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**DATE:** November 2, 2022

ALL PLAN LETTER 22-020 (*REVISED*)  
SUPERSEDES ALL PLAN/POLICY LETTER 20-007

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** COMMUNITY-BASED ADULT SERVICES EMERGENCY REMOTE SERVICES

**PURPOSE:**

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with policy guidance regarding the end of CBAS Temporary Alternative Services (TAS) effective September 30, 2022, and implementation of Community-Based Adult Services (CBAS) Emergency Remote Services (ERS) authorized under the California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration Waiver (Waiver), effective as of October 1, 2022.<sup>1</sup> The purpose of ERS is to allow for immediate response to address the continuity of care needs of Members participating in CBAS when an emergency restricts or prevents them from receiving services at their center. This policy guidance aligns with the California Department of Aging (CDA) All Center Letter (ACL) 22-04, Launch of New CBAS Emergency Remote Services (ERS).<sup>2</sup> Revised text is found in *italics*.

**BACKGROUND:**

Based on experiences of CBAS participants and caregivers, along with lessons learned during the COVID-19 public health emergency, the state, in consultation with CMS, determined that the CBAS program needed to expand its current service delivery model on an ongoing basis to include the provision of remote services. Inclusion of remote service delivery to CBAS participants by CBAS providers also supports the vision, principles and goals/initiatives adopted in California's Master Plan for Aging (MPA) and in the Waiver, including:<sup>3</sup>

<sup>1</sup> The CalAIM 1115 Demonstration Waiver is available at:

[https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx?utm\\_source=Resources&utm\\_medium=SideBar&utm\\_campaign=Waivers](https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx?utm_source=Resources&utm_medium=SideBar&utm_campaign=Waivers)

<sup>2</sup> ACL 22-04 is available at: [ACL 22-04 Launch of CBAS Emergency Remote Services \(ca.gov\)](https://www.dhcs.ca.gov/services/Pages/ACL22-04-Launch-of-CBAS-Emergency-Remote-Services.aspx)

<sup>3</sup> More information regarding California's MPA is available at: <https://mpa.aging.ca.gov/>

- Innovating service delivery to support seniors, and persons with disabilities, and their families and caregivers where and when services are needed.
- Expanding access to home and community-based services to support individuals remaining in their homes and communities.

The CalAIM 1115 Waiver, authorized by the Centers for Medicare and Medicaid Services (CMS) in January 2022, included the provision of CBAS ERS as a component of the CBAS benefit, available to CBAS participants as needed, under unique circumstances when ERS policy criteria are met. CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings such as the community, in or at the doorstep of the participant's home, or via telehealth to allow for immediate response to address the continuity of care needs of CBAS participants when an emergency restricts or prevents them from receiving services at their center.

Two types of "unique circumstances" listed in the 1115 Waiver Special Terms and Conditions (STCs) that may result in need for ERS are public and personal emergencies as determined by the CBAS provider in consultation with the MCP. The criteria to be considered when determining the appropriateness of ERS is further described in the Policy section below.

**POLICY:**

Effective October 1, 2022, CBAS ERS will be implemented as one of the required services under the CBAS program that all CBAS providers must make available to CBAS participants when all ERS policy criteria are met. CBAS providers are required to provide ERS as a mode of service delivery when participants experience emergencies, as described in this APL, and when all conditions for ERS are met. ERS is available only when CBAS participants meet all ERS criteria and all required ERS policy and processes are followed. When all ERS criteria are met and ERS policy and processes are followed, MCPs are required to provide coverage for this mode of service delivery of CBAS services.

The provision of ERS supports and services<sup>4</sup> is temporary and time-limited, and specifically either:

1. **Short-term:** Members may receive ERS for an emergency occurrence for up to three consecutive months. CBAS providers and MCPs must

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<sup>4</sup> The list of ERS supports and services can be found in ACL 22-04:  
<https://aging.ca.gov/download.ashx?IE0rcNUV0zat4VbuY0SwBw%3d%3d>

coordinate to ensure duration of ERS is appropriate during the Member's current authorized period and, as necessary, for reauthorization into a new period; or

2. **Beyond Three Consecutive Months:** ERS for an emergency occurrence may not exceed three consecutive months, either within or crossing over an authorized period, without assessment and review for possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan. CBAS providers and MCPs must coordinate on requests for authorization of ERS that exceed three consecutive months. Participants may need and/or be appropriate for ERS beyond three months. Per STC 21, "Participants will be assessed at least every three months as part of the reauthorization of the individual's care plan and a review for a continued need for remote/telehealth delivery of CBAS services." Instances of ERS that go beyond three months must be authorized by the MCP.

Two types of "unique circumstances" listed in the 1115 Waiver Special Terms and Conditions that may result in need for ERS are:

1. **Public Emergencies**, such as state or local disasters, regardless of whether formally declared. These may include, but are not limited to earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc. <sup>5</sup>
2. **Personal Emergencies**, such as serious illness or injury, crises, or care transitions, as defined below. Specific personal emergencies may include serious illness or injury, crises, care transitions such as to/from a nursing facility, hospital, and home.
  - "Serious Illness or Injury" means that the illness or injury is preventing the Member from receiving CBAS within the facility and providing medically necessary services and supports that are required to protect life, address or prevent significant illness or disability, and/or to alleviate pain. CBAS providers make the initial assessment regarding whether their participant has both

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<sup>5</sup> Further information regarding CBAS ERS – Public Emergency Requirements is located in CDA ACL 22-08.

experienced an emergency as defined in ERS policy AND per STC22, “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.”

- “Crises” means that the Member is experiencing, or threatened with, intense difficulty, trouble, or danger. Examples of personal crises would be the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
- “Care Transitions” means transitions to or from care settings, such as returning to home or another community setting from a nursing facility or hospital. If a CBAS participant is hospitalized or admitted to a SNF, the participant would not be attending the CBAS center for services or eligible for ERS. ERS may be appropriate as the participant transitions home and, once home, has need for remote CBAS supports and services appropriate and feasible at that time. ERS provided during care transitions should address service gaps and Member/caregiver needs and not duplicate responsibilities assigned to intake or discharging entities.

The determination of meeting these unique circumstances can be made by the CBAS provider in consultation with the MCP and the Member’s need must be appropriately documented. ERS policy specifies that all emergencies resulting in ERS be assessed initially by the CBAS center RN and social worker, with care plans modified as needed by the full CBAS multidisciplinary team. The MCPs and CBAS providers are to coordinate to ensure that service and support needs are met, and as indicated, the duration for provision of ERS. The list of considerations included here are to guide decisions regarding ERS. A Member’s emergency alone does not warrant provision of ERS. The Member must experience a public or personal emergency and need the services and supports CBAS provides under ERS. Members may choose to cease receipt of ERS at any time.

MCPs are required to cover ERS as part of the CBAS benefit when a Member meets the criteria established in ERS policy, including that ERS is determined to be the appropriate service for the Member and their emergency situation, and the CBAS provider meets the criteria specified in this APL. Once the MCP has approved for the Member to receive CBAS services, the mode of providing these services must include the provision of ERS as an option, provided that ERS is appropriate for the Member. Should there be a concern regarding the appropriateness of ERS, the MCPs and CBAS providers are required to collaboratively work towards an agreement regarding the method of providing ERS services. In determining the initial need for and/or duration of ERS, CBAS providers and MCPs may consider:

- Medical necessity – meaning that services and supports are necessary to protect life, address or prevent significant illness or disability, or to alleviate severe pain.
- Hospitalization – whether the Member has been hospitalized related to an injury or illness and is returning home but not yet to the CBAS center.
- Restrictions set forth by the Member’s primary/personal health care provider due to recent illness or injury.
- Member’s overall health condition.
- Extent to which other services or supports meet the Member’s needs during the emergency.
- Personal crises such as sudden loss of caregiver or housing that threaten the Member’s health, safety, and welfare.

### **ERS Provider Approval Process**

MCPs are required to ensure that their contracted CBAS providers complete the process for obtaining ERS approval, which is a two-step process.

MCPs must track the ERS approval process for all of their contracted CBAS providers until such time as all contracted providers have received appropriate approval to provide ERS.<sup>6</sup>

### **Care Coordination Requirements**

MCPs are required to collaborate with CBAS providers as TAS ends to ensure that each Member’s needs continue to be met, whether through in-person services provided at the CBAS center or through ERS, and that the Member’s needs are documented appropriately. For Members who choose to discontinue their CBAS services, the MCP is responsible for ensuring care coordination occurs for these Members to ensure their needs continue to be met. Members who are discharged from the CBAS program involuntarily may file a grievance with their MCP or request a state fair hearing or independent medical review.

Further, effective October 1, 2022, MCPs must ensure that their contracted CBAS providers meet all policy requirements specified in this APL, and CDA issued ACLs. MCPs and CBAS providers must regularly check the CDA website for updated CBAS and ERS letters<sup>7</sup>, including but not limited to the following:

22-09 ERS Monthly Reporting Requirements 09/26/2022

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<sup>6</sup> Copies of the approval letters can be obtained from the CBAS Center or from CDA.

<sup>7</sup> CBAS and ERS letters can be found at:

[https://aging.ca.gov/Providers\\_and\\_Partners/Community-Based\\_Adult\\_Services/#pp-ers](https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/#pp-ers)

22-08 Emergency Remote Services (ERS) – Public Emergencies 09/20/2022

22-07 ERS FAQ # 1 09/12/2022

22-06 Initiation of CBAS Emergency Remote Services (ERS) and CBAS ERS  
Initiation Form (CEIF) 08/26/2022

The Department of Health Care Services (DHCS) will monitor MCPs to ensure that this transition from TAS to ERS occurs successfully.

Within 30 days of discharge, MCPs must review and retain a copy of each participant's discharge plan from the CBAS provider. The MCP must review the discharge plan to determine if any further coordination of services for the Member is needed. When there are unmet needs due to the discharge from CBAS, the MCP is required to ensure the Member's needs are met through other covered non-CBAS services and that these needs are updated appropriately in the Member's care plan.

For participants who will remain enrolled in the CBAS program but have a reduction in the number of days they attend the program, the MCP is responsible for ensuring care coordination to ensure there are no unmet needs in care due to this reduction. Additionally, the participant's IPC must be updated to reflect the change in services provided.

In accordance with 1115 Waiver requirements, MCPs shall coordinate Member care for ERS with CBAS providers and CBAS participants to support the rapid response to CBAS participant needs when participants are restricted or prevented from receiving services at the center.<sup>8</sup> This includes but is not limited to developing processes that:

- Address the provider's submission of the CBAS ERS Initiation Form (CEIF) (CDA 4000) to the MCP that are in addition to provider ERS requirements established by CDA. MCPs must inform CBAS provider of any requirements specific to the MCP for submission of the CEIF (e.g., whether to submit by the same methods as for the IPC authorization, contact phones/faxes, care coordination requirements, etc.). These MCP processes for the CEIF submission and support of participants during ERS should be aligned with processes established for CBAS providers by CDA.
- Support timely review of the CEIF (CDA 4000) and communication regarding Member care that comport with expedited timelines for rapid response;
- Ensure consideration of need for additional or alternative supports and services the Member may need during the emergency

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<sup>8</sup> Further information regarding initiation of CBAS Emergency Remote Services and Completion of the CBAS ERS Initiation Form (CEIF) (CDA 4000) is located in CDA ACL 22-06.

To ensure that Members' needs are met at the conclusion of their ERS time period, MCPs should reach out to the CBAS provider for further information, in addition to reviewing Members' current CEIFs and IPCs, when needed.

### **Documentation and Reporting Requirements**

MCPs are required to provide oversight of their contracted CBAS providers to ensure that they are meeting the following documentation and reporting requirements: All customary CBAS documentation must be maintained in the Member's health record, such as: IPCs; ongoing assessments; progress notes, services provided; and discharge plans for Members who are no longer enrolled in the CBAS program.

1. Timely completion and submission of the CEIF (CDA 4000), no more than three working days after the start of ERS
2. Maintenance of all customary CBAS documentation in the Member's health record, such as IPCs, ongoing assessments, progress notes, reflecting services provided, and discharge plan for participants no longer enrolled in the CBAS program.

MCPs may require reporting by 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 required to report transition related metrics to DHCS for the initial 120 days of the transition from TAS to ERS (September – December 2022), using *the* DHCS-created reporting template.<sup>9</sup> These metrics include, but are not limited to: number of Members receiving TAS; number of Members transitioning from TAS to ERS; number of Members being discharged from CBAS; number of discharged Members with unmet needs; and number of discharged Members without unmet needs.

Further, CDA ACL 22-09<sup>10</sup> details the CBAS Monthly Emergency Remote Services Reporting Requirements that must be followed by CBAS providers.

### **DHCS Oversight**

Requirements contained in this APL, including any updates or revisions to this APL, and any other relevant guidance issued by CDA necessitate a change in an MCP's contractually required policies and procedures (P&Ps), therefore, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. The email must include the title of this APL as well as the applicable APL release date in the subject line.

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<sup>9</sup> MCPs should report to DHCS utilizing the reporting template, *an attachment to this APL*.

<sup>10</sup> ACL 22-09 can be found here:

<https://aging.ca.gov/download.ashx?IE0rcNUV0zZ0W89aMHHZ8g%3d%3d>

DHCS will monitor the timeliness of MCP submissions, as well as the content of the documents, and may request further information if submissions are incomplete. DHCS will send confirmation of approved submissions, as well as revision requests for incomplete submissions, to MCPs electronically.

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.<sup>11</sup> These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief  
Managed Care Quality and Monitoring Division

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<sup>11</sup> For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.