or Improve mobility/flexibility;  |                     |     | x      |              | Difficult to measure objectively  |   |
| 1 | 154 | c. Maintain or increase personal hygiene;   |                     |     |        |              |   |   |
| 1 | 155 | d. Maintain or Improve medical condition;   |                     |     | x      |              |   |   |
| 1 | 156 | e. Decrease Hospital admissions; and  |                     |     | x      |              | Some hospital admissions are unavoidable but emphasis is on readmissions.                       |   |

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| 1 | 157 | f. Decrease emergency department episodes.   |                     |     |        |           |                                   |  |
|   | 158 | 6. If it is found that the State did not meet the monitoring mechanisms described in the CBAS and ECM STCs, CMS reserves the right to withhold a portion or all of FFP related to CBAS and ECM services until which time the State provides adequate documentation assuring sufficient access. |                     |     |        |           |                                   | Table below reflects rates for unbundled services. Changes to this table are predicated on changes to unbundled services STCs. |

Community-Based Adult Services (CBAS) eligibility and enrollment. M. CBAS provider reimbursement; methodologies are detailed as follows:

| Unbundled CBAS Core Services   | Reimbursement Methodology  |
|--------------------------------|--|
| Professional Nursing Services* | Consistent with 1915(c) waiver rate (RN and LVN)<br>(\$10.14/15 min and \$7.35/15 min)*<br>Qualifications:<br><u>RN</u> : Licensed in the state of CA as an RN to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.<br><u>LVN</u> : Licensed in the state of CA as an LVN to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider. |
| Personal Care Services*        | Consistent with 1915(c) waiver rate (\$3.62/15 min)*<br>Qualifications:<br>Must meet 1915(c) waiver qualifications as a  |

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| <b>Unbundled CBAS Core Services</b>   | <b>Reimbursement Methodology</b>   |
|---|--|
|   | personal care provider. Must be enrolled in the Medi-Cal program as a waiver provider.   |
| Social Services   | Consistent with CCS rate (\$9.50/15 min)<br>Qualifications:<br>Licensed in the state of CA as a Licensed Clinical Social Worker or as a Licensed Marriage, Family and Child Counselor/Licensed Marriage and Family Counselor to practice pursuant to CA regulations regarding scope of practice; <u>or</u> must have a Master's or Baccalaureate degree in social services with minimum experience level pursuant to CA regulations regarding the ADHC program. Must be enrolled in the Medi-Cal program as a waiver provider. |
| Therapeutic Activities <ul style="list-style-type: none"> <li>• PT Maintenance Program</li> <li>• OT Maintenance Program</li> </ul> | Consistent with 1915(c) waiver rate (habilitation) (\$11.36/15 min)<br>Qualifications:<br>Approved as a PT or OT assistant pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.  |
| Nutrition/Registered Dietitian/Meal   | Consistent with CDA senior nutrition program (\$8.50/meal)<br>Qualifications: Registered as a registered dietitian pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.  |
| <b>Unbundled CBAS Additional Services</b>   |  |

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| Unbundled CBAS Core Services           | Reimbursement Methodology   |
|--|---|
| Physical Therapy*                      | Consistent with State Plan rate: \$10.60/15 min (current PT Treatment rate; X4110)*<br>Qualifications:<br>Licensed as a physical therapist in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.              |
| Occupational Therapy*                  | Consistent with State Plan rate: \$10.60/15 min (current OT Treatment rate; X3910)*<br>Qualifications:<br>Licensed as an occupational therapist in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.         |
| Speech and Language Pathology Services | Consistent with State Plan rate: \$11.32/15 min (current ST Treatment rate; X4304)*<br>Qualifications:<br>Licensed as a speech and language pathologist in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider. |
| Mental Health Services*                | Consistent with State Plan rate<br>Psychiatrist: \$22.90 (current Level I physician office visit)<br>Other professionals: \$9.49/15 min (current EPSDT rate)*<br>Qualifications:<br><u>Psychiatrist:</u> Licensed in the state of CA to practice pursuant to CA regulations regarding                         |

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| Unbundled CBAS Core Services | Reimbursement Methodology   |
|------------------------------|---|
|                              | <p>scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.</p> <p><u>Psychologist</u>: Licensed in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.</p> <p><u>Licensed Clinical Social Worker</u>: Licensed in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.</p> <p><u>Advanced Practice Mental Health Nurse</u>: Licensed in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.</p> <p><u>Psychological/psychiatric assistant</u>: Registered in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.</p> <p><u>Licensed Marriage, Family and Child Counselor/Licensed Marriage and Family Therapist</u>: Licensed in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.</p> <p><u>Certified Rehabilitation Counselor</u>: Certified in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a</p> |

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| Unbundled CBAS Core Services  | Reimbursement Methodology  |
|---|--|
|   | waiver provider.<br><u>Associate Clinical Social Worker</u> : Certified in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program as a waiver provider.  |
| CBAS Transportation (only between participant's home and place of CBAS service) | Consistent with State Plan rate: \$7.05/one-way trip (current NEMT, 2 patients per trip rate; X0202)<br>Qualifications:<br>Provider may provide the transportation directly or sub-contract for its provision. The vehicle must have current CA registration and the driver must have a current CA driver's license for the type of vehicle being used. Such requirements must be in compliance with CA regulations. |

\*Services provided in an FQHC that meet the FQHC/RHC service definition and requirements of the State Plan will be paid in accordance with the State Plan FQHC/RHC service reimbursement methodology.