

CBAS Stakeholder Workgroup Recommendations – Summary (Including 3/6/14 Meeting Additions)

Workgroup Recommendation	STC/SOP ⁱ Matrix Crosswalk	DHCS/CDA Concurrence ⁱⁱ			Comments
		Yes	No	Undetermined	
1. Delete provisions related to ADHC to CBAS transition that are no longer relevant, including enhanced case management.	STC Lines 14, 15, 16, 103-123	✓			
2. Continue access monitoring and streamline reporting requirements to CMS.	STC Lines 17, 82-95, 134-150	✓			Draft STCs to include one section on reporting that is consistent with 1115 Demonstration Waiver Quarterly Progress Report requirements. Additionally, CBAS Dashboard maintained on CDA website.
3. Create new STC/SOP section(s) for Plan/provider relationships – include: <ul style="list-style-type: none"> selective contracting per provider quality and Plan credentialing standards flexibility for Plans to arrange CBAS provider 	STC Lines 14, 15, 18-26, SOP Lines 35-47, 61, 66, 67	✓			Likely placement will be STCs for Plan specific items and SOPs for provider items. Other additions to these sections may include general references to establishment of new CBAS centers in counties where there is limited or no CBAS access (as defined per DHCS/CDA review). Specific provisions

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<p>payment based on participant level of acuity and scope of services</p> <ul style="list-style-type: none"> liaison and care plan collaboration timelines for eligibility determinations and service authorization discharge planning and reporting <p>03/06 Meeting Additions: STCs to express the intent that access to quality CBAS centers be maintained.</p>					<p>may include that new CBAS provider certification by CDA will be contingent upon Plan notification to CDA of intent to contract with a prospective CBAS provider to serve their plan members and the provider's obtaining of an ADHC license. See Item 10 below.</p> <p>Additionally, during discussion of the Organization and Administration section in the SOPs, the Workgroup recommended further discussion about Plan/provider communications about participant care be addressed in an IPC redesign workgroup going forward.</p>
<p>4. Retain language for fee-for-service (FFS) grievances and appeals.</p>	STC Line 27	✓			<p>Managed care grievances and appeals defined elsewhere in Waiver. FFS language in CBAS section to reference general Medi-Cal process.</p>
<p>5. Allow more Plan discretion regarding conducting face-to-face eligibility determination – should be driven by beneficiary's clinical status and provide</p>	STC Lines 29-34	✓			<p>Plans to develop policies and procedures to address eligibility determination processes. Minimum standard should remain that a face-to-face eligibility determination with standard CBAS Eligibility Determination</p>

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<p>for expediting of enrollment.</p> <p>03/06 Meeting Additions: STCs to include intent language about plans cooperating with each other to ensure continuity of care when individuals switch health plans. STCs regarding eligibility determination should be clear that plans have discretion to do/not do face-to-face eligibility determination when a Health Risk Assessment is already done or an individual is otherwise determined eligible.</p>					<p>Tool (CEDT) will be conducted for beneficiaries new to CBAS and not otherwise determined by Plan to be clinically appropriate for CBAS for expediting eligibility determination and the start of services.</p>
<p>6. Allow authorization for up to 12 months, based on clinical status.</p>	<p>STC Line 30, SOP Lines 62-64</p>	✓			<p>Plans to develop policies and procedures specifically identifying the frequency and process of reauthorization and criteria for level of services (days per week) authorized. Such policies and procedures for CBAS will be aligned with plans' overall care management of members.</p>

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7. Individual Plan of Care (IPC) to be redesigned. STC/SOP references revised to reflect Plan/provider collaboration on care planning to incorporate larger managed care plan participant care goals beyond CBAS.	STC Lines 35-48, SOP Lines 6, 63-65	✓			Workgroup to discuss formation of a small workgroup continuing past the CBAS Stakeholder process to work on CBAS issues such as IPC redesign.
8. Include references to “care coordination” that CBAS centers are required to provide per ADHC nursing and social services regulations.	STC Lines 49-61	✓			
9. Revise language describing basic CBAS benefits and service components to be clearer and reflect statutory/regulatory requirements (e.g., transportation definition, CBAS relationship to behavioral health, etc.)	STC Lines 49-61	✓			

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<p>10. Access - Allow planned growth of new CBAS centers</p> <p>03/06 Meeting Additions: Criteria for determining need should include consideration of fee-for-service participant needs as well as managed care need.</p>	STC Line 67	✓			After August 31, 2014, there will be no prohibitions against establishing new CBAS centers. CDA and DHCS will develop a CBAS application submission process and criteria for approval that include the rationale for new CBAS center(s) and managed care plan need.
<p>11. Retain unbundled services</p> <p>03/06 Meeting Additions: STCs should include intent language that addresses the plans' responsibility when there is an absence of a CBAS center and there are individuals who would be eligible. Specifically, plans should focus on coordinating delivery of services with the objective of supporting the individual's ability to live in a community setting.</p>	STC Lines 67-74, 86, 89, 90	✓	✓		When there is no access to CBAS, plans are to develop and implement care plans and provide plan covered benefits. Additionally, they are to make referrals to and coordinate delivery with other community resources to assist plan members who would otherwise be in CBAS centers, with the explicit objective of supporting their living in a community setting.

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12. Revise quality assurance requirements in STCs and further develop quality metrics for provider quality of care standards to add to the quality strategy .	STC Lines 82, 124-158	✓			<p>CBAS STC references to quality assurance and monitoring activities will be consistent with the Quality Strategy required in 42 CFR Part 438 Subpart D and consistent with quality under managed care and integrated into DHCS contracts.</p> <p>Additionally, the Workgroup has indicated interest in developing further CBAS quality metrics via a continuing small workgroup.</p>
<p>13. Rates:</p> <ul style="list-style-type: none"> allow Plans to pay CBAS providers based on acuity restore rate to the level pre-2011 10% rate reduction establish base rates for Plans and providers based on formula that more accurately reflects CBAS eligibility and 	STC Lines 96-102	✓	✓		Plans currently have the ability to pay providers above the fee-for-service rates. Restoration of the 10% and new CBAS rate development are beyond the scope of the Waiver amendment.

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program requirements rather than ADHC historical rates pre-Settlement.					
14. Add statutory references to SOPs	All relevant SOPs	✓			
15. Delete non-profit provider provisions	SOP Lines 9-14	✓			
16. Give CDA authority to grant program flexibility that CDPH currently has authority for under licensing statutes and regulations.	SOP Lines 27-34			✓	Current authority for granting program flexibility per H&S Code Section 1547.5 and Title 22 CCR Section 78217 rests with CDPH. Establishing program flexibility authority with CDA requires further exploration.
17. Create mechanism for payment for a day of services that is less than the 4 hours required by regulation. Exceptions could be defined such as participant level of acuity or emergent non-medical issues such as weather.	SOP Line 16			✓	Requires further consideration.

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18. Revise language regarding staffing requirements to clarify how the regulatory standard for average daily attendance in the previous quarter will be applied.	SOP Line 50			✓	During the February 2014 meeting, Workgroup members Celine Regalia and Diane Cooper-Puckett volunteered to draft potential clarifying language.

ⁱ STC – Special Terms and Conditions - refers to the CBAS provisions in the 1115 Waiver document that define the CBAS benefit.

SOP - Standards of Participation - refers to the program standards that providers must meet to be certified as a CBAS Medi-Cal waiver provider.

ⁱⁱ All STC/SOP changes subject to CMS negotiations.