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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 participant¹, 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.

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 follows²:

- ✓ 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.

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;
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