Draft Community-Based Adult Services (CBAS) Home and Community-Based (HCB) Settings Transition Plan (Draft CBAS Transition Plan)

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TABLE OF CONTENTS

INTRODUCTION

CBAS Home and Community-Based (HCB) Settings Transition Plan Directives

In the amendment to California's Bridge to Reform (BTR) 1115 Demonstration Waiver ("BTR 1115 Waiver"), approved November 28, 2014, the Centers for Medicare & Medicaid Services (CMS) directed the State to undertake a stakeholder process to develop a transition plan for bringing CBAS centers into compliance with requirements of the HCB Settings Rule by March 17, 2019. Requirements for the CBAS stakeholder process and plan were specified in Special Terms and Conditions (STC) 95 and 96 of the 1115 BTR Waiver amendment, including the requirement that the plan be incorporated into California's *Statewide Transition Plan (STP)* for HCB Settings and submitted to CMS by September 1, 2015. The *Draft CBAS HCB Settings Transition Plan* (*Draft CBAS Transition Plan*) was submitted to CMS for approval on August 14, 2015, as an attachment to California's *STP*, after a public comment period of May 19, 2015, through June 22, 2015.

CMS reviewed California's *STP* and the *Draft CBAS Transition Plan dated August 14, 2015*, and issued a letter dated November 16, 2015, to the California Department of Health Care Services (DHCS) requesting revisions to both plans. Subsequent to a series of technical assistance calls with CMS, DHCS and its partner departments, including the California Department of Aging (CDA), revised the *STP* and the *Draft CBAS Transition Plan* and posted them for public comment beginning Monday, August 29, 2016, and ending Thursday, September 29, 2016. The State reviewed all submitted public comments and revised both draft plans as appropriate for resubmission to CMS on November 23, 2016.

On May 9, 2017, CMS issued an Informational Bulletin to all States extending the transition period for compliance with HCB settings requirements until March 17, 2022. As a result of this extension, CMS requested that the State revise its Milestones & Timelines in the *STP* and *Draft CBAS Transition Plan*. In addition, based on CMS's review of the *STP* and *CBAS Transition Plan dated November 23, 2016*, CDA revised *Appendix III: Analysis of Statutes, Regulations, Waiver Provisions, Policies, and Other Requirements* of the *Draft CBAS Transition Plan*. The State submitted to CMS for review the *STP* and *Draft CBAS Transition Plan dated September 1, 2017,* with the revised *Appendix I: Milestones & Timelines and Appendix III: Analysis of Statutes, Regulations, Waiver Provisions, Policies, and Other Requirements*. CMS requested additional revisions to the *STP* resulting in the resubmission of the *STP* and *Draft CBAS Transition Plan dated January 11, 2018*.

On February 23, 2018, CMS granted initial approval of the *STP*, which includes the *Draft CBAS Transition Plan* as Attachment I, based on the State's revised systemic assessment and proposed remediation strategies. CMS is requesting additional revisions to the *STP* and *Draft CBAS Transition Plan* before it will give final approval. Refer to the CMS Initial Approval Letter posted on the DHCS website.

On July 14, 2020, CMS informed state Medicaid agencies that in response to the COVID-19 pandemic, it extended the deadline for states to demonstrate compliance with the federal Home and Community-Based Services (HCBS) Settings Rule for one year, until March 17, 2023. Refer to the CMS letter posted on the CMS website for more details.

In March 2020, in response to the COVID-19 pandemic, CBAS implemented Temporary Alternative Services (TAS) as a short-term, modified service delivery model that grants CBAS providers time-limited flexibility to provide limited in-center individual, non-congregate services as well as telephonic, telehealth, live virtual video conferencing and/or in-home services if proper safety precautions are taken and if no other option for providing services is able to meet participants' needs. Services provided under CBAS TAS, similar to CBAS in-center congregate services, are to be person-centered; based on participants' assessed and expressed needs and conditions; identified in the participants' current Individual Plans of Care (IPC) and in subsequent assessments, and noted in the health record. This service option was approved by CMS on October 9, 2020, effective from March 13, 2020, through March 12, 2021. Refer to the CMS letter posted on the DHCS website. CMS extended the approval period of CBAS TAS from March 13, 2021, through six-months after the conclusion of the declared public health emergency (PHE). Refer to the CMS letter and Appendix K specific to CBAS which are posted on the DHCS website.

Note: The *Draft CBAS Transition Plan* is written to reflect the delivery of CBAS services in the congregate setting model of service delivery, not as CBAS TAS, with CDA determining a center's compliance with the federal requirements during on-site certification/ recertification surveys. There has been no stoppage of CDA certification/recertification surveys due to the pandemic.

In preparation for submission of the *STP* and *Draft CBAS Transition Plan* to CMS for final approval, the State posted the *STP* and *Draft CBAS Transition Plan* for public comment starting June 19, 2021, through July 19, 2021, after public comment period notifications. However, DHCS decided to postpone the submission to CMS in order to include clarifying information in the STP on the remediation process and to complete assessment activities.

The State posted the revised *STP* and *Draft CBAS Transition Plan* for public comment starting October 14, 2022 through November 13, 2022. Refer to the DHCS STP webpage and the CBAS Transition Plan Appendix II for more information about public comment period notifications. DHCS submitted the *STP* and *Draft CBAS Transition Plan* to CMS for final approval on XXXX.

The *Draft CBAS Transition Plan* provides a blueprint for the California Department of Aging (CDA) and the Department of Health Care Services (DHCS) in partnership with interested stakeholders, including CBAS providers, participants and their family/caregivers, managed care plans, advocates, and community providers to transition CBAS centers into compliance with the requirements of the HCB Settings Rule by March 17, 2023, and thereafter. The

goal of this transition is to ensure that CBAS centers meet the needs, preferences, and choices of CBAS participants in collaboration with their family/caregivers/authorized representatives. Refer to Appendix I: Milestones & Timelines which identifies the status of the activities and processes to validate CBAS center compliance with the HCB Settings requirements by March 23, 2023, and thereafter. All *Draft CBAS Transition Plans* including their respective Appendices are posted on the CDA website.

CBAS 1115 Waiver Provisions Addressing HCB Settings Rule

On December 30, 2015, CMS approved the State's extension of the 1115 BTR Waiver, titled California Medi-Cal 2020 Demonstration (Medi-Cal 2020 Waiver), effective December 30, 2015, through December 31, 2020. This extension resulted in a change in the numbering of the CBAS Special Terms and Conditions (STC) and the addition of CBAS STC 51. CMS extended the Medi-Cal 2020 Waiver an additional year through December 31, 2021, and approved California's California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration Waiver (CalAIM Demonstration Waiver), effective January 1, 2022, through December 31, 2026. This resulted in a change in numbering of the STCs and the addition of new STCs. CDA has revised the CBAS STC numbers referenced in the *Draft CBAS Transition Plan* to reflect the current CalAIM Demonstration Waiver, and has posted a link to the CalAIM Demonstration Waiver and the STCs on the CDA website.

The federal HCB Settings requirements are specified in STC 19(c) Home and Community-Based Settings as follows: "The state must ensure that home and community-based settings have all of the qualities required by 42 CFR 441.301(c)(4), and other such qualities as the secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by CFR 441.301(c)(4)(vi) must be met. The state engaged in a CBAS stakeholder process to amend the HCB settings statewide transition plan to ensure that all home and community-based settings found in the 1115 Demonstration have all of the qualities required by 42 CFR 441.301(c)(4). The state will amend the statewide transition plan to include all HCBS settings used by individuals in the section 1115 demonstration, to ensure complete compliance with HCB Settings by March 17, 2023."

CBAS Program Overview

CBAS is a Medi-Cal benefit with a long history and roots in California's adult day health care (ADHC) program, which became a State Plan Benefit in 1978. California's ADHC program was an optional Medi-Cal State Plan benefit until its elimination on March 31, 2012. CBAS was created under a federal court settlement agreement on the basis that CBAS services can help participants avoid unnecessary institutionalization, and that CBAS-type services are critical to Olmstead compliance and for ensuring that participants are able to remain in the

community. CBAS began as a benefit under California's Bridge to Reform 1115 Medicaid Demonstration Waiver on April 1, 2012.

Similar to ADHC, CBAS is a licensed community-based day health program that provides services to persons age 18 and older with chronic medical, cognitive, or mental health conditions and/or disabilities who are at risk of needing institutional care. CBAS participants must meet specific medical necessity and eligibility criteria specified in the CBAS provisions of the CalAIM Demonstration Waiver and in state law and regulations, as determined by the managed care plans and/or DHCS prior to authorization of services. These criteria specify that participants must: 1) meet or exceed the "Nursing Facility Level of Care" (NF-A) criteria established in regulation; 2) have a diagnosed organic, acquired or traumatic brain injury, and/or chronic mental disorder with specified functional needs; 3) have moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or equivalent to, Stage 5, 6, or 7 Alzheimer's disease, with specified functional needs; 4) have a mild cognitive impairment including Alzheimer's disease or other dementias, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's disease, defined as mild or early-stage Alzheimer's disease, with specified functional needs; or 5) have a developmental disability. CBAS program standards require CBAS centers to be sensitive and responsive to participants' complex needs.

The primary objectives of the program are to:

- Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and
- Delay or prevent inappropriate or personally undesirable institutionalization.

The CBAS program is an alternative to institutionalization for those individuals who are capable of living at home with the aid of appropriate health, rehabilitative, personal care, and social supports. The Program stresses partnership with the participant, the family and/or caregiver, the primary care physician, the managed care plan and other community providers and resources such as In-Home Supportive Services (IHSS) in working toward maintaining the participant's personal independence.

Each center has a multidisciplinary team of health professionals who in collaboration with the participant and/or participant's authorized representative conduct a comprehensive assessment of each potential participant to determine and plan services needed to meet the individual's specific assessed and expressed health and social needs. Services provided at the center include the following: professional nursing services; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; hot meals and nutritional counseling; and transportation to and from the participant's residence. To be reimbursed for services, CBAS centers must provide a minimum of four hours of therapeutic services per day to CBAS participants. Managed care plans determine the level of service authorization (i.e., days per week authorized) based on the member's assessed needs and

medical necessity. Most CBAS centers operate Monday through Friday from approximately 9 a.m. to 3 p.m.; however, there is nothing in the licensing regulations to restrict centers from operating seven days per week.

CBAS is a Medi-Cal managed care benefit but remains a Medi-Cal fee-for-service benefit for a very small number of individuals who are exempt from Medi-Cal managed care enrollment (approximately 20 as of February 28, 2022). ADHC remains a non-Medi- Cal program for individuals who pay "out-of-pocket" for services in licensed ADHC centers. Third party payers such as long-term care insurance companies, Regional Centers, or the Veterans Administration may also pay for ADHC services.

Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDPH licenses ADHC centers and CDA certifies them for participation in the Medi-Cal Program.

It is important to note that as a managed care benefit, some of the HCB Settings requirements are to be met at the managed care plan level (e.g., person-centered planning, informing beneficiaries of service options/choices, coordination of care) or in collaboration with the CBAS centers. CBAS Waiver requirements specify that managed care plans and CBAS providers must coordinate member care and care planning in collaboration with participants, their family/caregivers and community providers, and share the responsibility for delivering quality services.

As reflected in STC 24 of the CBAS provisions of the CalAIM Demonstration Waiver (CBAS Center Provider Oversight, Monitoring, and Reporting), the State is to maintain a plan for oversight and monitoring of CBAS providers to ensure compliance with provider standards, access, and delivery of quality care and services. As reflected in STC 26 of the CBAS provisions of the CalAIM Demonstration Waiver (Quality Improvement Strategy 1915(c) or 1915(i) approvable HCBS Services), "….the state's Quality Assessment and Performance Improvement Plan must encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CR 441.301 and 441.302. The state will work on establishing performance measures with CMS to ensure there is no duplication of effort and will report on the initial series within one year of finalization and from that point will report annually. …"

CBAS Center and Participant Facts

As of February 28, 2022, 274 CBAS centers were certified and operating statewide, serving approximately 41,308 participants (40,499 Medi-Cal participants and 809 Private Pay participants.) CBAS centers operate in a variety of locations, in urban and rural areas, churches, strip malls, standalone buildings, business complexes, senior housing, and more. CBAS centers range in size from a licensed capacity of 30 to 400 persons per day. Individuals served at these

centers have complex medical, social, and therapeutic conditions and needs; 51 percent of participants have mental health diagnoses and 23 percent have dementia diagnoses. Additional CBAS center and participant statistics can be found on the CBAS Dashboard and CBAS Data & Reports on the CDA website.

Summary – Key Features of CBAS

CBAS is a community-based setting. Centers operate as a part of local communities and meet local needs. Individuals who attend CBAS centers make the informed choice and voluntary decision to participate and may choose from among various services and supports options, depending on their local communities and the availability of other community-based services that can meet their needs. Under the terms of their contract with DHCS, managed care plans are responsible for informing their members of the home and community-based service options available to address their needs and preferences. CBAS participants are required to sign a participation agreement reflecting their voluntary decision to participate in CBAS. For those individuals who do not have decision-making capacity, their authorized representatives may make choices on their behalf for services and supports to ensure their needs are met and their rights are protected. Statewide, all CBAS participants may choose to receive IHSS, which is a consumer-directed model of in-home care. With the formal and/or informal help of the IHSS Program and other caregivers, the support of their managed care plan care coordinators, and the assistance of the CBAS center, CBAS participants exercise choice and continue to participate in community life to a degree that is equal to – if not greater than – individuals with similar needs who do not receive Medi-Cal HCB services.

The CBAS model is explicitly designed to promote autonomy and independence and maximize individuals' capacity for self-determination. It supports participants' involvement in treatment planning decisions and engagement in activities of their own choosing consistent with their needs, preferences, interests, and abilities. In turn, participants may choose to discontinue their voluntary participation at the CBAS center at any time.

CBAS centers are licensed and certified settings, located in diverse communities across the state, and offer a unique, multidisciplinary model of care that has long been person- centered. Participants have complex needs and, in many cases, require protective supervision. CBAS centers develop specialized programming with trained professional staff to meet those needs. While CBAS centers may specialize in serving target groups in their communities such as individuals of similar ethnicity, those with a common language, or those with certain health conditions (e.g., dementia) and related needs, CBAS centers are not allowed to exclude eligible individuals. Most CBAS centers serve a diverse mix of individuals, of varying ages, diagnoses, conditions, functional abilities, ethnicities, and spoken languages.

The vast majority of CBAS centers are located in highly visible leased spaces in their community. No centers in California are located within a hospital or a nursing facility. There are some CBAS centers that are affiliated with a hospital

or nursing facility/assisted living company but are located on separate grounds in an accessible and visible community setting. CDA will not consider these centers to be "de facto" institutional settings. There is one CBAS center that is on the grounds of a hospital campus. CDA will review this center and every center on site to determine whether in fact they have the characteristics of an institution requiring heightened scrutiny as defined by CMS. Refer to Section 3 for more information about the heightened scrutiny process for HCB Settings presumed to have institutional qualities.

Some CBAS centers use secured perimeters and delayed egress technology, in addition to person-centered programming, to address the personal safety and security needs of persons with dementia, as permitted and strictly governed by state law. These centers tailor programs through specialized person-centered care to maximize participants' autonomy and well-being and provide participants independence at the center that they might not enjoy at any other time. Secured perimeters and delayed egress provisions enable CBAS centers to address individuals' complex care needs, making it possible for them to remain in their own homes and communities, and affording them lives that are more integrated and community-oriented than they might otherwise be if they (and their caregivers) did not have access to a CBAS center.

Additionally, the CBAS center has an important role to play through the person-centered planning process in ensuring that individuals with dementia retain access to the broader community, to the degree that they choose and are able. Refer to Section 2 and Appendix III for more information about the state's regulation on the use of secured perimeters and delayed egress technology in the CBAS setting.

While compliance with HCB Settings regulations will only be demonstrated when the State completes its onsite review process for all centers on a biennial basis as specified in Section 3 below, CBAS – as defined in program requirements and demonstrated over its 40-year history – is a model that reflects the spirit and intent of the HCB Settings Rule. CBAS is an integrated, community setting that supports the participants' right to choose, to be treated with dignity and respect, and to enjoy as much freedom as possible, consistent with their desires and abilities – all while addressing their significant health, functional and social care needs.

As stakeholders shared during the CBAS HCB Settings Stakeholders meetings, California's CBAS program:

- Was created with the intent to keep people out of nursing facilities, with a strong purpose of community integration;
- Evolved with a local feel; centers meet local need;
- Provides services similar to nursing facilities, minus a bed in which to sleep;
- Promotes independence and supports life in the community;
- Is a managed care benefit – California is in the minority with CBAS' full

integration into managed care; this brings another set of rules for programs to comply with;

- Uses a full interdisciplinary team working in the CBAS setting to provide multiple services, including therapy. This is not the case in other states with adult day health care models;
- Offers choice – of centers, staff at centers, where participants want to go and who will care for them;
- Is not just a five-day program; CBAS services can be tailored to meet individual needs for independence;
- Offers dementia-specific programs that foster more choice and independence – these offer a specialized program, trained staff, and can work with individuals longer and with more quality. In this sense, CBAS actually facilitates more choice and independence.

Stakeholder comments about CBAS reflect the value they place on the model of care and how well they believe it supports the HCB Settings requirements. Still, it is incumbent upon the State through its monitoring and oversight responsibilities, with stakeholder oversight that includes participation by CBAS participants and family/caregivers, to ensure that the CBAS model is implemented in compliance with California laws/regulations and federal HCB Settings requirements. Details are provided in Sections 3 and 6.

SECTION 1: EDUCATION AND OUTREACH

CBAS HCB Stakeholder Process – Meetings

In February 2015, the Department of Health Care Services (DHCS) and the California Department of Aging (CDA) convened the CBAS HCB Settings stakeholder process as directed by CMS and required by STCs 95 in the 1115 BTR Waiver, now referenced in STC19(c) in the CalAIM Demonstration Waiver. Over the course of three meetings lasting three-hours each in February, March, and April 2015, and with individuals participating in-person at CDA and via webinar, stakeholders engaged in thoughtful conversation about the HCB Settings regulations. This conversation included consideration of person-centered planning and the CBAS program in the context of both the State and HCB Settings regulations. Stakeholders completed group exercises to develop greater understanding of the HCB Settings regulations, to assist in considering the level of compliance of the CBAS program and individual centers statewide with the regulations, and to participate in drafting content for the CBAS HCB Settings Transition Plan. The meetings used the *CMS Statewide Transition Toolkit* to focus group discussion, including engaging participants in answering the "Exploratory Questions to Assist States in Assessment of Non-Residential Home and Community-Based Service (HCBS) Settings" Refer to the CDA website to review the CBAS HCB Settings Stakeholder Activities Work Tool that documents this stakeholder discussion. The CBAS HCB Settings Stakeholder

Process calendar that was shared with stakeholders in February 2015 is posted on the CDA website.

Website

In addition to the three meetings held prior to drafting and releasing the *Draft CBAS Transition Plan dated May 19, 2015,* for public comment, DHCS and CDA developed webpages to share key documents to inform stakeholders on the regulations and to capture meeting materials and public comments made throughout the CBAS HCB Settings stakeholder process. CDA made the webpages available beginning in February 2015 and posted resources, links, and meeting materials regularly. Document postings and links on the CBAS HCB Settings Stakeholder Activities webpages include the Final Rule, the CMS Statewide Transition Plan Toolkit, a Flyer and Fact Sheet designed for participants and caregivers, access to the *STP* and *Draft CBAS Transition Plans* and numerous other materials that offer stakeholders and the general public opportunities for understanding the HCB Settings Rule. The CDA webpages and materials, which include a schedule of the stakeholder meetings held February 2015 through May 2015, will remain available throughout the CBAS transition.

Distribution of Meeting Announcements, Public Comment Notices and Informational Materials

On CMS' approval of the CBAS provisions in the 1115 Waiver, effective December 1, 2014, CDA and DHCS began to inform CBAS stakeholders about the new federal HCB Settings requirements and directives in the 1115 Waiver's STCs 95 and 96 (now STCs 19 and 20 in the current 1115 CalAIM Demonstration Waiver.) CDA launched the CBAS HCB Settings Stakeholder Activities webpage and distributed CBAS HCB Settings meeting announcements, public comment notices and other HCB Setting information. Refer to CBAS Appendix II: Distribution of Meeting Announcements, Public Notices and Informational Materials.

In preparation for posting the *STP* and the *Draft CBAS Transition Plan dated August 29, 2016*, for public comment, DHCS and CDA posted a joint General Public Interest Notice for the California Regulatory Notice Register (non-electronic) to inform the general public about the public comment period beginning August 29, 2016, and ending September 29, 2016.

In addition, CDA distributed a *CBAS Updates* newsletter on August 26, 2016, to CBAS providers, managed care plans, legislators, advocates and other interested stakeholders who have subscribed to the CBAS Updates newsletter distribution list, requesting their feedback on the *Draft CBAS* Transition Plan dated August 29, 2016.

This newsletter included a link to a Flyer and Fact Sheet that CBAS providers could distribute and post at CBAS centers to inform CBAS participants, their families and caregivers about the public comment opportunity for the *Draft CBAS*

Transition Plan. .

During the public comment period DHCS, in coordination with partner departments including CDA, hosted a conference call for stakeholders on September 27, 2016, to discuss and address any questions about the *STP* and the *Draft CBAS Transition Plan*. Conference call information is posted on the DHCS HCBS Statewide Transition Plan webpage.

CDA received three public comments specific to the *Draft CBAS Transition Plan dated August 29, 2016*. We have documented these comments in *Appendix VI: Public Comment Log* and indicated actions taken. Comments submitted to DHCS specific to the *STP* are addressed in the *STP*. Disseminating information to CBAS stakeholders will be an ongoing process throughout the development of the CBAS Transition Plan and its implementation. Refer to *Appendix II: Distribution of Meeting Announcements, Public Comment Notices and Informational Materials* to view the documents distributed, the methodology used, and the audiences targeted.

Training and Education

Discussions during the stakeholder process made clear that there is a need for statewide provider training and education to promote consistent understanding of, and compliance with, the HCB Settings requirements. DHCS and CDA continues to partner with CBAS providers, Medi-Cal managed care plans and other stakeholders to develop and implement training and education strategy designed to reach CBAS providers, CBAS participants and their family/caregivers, and managed care plans. The training and educational materials developed may also serve to inform other community providers and the general public. The overarching goal of training and educational efforts is to provide information about the HCB Settings requirements to ensure that CBAS centers meet participant needs. Areas of focus for training and education – identified during stakeholder meetings and in the public comment process – include person-centered planning and care, and participants' rights to choice and dignity.

Each year the adult day services industry association, California Association for Adult Day Services (CAADS), hosts two conferences – one in Southern California in November and one in Northern California in April. CDA participates on the conference planning committee for each of these conferences and helps develop the schedule and content for workshops and plenary speakers. CDA and DHCS participate in the conferences, providing program updates during business meetings and conducting workshops. CDA and DHCS have and will continue to partner with CAADS and managed care plans to conduct workshops for CBAS providers, managed care plans and other conference attendees on HCB Settings requirements and person-centered planning for all CAADS conferences. Information about these training opportunities has been, and will continue to be, distributed via the *CBAS Updates* and *All Center Letters (ACL)*. Additionally, CDA develops and posts website training modules designed to promote better understanding of the federal regulations and the CBAS setting among CBAS

participants, caregivers, and providers.

CDA has trained and continues to train state staff responsible for the certification, oversight, and monitoring of CBAS centers about HCB Settings requirements, including person-centered planning. The CBAS stakeholder outreach flyers and fact sheets are one strategy to educate and inform CBAS participants and their family/caregivers about the HCB Settings requirements that has been implemented with the assistance of CBAS providers. CDA has incorporated into its onsite monitoring surveys a review of CBAS center postings to ensure that CBAS providers have made outreach flyers and fact sheets available for viewing by participants and caregivers. Refer to the Flyer and Fact Sheet that was distributed via the *CBAS Updates* newsletter on August 26, 2016, to inform stakeholders about the revised *Draft CBAS Transition Plan* (dated August 29, 2016) and the public comment period beginning August 29, 2016 and ending September 29, 2016.

In addition, CDA survey staff interviews and informs CBAS participants about the HCB Settings requirements and determines from participants' perspectives if the center is meeting their needs and preferences and protecting their rights. During the onsite survey and compliance monitoring process, CDA survey staff use the CBAS Participant Setting Assessment Tool developed with participant and family/caregiver input. Refer to Section 3 for more information about the Participant Setting Assessment Tool.

Stakeholder education and outreach activities will continue through March 17, 2023, and thereafter, to promote stakeholder engagement in, and oversight of, the implementation of the *Draft CBAS Transition Plan*. CDA provided a webinar on October 25, 2016, to update CBAS providers and interested stakeholders about the changes CDA made to the CBAS monitoring and onsite certification renewal survey processes pursuant to the federal HCB Settings and Person-Centered Planning regulations. Refer to the *CBAS Updates* newsletter notifying CBAS providers and interested stakeholders about this webinar. Webinar information including the slides and recording are posted on the CDA website under Program Updates.

The State continues to keep stakeholders informed and seek stakeholder input throughout the implementation process. Refer to *Appendix I: Milestone & Timelines* to view the Education and Outreach Milestones & Timelines.

SECTION 2: ASSESSMENT OF STATUTES, REGULATIONS, WAIVER PROVISIONS, POLICIES, AND OTHER REQUIREMENTS

Initial and Comprehensive Reviews

Review of ADHC/CBAS laws, regulations, waiver provisions, policies, and other requirements to determine whether they align with HCB Settings regulations began with the first CBAS stakeholders meeting on February 24, 2015. At this meeting, stakeholders completed a group exercise during which they discussed

and answered CMS' Exploratory Questions to Assist States in Assessment of Non-Residential Home and Community-Based Service (HCBS) Settings, considering current CBAS program requirements pertaining to the question areas. Subsequently, DHCS and CDA added statutory and regulatory references that supported/addressed responses given during the meeting and added them to the CMS Exploratory Questions Work Tool located on the CDA website.

Additionally, DHCS and CDA completed a more comprehensive review of ADHC/CBAS laws, regulations, waiver provisions, policies, and other requirements to determine whether they are silent, conflict with, or align with the requirements of the HCB Settings regulations. Based on this review, CDA assessed that CBAS program requirements addressed all requirements of the non-residential HCB Settings regulations and did not conflict. Minimal work may be necessary to clarify and reinforce existing CBAS policies accomplished through All Center Letters (ACL), Medi-Cal Provider Bulletins, and Medi- Cal Manual updates. For example, the HCB Settings regulations for non-residential settings has been incorporated into the existing Medi-Cal Manual to support their implementation.

CMS requested more information from the State about CBAS policies that support Federal Requirements #1, 3 and 7 which CDA inserted into the relevant federal requirement sections of *Appendix III: Assessment of ADHC/CBAS Statutes, Regulations, Waiver Provisions, Policies and Other Requirements* of the *Draft CBAS Transition Plan dated November 23, 2016*. The following are excerpts of CDA's response:

1. Federal Requirement #1: the following ADHC/CBAS program requirements support this requirement – T-22 §78341, T-22 §54329, T-22§54211, T-22 §54207, T-22

   §78303, STC 45(c), now STC 20(c).

2. Federal Requirement #3: CMS requires the State and CBAS centers to implement certain protocols, practices, documentation, and training for the use of soft restraints to comport with the HCB Settings requirements and person-centered planning and plan requirements. CDA issued an All Center Letter (ACL) to CBAS providers explaining the protocols, practices, documentation, and training requirements specified by CMS on the use of soft restraints that are largely addressed in current regulation and the methods by which the State monitors the CBAS center's adherence to the state and federal requirements.

3. Federal Requirement #7: this requirement applies to residential settings, not the non- residential CBAS setting. However, the State believes that all HCB settings should permit visitors and has included a question in the Provider Self-Assessment Tool to monitor both residential and non-residential settings for compliance with this requirement.

Based on additional CMS guidance to the State, CDA revised *Appendix III* in the *Draft CBAS Transition Plan dated September 1, 2017, and January 11, 2018,* for CMS' review. In addition, on March 9, 2017, per a CMS directive, CDA

distributed a policy letter, ACL #17-03, on the use of soft restraints to comply with the HCB settings requirements. This ACL is posted on the CDA website.

Note: In preparation for the submission of the *Draft CBAS Transition Plan* to CMS for final approval, CDA indicated in Appendix III that the target dates for completion of all specified remediation strategies have been met.

Secured Perimeters and Delayed Egress

During the review of the ADHC/CBAS laws and regulations, stakeholders and the State paid careful attention to the subject of secured perimeters as defined in state law and used in centers to ensure the safety of individuals at risk of wandering.

The Alzheimer's Association and other advocates have made it clear in their public comments that the availability of CBAS centers with delayed egress is essential for individuals at risk of wandering who would otherwise not have a community-based option and would be required for safety and security reasons to be placed in a skilled nursing facility. Statistics indicate that 60 percent of persons with Alzheimer's disease will wander at some point. Often, a wandering/elopement incident is a precursor to CBAS, as the in-home family caregiver realizes that he/she can no longer adequately monitor their loved one and the loved one needs the additional support that the CBAS center's staff and safety measures provide. Remaining at home is not an option for many individuals with dementia unless there is a CBAS center available to promote their social, emotional, and physical wellbeing and to offer respite to family caregivers.

Secured perimeters and delayed egress devices are permitted only when approved by the local fire marshal, in compliance with state law. Some buildings may qualify for delayed egress devices on some exterior doors but do not qualify for secured perimeters. "Secured perimeters" are rarely used in the community setting, as very few CBAS facilities have the minimum exterior square footage to allow for a secured fence line. More sites qualify for "delayed egress," which is designed for safety to alert staff in dementia care programs, in particular, of an egress door opening. The exit door is not allowed to be locked; it opens after a short delay of 10 - 30 seconds. There are extensive detailed California fire codes defining secured perimeters, delayed egress devices and physical setting requirements. California law and regulations are well balanced to promote free movement while providing for the safety of those individuals with impaired judgment. Delayed egress is a tool that allows staff to gently redirect the person from exiting the building. The ability to have this warning device saves persons with dementia from becoming lost, being injured, or dying as a consequence of wandering behaviors involved in the disease process.

CMS required the State to define secured perimeters and delayed egress in the STP, to identify settings that are using this technology and how the State is ensuring that a center's use comports with the HCB Setting requirements. CMS informed the State that the use of secured perimeters and delayed egress is

permissible if this technology is used according to state and federal regulation and is justified in the person-centered plan as being necessary to ensure the participant's health and safety.

CDA has included in the revised *Appendix III* the state and federal regulations required for the use of secured perimeters and delayed egress. Through its monitoring and oversight activities, CDA identifies which CBAS centers use either one or both of these technologies and if these centers are adhering to state and federal requirements, including documenting the need for their use in the person-centered plan. The documentation of need in the CBAS person-centered plan (Individual Plan of Care/IPC) should be based on the assessments of the multidisciplinary team to address an individual's unsafe wandering or exit-seeking behavior. In addition, for clarification, the CBAS multidisciplinary team is the same as the person-centered planning team referred to by CMS. On March 10, 2017, per a CMS directive, CDA distributed ACL #17-04 to CBAS providers about the state and federal requirements for the use of delayed egress and secured perimeter technology in the CBAS setting so that CBAS providers using these devices comply with state and federal requirements. This ACL is posted on the CDA website.

Further Stakeholder Engagement on Assessment of Statutes, Regulations, Waiver Provisions, Policies, and Other Requirements

DHCS and CDA worked with stakeholders to identify areas of current ADHC/CBAS program requirements that may need strengthening and to develop appropriate guidance. These discussions included opportunities for standardizing certain center protocols and forms (e.g., participation agreement, care planning tools, etc.) that would support consistent implementation of HCB Settings requirements, as stakeholders noted during the February, March, and April 2015 meetings. Refer to *Appendix III*.

SECTION 3: COMPLIANCE DETERMINATION PROCESS FOR HCB SETTINGS

CBAS centers are community-based settings and must conform to the HCB Services Rule. As a managed care benefit, some of the requirements specified under the HCB Services regulations, such as person-centered planning, are to be met at the managed care plan level and/or are a shared responsibility between the managed care plans and CBAS centers.

Initial and Ongoing Compliance Determination Process

CDA, in coordination with DHCS, verifies compliance of all CBAS centers with the HCB Settings requirements to ensure ongoing compliance through and beyond March 17, 2023. To determine initial and ongoing levels of compliance, remediate non-compliance, and maintain full and continuous compliance, the State is using existing oversight and monitoring mechanisms required by state

law. CDA is the lead state agency for CBAS provider oversight.

By state law, all CBAS providers must reapply for continuing participation in the Medi- Cal program at least once every two years. This certification renewal process begins with an application (e.g., standardized disclosure forms, provider agreements, and various other program documents) and includes a desk review of requested documents, an onsite survey of the center to determine compliance with CBAS program requirements, and statements of deficiency and corrective action plans as indicated.

Refer to *Appendix IV: CBAS Certification Renewal Process* and the CDA website for more details about the CBAS certification renewal application process.

CDA survey staff conduct the onsite monitoring and oversight processes at CBAS centers. Staff are comprised of registered nurses and generalist analysts with a variety of qualifications and experience in health and aging services including social workers, gerontologists, occupational therapists and other health and social service specialists. Note: CDA survey staff do not provide direct services to CBAS participants and do not work for CBAS providers.

With input from stakeholders, CDA added the following to the CBAS provider certification renewal process to create a robust, ongoing oversight and monitoring process to determine compliance with HCB Settings regulations:

1. Provider Self-Assessment Tool to be completed and submitted to CDA by all CBAS providers at the time of the CBAS provider's application for certification renewal;
2. Process for review of the Provider Self-Assessment Tool by the CDA survey team during the in-house "desk review" prior to the CDA onsite survey visit;
3. Participant Setting Assessment Tool to be used by CDA survey staff in a face-to- face interview with CBAS participants during the onsite survey and evaluated as part of the survey validation process;
4. Validation processes for HCB Settings compliance incorporated into the onsite survey instrument and process currently used by CDA survey staff, including participant interviews, CBAS center staff interviews, observations, and review of specific health and administrative records.

Provider and Participant Assessment Tools

Provider Self-Assessment Tool

The Provider Self-Assessment Tool developed with stakeholders as part of California's *STP* was piloted in CBAS centers in November 2015 and modified as necessary to address CBAS setting and program characteristics. For example, CDA modified terminology in the tool by replacing "setting" with "center" and replacing "individuals" with "participants" to use terms specific to CBAS and understandable to CBAS center staff and participants. No modifications were made that changed the CBAS Provider Self-Assessment Tool questions from the

state's core assessment questions submitted to CMS on August 14, 2015. The CBAS Provider Self-Assessment Tool is being used during onsite monitoring and oversight surveys for all CBAS centers.

The CBAS Provider Self-Assessment Tool includes 23 core questions derived from the *Exploratory Questions for Non-Residential Settings* provided by CMS that focus on the center's compliance with each of the non-residential HCB Settings requirements. CDA requires CBAS providers to complete the Provider Self-Assessment Survey as part of their center's certification renewal process in preparation for their biennial certification visits. Providers must submit the completed survey to CDA within 45 days of the date of their certification renewal notification letter. Failure to complete this survey could result in their not being re-certified. CBAS center staff who are to complete the Provider Self-Assessment Survey include Program Directors and Administrators who are required by state law and regulations to be professionals in the areas of health and social services.

CDA's onsite survey validation tool and process mirrors the Provider Self-Assessment. CDA reviews and validates the CBAS provider's responses to all 23 questions that apply to each of the federal HCB Settings requirements for non-residential settings.

Whether the CBAS provider answers "Yes" to a question or "No," CDA staff evaluates the evidence of compliance during the onsite validation process. If CDA determines that the center is not in compliance with the federal regulations, remedial action through a plan of correction process is required. The CDA staff tests the veracity of the CBAS provider's responses by validating with the following methods: 1) reviewing the written evidence of compliance submitted by the provider; 2) observing setting and program activities onsite; and 3) interviewing participants and key staff to validate observations and written documentation.

CBAS Participant Setting Assessment Tool

The CBAS Participant Setting Assessment Tool was developed as part of California's *STP* with input from stakeholders, including CBAS participants and their families/caregivers, and focuses on the CBAS participants' goals and satisfaction with how the center: 1) conducts the person-centered planning process; 2) affords participants choices regarding services and the center staff who provide them; 3) supports freedom of movement through the center; 4) respects participants' rights to privacy, dignity and respect, and freedom from coercion and restraint. The CBAS Participant Setting Assessment Tool includes questions that reflect all aspects of the HCB settings criteria for non-residential settings.

CDA survey staff interview a sample of CBAS participants using the CBAS Participant Setting Assessment Tool during every center's onsite certification renewal survey.

These are participants randomly selected for health record reviews and interviews during the center's onsite certification renewal survey. The addition of

this tool requires it to be understandable to participants with a range of cognitive abilities and literacy levels, to ensure that the onsite CBAS center monitoring and oversight process includes meaningful consumer/beneficiary participation. Due to these considerations, the CDA survey team interview participants face-to-face during the on-site certification survey to be able to provide clarifying information if needed to help participants understand and respond to the survey questions.

The CBAS survey staff validates CBAS compliance with HCB Settings requirements onsite, using and comparing the results of the CBAS Provider Self-Assessment Survey Tool and the CBAS Participant Setting Assessment Survey Tool in combination with onsite observation, interviews, and review of administrative and health records.

If the CDA survey staff identifies discrepancies between CBAS Provider Self-Assessment Survey responses and CBAS Participant Setting Assessment responses (e.g., if a participant's responses indicate provider non-compliance with the federal requirement), the CDA survey staff provide an in-depth review of evidence including review of administrative and health records, observations, and interviews with other center staff and participants. The goal of this in-depth review is to determine the reason for any discrepancies and to identify the appropriate course of action such as require CBAS provider remediation through the corrective action plan process. The following are examples of validation strategies that CDA survey staff are implementing to rectify discrepancies between provider and participant responses:

1. Review and compare the evidence that supports or does not support provider and participant responses on the survey tools via in-depth review of administrative and health records, interviews with center staff who did not complete the Provider Self-Assessment Tool, interviews with additional participants who were not included in the sample interviews, and observations of interactions between center staff and all participants that relate to specific survey responses in question.
2. Identify patterns of responses among center staff and participants to determine the validity of the responses on the Provider Self-Assessment and Participant Setting Assessment Tools.

In addition, CDA has included a specific section on the PSA Validation Tool that requires documentation by CDA survey staff of participant interview responses to each of the federal requirement questions on the Participant Setting Assessment Tool. This enables CDA survey staff to identify if a participant's responses align with the provider's responses for each of the federal settings requirements. A "no" response by a participant would trigger implementation of the validation strategies described above.

Ultimately, the CDA survey staff determine the validity of the provider's survey responses in comparison with participant interview responses. After reviewing all evidence, if the CDA survey staff determines that the center is out of compliance with the federal requirements, then remediation by the provider is required

through the center's plan of correction process.

In summary, the CBAS survey staff validates CBAS center compliance with HCB Settings requirements using the CBAS Provider Self-Assessment Survey Tool and the CBAS Participant Setting Assessment Survey Tool, in combination with onsite observation, interviews, and review of documentation on an ongoing basis every two years during each center's onsite certification survey.

Refer to *Appendix V: CBAS Setting Assessment Process* for more details about the CBAS monitoring and oversight process, the onsite monitoring protocols, and the onsite setting assessment and validation process.

Provider Deficiencies

Current state law defines oversight and monitoring processes that are designed to allow CBAS providers the opportunity to correct deficient practices. Rarely are providers found to be substantially out-of-compliance with program requirements. When they are found to be so, in nearly all cases they regain compliance through a structured corrective action process.

DHCS and CDA anticipate all CBAS centers either will be in full compliance with the HCB Settings regulations or can be brought into full compliance through remediation before March 17, 2023. Therefore, the need to transition CBAS participants from non- compliant centers is not anticipated. However, in the event that a CBAS center is unable to come into full compliance with the federal requirements before March 17, 2023, and thereafter, resulting in its decertification and closure, the CBAS center will be required to follow state policies and procedures to transition its center's participants to compliant settings in collaboration with its contracted managed care plans. Refer to Section 6 for a description of the orderly closure and participant referral and discharge process required when a CBAS center closes.

Heightened Scrutiny Process for CBAS Centers Presumed Institutional

As described in detail in the *STP*, CMS requires the State to identify HCB settings that have institutional qualities that trigger a heightened scrutiny process. Settings presumed to be institutional include those that: 1) are located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment; 2) are in a building located on the grounds of, or immediately adjacent to, a public institution; or 3) have the effect of isolating individuals receiving Medicaid Home and Community-Based Services (HCBS) from the broader community of individuals not receiving Medicaid HCBS services.

Settings that may have the effect of isolating HCBS members are settings designed to provide members with multiple types of services and activities on-site, including housing, day services, medical, behavioral health, and therapeutic services, and/or social and recreational activities. These settings provide little or no interaction with the broader community and use interventions or restrictions

that are used in institutional settings.

Settings that have one or more of these institutional characteristics must be approved by CMS to continue to receive Medi-Cal HCBS funding. These settings are required to submit evidence to the State to demonstrate how they have the qualities of HCB settings, which the State then reviews and submits to CMS if the State believes the setting has overcome the institutional presumption. The evidence should focus on the qualities of the setting and how it is integrated in and supports full access to the community. The State must demonstrate to CMS that the setting meets the HCB Settings requirements.

Specific evidence to be submitted to the State may include:

1. Licensure requirements or other state regulations that clearly distinguish a setting from licensure or regulations of institutions,
2. Provider qualifications for staff employed in the setting that indicate training or certification for HCB services,
3. Procedures that indicate support for activities in the greater community according to the individual's preferences and interests,
4. Description of the setting's proximity to avenues of available public transportation or an explanation of how transportation is provided when desired by the member.

Through the CDA oversight and monitoring process, CDA reviews all CBAS centers to determine if they have the characteristics of an institution according to CMS criteria and are therefore presumed to be institutional. Centers having one or more of these institutional characteristics would trigger application of the State's heightened scrutiny process as described above and in the *STP*.

The State's heightened scrutiny review process for the CBAS program consists of 1) a review of the evidence provided by the setting; 2) a review of the setting's policies and services; 3) an onsite visit and an assessment of the setting's physical characteristics; 4) a review of policies and procedures governing person-centered plan development and implementation; 5) provider and member interviews and observation; and 6) collection of evidence to submit to CMS for review in order to overcome the institutional presumption.

Based on a full review of CBAS center locations and their surrounding communities during calendar year 2016, CDA identified one CBAS center that might be presumed to have institutional characteristics because of its location on a hospital campus. However, CDA determined during this center's onsite survey review that it did not have institutional characteristics or require heightened scrutiny. During onsite survey reviews conducted through calendar year 2021 and which will continue on an ongoing basis, CDA evaluated all centers to determine if they have institutional characteristics including the effect of isolating participants and no CBAS centers required heightened scrutiny. This was accomplished during the onsite validation process.

As a result of CDA's onsite monitoring and oversight process for determining CBAS center compliance with the HCB Settings requirements, CDA collects data

on the following once all center assessment and validation activities are completed and on an ongoing basis: 1) CBAS centers that are fully compliant with HCB Settings requirements; 2) CBAS centers that are partially compliant and will require remediation and corrective action to come into full compliance; 3) CBAS centers that cannot meet the federal requirements and will be decertified, requiring closure and the transitioning of CBAS participants to another CBAS center compliant with the federal requirements or other services as available; and 4) CBAS centers that are presumed institutional requiring heightened scrutiny and the outcome of this process.

Refer to *Appendix I* to view the Milestones &Timelines for the initial review of CBAS centers for HCB Settings compliance determination and ongoing compliance determination beyond March 17, 2023.

SECTION 4: PERSON-CENTERED PLANNING

CMS Directives to California in 1115 Waiver Special Terms and Conditions (STCs)

Through CBAS 1115 BTR Waiver STC 95(c), now referenced in STC 19(c) in the current Medi-Cal CalAIM Demonstration Waiver, CMS directed the State to conduct a stakeholder process to develop a transition plan for ensuring that CBAS centers meet HCB Settings regulations. CMS included the following person-centered planning directives to STC 96(c), now STC 20(c) Individual Plan of Care (IPC):

"The planning process and the development and review of the IPC will comply with the requirements of 42 CFR 441.301(c)(1) through (3), including specifying 1) How the IPC will identify each enrollee's preferences, choices and abilities; 2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee."

Note: The federal person-centered planning requirements became effective as of March 2014 and do not have a transition period for compliance. CDA determines a center's compliance with the federal HCB settings and person-centered planning requirements during the center's onsite certification renewal survey through March 17, 2023, and on an ongoing basis thereafter every two years during the center's onsite certification renewal survey.

CMS has indicated that compliance determination activities related to the federal person-centered planning regulations are not to be included in the *STP* and *Draft CBAS Transition Plan*. Per information in California's *STP* (Role of Person-Centered Planning): "Even though implementation of the new federal regulations affecting the person- centered service planning process is not technically part of

this STP, person-centered service planning is inextricably linked to the HCB setting requirements…. The person-centered service plan documents the members choice of settings and services based on the needs and preferences of the member." CDA determines CBAS center compliance with the person-centered planning directives in STC 20(c) as part of its ongoing oversight responsibilities.

SECTION 5: APPEAL PROCESS

Processes currently in place for CBAS participants, their family/caregivers/authorized representatives, and providers to file appeals and grievances offer strong protections and support compliance with HCB Settings regulations.

CBAS Participant Appeal and Grievance Rights

All Medi-Cal beneficiaries have the right to file an appeal and/or grievance under state law when they receive a written notice of action regarding a loss of benefits or a denial or reduction of CBAS services. Additionally, all managed care members may file a grievance with their managed care plans at any time that they experience dissatisfaction with the services or quality of care provided to them.

Additionally, CBAS regulations afford participants the right to file grievances at their CBAS centers to address problems they identify in the delivery of their care at the CBAS center and in the center's compliance with HCB Settings requirements.

CBAS providers are required to inform participants and their family/caregivers/authorized agents about their grievance rights and protections as part of the Participation Agreement they must sign before they begin receiving services at a CBAS center. These rights and protections are to be posted for public view in a conspicuous place at the CBAS center in the predominant languages spoken by center participants. The State enhances existing processes for monitoring CBAS centers to determine if CBAS participants and their family/caregivers/authorized representatives have been informed about and received a copy of their grievance rights and protections, that policies and procedures for filing grievances/complaints are in place, and that grievances and subsequent actions taken are documented and available for review by the State. In addition, the State must ensure that there are no retaliatory actions toward anyone filing a grievance/complaint or appeal.

CBAS Provider Appeal Process

CBAS providers may dispute deficiency findings through the Statement of Deficiency and Plan of Correction process.

In cases where the State brings a case against a provider for substantial non-

compliance, the State notifies the provider of termination or non-renewal of certification and the provider has rights to a full evidentiary hearing in front of a state administrative law judge to appeal their case.

The vast majority of disputes are resolved during the corrective action phase. Formal due process structures are in place to resolve the more significant appeals of certification termination or non-renewal.

SECTION 6: COMPLIANCE MONITORING

Existing Monitoring Processes

Under an interagency agreement with DHCS, CDA is responsible for CBAS provider oversight of compliance with state laws/regulations, and federal requirements. Managed care plans have additional responsibilities for credentialing of and contracting with providers to ensure quality service delivery to their members. Communication and collaboration among DHCS, CDA, and managed care plans continue to develop and strengthen as the CBAS provisions of the CalAIM Demonstration Waiver and the HCB Settings regulations are implemented. The compliance discussion here focuses on the CDA certification process as described in *Appendix IV: CBAS Certification Renewal Process.*

As discussed in Section 3 – Compliance Determination Process – CDA will determine initial levels of compliance, remediate non-compliance, and assure full and ongoing compliance beyond March 17, 2023, using existing oversight and monitoring mechanisms required by state law that have been modified to include review and validation of CBAS centers' ongoing compliance with the HCB Settings requirements.

Key features of CBAS oversight include the following:

1. Ensuring that providers maintain an ADHC license in good standing at all times.
2. Monitoring for compliance with Medi-Cal certification standards. More detail can be found on the CDA website.
3. Conducting certification renewal of each provider at least every two years.

Note: This means that half of all CBAS providers apply for renewal and receive an onsite survey every year.

Certification renewal steps include:

1. **Application** – including filing standardized disclosure forms, a provider agreement, and staffing sheets
2. **Desk Review** – including reviewing provider records, compliance history, staffing levels, and cross-comparing application documents
3. **Onsite Survey** – performed by nurses and analysts, including review of

participant health records, observing service delivery and participant and family/caregiver interviews, reviewing center administrative records, general observation of the facility and program activities, and interviewing key staff to determine compliance with program standards. Onsite surveys focus on the care planning process – from assessment of the participant and their home by the MDT, to development, implementation, and revision of the individual plan of care (IPC), to determine whether desired outcomes and goals are met.

4. **Remediation of Deficient Practice** – by issuing a Statement of Deficiency report and completing a Plan of Correction process.

With input from stakeholders, CDA has incorporated the following elements into the biennial CBAS provider certification renewal process to ensure ongoing compliance with the HCB Settings regulations:

1. Provider Self-Assessment Tool to be submitted to CDA at time of application for certification renewal and Participant Setting Assessment Tool to be administered to CBAS participants by CDA survey staff in a face-to-face interview during the onsite survey.
2. A process for reviewing the Provider Self-Assessment Tool during the in-house "desk review."
3. Validation processes for the Provider Self-Assessment Tool incorporated into the onsite certification survey instrument currently used, including participant interviews observations, and review of specific health and administrative records.
4. Review and validation processes for the Participant Setting Assessments obtained during the onsite survey. All review and validation processes by the CDA survey teams for Participant Setting Assessments occur during the onsite certification survey. There are no follow-up processes to validate participant surveys after CDA's onsite survey.

Note: CDA's monitoring responsibilities and activities are ongoing throughout a center's two-year certification period. Settings found to be out of compliance with the new regulations during these routine reviews will be required to submit and have approved a corrective action plan which includes a timeframe for its completion. Centers generally implement corrections within 60 days of submission of their corrective action plans. Failure to complete a plan of correction may jeopardize the provider's certification and participation in the CBAS program. As mentioned in Section 3 above, providers rarely fail to regain compliance during the corrective action process.

Nonetheless, CDA has CBAS center closure procedures which CBAS centers must follow if a CBAS center closes, requiring the transitioning of CBAS participants out of the center. Center closure procedures can be found on the CDA website.

These closure procedures would apply to CBAS centers that are unable to come

into compliance with the HCB Settings requirements by March 17, 2023, and thereafter as determined during the CBAS center certification renewal process every two years. The following describes this process:

1. CDA determines if CBAS providers are in compliance with the HCB Settings regulations on an ongoing basis through the CBAS certification renewal oversight and monitoring process for all centers every two years. If CDA identifies that a CBAS center fails to meet one or more of the HCB Settings regulations, CDA does the following: 1) issues a statement of deficiency report; 2) requires a written plan of correction; and 3) determines whether the corrective action remediated the problem(s).”
2. If the center fails to remediate the problems to come into compliance with state laws/regulations and the federal requirements, CDA initiates an adverse action process to terminate certification. If the certification is terminated or the center otherwise closes, CDA will ensure that the CBAS center complies with orderly closure requirements. This includes the following: 1) reasonable written notice by the center (at least 30 days’ notice) to its participants and their authorized representatives that the center is not in compliance with the federal regulations, that the center will be closing due to its Medi-Cal decertification, and that participants will be provided assistance in transitioning to a setting compliant with the federal regulations and/or in accessing other services; 2) participant referral, discharge, and relocation assistance services resulting from a person-centered planning process coordinated by the center’s multidisciplinary team involving the participant, family caregivers and/or participant’s authorized representative; 3) coordination by the center with the CBAS participant’s managed care plan and other community service agencies providing services and supports to the participant, to ensure that services and supports are in place in advance of the participant’s discharge from the noncompliant CBAS center so there is no disruption of services; and 4) coordination by the center with other CBAS centers and settings that are in compliance with the federal regulations for possible referral.
3. Through a person-centered planning process, the center’s multidisciplinary team meets with participants, family caregivers and authorized representatives to provide the opportunity, information and supports necessary to make informed choices of services and setting options for continued service provision to meet participant needs, to ensure a smooth discharge and transition to other services and supports without disruptions in services. CBAS participants’ managed care plans shall provide or arrange for all medically necessary covered services for their members which would include informing their members of alternate available services that the managed care plans coordinate. The State provides oversight and monitoring to ensure that all center closure activities are met and that participants, through a person-centered planning process, have transitioned to a compliant setting or other services of their choosing prior to the center’s Medi-Cal decertification and closure. The transition of participants to a compliant setting and other

services and supports should occur as soon as possible but at most within a six-month period.

In summary, if a center is not able to come into full compliance with the federal requirements during ongoing certification renewal processes every two years, then the center would be decertified and center closure procedures would be followed, including participant notification and transition assistance to a compliant setting or to other services.

The State will know the number of individuals who need transition assistance after completion of a center's compliance determination certification renewal survey and after reviewing a center's plan of correction for remediation. The number of participants who may need transition assistance will depend on the number of participants attending the center. As of February 28. 2022, the licensed capacity of CBAS centers ranged from 30 to 400 persons per day, and the average daily attendance was126. CDA is confident that all CBAS centers will come into compliance with the federal requirements during their certification renewal process every two years on an ongoing basis. Initial assessment of all CBAS centers for compliance with HCB Settings Requirements was completed by December 31, 2019. CDA found all CBAS centers in compliance with HCB Settings requirements during their onsite certification survey or they gained compliance through corrective action by March 30, 2020. No CBAS centers were decertified due to noncompliance with the federal requirements after completion of their corrective action plans. Therefore, no CBAS participants needed to be transitioned to a compliant setting or referred to other services due to a center's decertification and closure as of March 30, 2020.

The following is the compliance determination data for CBAS centers that have been assessed for compliance with the HCB Settings Requirements and have completed their plans of correction as of February 28, 2022:

1. Fully compliant with the federal HCBS requirements: 100%
2. Could come into full compliance with modifications: 100%
3. Cannot comply with the federal requirements: None
4. Are presumptively institutional in nature: None

The State will continue to determine the compliance of all CBAS centers with the HCB Settings requirements on an ongoing basis every two years during the center's Medi-Cal certification renewal process, using all the same processes and procedures including center closure procedures described in detail in Section 6: Compliance Monitoring. Utilization and validation of the Provider Self-Assessment and Participant Setting Assessment Tools are ongoing as part of the

CBAS certification renewal process for all CBAS centers every two years as described in detail in Section 3: Compliance Determination Process for HCB Settings to ensure full and continued compliance beyond March 17, 2023.

Community-Based Adult Services (CBAS) Draft CBAS Transition Plan

Appendix I: Milestones & Timelines

Table 1: Education and Outreach		
Milestone	**Target Start Date**	**Target End Date**
A. Participate on Planning Committee for California Association for Adult Day Services (CAADS) Annual Conference (to work in collaboration with providers and managed care plans to develop presentations and training workshops)	July 2015	November 2018 completed (ongoing)
B. Present at CAADS Annual and Spring Conferences	November 16, 2015	November 2018 completed (ongoing)
C. Work with stakeholders to 1) identify education and training needs relevant to HCB Settings requirements of CBAS providers, participants and family/caregivers, managed care plans and the broader stakeholder community; 2) develop and implement education/training strategies to reach target audiences; 3) deliver training via webinars and at CAADS conferences; and 4) post materials on the CDA website.	July 2015	March 17, 2019 completed (ongoing)
D. Train State staff on HCB Settings Requirements and CBAS Center Oversight and Monitoring Processes and Tools to determine CBAS center compliance with HCB Setting requirements	December 2015	December 2016 completed (ongoing as needed)
E. Educate/Train CBAS providers and managed care plans on HCB Settings requirements, including onsite monitoring and oversight activities and the CBAS Provider Self-Assessment Tool and the Participant Setting Assessment Tool to determine CBAS center compliance with HCB Settings requirements.	September 2016	December 2016 completed (ongoing as needed)

Community-Based Adult Services (CBAS) Draft CBAS Transition Plan

Appendix I: Milestones & Timelines

Table 2: Assessment of Statutes, Regulations, Policies and Other Requirements		
Milestone	**Target Start Date**	**Target End Date**
A. Work with stakeholders to identify CBAS program requirements that may need clarifying or strengthening to enhance compliance with HCB Settings regulations (to include possible standardization of center protocols and forms)	July 2015	July 31, 2016 completed (ongoing as needed)
B. Develop/distribute Medi-Cal Manual revisions, Provider Bulletins, and program/policy directives (e.g., All Center Letters) to support implementation of the HCB Settings regulations	January 2015	March 2019 Revise Medi-Cal Provider Manual completed March 17, 2021 Develop/distribute program/policy directives completed December 31, 2021 Revise ADHC/CBAS statutes completed
C. Develop standardized center protocols and forms (e.g., participation agreement, revised CBAS Individual Plan of Care (IPC), etc.) to support implementation of the HCB Settings regulations	January 2015	June 30, 2017 completed (ongoing as needed)
D. Distribute an All Center Letter (ACL) describing the CMS requirements for the State and CBAS providers on the use of soft restraints in CBAS centers	September 2016	March 10, 2017 completed
E. Distribute an All Center Letter (ACL) clarifying the statutory requirements for using delayed egress or secure perimeter technology, including documentation requirements	September 2016	March 9, 2017 completed

Community-Based Adult Services (CBAS) Draft CBAS Transition Plan

Appendix I: Milestones & Timelines

Table 2: Assessment of Statutes, Rations, Policies and Other Requirements		
F. Complete a revised Systemic Assessment of ADHC/CBAS laws, regulations, waiver provisions, policies, and other requirements to determine if silent, conflict or align with HCB Settings regulations (CMS directive)	March 2017	January 11, 2018 completed
Table 3: Initial and Ongoing Compliance Determination		
Milestone	**Target Start Date**	**Target End Date**
A. Develop CBAS Provider Self-Assessment Tool with Stakeholder Input (coincides with STP tool)	May 2015	November 2015 completed
B. Pilot Test CBAS Provider Self-Assessment Tool	November 2015	December 2015 completed
C. Modify Provider Self-Assessment Tool Based on Pilot Results	January 2016	April 2016 completed
D. Develop CBAS Participant Setting Assessment Tool with Stakeholder Input	July 2015	December 2016 completed
E. Modify CDA Certification Renewal Processes and Tools with Stakeholder Input	September 2015	August 2016 completed
F. Implement use of Provider Self-Assessment and Participant Setting Assessment Tools with Certification Renewal	June 2016	June 2019 completed ongoing

G. Validate Provider Self-Assessment Tool at time of Certification Renewal for all CBAS centers during onsite surveys	September 2016	December 31, 2019 completed ongoing
H. Conduct review of CBAS Centers for institutional characteristics and identify those centers that overcome the institutional presumption requiring Heightened Scrutiny	November 2016	December 31, 2020 completed ongoing
I. Gather information/evidence on centers requiring Heightened Scrutiny to present to CMS	December 31, 2020	March 31, 2021 completed (ongoing as needed)
Table 3: Initial and Ongoing Compliance Determination		
Milestone	**Target Start Date**	**Target End Date**
J. Post public notices identifying CBAS centers requiring Heightened Scrutiny, detailing the Department's analysis of evidence provided, requesting public input and analyzing public comments	April 30, 2021	December 31, 2021 No CBAS centers required Heightened Scrutiny
K. Submit STP/CBAS Transition Plan with Heightened Scrutiny information to CMS for review	September 2021	September 30, 2021 No CBAS centers required Heightened Scrutiny Review by CMS
L. Approve provider remediation plans (Plans of Correction)	October 2016	March 30, 2020 completed ongoing
M. Identify non-compliant centers for termination/decertification	January 2017	March 30, 2020 completed ongoing

N. Terminate/decertify any non-compliant CBAS Center(s)	January 2017	December 31, 2020 completed (ongoing)
O. Notify and relocate/transition CBAS participants to compliant CBAS Centers		
a. Notify participants/authorized representatives	January 2017	April 30, 2020 completed (ongoing)
b. Relocate/transition participants	January 2017	July 31, 2020 completed (ongoing)
P. Achieve full compliance		March 17, 2023
Q. Continue compliance determination (ongoing process)		Ongoing (beyond March 17, 2023)

Table 4: Person-Centered Planning

Milestone	Target Start Date	Target End Date
A. Convene stakeholder workgroups to revise CBAS Individual Plan of Care (IPC) to meet CMS requirements of Person-Centered Planning and to develop a quality strategy for service delivery and participant outcomes	July 2015	June 2016 completed
B. Develop and provide training on implementation of revised IPC	November 2016	October 2018 completed (ongoing as needed)

Appendix II: Method, Dates Distributed, Target Audiences

Method	Dates Distributed	Target Audiences
A. Websites a. CDA CBAS HCB Settings Stakeholder Activities (updated as needed)	Launched February 2015	General Public
b. DHCS Stakeholder Engagement Initiative -Calendar of Events (continually updated)	Launched January 2015	General Public
B. *CBAS Updates* Newsletters (Electronic – ongoing) *CBAS Updates* have been distributed since November 2014 and provide information relevant to CBAS program operation, education/training opportunities and more. This includes CBAS HCB Settings requirements and stakeholder activities, CBAS Transition Plan updates, and person-centered planning education and training opportunities. *CBAS Updates* not posted are available upon request.	November 17, 2014 to present	CBAS Providers; Managed Care Plans; ADHC/CBAS Provider Associations; Senior and Adults with Disabilities Service Providers and Advocacy Organizations; Legislative Staff; Interested Individuals
C. All Center Letters (ACLs) (Electronic - ongoing) All Center Letters are posted on the CDA website and provide information to CBAS providers and other stakeholders about CBAS policies including HCB Settings requirements, CBAS Transition Plan public comment periods, relevant training opportunities and more.	March 27, 2015 (ACL#15-02) April 17, 2015 (ACL#15-03) May 14, 2015 (ACL#15-05)	CBAS Providers; Managed Care Plans; ADHC/CBAS Provider Association; State Partners

	September 24, 2015 (ACL#15-07) March 9, 2017 (ACL#17-03) March 10, 2017 (ACL#17-04)	
D. Public Comment Period Notices		
a. General Public Interest Notice- California Regulatory Notice Register (Non-electronic)	May 22, 2015 August 26, 2016 June 18, 2021 October 14, 2022	California State Library and State document depository libraries; General Public
b. All Center Letter 15-05 with CBAS Stakeholder Outreach Flyer and Fact Sheet (Electronic & Non-electronic)	May 14, 2015	All Center Letter Target Audiences CBAS Providers; Managed Care Plans; ADHC/CBAS Provider Association; State Partners
c. All Center Letter 21-07 with CBAS Stakeholder Outreach Flyer and Fact Sheet (Electronic Provider & Non-electronic) for Public Comment Period	June 18, 2021	See above
d. All Center Letter 22-10 with CBAS Stakeholder Outreach Flyer and Fact Sheet (Electronic & Non-electronic) for Public Comment Period	October 10, 2022	See above
e. CBAS Updates Newsletters with CBAS Stakeholder Outreach Flyer and Fact Sheet (Electronic) for Public Comment Period	May 13-15, 2015 August 26, 2016 July 1, 2021 October 10, 2022	CBAS Newsletter Target Audiences CBAS Providers; Managed Care Plans; State Partners;

	ADHC/CBAS Provider Association; Seniors and Adults with Disabilities Service Providers; Advocacy Organizations; Legislative Staff; Interested Individuals

Provider Setting Type – Community-Based Adult Services (CBAS) Centers

The California Department of Aging (CDA) has completed the systemic assessment of the "Adult Day Health Care (ADHC)/Community-Based Adult Services (CBAS) program authorities" ("program authorities") to determine if they align with ("compliant"), partially align with ("partially compliant"), conflict with ("non-compliant"), or are silent ("silent") on the federal Home and Community-Based (HCB) settings requirements for non-residential settings. The term "program authorities" used in this document refers to the ADHC/CBAS laws, regulations (state and federal) and waiver requirements to which ADHC/CBAS centers must comply. URL links are provided for each of the cited program authorities.

CDA has identified the following information in Appendix III on the CBAS systemic assessment template:

- the five federal HCB settings requirements for non-residential settings
- the components for each of the five federal requirements—*14 total components*
- the program authorities relevant to each of the components
- a brief description/analysis of the relevance of the cited program authorities to each of the federal requirement components and the rationale for the compliance-level determination—*some of the descriptions/analyses apply to multiple program authorities*
- the compliance level for the compilation of program authorities cited for each of the 14 components of the federal requirements e.g., compliant, partially compliant, non-compliant, silent—*there is only one compliance level determination per federal requirement component based on the compilation of program authorities cited for that component*
- the remediation strategies the State will implement to bring the program authorities into compliance with each of the components of the five federal requirements for non-residential settings to which all CBAS providers must comply

CDA has determined that the program authorities cited for each of the 14 federal requirement components are compliant with 6 out of 14 federal requirement components (3a, 3b, 3c, 3d, 4a, 5a), partially compliant with 2 out of 14 federal requirement components (1a, 1d), and silent on 6 out of 14 federal requirement components (1b, 1c, 2a, 2b, 4b, 5b). We did not identify any program authorities that are in conflict with the federal requirements.

Appendix III: CBAS Assessment of ADHC/CBAS Statutes, Regulations, Waiver Provisions, Policies and Other Requirements

To remediate the program authorities that CDA has determined to be partially compliant or silent and to ensure that all ADHC/CBAS program authorities align with all of the federal HCB settings requirements for non-residential settings, the State will insert into the CBAS section of the *Medi-Cal Provider Manual* all of the federal HCB settings requirements for non-residential settings. The target date of June 30, 2018, for publication of the revised Medi-Cal Provider Manual was met. In addition, the State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date of December 31, 2021, for completion was met.

CDA will continue to develop and distribute provider bulletins, All Center Letters (ACLs), and standardized center protocols and forms as necessary to provide federal and/or state policy directives and guidance to CBAS providers relevant to the HCB settings and person-centered planning regulations. The following are examples of these policy directives/documents:

- CDA distributed two ACLs in March 2017 in response to directives from the Centers for Medicare & Medicaid Services (CMS) to inform CBAS providers about the federal requirements for the use of soft restraints (ACL #17-03), and the use of delayed egress and secured perimeters (ACL #17-04). CDA has referenced these documents in the CBAS systemic assessment for Federal Requirement #3
- CDA in collaboration with the California Department of Health Care Services (DHCS) revised the CBAS *Individual Plan of Care (IPC*) form and standardized a new *Participation Agreement* form through a stakeholder process to assist CBAS providers in complying with the HCB settings and person-centered planning requirements. The CBAS IPC and its instructions will be included in the revised CBAS section of the Medi-Cal Provider Manual and are pending approval by DHCS. The new CBAS Participation Agreement form, instructions, and ACL # 17-01 "Implementation of ADHC / CBAS Participation Agreement are posted on the CDA website. The new CBAS Participation Agreement was implemented effective March 1, 2017. CDA has referenced these documents in the CBAS systemic assessment for Federal Requirement #2.
- CDA in collaboration with DHCS developed a Provider Self-Assessment (PSA) Survey with instructions for all CBAS providers to complete as part of their certification renewal process every two years. The questions on the PSA are specific to the HCB settings requirements for non-residential settings. (CDA included a question on the PSA about physical accessibility of the CBAS center to participants even though this federal requirement is for residential settings only because the State believes that physical accessibility is important for all HCB settings.)
- CDA has referenced the PSA survey in the CBAS systemic assessment for all of the Federal Requirements.

During the CBAS center's certification renewal on-site survey visit, CDA survey staff determine if a CBAS center is in

compliance with the HCB settings requirements by reviewing and validating the CBAS provider's PSA survey responses and evidence to support the PSA responses. This evidence includes review of documents such as policies and procedures, participant health records, employee records; observations at the center; and interviews with the CBAS staff and participants. If the center does not show sufficient evidence of compliance for each of the federal requirements, the center will be required to remediate their non-compliance through a Plan of Correction (POC) process. Refer to the *CBAS HCB Settings Transition Plan, Section 3: Compliance Determination Process for HCB Settings* for more details about the CBAS compliance determination process.

ADHC/CBAS Program Authorities

CBAS centers must comply with the California Health and Safety Codes (HSC) and the California Codes of Regulations (CCR) for licensed ADHC facilities; the Welfare and Institutions Codes (WIC) and the CCRs for licensed ADHC facilities certified to participate in the Medi-Cal program; the CBAS Special Terms and Conditions (STC) and Standards of Participation (SOP) in California's 1115 Demonstration Waiver (Medi-Cal 2020); and the federal HCB settings and person-centered planning regulations. Under an interagency agreement, the CBAS Program is administered by DHCS, the California Department of Public Health (CDPH), and CDA. CDPH licenses ADHC facilities and CDA certifies them for participation in the Medi-Cal Program. Refer to the CDA website for information about the ADHC/CBAS program.

- Licensing Provisions

  California Health and Safety Code (HSC), Division 2, Chapter 3.3, Sections 1570-1596.5

- Medi-Cal Provisions

  California Welfare and Institutions Code (WIC), Division 9, Part 3, Chapter 7, Section 14043.46

California Welfare and Institutions Code (WIC), Division 9, Part 3, Chapter 8.7, Sections 14520-14590

- Regulations

  Title 22, Division 3, California Code of Regulation (CCR), Chapter 5, Sections 54001-54507

  Title 22, Division 5, California Code of Regulation (CCR), Chapter 10, Sections 78001-78609

- Waiver Requirements

  California CalAIM Section 1115(a) Demonstration Waiver

  - CBAS Special Terms and Conditions (STC) (pages 16 through 31)
  - CBAS Standards of Participation (SOP) (pages 127 through 136)

- Federal Home and Community-Based Services (HCBS) Regulations

  Home and Community-Based Services (HCBS) Regulations [42 CFR 441.301]

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
1	***Federal Requirement #1:*** The setting is integrated in and supports full access of individuals receiving Medicaid HCB services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCB services.			
1a	The setting is integrated in and supports full access to the greater community… to the same degree of access as individuals not receiving Medicaid HCB Services	**WIC § 14521 – *General Provisions*** "It is the intent of the Legislature in authorizing this Medi-Cal benefit to establish and continue a community-based system of quality adult day health care services that will accomplish all of the following: (a) Ensure that elderly persons and adults with disabilities will not be institutionalized prematurely and inappropriately. (b) Provide appropriate health and social services designed to maintain elderly persons in their own communities. (c) Establish adult day health care centers in locations easily accessible to persons who are economically disadvantaged. Encourage the establishment of rural alternative adult day health care centers that are designed to make adult day health care accessible to elderly persons and adults with disabilities living in rural areas." *Relevance: This program authority supports that CBAS centers are integrated in the greater community—"It is the intent of the Legislature in authorizing this Medi-Cal benefit to establish and continue a community-based system of quality adult day health care services…." It requires CBAS settings to be in locations that are easily accessible in the community to a variety of population groups including persons who are economically disadvantaged, and to*	Partially Compliant	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential

		provide health and social services to keep participants in the community and prevent institutionalization. ." However, this programauthority does not specify explicitly "to the same degree of access as individuals not receiving Medicaid HCB Services." Therefore, it is ***partially compliant.*** **T-22 §54329 – *Medical Social Services*** (a) Medical social services shall as a minimum: (5) Provide counseling and referral to available community resources. (8) Serve as liaison with other community agencies who may be providing services to a participant and work with these agencies to coordinate all services delivered to the participant to meet the participant's needs and avoid duplication. Liaison shall include, but not be limited to the following agencies: (A) In-Home Supportive Services in the county welfare department. (B) Home Health Agency providers.		settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS center compliance with all of the HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers at the time of their certification renewal process every two years

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
		(9) Provide discharge planning for all discharged participants. *Relevance: This program authority supports access to and receipt of services in the greater community by referral to available community resources and coordination among services to meet participants' needs. Some of the resources listed such as Home Health Agency providers are resources available/accessible to individuals who do not receive Medicaid HCB Services, therefore this is an example where CBAS participants have "the same degree of access as individuals not receiving Medicaid HCB Services." However, this program authority does not specify explicitly "to the same degree of access as individuals not receiving Medicaid HCB Services." Therefore, it is* ***partially compliant****.* **WIC § 14525 - *Eligibility, Participation and Discharge*** (d) The person requires adult day health care services, as defined in Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the adult day health care program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a		

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
		a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care. *Relevance: This program authority supports access to and receipt of formal and informal services in the greater community outside the CBAS center through care coordination to support participants in their living arrangement of choice and to prevent institutionalization. However, it does not specify this explicitly. Therefore, it is* ***partially compliant****.* **WIC § 14522.4 – *Definitions*** (4) "Care coordination" means the process of obtaining information from, or providing information to, the participant, the participant's family, the participant's primary health care provider, or social services agencies to facilitate the delivery of services designed to meet the needs of the participant, as identified by one or more members of the multidisciplinary team. *Relevance: This program authority supports access to and receipt of community services via care coordination to meet participants' needs identified by the center's multidisciplinary team (MDT). However, it does not state explicitly "to the same degree of access as individuals not receiving Medicaid*		

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
		HCB Services." Therefore it is ***partially compliant****.* **T-22 §54211 –** ***Multidisciplinary Team*** (b) The multidisciplinary assessment team shall: (1) Determine the medical, psychosocial and functional status of each participant. (2) Develop an individualized plan of care including goals, objectives and services designed to meet the needs of the person. (A) The individualized plan of care shall include: 6. An individualized activity plan designed to meet the needs of the participant for social and therapeutic recreational activities. 8. A plan to meet transportation needs. 10. A plan for other needed services which the adult day health center will coordinate. *Relevance: This program authority supports access to and receipt of services in the community to meet participants' needs. The CBAS multidisciplinary team (MDT) must provide an assessment of every participant and develop an individualized plan of care to meet participants' needs including social, therapeutic recreational activity and transportation needs, and to develop a plan for other services*		

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
		needed by the participant to be coordinated by the center. However, it does not specify explicitly "to the same degree of access as individuals not receiving Medicaid HCB Services." Therefore, it is ***partially compliant.*** **STC 20(c) – *Individual Plan of Care (IPC)(Excerpts)*** The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. …Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports. Person-Centered Planning includes consideration of the current and unique bio-psycho-social-cultural and medical needs and history of the individual, as well as the person's functional level, support systems, and continuum of care needs….The IPC shall include at a minimum: (x.) A plan for any other necessary services that the CBAS center will coordinate. *Relevance: This program authority requires that the CBAS center develop an individualized plan of care (IPC) based on*		

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
		person-centered planning principles that focus on a participant's abilities and preferences for the delivery of services and supports. This includes necessary services outside the center that the center will coordinate to meet a participant's assessed needs. "However, this program authority does not specify explicitly "to the same degree of access as individuals not receiving Medicaid HCB Services." Therefore, it is ***partially compliant.***		
1b	The setting supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings … to the same degree of access as individuals not receiving Medicaid HCB	**T-22 §54211 – *Multidisciplinary Team*** The multidisciplinary team conducting the assessment pursuant to Section 54207 shall consist of at least a physician, nurse, social worker, occupational therapist and physical therapist. The physician may be either a salaried staff member of the adult day health center or the participant's physician. When indicated by the needs of the participant, a psychiatrist, psychologist, psychiatric social worker, speech therapist and dietitian shall be included as members of the assessment team and assist in the assessment. (a) The multidisciplinary assessment team shall: (1) Determine the medical, psychosocial and functional status of each participant. Develop an individualized plan of care including goals,	Silent	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
	Services	objectives and services designed to meet the needs of the person. (A) The individualized plan of care shall include: 5. The specific elements of the services which need to be identified with individual objectives, therapeutic goals and duration of treatment. 10. A plan for other needed services which the adult day health center will coordinate. *Relevance: This program authority requires the center's multidisciplinary team (MDT) to provide a medical, psychosocial and functional assessment of all CBAS participants and to develop an individualized plan of care to address participants' assessed needs. This individualized care plan identifies what services the CBAS center will provide directly at the center and/or by referral to and care coordination with other needed services. These services could include a referral to integrated employment opportunities in the community to address a participant's needs and goals to seek employment. Although this program authority supports the intent of this federal requirement component, it does not state explicitly that it "supports access to opportunities to seek employment and work in competitive integrated settings" or "to the same degree of access as individuals not receiving Medicaid HCB Services." Therefore, it is considered* ***silent****.*		non-residential settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS center compliance with the HCB settings and person- centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers during their certification renewal process every two years.

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
1c	The setting supports full access to the greater community, including opportunities to control personal resources… to the same degree of access as individuals not receiving Medicaid HCB Services.	**T-22 §78421 – *Finances*** No adult day health center shall assume responsibility for the funds of its participants. *Relevance: According to this program authority, CBAS centers may not assume responsibility for the funds of its participants. However, it is **silent** on the requirement that a CBAS center supports opportunities for participants to control personal resources to the same degree of access as individuals not receiving Medicaid HCB Services.* **T-22 §54211 – *Multidisciplinary Team*** (a) The multidisciplinary team conducting the assessment pursuant to Section 54207 shall consist of at least a physician, nurse, social worker, occupational therapist and physical therapist. The physician may be either a salaried staff member of the adult day health center or the participant's physician. When indicated by the needs of the participant, a psychiatrist, psychologist, psychiatric social	Silent	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
		worker, speech therapist and dietitian shall be included as members of the assessment team and assist in the assessment. (b) The multidisciplinary assessment team shall: (1) Determine the medical, psychosocial and functional status of each participant. (2) Develop an individualized plan of care including goals, objectives and services designed to meet the needs of the person. (A) The individualized plan of care shall include: 5. The specific elements of the services which need to be identified with individual objectives, therapeutic goals and duration of treatment. 10. A plan for other needed services which the adult day health center will coordinate. *Relevance: This program authority requires the CBAS multidisciplinary Team (MDT) to assess the medical, psychosocial and functional status of participants and develop an individualized plan of care to meet participant's needs. As part of the functional assessment, CBAS providers assess the participant's activities of daily living and instrumental activities of daily living which includes an assessment of a participant's money management abilities/needs. The results of this assessment are documented on the individualized plan of care (IPC). Based on the assessment, the IPC would identify interventions and goals to meet the assessed need.*		center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers during their certification renewal process every two years

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
		For example, if during the assessment the CBAS participant expressed or was assessed as needing assistance in controlling/managing his/her personal resources, the CBAS MDT would identify what assistance is needed and discuss with the participant the resources/services that could be helpful in addressing this request/need. Such resources/services might include a referral to private or public fiduciary services. If the participant expressed that someone is controlling his/her personal resources/money without the participant's consent, a referral to Adult Protective Services may be required if the participant is assessed as being at-risk for or is a victim of physical and/or financial abuse or exploitation. *According to CBAS Participant Characteristics Report data posted on the CDA website (as of December 2016), 72% of CBAS participants require assistance with money management. This data is the result of the MDT's assessment of a participant's money management abilities and is reported by CBAS centers to CDA.* *Therefore, this program authority aligns with and supports the intent of the federal requirement for a CBAS center to ensure a participant's access to opportunities to control personal resources based on their assessed money*		

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
		management abilities. However, it does not state this language explicitly including "to the same degree of access as individuals not receiving Medicaid HCB Services" and therefore is considered ***silent****.*		
1d	The setting includes opportunities to engage in community life and receive services in the community … to the same degree of access as individuals not receiving Medicaid HCB Services.	***T-22 §78341 – Basic Services Recreation or Planned Social Activities*** (c) The activity coordinator's duties shall include at least the following: (6) Utilization of adult day health center's transportation to provide activities in the community as indicated by participant's needs and interests. *Relevance: This program authority supports the engagement of CBAS participants in community life by using the CBAS center's transportation to provide activities in the community as indicated by participant's needs and interests. However, it does not specify explicitly "to the same degree of access as individuals not receiving HCB Services." Therefore, it is* ***partially compliant****.*	Partially Compliant	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The

				target date for completion by December 31, 2021, was met.

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
		T-22 §54207 – *Multidisciplinary Team Assessment* (a) Each applicant shall be assessed by a multidisciplinary team prior to acceptance into the program. The assessment shall be conducted by the adult day health care provider in order to ascertain the individual's pathological diagnosis, physical disabilities, functional abilities, psychological status and social and physical environment. The assessment shall include: (2) Assessment of the home environment based on a home visit within the last 12 months. The assessment shall include: (A) Living arrangements (B) Relationship with family or other person (D) Existence of environmental barriers such as stairs or other features not negotiable by the impaired individual. (E) Access to transportation, shopping, church or other needs of the individual *Relevance: This program authority supports participant engagement with community life and receipt of services in the community as a result of the CBAS home assessment. This home assessment identifies participants' access to transportation, shopping, church or other needs. However, this program authority does not specify explicitly "to the same degree of access as individuals not receiving Medicaid HCB Services." Therefore, it is* ***partially compliant.***		The State will continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers during their certification renewal process every two years.

	HCBS Settings Requirements	Evidence	Compliance Level	Remediation Strategies and Timeline
2	**Federal Requirement #2:** The setting is selected by the individual from among setting options including non-disability specific settings *and an* *option for a private unit in a residential setting. The settings options are identified and documented in the person-centered plan and are based on the individual's needs, preferences and for residential settings,*resources available for room and board. **Required for residential settings only*			
2a	The setting is selected by the individual from among setting options including non-disability specific settings	**T-22 §54111 – *Definitions: Beneficiary Agreement of Participation*** Beneficiary agreement of participation means the agreement voluntarily signed by a beneficiary or the beneficiary's guardian or legal conservator in which the beneficiary agrees to receive day health services from the adult day health center. **T-22 §54203 – *Participation*** a) Participation by an eligible Medi-Cal beneficiary in adult day health care program shall require: (3) An agreement of participation signed by the participant or the participant's guardian or conservator.	Silent	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The revised CBAS IPC with instructions will be included in the CBAS provisions of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met.

		T-22 §54217 – *Beneficiary Agreement of Participation* When the initial assessment has been completed and the individualized plan of care prepared, an agreement of participation on forms furnished by the Department shall be prepared by the adult day health care provider and discussed with the prospective participant or the participant's guardian or conservator. (a) If the terms of agreement are satisfactory, the participant shall sign the statement. The statement shall be sent to the Department with the initial Treatment Authorization Request. The signing of the agreement of participation does not mandate participation and the participant may end participation at any time. **WIC § 14530 – *Eligibility, Participation, and Discharge*** (b) Each provider shall supply a written statement to the participant explaining what services will be provided and specifying the scheduled days of attendance. This statement, which shall be known as the participation agreement, shall be signed by the participant and a provider representative and retained in the participant's file.		The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers at the time of their certification renewal process every two years.

		*Relevance: These four program authorities support that a CBAS participant (or authorized representative) voluntarily selects/chooses to attend the CBAS center on certain days and agrees to receive the services identified in the participant's individualized plan of care. This choice and decision is documented in the Beneficiary Agreement of Participation. In addition, CDA developed a new standardized Participation Agreement with instructions to assist CBAS centers in complying with the federal HCB settings and person-centered planning requirements as specified in CBAS STC 44(c) and 45(c). The new Participation Agreement requires the ADHC/CBAS center to discuss with the CBAS participant the availability of community services and settings options in addition to ADHC/CBAS. The participant must sign the Participation Agreement prior to the start of CBAS services which attests that the participant is voluntarily selected to participate in the CBAS program and receive the services identified on the participants Individual Plan of Care (IPC.) CDA distributed (ACL) # 17-01 to providers with this directive. Although these program authorities and new Participation Agreement support this federal requirement, they do not state explicitly that the setting is selected among setting options including non-disability specific settings and therefore are **silent**.*		CDA distributed All Center Letter (ACL) # 17-01 "Implementation of the CBAS Participation Agreement to ensure compliance with HCB settings and person-centered planning requirements" on January 31, 2017.
2b	The setting options are identified and documented in	**T-22 §54119 – *Individualized Plan of Care*** Individualized plan of care (e.g., person-centered service plan) means a written plan designed to provide a participant of an adult day health center with appropriate treatment in accordance with the assessed needs of the participant.	Silent	The State inserted all of the federal HCB settings requirements for

	the person-centered service plan and are based on the individual's needs, preferences	**STC 20(c) – *Individual Plan of Care (IPC)*** "The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request. The whole person-centered project will comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying: 1) How the IPC will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee.		non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation

		The IPC is prepared by the CBAS center's multidisciplinary team based on the team's assessment of the beneficiary's medical, functional, and psychosocial status, and includes standardized components approved by the State Medicaid Agency. Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports…" **WIC § 14530 – *Eligibility, Participation, and Discharge*** (c) Each provider shall supply a written statement to the participant explaining what services will be provided and specifying the scheduled days of attendance. This statement, which shall be known as the participation agreement, shall be signed by the participant and a provider representative and retained in the participant's file. *Relevance: These three program authorities support and align with the requirement that the CBAS center must develop for all participants an individualized plan of care (e.g., a person-centered service plan) using a person-centered planning process that is based on the participant's assessed needs and preferences. The IPC and Participation Agreement identify the services to be provided including the scheduled days of attendance. CDA's new standardized Participation Agreement is a companion document to the IPC that includes a requirement that the provider must discuss*		of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers at the time of their certification renewal process every two years.

		with the participant setting options in addition to CBAS. The Participation Agreement is to be signed by the participant and provider representative before CBAS services are started and then filed in the health record. Although these program authorities support and align with this federal requirement, they do not state explicitly that the setting options are identified and documented in the person-centered service plan. Therefore, they are considered ***silent****.*		
3	***Federal Requirement #3:*** The setting ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint.			
3a	The setting ensures an individual's rights of privacy	***T-22 §78437 – Participant Rights*** (a) Each participant shall have rights which include, but are not limited to, the following: (7) To have reasonable access to telephones, both to make and receive confidential calls, or to have such calls madefor the participant, if necessary. (13) To be insured of the confidential treatment of all information contained in participant records, including information contained in an automated data bank. (15) To dignity, privacy and humane care, including privacy in treatment and in care for personal needs.	Compliant	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings

		T-22 §78311 – *Basic Program Services: Medical Services* (c) Space shall be provided that allows privacy for the participant during examination by and consultation with the physician. **Standards of Participation (SOP) D – *Physical Plant and Health and Safety Requirements*** To ensure the health and safety of the CBAS participants, the physical plant of each center shall conform to the requirements of applicable sections of Title 22 of the CCR as described in part by the following: 2. Space Requirements – Demonstrate all of the following, to include but not be limited to: c. A secluded area that is set aside for participants who require bed rest and privacy during medical treatments or social service interventions. **Standards of Participation (SOP) H – *Organization and Administration*** 10. Civil Rights and Confidentiality – Adherence to all laws		requirements for non-residential settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey during their certification renewal process every two years.

		and regulations regarding civil rights and confidentiality of both participants and CBAS staff. CBAS providers are subject to Federal and State laws regarding discrimination and abuse and the reporting of such, inclusive of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Information Practices Act (IPA). *Relevance: These four program authorities support a participant's right to privacy at the center during medical, social service and personal care treatment/interventions. Privacy includes the right to confidential phone calls and confidential treatment of participants' health records. CBAS providers are covered entities under HIPAA (Health Insurance Portability and Accountability Act) which provides privacy and security provisions for safeguarding medical information. CBAS providers must comply with HIPAA privacy rules. Therefore, these program authorities are **compliant** with this component of the HCB Settings requirement.*		
3b	The setting ensures an individual's rights of dignity;	**T-22 §78437 – *Participant Rights*** (a) Each participant shall have rights which include, but are not limited to, the following: (15) To dignity, privacy and humane care, including privacy in treatment and in care for personal needs.	Compliant	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual.

		T-22 §78301 – *Basic Program Services; General* (c) Each participant shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind. **T-22 §54325 – Psychiatric and Psychological Services** (c) Services shall provide a therapeutic setting conducive to restoring dignity and self-esteem and good mental health to all participants. *Relevance: These three program authorities identify, align and comply with a participant's right to dignity and therefore are considered **compliant** with this component of the HCB Settings requirement.*		The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers during their

				certification renewal process every two years.
3c	The setting ensures an individual's rights of respect;	**T-22 §78301 – *Basic Program Services; General*** (c) Each participant shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind. *Relevance: This program authority aligns with the requirement that ADHC /CBAS centers must treat participants with respect as part of the center's basic/general program services. Therefore, it is considered **compliant**.*	Compliant	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date for completion by December 31, 2021, was met.

				continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers during their certification renewal process every two years.
3d	The setting ensures an individual's freedom from coercion and restraint.	***T-22 §78437 – Participant Rights*** (a) Each participant shall have rights which include, but are not limited to, the following: (8) To be encouraged and assisted throughout the period of participation to exercise rights as a participant and civil and legal rights, and to this end to voice grievances and recommend changes in policies and services to center staff and to outside representatives of participant's choice, free from restraint, interference, coercion, discrimination or	Compliant	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met.

		reprisal. (10) To end participation at the adult day health center at any time. (11) To refuse treatment and be informed of the consequences of such refusal. (16) To be free from harm, including unnecessary physical restraint, or isolation, excessive medication, physical or mental abuse or neglect. *Relevance: This program authority supports that a participant has the right to be free from unnecessary physical restraint as well as other types of coercion and restraint such as isolation, excessive medication, and physical or mental abuse or neglect. In addition, participants have the right to refuse treatment, to voice grievances and to end participation at the adult day health care center at any time. Therefore, this program authority is* ***compliant*** *with this component of the HCB Settings requirement.* **T-22 §78315 – *Nursing Services-Restraints*** (a) Restraints shall be used only as measures to protect the participant from injury to self, based on the assessment of the participant by the multidisciplinary team. (b) Restraints shall be used only under the following conditions:		The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers during their certification renewal process every two years.

		(1) Treatment restraints for the protection of the participant during treatment and diagnostic procedures. (2) Supportive restraints for positioning the participant and to prevent the participant from falling out of a chair or from a treatment table or bed. (c) Acceptable forms of restraints shall include only cloth vests, soft ties, soft cloth mittens, seat belts and trays with spring release devices. Soft ties mean soft cloth which does not cause skin abrasion and which does not restrict blood circulation. (d) Restraints shall not be used as punishment or as a substitute for medical and nursing care. (e) No restraints with locking devices shall be used or available for use. (f) Restraints shall be applied in a manner so that they can be speedily removed in case of fire or other emergency. (g) Various types of adult chairs referred to as geriatric chairs are not defined as a restraint if the type of closing mechanism of the chair and the physical and mental capability of the specific participant allow for easy removal. *Relevance: This program authority permits the use of soft restraints in the CBAS setting under limited conditions for the purpose of protecting the participant's health and safety. However, CMS directed the State to ensure that CBAS centers using restraints meet not only the state requirements but also the federal HCB Settings requirements under 42 Code of Federal Regulations (CFR) 441.301(c)(4)(iii) and the person-centered service planning and plan requirements*		At the direction of CMS, CDA distributed two All Center Letters (ACLs) that gave policy directives to all CBAS providers to be in compliance with state and federal requirements when using soft restraints and secured perimeters and/or delayed egress devices: ACL #17-03 "Use of Soft Restraints", distributed March 9, 2017. ACL #17-04 "Use of Secured Perimeter Fences and Egress Control Devices in ADHC/CBAS Centers" distributed March 10, 2017.

		under 42 CFR 441.301(c)(1) and (c)(2). CMS identified the following additional requirements: *Document that the use of soft restraints is the result of a specific assessed need and documented in the individual plan of care,* *Document that alternative strategies have been considered to avoid the use of restraints,* *Document methods for detecting the unauthorized use of or misapplication of restraints,* *Develop protocols that must be followed when restraints are employed (including the circumstances when their use is permitted and when they are not) and how their use is authorized,* *Establish practices that must be employed in the administration of a restraint to ensure the health and safety of individuals, and that the interventions and supports will cause no harm to the individual,* *Require documentation (record keeping) concerning the use of restraints, and* *Establish education and training requirements that provider agency personnel must meet who are involved in the administration of a restraint.* *CDA distributed ACL #17-03 "Use of Soft Restraints in ADHC/CBAS Centers on March 9, 2017, requiring CBAS centers to implement the protocols, practices, documentation and training on the use of soft restraints to comport with the HCB Setting and person-centered planning requirements. The State is monitoring the center's adherence to state and*		

		federal requirements for the use of soft restraints during the center's on-site certification survey. Therefore, this program authority along with policy directive ACL #17-03 supports ***compliance*** *with this component of the HCB Settings requirement.* **HSC §1584 – *Facilities for Alzheimer or Dementia Participants – Installation of Secure Perimeter Fences or Egress Control Devices; Emergency Evacuation Procedures*** (a) An adult day health care center that provides care for adults with Alzheimer's disease and other dementias may install for the safety and security of those persons secured perimeter fences or egress control devices of the time-delay type on exit doors. (b) As used in this section, "egress control device" means a device that precludes the use of exits for a predetermined period of time. These devices shall not delay any participant's departure from the center for longer than 30 seconds. Center staff may attempt to redirect a participant who attempts to leave the center. (c) Adult day health care centers installing security devices pursuant to this section shall meet all of the following requirements: (1) The center shall be subject to all fire and building codes, regulations, and standards applicable to adult day health care centers using egress control devices or secured perimeter fences and shall receive a fire clearance from the		

		fire authority having jurisdiction for the egress control devices or secured perimeter fences. (2) The center shall maintain documentation of diagnosis by a physician of a participant's Alzheimer's disease or other dementia. (3) The center shall provide staff training regarding the use and operation of the egress control devices utilized by the center, the protection of participants' personal rights, wandering behavior and acceptable methods of redirection, and emergency evacuation procedures for persons with dementia. (4) All admissions to the center shall continue to be voluntary on the part of the participant or with consent of the participant's conservator, an agent of the participant under a power of attorney for health care, or other person who has the authority to act on behalf of the participant. Persons who have the authority to act on behalf of the participant include the participant's spouse or closest available relative. (5) The center shall inform all participants, conservators, agents, and persons who have the authority to act on behalf of participants of the use of security devices. The center shall maintain a signed participation agreement indicating the use of the devices and the consent of the participant, conservator, agent, or person who has the authority to act on behalf of the participant. The center shall retain the original statement in the participant's files at the center. (6) The use of egress control devices or secured perimeter fences shall not substitute for adequate staff. Staffing ratios shall at all times meet the requirements of applicable regulations.		

		(7) Emergency fire and earthquake drills shall be conducted at least once every three months, or more frequently as required by a county or city fire department or local fire prevention district. The drills shall include all center staff and volunteers providing participant care and supervision. This requirement does not preclude drills with participants as required by regulations. (8) The center shall develop a plan of operation approved by the department that includes a description of how the center is to be equipped with egress control devices or secured perimeter fences that are consistent with regulations adopted by the State Fire Marshal pursuant to Section 13143. The plan shall include, but not be limited to, the following: (A) A description of how the center will provide training for staff regarding the use and operation of the egress control device utilized by the center. (B) A description of how the center will ensure the protection of the participant's personal rights consistent with applicable regulations. (C) A description of the center's emergency evacuation procedures for persons with Alzheimer's disease and other dementias. (d) This section does not require an adult day health care center to use security devices in providing care for persons with Alzheimer's disease and other dementias. *<u>Relevance</u>: This program authority permits the use of secured perimeters and delayed egress technology to meet the personal safety needs of persons with Alzheimer's disease and other dementias. State law allowing use of*		

		secured perimeters is detailed and explicit in how and when devices may be used. Most notably, fences and delayed egress devices may only be used for the purpose of ensuring the safety of individuals with dementia and may not be used in lieu of the CBAS center having an adequate number of qualified staff and appropriate programming. *If a CBAS center uses secured perimeter fences and/or egress control devices, it is required to have in place and operationalize the necessary policies and procedures including staff training to comply with the state's Health and Safety Code and the federal HCB Settings regulations. Further, their use requires the CBAS center to secure the informed consent of all CBAS center participants (or their authorized representatives) that the CBAS center they are attending uses this technology. Policies and procedures need to be in place to protect the rights of CBAS participants to freedom from coercion and restraints for individuals attending a center that uses this technology and who do not exhibit unsafe wandering or exit-seeking behavior.* *CMS directed the State to issue a policy letter with additional requirements for CBAS providers using secured perimeter and delayed egress devices to ensure their compliance with the federal requirements. CDA distributed ACL #17-04 on March 10, 2017, which describes the state and federal requirements for the use of secured perimeters and delayed egress devices at CBAS centers.* *Through the State's on-site monitoring and oversight*		

		activities for CBAS center certification, the State determines which CBAS centers use either one or both of these technologies and if these centers are adhering to the state and federal regulations evidenced by the following: *Maintaining documentation of a participant's diagnosis of Alzheimer's disease or other dementia by a physician.* *Documenting in the participant's person-centered plan the need for the use of these devices, based on the MDT assessment, to address an individual's unsafe wandering or exit-seeking behavior.* *Informing all participants, conservators, agents, and persons who have the authority to act on behalf of participants on the center's use of security devices. The center is to maintain in the participant's health record a signed participation agreement indicating the use of the devices and the consent of the participant, conservator, agent, or person who has the authority to act on behalf of the participant.* *Providing staff training regarding the use and operation of the egress control devices utilized by the center, the protection of participants' personal rights, wandering behavior and acceptable methods of redirection, and emergency evacuation procedures for persons with dementia.* *Maintaining adequate staffing ratios at all times and not using egress control devices or secured perimeter fences to substitute for adequate staff.* *Therefore, this program authority and ACL #17-04 support* ***compliance*** *with this component of the HCB Settings*		

		requirement.		
4	**Federal Requirement #4**: The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact.			
4a	The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.	**T-22 §54001 – *General*** (a) Adult day health care providers shall: (2) Promote the social, emotional, and physical well-being of impaired individuals living in the community, alone or with others, in order to maintain them or restore them to their optimal functional potential and to help them remain at or return to their homes. **T-22 §54103 – *Adult Day Health Care*** Adult day health care means an organized day program of therapeutic, social and health activities and services, provided to elderly persons or other persons with physical or mental impairments for the purpose of restoring or	Compliant	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target for completion by

		maintaining optimal capacity for self-care. **T-22 §78301 – *Basic Program Services; General*** (b) Each participant shall be encouraged and assisted to achieve and maintain the highest level of self-care and independence. **T-22 §54309 – *Required Services*** (a) Each adult day health center shall provide directly on the premises, at least the following services: (B) Self-care training and services oriented toward activities of daily living and personal hygiene, such as toileting, bathing and grooming. **T-22 §78341 – *Basic Services Recreation or Planned Social Activities*** (a) The adult day health center shall provide an activity		December 31, 2021, was met. The State will continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers during their certification renewal process every two years.

		program that is supervised and directed by an activity coordinator to meet the needs and interests of each participant. The activity program shall assist the participant to resume self-care and normal activities or to prevent further deterioration. (c) The activity coordinator's duties shall include at least the following: (4) Involvement of participants in the planning of the program. (d) Each participant shall have time to engage in activities of the participant's own choosing. **T-22 §54315 – *Occupational Therapy Services*** (a) Occupational therapy services shall: (3) Increase or maintain the participant's capability for independence. (4) Enhance the participant's physical, emotional and social well-being. (5) Develop function to a maximum level. (6) Guide participants in the use of therapeutic, creative and self-care activities for improving function.		

		T-22 §54339 – *Activity Program* (a) The activity program shall be staffed and equipped to meet the needs and interests of each participant and shall encourage self-care and resumption of normal activities. Participants shall be encouraged to participate in activities suited to their individual needs. The activity program shall provide a planned schedule of social and other purposeful independent or group activities. Opportunities shall be provided for involvement, both individual and group, in the planning and implementation of the activity programs. (b) The primary objectives of activity programs shall be to encourage the participant toward restoration to self-care and the resumption of normal activities or for those who cannot realistically resume normal activities, to prevent further mental or physical deterioration. (c) The individual plan of care of each participant shall include an individual activity plan. This plan shall be reviewed quarterly. **T-22 §54331 – *Nutrition Service*** (b) Participant food preferences, including ethnic foods shall be adhered to as much as possible.		

		T-22 §78437 – *Participant Rights* (a) Each participant shall have rights which include, but are not limited to the following: 2) To participate in development and implementation of the participant's individual plan of care. (6) To treatment and rehabilitative services designed to promote the participant's functional ability to the optimal level and to encourage independence. (8) To be encouraged and assisted throughout the period of participation to exercise rights as a participant and civil and legal rights, and to this end to voice grievances and recommend changes in policies and services to center staff and to outside representatives of participant's choice, free from restraint, interference, coercion, discrimination or reprisal. (10) To end participation at the adult day health center atany time. (11) To refuse treatment and be informed of the consequences of such refusal. *Relevance: These nine program authorities support **compliance** with this federal requirement component to optimize, not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment. The CBAS model is explicitly designed to promote autonomy and independence and maximize individuals' capacity for choice and self-determination. It supports participants' involvement*		

		in treatment planning decisions and engagement in activities of their own choosing that meet their needs, preferences and interests including self-care and choice of food offerings at the center. There are opportunities to exercise their civil rights through a grievance procedure to address participants' problems or concerns regarding the provision of CBAS services and supports.		
4b	The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.	**T-22 §78437 – *Participant Rights*** (a) Each participant shall have rights which include, but are not limited to the following: (8) To be encouraged and assisted throughout the period of participation to exercise rights as a participant and civil and legal rights, and to this end to voice grievances and recommend changes in policies and services to center staff and to outside representatives of participant's choice, free from restraint, interference, coercion, discrimination or reprisal. *Relevance: This program authority supports the right of participants to choice and to be free from restraint, interference and coercion at the center. Therefore, its intent supports the right of participants to interact with whomever the participant wants, e.g., staff and other participants. However, this program authority does not explicitly state that CBAS participants may interact with whomever they want at*	Silent	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date for completion by December 21,

		*the center and therefore is considered **silent**.*		2021, was met. The State will continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers at the time of their certification renewal process every two years.
5	**Federal Requirement #5:** The setting facilitates individual choice regarding services and supports, and who provides them.			
5a	The setting facilitates individual choice regarding services and	**T-22 §78437 – *Participant Rights*** (a) Each participant shall have rights which include, but are	Compliant	The State inserted all of the federal HCB settings requirements for non-residential settings into the

	supports, and who provides them.	not limited to the following: (1) To be fully informed by the multidisciplinary team of health and functional status unless medical contraindicated, as documented by a physician in the participant's medical record. (2) To participate in development and implementation of the participant's individual plan of care. (3) To be fully informed regarding the services to be provided, including frequency of services and treatment objectives, as evidenced by the participant's written acknowledgement. (6) To treatment and rehabilitative services designed to promote the participant's functional ability to the optimal level and to encourage independence. (10) To end participation at the adult day health center at any time. (11) To refuse treatment and be informed of the consequences of such refusal. **STC 20(c) – *Individual Plan of Care (IPC)*** The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law… The whole person-centered project will comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying: 1) How the IPC will identify each enrollee's preferences,		CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS center compliance with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-

		choices and abilities and the strategies to address those preferences, choices, and abilities;		

		2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee. Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports. Person-Centered Planning includes consideration of the current and unique bio-psycho-social-cultural and medical needs and history of the individual, as well as the person's functional level, support systems, and continuum of care needs. CBAS center staff, the beneficiary, and his/her support team shall review and update the beneficiary's IPC at least every six months or when there is a change in circumstance that may require a change in benefits. ***T-22 §78341 – Basic Services Recreation or Planned Social Activities*** (c) The activity coordinator's duties shall include at least the		Assessment (PSA) Survey for all CBAS centers at the time of their certification renewal process every two years.

		following: (4) Involvement of participants in the planning of the program. (d) Each participant shall have time to engage in activities of the participant's own **choosing**. *Relevance: These three program authorities support **compliance** with this component of the federal requirement by requiring that participants are involved in the development and implementation of their individualized plan of care (IPC), including the planning of their activity program. Therefore, they have a choice about the services and supports they will receive and participate in at the center. Also, having choice means the right to end participation at the adult day health center at any time and to refuse treatment.* **T-22 §78023 – *Basic Program Services*** "Basic program services" means those services required to be provided by an adult day health center in order to obtain and maintain a license. The basic services include: rehabilitation services, medical services, nursing services, nutrition services, psychiatric or psychological services, social work and planned therapeutic recreational and social activities and transportation.		

		T-22 §54309 – Required Services (a) Each adult day health center shall provide directly on the premises, at least the following services: (1) Rehabilitation services, including: (A) Physical therapy as specified in Section 54313. (B) Occupational therapy as specified in Section 54315. (C) Speech therapy as specified in Section 54317. (2) Medical services supervised by either the participant's personal physician or a staff physician or both. (3) Nursing service, including: (A) Skilled nursing care rendered by a professional nursing staff who evaluate the particular nursing needs of each participant and provide the care and treatment indicated. (B) Self-care training and services oriented toward activities of daily living and personal hygiene, such as toileting, bathing and grooming. (4) Nutrition services, including: (A) A minimum of one meal per day which is in accordance with the requirements stated in Section 54331. Therapeutic diets and supplemental feedings shall be available if therapeutically indicated. (B) Dietary counseling and nutrition education for participants and their families. (5) Psychiatric and psychological services including:		

		(A) Consultation. (B) Individual assessment. (C) Supervision of treatment by a psychiatrist, psychologist, psychiatric social worker or psychiatric nurse, when indicated. (6) Medical social services to participants and their families to help with personal, family and adjustment problems that interfere with the effectiveness of treatment. (7) Planned recreational and social activities suited to the needs of the participants and designed to encourage physical exercise to prevent deterioration and to stimulate social interaction. (8) Nonmedical and medical transportation service for participants, only if necessary, to and from their homes. Specially equipped vehicles shall be utilized when medically necessary to accommodate participants with severe physical disabilities that limit mobility. **T-22 §54331 – *Nutrition Service*** (b) Participant food preferences, including ethnic foods shall be adhered to as much as possible.		

		T-22 §54329 – *Medical Social Services* (a) Medical social services shall as a minimum: (5) Provide counseling and referral to available community resources. (8) Serve as liaison with other community agencies who may be providing services to a participant and work with these agencies to coordinate all services delivered to the participant to meet the participant's needs and avoid duplication. Liaison shall include, but not be limited to the following agencies: (A) In-Home Supportive Services in the county welfare department.) Home Health Agency providers. (9) Provide discharge planning for all discharged participants *Relevance: The four program authorities identify the services and supports that CBAS centers are required to provide at the center or via referral to and coordination within the community. Through the assessment process, participants are directly involved in developing their individualized plan of care using person-centered planning principles which identifies the individualized services and supports that the center will provide that focus on the participants' abilities, needs and preferences. Therefore, all of these program authorities support* ***compliance*** *with this component of the federal requirement.*		

5b	The setting facilitates choice regarding services and supports, and who provides them.	**SOP G - *CBAS Staffing*** 1. A CBAS provider shall employ or contract with a variety of staff and render required services as described in these SOPs. The staff providing CBAS center services shall meet all licensing requirements as specified in the California Business and Professions Code, as well as these SOPs, as appropriate to the individual staff person. A CBAS provider's staffing requirements shall be based on the provider's hours of service and the average daily attendance (ADA) from the previous three consecutive months. The ADA can also be tied to ADA levels on various days of the week so long as the CBAS provider can demonstrate that the ADA for those days is consistent. 2. Professional nursing coverage of the center shall include Registered Nurse (RN) staffing at a ratio of one RN for every40 participants in ADA, or one RN for the first 40 participants and a half-time Licensed Vocational Nurse (LVN) for every increment of 10 in ADA exceeding 40 participants. a. There shall be at least one licensed nurse physically present and performing nursing duties at the center at all times during the center's hours of service during which participants are present. The licensed nurse physically present may be an LVN, providing the LVN is under the supervision of the RN, is working within scope of practice, and the RN is immediately available by phone if needed. 3. Social services staffing must include social workers at a ratio of one medical social worker for every 40 participants in	Silent	The State inserted all of the federal HCB settings requirements for non-residential settings into the CBAS section of the Medi-Cal Provider Manual. The target date for publication by June 30, 2018, was met. The State revised the ADHC/CBAS statutes to include the HCB settings requirements for non-residential settings. The target date for completion by December 31, 2021, was met. The State will continue to determine CBAS center compliance

		ADA, or one medical social worker for the first 40 participants and a half-time social worker assistant for every increment of 10 in ADA exceeding 40 participants. 4. The program aide staffing shall be at a ratio of one program aide on duty for up to and including 16 participants b. Any number of participants up to the next 16 shall require an additional program aide (for example, 17 participants require two program aides). 5. Participants' needs supersede the minimum staffing requirements specified in these SOPs. The CBAS provider shall be responsible for increasing staffing levels as necessary to maintain the health and safety of all participants and to ensure that services are provided to all participants according to their IPCs. 6. Physical, occupational, and speech therapy, and mental health services shall be provided at a minimum monthly rate of 20 total therapy hours for each increment of five participants in ADA. ***T-22 §54423 – Staffing Requirements*** (a) The program director, a registered nurse with public health background, a medical social worker, a program aide and the activity coordinator shall be on duty. Other staff shall be employed in sufficient numbers to provide services as prescribed in the individual plans or care, in accordance with the following minimal requirements, determined by each		with HCB settings and person-centered planning requirements during the onsite validation of the CBAS Provider Self-Assessment (PSA) Survey for all CBAS centers at the time of their certification renewal process every two years.

		center's average daily attendance based on the previous quarter experience. (7) An additional half-time licensed vocational nurse shall be provided for each increment of 10 in average daily attendance exceeding 40. (8) An additional half-time social work assistant shall be provided for each increment of 10 in average daily attendance exceeding 40. (9) Program aides shall be provided in a ratio of one-half aide for every increment of eight in average daily attendance. (10) The program director of centers whose average daily attendance is 20 or less may also serve as the registered nurse, social worker, occupational therapist, physical therapist, speech therapist or dietitian, provided that: (A) The program director meets the professional qualifications for that position. (B) The program director and the administrator are not the same person. (11) The center may request staffing variations to these staffing requirements according to Section 78217, Title 22, California Administrative Code. (b) Adult day health centers which serve participants whose primary language is other than English, shall employ sufficient trained staff to communicate with and facilitate rendering services to such participants. When a substantial number of the participants are in a non-English speaking group, bilingual staff shall be provided. Bilingual staff shall be persons capable of communicating in English and the		

		preferred language of the participant. *Relevance: These two program authorities related to staffing are **silent** on this component of the federal requirement. They identify the staffing requirements for CBAS centers which are based on the center's average daily attendance. Due to differences across centers in their average daily attendance, not all CBAS centers would be required to have alternate staff available for each multidisciplinary team member positions such as two Registered Nurses, two Social Workers, two Activity Coordinators, two Occupational Therapists, two Physical Therapists, two Dieticians, two Mental Health Consultants, etc.* *However, if alternate staff is available who can meet the needs of the participant within his/her scope of practice, then the participant would be able to request that his/her services be provided by the alternate staff person. If alternate staff within their scope of practice is not available and a CBAS participant has concerns about the unavailability of alternate staff for specific services, he/she may file a grievance with the center and/or managed care plan to find a resolution. If no resolution is possible, the participant has a right to terminate his/her agreement to attend the CBAS center and locate another center that may have alternate staff available who are acceptable to the participant. Refer to T-22 § 54407 - Grievance Procedure.*		

CBAS Certification Renewal Process
Medi-Cal Certification Renewal: • Providers are certified to provide Community-Based Adult Services (CBAS) for up to two years • At month 18 (180 days prior to certification expiration), CDA sends the provider a renewal application • Between months 18 and 20, CBAS providers submit the renewal application • Upon receipt of the renewal application, CDA reviews the application and completes the Medicaid Integrity provider screening and data base checks of applicant, 5% owners, and directors • Between months 18 and 22, CDA conducts an "in house" desk review prior to an onsite survey of the CBAS center • Between 20 and 22, CDA conducts an onsite survey • Prior to certification expiration, CDA prepares a report of survey findings • Prior to certification expiration, CDA reviews/approves plans of correction • At month 24 CDA renews certification
CBAS Onsite Survey Protocol: The Medi-Cal certification survey is an unannounced inspection visit that evaluates the quality of services received by CBAS center participants. The survey's primary focus is the measuring of participant outcomes and evaluation of the essential components of the center's service delivery and administrative systems, which must be present for positive outcomes to occur. All certification requirements contained in the California Code of Regulations (CCR), Title 22, Chapter 5 are assessed as are applicable statutory requirements found within the Welfare and Institutions Code, Division 9, Chapter 8.7 and the 1115 Medi-Cal 2020 Waiver. In evaluating participant outcomes, observation and interview are the primary methods of information gathering. The survey team observes the delivery of CBAS center services and interviews participants and center staff to confirm that participants' needs are met and required services are delivered. The focus of the survey is on appropriate assessing of participants' needs, and developing, implementing, and monitoring of needs-based, person-centered individual plans of care (IPC). The survey team also evaluates the center's administrative organization to determine if overall center operations result in effective program development, implementation, evaluation, and supervision. CDA's onsite survey is conducted by generalist analysts and nurses. It includes the following eight steps: ❖ Task 1 Entrance Conference ❖ Task 2 Sample Selection (participants randomly selected for health record reviews and interviews) ❖ Task 3 Observation (program, participants, center staff) ❖ Task 4 Interview (participants, center staff) ❖ Task 5 Participant Record Verification ❖ Task 6 Review of Organization and Administrative Systems ❖ Task 7 Review of Survey Findings (*Pre-Exit Conference)* ❖ Task 8 Exit Conference

MONITORING & OVERSIGHT

Waiver Name	Site Visit Frequency		Federal Assurance Review	Monitoring Team Staff			Other Compliance				Corrective Action Plan for Noncompliance	CAP Approval Based on Verification of Issue Resolution	Technical Assistance and Training
	Each Year	Each 24 Month		Nurse	Program Analyst	Social Worker	HCBS Setting Compliance	Provider Self-Survey Validation	CA Licensing and Certification Standards	Standard Agreements			
CBAS		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**

ON-SITE MONITORING PROTOCOLS

Waiver Name	Site Visit Notification					Participant Records Requested	Monitoring Tasks															
	None	One Week Notice	30 Days Notice	6 Weeks Notice	60 Days Notice		Entrance Conference	Participant Record Review	Review of Billing Records	Vendor Record Review	Review of Administrative Records	Review of Peer and Internal Review Process	Member and/or Guardian Interviews	Staff Interviews	Review Special Incident Reports	Review Participant Experience Surveys	Participant Home Visit Conducted	Assessment of Members' Residences that are Provider	Review of Findings and Trend Analysis (MOS team)	Technical Assistance	Exit Conference	M&O Report Issues Within 60 Days of Exit
CBAS	**X**					**X**	**X**	**X**			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**

Setting	CBAS

Provider Self-Survey		
% Sampled	Frequency	Method Of Distribution
100% of Centers	**6 months prior to certification expiration date.** **(Ongoing every two years during center's certification renewal process)**	**U.S. Mail**

Beneficiary Self-Survey Validation		
% Sampled	Frequency	Method Of Distribution
CDA administers a survey to up to a 10% sample of participants at each center during a face-to-face interview. Sample includes participants randomly selected for chart review during certification renewal onsite survey by CDA staff.	**At time of onsite certification renewal survey by CDA staff.** **(Ongoing every two years during center's onsite certification renewal survey)**	**Face-to-face interview of sampled participants by CDA survey staff during the center's onsite certification renewal survey.**

Setting	CBAS	
On-Site Assessment Validation		
% Sampled	Frequency	Method Of Completion
100% of Centers	**At time of center's onsite certification renewal survey.** **(Ongoing every two years during center's onsite certification renewal survey)**	**Completed by CDA nursing and analyst staff during onsite certification renewal surveys. Staff reviews center administrative and health records, interviews center staff and participants/caregivers or authorized representatives, and observes program activities.**
Additional Comments		
All CBAS centers are required to complete the Provider Self-Assessment survey at the time of their certification renewal application. All CBAS centers receive an onsite validation of compliance by CDA survey staff, with corrective action plans required where non-compliance is identified. Initial compliance determination activities concluded on December 31, 2019. Centers completed their corrective action plans as of March 31, 2020. CDA's monitoring and onsite validation of compliance of all CBAS centers is ongoing every two years during each center's certification renewal period and continuing beyond March 17, 2023.		

Community-Based Adult Services (CBAS)
Revised Draft CBAS Home and Community-Based (HCB) Settings Transition Plan
Appendix VI: Public Comment Log
(Public Comment Period 8/29/16 through 9/29/16)

Category	Name/Organization/E-mail/Phone	Comment
All	LMS Health Partners Luba Lmshealthpartners.hotmail.com 310-536-6511	No Comments
	CDA/DHC Comments & Action Taken	
	None	
	Proposed Revision	
	None	

Category	Name/Organization/E-mail/Phone	Comment
General Comment	Steve Connors Owner of ARF Care Home	I have been working with people with developmental disabilities in one form or another for the past 32 years. I have seen numerous positive steps over the years in the areas of advocacy, client rights, health and wellness, safety, careers, recreation, and general quality of life. The residents that live in my care home invited me to a meeting to discuss the new Federal requirements affecting Community-Based Adult services (CBAS). They are worried that the place they are currently working will get shut down if it cannot comply with the new Federal Regulation about giving minimum wage to all that work at the facility. One of my residents has been happily working for this organization for over 40 years! He is

Category	Name/Organization/E-mail/Phone	Comment
		completely happy seeing his friends, socializing at community events, and yes--going to work each day. He looks forward to going to work each day and gives his best effort. He will never be able to produce enough to make his time profitable for the company that employs him, which is why they cannot give him minimum wage. In fact, none of the residents that live in my care home have the qualities to compete with non-disabled individuals. So if the CBAS company that they are currently employed goes under because they need to pay minimum wage, where will all the people currently employed by these kinds of places go each day? What will their quality of life be like? They are worried that there will be nothing to replace their current reality and support system. Is this really the direction we want to go? It all sounds good on paper until you realize the true effect on the individual who will never be able to compete with others who do not have Intellectual and other developmental disabilities. Continue to look for ways to support competitive employment, but don't throw the baby out with the bath water!

Category	Name/Organization/E-mail/Phone	Comment
	CDA/DHC Comments & Action Taken	
	CDA contacted Mr. Connors to clarify the following: 1) the CBAS program is a licensed health facility, not a work program and 2) the HCB Settings federal requirements do not state that a work activity program must pay participants a minimum wage to comply with the federal requirements. Federal Requirement #1 states that "the setting is integrated and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS." There seems to be confusion among some in the Developmental Disability community about the HCB Settings requirements and information in the Department of Rehabilitation Employer Fact Sheet on Subminimum Wage Limitations and Responsibilities related to the Rehabilitation Act of 1973, as amended by the Workforce Innovation and Opportunity Act (WIOA). This Act gave the Department of Rehabilitation responsibility to provide career counseling and information and referral services (CC&IR) to all individuals employed at subminimum wage who are known to DOR, effective July 22, 2016. The Fact Sheet describes that "Employers are restricted from continuing to employ any individual in a subminimum wage setting, regardless of age, unless the individual is provided CC&IR by DOR to facilitate independent decision making and informed choice, and informed by the employer of self-advocacy, self-determination, and peer mentoring training opportunities available in the individual's geographic area. The training opportunities cannot be provided by an entity that holds a special wage certificate described in section 14(c) of the Fair Labor Standards Act. Refer to the California Department of Rehabilitation (DOR) website for more information about the Workforce Innovation and Opportunity Act (WIOA). http://www.dor.ca.gov/Public/WIOA-Information.html The State will clarify through its public education materials the distinction between the HCB Settings federal requirements and the Workforce Innovation and Opportunity Act (WIOA) regarding subminimum wage requirements.	

Community-Based Adult Services (CBAS)
Revised Draft CBAS Home and Community-Based (HCB) Settings Transition Plan
Appendix VI: Public Comment Log
(Public Comment Period 8/29/16 through 9/29/16)

Category	Name/Organization/E-mail/Phone	Comment
	Proposed Revision	
	None	

Category	Name/Organization/E-mail/Phone	Comment
Assessment of Statutes	Health Net Sydney Ryden, Business Analyst, Government Programs 916) 552-5287; sydney.a.ryden@healthnet.com	Health Net has a concern surrounding non-residential settings and the concept of CBAS and "secure perimeter technology" on page 17 of 30 of the Revised Draft CBAS HCB Settings Transition Plan. There has been much discussion about "delayed egress" as an essential safety mechanism for specified CBAS members at specified facilities. Given today's increasing notice of public safety risks, can the Settings and Transition Plan include comments or requirements about "entrance door safety mechanisms" for community based non-residential CBAS facilities? According to 42 CFR 441.301(c)(4)(vi)(B)(1) "entrance doors lockability" is a documented regulation for controlled residential settings, but there does not appear to be a similar regulation for community based non-residential facilities. Furthermore, we support the comments note on page 30 of 32 in Appendix III (Analysis of Laws, Regulations, Waiver, Policies, and Other Requirements) "program requirements do not prohibit visitors" and the resulting addition of a question on the Provider Assessment Tool to validate visitor access. Safety needed for both entrance and exit security.

Category	Name/Organization/E-mail/Phone	Comment
	CDA/DHC Comments & Action Taken	
	Although the HCB Settings regulations for controlled residential settings require "entrance door safety mechanisms" there is no federal requirement for "entrance door safety mechanisms" for community-based non-residential settings. Also, there is no ADHC regulation requiring "entrance door safety mechanisms" for ADHC/CBAS facilities. It would be the responsibility of each CBAS center to have policies and procedures in place to assure the health, safety and security of its participants.	
	Proposed Revision	
	None	