

**California's Bridge to Reform 1115 Waiver
Community-Based Adult Services (CBAS)
Special Terms and Conditions
(March 19, 2014)**

C. Community- Based Adult Services (CBAS) and Enhanced Case Management (ECM) for Medi-Cal State Plan Populations

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

“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.

- a. CBAS Program must be operational for the period from April 1, 2012, through August 31, 2014 for CBAS Beneficiaries who:
 - i. Are those persons who are age 18 years and older;
 - ii. Derive their Medicaid eligibility from the State Plan and are either aged, blind, or disabled; including those who are recipients of Medicare.

- b. CBAS Program Enrollment Criteria. 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:
 - i. Meet medical necessity criteria as established by the State; and
 - ii. Meet “Nursing Facility Level of Care A” (NF-A) criteria as set forth in the California Code of Regulations, or above NF-A Level of Care; or
 - iii. Have a moderate to severe cognitive disorder such as Dementia, including Dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 of the Alzheimer’s Type. ; or
 - iv. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer’s Type, AND needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
 - v. Have a developmental disability. “Developmental disability” means a disability which originates before the individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations; or
 - 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 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:

1. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
2. One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation.

vii. *Enrollment for Non-CBAS services.* 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.

c. CBAS Patient Protections.

- i. *No Disruptions in Care.* State Plan beneficiaries who previously received Adult Day Health Care Services between July 1, 2011 and February 29, 2012 must have a face to face assessment to determine CBAS enrollment qualification, but there will be no disruption in care until the face to face assessment has been conducted.
- ii. *Second Level Review.* 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 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 paid pending while awaiting the outcome of a hearing or appeal.

On a yearly basis in the report required by paragraph 99, the State must report the number of second level reviews requested, including but not

limited to the number of second level reviews that resulted in a reversal of the initial decision. If the data reveal that there are issues with the second level reviews, CMS reserves the right to require that the second level review be completed by an entity/agency independent of the initial assessment reviewer.

- iii. *Continuity of Care.* In referring a beneficiary for CBAS services under paragraph 95(d)(iii) to a CBAS Center, consideration will be given to the CBAS beneficiary's relationship with previous providers of similar services
- iv. *Discharge Plan of Care.* 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:
 - 1. The name(s) of the patient's physician(s) and the patient's ID number.
 - 2. The date the Notice was issued.
 - 3. The date the CBAS services are to end.
 - 4. Specific information about the patient's current medical condition, treatments and medication regime.
 - 5. A statement about Enhanced Case Management Services and how they will be provided to those eligible State plan beneficiaries
 - 6. A statement of the right to file a Grievance or Appeal, or to request a second level review.
 - 7. A space for the beneficiary or representative to sign and date the document.
- v. *Grievances and Appeals.* 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.
- 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.

d. CBAS Assessment. Assessment for the CBAS benefit will be performed as follows:

- i. The initial assessment for the CBAS benefit will be performed through a face-to-face review 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 beneficiary's Managed Care Plan.
- ii. CBAS beneficiaries' eligibility must be re-determined at least every six months, or whenever a change in circumstances occurs that may require a change in the individual's CBAS benefit.
- iii. CBAS will be provided:
 - a. To CBAS beneficiaries who have been referred for an assessment, are assessed, and are determined to meet the eligibility criteria in STC 95;
 - 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 95;

- c. State Plan beneficiaries who previously received ADHC services 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
 - 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.
- e. CBAS Individual Plan of Care (IPC). “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. 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. Person-Centered Planning includes consideration of the current and unique bio-psycho-social and medical needs and history of the individual, as well as the person’s functional level, support systems, and continuum of care needs. The IPC will include:
- i. Medical diagnoses.
 - ii. Prescribed medications.
 - iii. Scheduled days at the CBAS center.
 - iv. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis.
 - v. Elements of the services that need to be linked to individual objectives, therapeutic goals, and duration of service(s).
 - vi. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities.
 - vii. Participation in specific group activities.
 - viii. Transportation needs, including special transportation.
 - ix. Special diet requirements, dietary counseling and education, if needed.
 - x. A plan for any other necessary services that the CBAS center will coordinate.
 - xi. IPCs will be reviewed and updated 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.
- f. Basic CBAS Benefits. The following services will be provided to all eligible CBAS beneficiaries:
- 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.
 - 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.

- iii. Therapeutic activities aimed at enhancement of the social, physical, or cognitive functioning of the CBAS beneficiary.
 - iv. Facilitated participation in group or individual activities for CBAS beneficiaries whose physical frailty or cognitive function precludes them from independent participation in activities.
 - v. Social services provided by a social worker to facilitate and assist the CBAS beneficiary and his/her family and/or caregivers in providing necessary home care and to cope with issues related to aging and disability.
 - 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).
- g. Additional CBAS Benefits. The following additional benefits will be provided to all eligible CBAS beneficiaries when specified on the person's IPC:
- i. Physical therapy provided by a licensed, certified, or recognized physical therapist within his/her scope of practice.
 - ii. Occupational therapy provided by a licensed, certified, or recognized occupational therapist within his/her scope of practice.
 - iii. Speech therapy provided by a licensed, certified, or recognized speech therapist within his/her scope of practice.
 - iv. Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by 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.
 - 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.
 - 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.
- 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:
- 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.

- ii. Counties that have not yet implemented managed care: CBAS will be provided, bundled (through CBAS centers) and 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.
 - 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.
 - iv. Nothing in this section exempts the State from managed care requirements of 42 CFR 438.
 - 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:
 - 1. Managed care beneficiaries: For managed care beneficiaries, if the MCO assessed a beneficiary and 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.
 - 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:
 - DHCS will identify the type, scope and duration of the CBAS services the beneficiary needs.
 - DHCS will arrange for
 - needed nursing services,
 - 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).
 - If the beneficiary needs therapeutic services, DHCS will internally coordinate with the Medi-Cal Field Office having jurisdiction for the authorization of these services.
 - If the beneficiary needs mental health services, DHCS will refer the beneficiary to the local mental health services program.
 - vi. The State must ensure that plans have mechanisms to provide care coordination, personcentered planning continuity of care, out of network care, etc to newly enrolled managed care beneficiaries as described in STC 85.f.
 - 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.
- i. CBAS Provider Specifications.
- 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.

- 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.
- 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.
- iv. Professional and non-professional staff are required to have appropriate experience and training at the time of hiring.
- 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.

j. CBAS Center Provider Oversight and Monitoring. 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. 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 23 on Quarterly reporting.

- i. No later than April 16, 2012, the State will submit to 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 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 plan that addresses such variances.
- ii. 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.
- iii. 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.

k. CBAS FFS Access Monitoring. 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 plan is available at: <http://www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%200092811.pdf> (Department of Health Care Services, September 2011).

- I. CBAS Managed Care Access Monitoring.
- i. The State Medicaid Agency will assure sufficient CBAS access/capacity, through 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. 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 plan that addresses such variances.
 - 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 plan that addresses such variances.
 - 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 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 plan that addresses such variances.
 - 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 plan that addresses such variances.
 - 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 plan that addresses such variances.

- 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.
 - iii. If it is found that the State did not meet the monitoring mechanisms listed above, CMS reserves the right to withhold a portion of, or all of FFP related to CBAS services until such time the State provides adequate documentation assuring sufficient access.
- m. CBAS Provider Reimbursement. Payment for CBAS will be as follows:
- 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.
 - ii. Under the fee-for-service payment system, CBAS providers will be reimbursed for providing the CBAS benefit at least at the rate described below, minus ten percent, except in exempted Medical Service Study Areas (MSSA)², which will receive the rates below.
 - a) Comprehensive multidisciplinary evaluation - \$80.08 per evaluation.
 - b) Community-Based Adult Services, adult - \$76.27 per day.
 - 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.
 - 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.
 - iv. Non-State plan services offered through the demonstration as unbundled services per (h)(v) are paid at a fee-for service rate basis as established by DHCS.

²“Medical Service Study Areas (MSSA) are the defined geographic analysis unit for the Office of Statewide Health Planning and Development (OSHPD) and are reproduced on the decadal census. The boundaries are approved by the Health Manpower Policy Commission and the U.S. Department of Health and Human Services, Health Resources Service and Administration (HRSA) formally recognizes California MSSAs as the Rational Service Area (RSA) for medical service for California. They are composed of one or more complete U.S. Census Bureau census tracts.”

v. Reimbursement methodologies are detailed as follows:

Unbundled CBAS Core Services	Reimbursement Methodology
Professional Nursing Services*	Consistent with 1915(c) waiver rate (RN and LVN) (\$10.14/15 min and \$7.35/15 min)* Qualifications: RN: 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. LVN: 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)* Qualifications: Must meet 1915(c) waiver qualifications as a 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) Qualifications: 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; or 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">• PT Maintenance Program• OT Maintenance Program	Consistent with 1915(c) waiver rate (habilitation) (\$11.36/15 min)

Qualifications:
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)
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.

Unbundled CBAS Additional Services

Physical Therapy*

Consistent with State Plan rate: \$10.60/15 min (current PT Treatment rate; X4110)*
Qualifications:
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)*
Qualifications:
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)*
Qualifications:
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
Psychiatrist: \$22.90 (current Level I physician office visit)
Other professionals: \$9.49/15 min (current EPSDT rate)*
Qualifications:

Psychiatrist: 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.

Psychologist: 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.

Licensed Clinical Social Worker:
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.

Advanced Practice Mental Health Nurse:
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.

Psychological/psychiatric assistant:
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.

Licensed Marriage, Family and Child Counselor/Licensed Marriage and Family Therapist: 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.

Certified Rehabilitation Counselor:
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.

Associate Clinical Social Worker:
Certified in the state of CA to practice pursuant to CA regulations regarding scope of practice. Must be enrolled in the Medi-Cal program.

Consistent with State Plan rate:
\$7.05/one-way trip (current NEMT, 2 patients per trip rate; X0202)

Qualifications:
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.

CBAS Transportation (only between participant's home and place of CBAS service)

* 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.

- vi. Contracts with the managed care entities will require payment to CBAS providers no less than the rates detailed in (ii), above.
- 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.

96. **Enhanced Case Management (ECM).** "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.

- a. ECM Eligibility. From April 1, 2012, through August 31, 2014, the ECM benefit will be available to all Medi-Cal beneficiaries who:
 - i. Received ADHC services through the California Medicaid program at any time from July 1, 2011 through February 29, 2012.
 - 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.
 - 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.
 - 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.

- b. ECM Benefits. The following services will be provided as ECM to all eligible state plan beneficiaries:
 - i. Complex Case Management Services means the systematic coordination and 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,
 - ii. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services;
 - iii. 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, including;
 1. activities such as ensuring the active participation of the eligible individual, and
 2. working with the individual (or the individual's authorized health care decision maker) and others to develop those goals and identify a course of action to respond to the assessed needs of the eligible individual.
 - iv. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services;
 - v. Monitoring and follow-up activities; and
 - vi. 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 85.f.iv.

- c. ECM Delivery System. 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.
- d. ECM Provider Specifications. 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:
 - i. A baccalaureate degree in a human services area and at least one year's experience working with populations with special needs (e.g. older adults, developmental disabilities, medically fragile, etc.); or
 - ii. A RN license issued by the State and one year's experience working with populations with special needs; or
 - iii. A master's degree in a human services area without one year's experience performing case management.
- e. ECM Reimbursement. Payment for ECM will be as follows:
 - i. 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).
 - ii. 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.

97. CBAS/ECM Quality Strategy.

- a. Amendment to the Quality Strategy. The State will amend the managed care Quality Strategy required in 42 CFR Part 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.
- b. Quality Strategy Design Elements. An overarching Quality Assurance and Improvement (QAI) strategy must assure the health and welfare of enrollees receiving HCBS and must address the:
 - i. Enrollee's person-centered IPC development and monitoring,
 - ii. Specific eligibility criteria for particular HCBS,
 - iii. Adherence to provider qualifications and/or licensure,
 - iv. Assurance of health and safety of Medi-Cal beneficiaries,
 - v. Financial oversight by the State Medicaid Agency, and
 - vi. Administrative oversight of the managed care plans by the State Medicaid Agency

98. CBAS/ECM Fair Hearing and Appeal Rights.

- 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.

- 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.

99. **CBAS/ECM Annual Report.** The State must provide the CMS with a draft annual CBAS report as part of the annual report requirement for the Demonstration as stipulated in STC 25. The first draft CBAS report will be due no later than October 1, 2012. The CBAS report will at a minimum include:
- a. An introduction;
 - b. A description of each HCBS in the approved Demonstration including Community Based Adult Services and Enhanced Case Management;
 - 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;
 - d. An update on service use by enrollees;
 - e. A general update on managed care and FFS CBAS including the collection, analysis and reporting of data at the aggregate level;
 - f. Monitoring of the quality and accuracy of screening and assessment of enrollees who qualify for CBAS and ECM;
 - g. CBAS provider capacity to ensure sufficient access, barriers, and possible solutions;
 - h. An update on the use of the ECM benefit;
 - i. The various service modalities employed by the State, including updated service models, opportunities for self-direction, etc.;
 - j. Specific examples of how HCBS have been used to assist Medi-Cal enrollees;
 - 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 Home Health benefit, etc.);
 - l. Contract requirements for provider capacity and service availability; and
 - m. Other topics of mutual interest between CMS and the State related to the HCBS included in the Demonstration.
 - n. The Report may also address such topics as 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.

- o. Additionally, the Report will also summarize the outcomes of the State's QAI for HCBS as outlined above.
 - 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.
100. **CBAS/ECM Research Study Design.** 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 functionality 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 enrollee's ability to:
- a. Maintain or expand conversation or communication;
 - b. Maintain or improve mobility/flexibility;
 - c. Maintain or increase personal hygiene;
 - d. Maintain or improve medical condition;
 - e. Decrease hospital admissions; and
 - f. Decrease emergency department episodes.
101. 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 of, or all of FFP related to CBAS and ECM services until such time the State provides adequate documentation assuring sufficient access.