April 15, 2020

PROVIDER ALERT

To: **Community-Based Adult Service Providers (CBAS)**

From: HPSJ Provider Services Department

Subject: **DHCS APL and Guidance: Community Based Services in Response to COVID-19**

Business: Medi-Cal

The Department of Health Care Services (DHCS) has issued this All Plan Letter (APL 20-007) with policy guidance during the COVID-19 pandemic for Community-Based Adult Services

DHCS also has provided an accompanying All Center Letter (ACL 20-007) with further guidance for CBAS Administrators and Program Director.

Health Plan of San Joaquin (HPSJ) requires that you follow these regulatory requirements.

Please notify HPSJ staff if your organization cannot meet these requirements.
Contact: Provider Services Department (209) 942-6340

Attached:

1. APL 20-007 (Revised) – 5 pages
2. ACL 20-007 – 5 pages

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: *April 13, 2020*

ALL PLAN LETTER 20-007 (*REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: POLICY GUIDANCE FOR COMMUNITY-BASED ADULT SERVICES IN RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with policy guidance regarding the temporary authorization of Community-Based Adult Services (CBAS) provided telephonically, in participants' homes, and individually in centers, in lieu of congregate services provided at CBAS centers, during the period of this current public health emergency. This guidance is being provided in response to public health stay-at-home and social distancing guidance and directives resulting from the *Novel Coronavirus Disease (*COVID-19*)* outbreak. This APL outlines mechanisms by which CBAS centers may continue to provide services to CBAS participants now remaining at home. Finally, the APL addresses reimbursement for these temporary services, as well as reporting requirements for CBAS centers. *Revisions to this APL have been italicized for ease of reference.*

BACKGROUND:
On March 16, 2020, Governor Newsom issued an Executive Order directing the California Health and Human Services Agency to support vulnerable individuals such as seniors and those with chronic underlying health conditions isolated at home by: 1) developing alternatives to community-based services; and 2) leveraging existing programs and service providers. Then, on March 19, 2020, Governor Newsom issued a stay-at-home Executive Order to protect the health and well-being of all Californians and to establish consistency across the state in order to slow the spread of COVID-19. In response, the California Department of Aging (CDA), in collaboration with the Department of Health Care Services (DHCS), issued All Center Letter *(ACL)* 20-06 to provide guidance to CBAS centers regarding the temporary provision of CBAS services. *CDA issued additional guidance in ACL 20-07 to further clarify requirements for CBAS Temporary Alternative Services (TAS) during the public health emergency.* In addition, the California Department of Public Health issued All Facilities Letter 20-27.1

to provide guidance to adult day health centers to mitigate and prevent the transmission of COVID-19.
The goal is to continue to partner with CBAS providers, enabling the redesign service delivery to those at greatest risk, in the safest possible manner during this time of the COVID-19 emergency.

POLICY:
The following guidance will remain in effect until further notice.

Congregate services provided inside the center are not allowed during the period of this public health emergency. Essential services to individual participants may be provided in the center *or the home* so long as they meet criteria defined in this APL and with proper safety *and infection control* precautions.

Upon approval by CDA, CBAS centers may provide CBAS TAS in accordance with CDA ACL 20-07. CBAS centers are granted time-limited flexibility to reduce day-center activities and to provide CBAS *TAS, as appropriate*, telephonically*, via telehealth*, live virtual video conferencing, or in the home *(if proper safety precautions are taken and if no other option for providing services is able to meet the participant's needs)*, including but not limited to:

- Professional nursing care
- Personal care services
- Social services
- Behavioral health services
- Speech therapy
- Therapeutic activities
- Registered dietician-nutrition counseling

DHCS supports and encourages the use of all Health and Human Services Office of Civil Rights (HHS-OCR) allowable means of communication. Additional guidance regarding HHS-OCR's *Health Insurance Portability and Accountability Act* enforcement can be found on HHS-OCR's webpage.

Further, during the effective dates of this guidance, CBAS centers may provide these additional services at a participant's home*, with appropriate infection control precautions and equipment*:

- Physical therapy
- Occupational therapy

Activities related to the above-listed CBAS services could include:

- Care coordination
- Communication with the participant's personal health care provider
- Medication monitoring

- Assessing and monitoring for COVID-19 symptoms such as cough and fever
- Assessment and reassessment
- Wellness checks
- Behavioral health screenings
- Family training and participant education
- Verbal cueing (e.g., personal care services, therapies, etc.)
- Providing home-delivered care packages (e.g., food items, hygiene products, medical supplies)
- Providing transportation services, such as non-emergency medical transportation
- Maintaining a dedicated telephone support line for participants and family

In addition to the services described above, all CBAS providers are required to do the following:

1. *Maintain phone and email access for participant and family support, to be staffed a minimum of six hours daily, during provider-defined hours of services, Monday through Friday. The provider-defined hours are to be specified in the CBAS center's plan of operation.*
2. *Provide a minimum of one service to the participant or their caregiver for each authorized day billed. This service could include a telehealth (e.g., telephone, live video conferencing) contact, a service provided on behalf of the participant,[1] or an in-person "door-step" brief well check conducted when the provider is delivering food, medicine, activity packets, etc.*
3. *Conduct a COVID-19 wellness check and risk assessment for COVID-19 at least once a week, with greater frequency as needed.*
4. *Assess participants' and caregivers' current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.*
5. *Respond to needs and outcomes through targeted interventions and evaluate outcomes.*
6. *Communicate and coordinate with participants' networks of care supports based on identified and assessed need.*
7. *Arrange for delivery or deliver supplies based on assessed need, including, but not limited to, food items, hygiene products, and medical supplies. If needs cannot be addressed, staff will document efforts and reasons why needs could not be addressed.*

CBAS Center Staffing Requirements
Providers must staff CBAS TAS with a 1) Program Director; 2) Registered Nurse(s); and 3) Social Worker(s) to carryout CBAS TAS tasks.

[1] *Services provided on behalf of the participant include care coordination such as those listed under Items 4, 5, 6, and 7.*

Providers must have additional staff as needed to address the number of participants served and their identified needs and to assist in the delivery of services required for CBAS TAS participation, and as described in the provider's CDA approved CBAS TAS Plan of Operation. All staff must function within their scope of practice, qualifications, and abilities.

Authorization and Reimbursement
CBAS centers are eligible to receive their existing per diem rate for the provision of CBAS TAS, and as described *below*:

- *Providers will receive, from their contracting MCP, not less than their existing per diem rate for each participant with a current, or new, authorization for CBAS services. Reimbursement for CBAS TAS is retroactive to March 16, 2020.*
- *Provide a minimum of one service to the participant or their caregiver for each authorized day billed. This service could include a telehealth direct contact (e.g., telephone, live video conferencing), an in-person "door-step" well check conducted when the provider is delivering food, medicine, activity packets, etc., or care coordination on behalf of the participant.*
- *The required CBAS center staff must be available to all CBAS participants during the specified hours for phone and/or email contacts initiated by CBAS participants and caregivers.*
- *If a participant or caregiver requests to be disenrolled from the program or refuses all services after attempts to reengage them in CBAS TAS during this period, they may be considered "on hold" until the return of traditional CBAS or discharged, as appropriate based on existing discharge requirements. The provider may not bill for those individuals unless services are provided.*
- *Delivery of services must be based on a CBAS TAS Plan of Operation approved by CDA.*
- *The claims format, information contained therein, coding, and submission process will remain the same.*

MCPs must authorize and reimburse CBAS centers for the delivery *or arrangement* of services provided *in person,* telephonically, *telehealth,* via live virtual video conferencing, *or other appropriate person-centered means, as described in this APL*. Delivery of services must be based on a CBAS participant's assessed needs as documented in the current Individual Plan of Care (IPC), and/or identified by subsequent assessment by the center's multidisciplinary team.

Per the current 1115 Waiver special terms and conditions, for initial eligibility determinations, an initial face-to-face review is not required when an MCP determines that a member is eligible to receive CBAS and that the receipt of CBAS is clinically

appropriate based on the information that the MCP possesses. *MCPs are allowed to conduct the CBAS Eligibility Determination by phone, as needed.* MCPs may extend eligibility re-determinations for the ongoing receipt of CBAS to up to 12 months for members determined by the MCP to be clinically appropriate. DHCS encourages MCPs to minimize or eliminate requirements for face-to-face *interactions and to extend authorizations or eligibility re-determinations*, whenever possible.

Documentation and Reporting Requirements
Existing CBAS health record documentation standards for services provided will continue to apply. CBAS centers are responsible for updating participant IPCs when a change in assessed need is identified through regularly scheduled reassessments, and reassessments conducted due to a change in participant condition. *CBAS providers must document services, provided during the public health emergency, in accordance with CDA's guidance, as detailed in ACL 20-07.*

MCPs may require regular reporting by the CBAS centers, at a frequency and format required by the MCP, to substantiate the provision of services provided in accordance with this APL.

MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all subcontractors and network providers.

If you have any questions regarding this guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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ACL 20-07

Date: April 13, 2020

To: Community-Based Adult Services (CBAS) Center Administrators and Program Directors

From: California Department of Aging (CDA) CBAS Branch

Subject: CBAS Temporary Alternative Services (TAS) Overview & Requirements

Purpose

This All Center Letter (ACL) supplements the guidance contained in ACL 20-06. It outlines the requirements for CBAS Temporary Alternative Services (TAS) and the steps that certified CBAS providers must take for approval to participate in CBAS TAS. The temporarily redesigned CBAS program described in this ACL is intended to:

- Protect individuals most at risk during this COVID-19 outbreak and reduce their need to access other parts of the health care system that may become overwhelmed;
- Protect CBAS center staff; and
- Maintain CBAS center infrastructure so that centers are ready to reopen when the crisis ends

What Is CBAS TAS

CBAS TAS is a short-term, modified service delivery approach that allows certified CBAS providers to deliver essential services to participants most at risk during the COVID-19 outbreak. CBAS providers who are approved for CBAS TAS will be allowed to provide limited individual in-center activities, as well as telephonic, telehealth and in-home services to CBAS participants.

NOTE: Providers must consider the participants' most urgent needs and deliver them in the safest possible manner. Providers may serve participants in person **ONLY** when absolutely necessary and when using infection control measures to protect participants and staff to reduce exposure to, and transmission of, COVID-19.

What Services Are Required

Services provided under CBAS TAS should be person-centered; based on the assessed health needs and conditions identified in the participants' current Individual Plans of Care (IPC); identified through subsequent assessments; and noted in the health record.

In addition to the in person, telephonic, and telehealth services that may be provided as outlined in ACL 20-06, **all CBAS TAS providers are required to do the following**:

1. Maintain phone and email access for participant and family support, to be staffed a minimum of 6 hours daily, during provider-defined hours of services, Monday through Friday. The provider-defined hours are to be specified in the CBAS Center's plan of operation.
2. Provide a minimum of one service to the participant or their caregiver for each authorized day billed. This service could include a telehealth (e.g., telephone, live video conferencing, written communication via text or email) contact, a service provided on behalf of the participant[1], or an in-person "door-step" brief well check conducted when the provider is delivering food, medicine, activity packets, etc.
3. Conduct a COVID-19 wellness check and risk assessment for COVID-19 at least once a week, with greater frequency as needed.
4. Assess participants' and caregivers' current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.
5. Respond to needs and outcomes through targeted interventions and evaluate outcomes.
6. Communicate and coordinate with participants' networks of care supports based on identified and assessed need.
7. Arrange for delivery or deliver supplies based on assessed need, including, but not limited to, food items, hygiene products, and medical supplies. If needs cannot be addressed, staff will document efforts and reasons why needs could not be addressed.

Which Staff Are Required

Providers must staff CBAS TAS with a 1) Program Director; 2) Registered Nurse(s); and 3) Social Worker(s) to carry out CBAS TAS tasks.

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[1] Services provided on behalf of the participant include care coordination such as those listed under Items 4, 5, 6, and 7

Providers must have additional staff as needed to address the number of participants served and their identified needs and to assist in the delivery of services required for CBAS TAS participation, and as described in the provider's CDA approved *CBAS TAS Plan of Operation*. All staff must function within their scope of practice, qualifications, and abilities.

Note: Staff are not expected to convene at the center but must have methods to be able to work collaboratively as a team from remote locations. CDA will review the Plan of Operation to ensure that staff levels are adequate to the number of participants served.

Who Is Eligible To Receive CBAS TAS

- ✓ Participants who have previously been approved or are in the process of approval by the Medi-Cal managed care plan (MCP), or for fee-for-service participants, by DHCS. These participants will be considered "continuing" participants and may only require additional authorization for CBAS TAS if their treatment authorization period is expiring. Providers will need to work with their contracting MCPs, or DHCS for fee-for-service participants, regarding processes for reauthorizations.
- ✓ New participants may be enrolled. Providers will need to consult with their contracting MCPs, or DHCS for fee-for-service, for guidance regarding the process for enrollment of any new participants.

How Are Services To Be Documented

Providers must document all required services provided under CBAS TAS and listed above, as well as all services indicated in their CDA approved *CBAS TAS Plan of Operation*. NOTE: This includes customary administrative records (e.g., staff timesheets, transportation logs, TAS Plan of Operation) and participant health records.

Documentation to be included in **participant health records** includes but is not limited to:

- ✓ Care plans, action plans, and targeted interventions that have been modified as participants' needs change*
- ✓ Services provided, including date, type of service, and name/signature of person providing*
- ✓ Notes reflecting ongoing assessment of participant needs and progress with care plans*

*Providers should maintain existing processes with MCPs and DHCS for electronic health records and signatures.

NOTE: For CBAS providers admitting and serving new participants during CBAS TAS, the health record must include at least a telehealth assessment and care plan.

How Will Reimbursement Work

To ensure delivery of urgent CBAS TAS and recognizing that some participants may require increased care via CBAS TAS while others may need less than currently authorized/scheduled per existing IPCs, reimbursement will temporarily work as follows[2]:

- ✓ Providers will receive their existing per diem rate from their contracting managed care plans and DHCS fee-for-service, providing they meet all requirements for CBAS TAS participation, and:
- ✓ Provide a minimum of one service to the participant or their caregiver for each authorized day. This service could include a telehealth contact (e.g., telephone, live video conferencing, written communication via text or email), an in-person "door-step" well check conducted when the provider is delivering food, medicine, activity packets, etc. , or care coordination on behalf of the participant.
- ✓ The required CBAS center staff must be available to all CBAS participants during the specified hours for phone and/or email contacts initiated by CBAS participants and caregivers.

  NOTE: If a participant or caregiver requests to be disenrolled from the program or refuses all services after attempts to reengage them in CBAS TAS during this period, they may be considered on hold until the return of traditional CBAS or discharged, as appropriate, based on existing discharge requirements. The provider may not bill for those individuals unless services are provided.
- ✓ The claims format, information contained therein, coding, and submission process will remain the same.

NOTE: Providers will receive, from their contracting MCP, not less than their existing per diem rate for each beneficiary with a current, or new, authorization for CBAS services. Reimbursement for CBAS TAS is retroactive to March 16th, 2020. Providers pending approval for CBAS TAS as described in this ACL may begin billing. immediately, but payments will be subject to recoupment/cancellation if participation requirements for CBAS TAS are not met in good faith.

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[2] Medi-Cal managed care health plans (MCP) are subject to the CBAS provisions of DHCS All Plan Letter 20-007 which discusses authorization and that the rate of reimbursement is subject to the contract with the MCP and CBAS center.

How Do Providers Obtain Approval For CBAS TAS

Providers wanting to participate in CBAS TAS will need to submit the following to CDA for review and approval:

- CBAS TAS Plan of Operation Form (CDA 7012)
- CBAS TAS Provider Participation Agreement (CDA 7013)
- Updated Staffing/Services Arrangement Form (ADH 0006)

Forms are located on the CDA website. Providers wishing to participate in CBAS TAS will be required to submit forms to CDA by Monday April 20, 2020. CDA will **expedite** review of all provider requests to participate in CBAS TAS, communicate with providers to resolve any outstanding questions or concerns, and notify providers and MCPs of approvals and effective dates. Providers that are unable to meet the April 20, 2020, filing deadline should contact CDA regarding a possible extension.

Providers that fail to submit the required forms for participation in CBAS TAS or provide acceptable plans of operation will not be approved for CBAS TAS. CDA will notify those providers and their contracting MCPs of their status.

When Can CBAS TAS Be Provided

- NOW and until further notice
- Each provider's effective dates for service will be when CBAS TAS either began, March 16th, 2020 after the Governor's Orders, or the date they are scheduled to begin in the future, if services have not yet begun. Services provided prior to March 16th, 2020, are subject to regular CBAS standards and processes.
- CDA will notify providers and MCPs of CBAS TAS approval. Effective dates of commencement of CBAS TAS for each provider will be certified by CDA in the revised *CBAS TAS Provider Participation Agreement.*

Questions

Please contact the CBAS branch if you have any questions: (916) 419-7545; cbascda@aging.ca.gov