CBAS EMERGENCY REMOTE SERVICES (ERS) POLICY SUMMARY – Revised October 2023

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1. What Is CBAS Emergency Remote Services (ERS)	Under specified emergency situations, 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. ERS is a component of the CBAS benefit, available to **CBAS participants** as needed and when ERS policy criteria are met. CBAS ERS is the provision of CBAS in a setting other than the CBAS center. **Purpose:** • 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. **Difference Between CBAS and CBAS ERS:** • where/how services are provided; • modified care plan services and supports related to the participant's needs during the emergency.	❖ STCs 5.3 and 5.4 ❖ SOPs B.2 and C.1.a, E.2 ❖ ACL 22-04(Rev) ❖ APL 22-020 (Rev)

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2. Who may receive ERS?	CBAS ERS is available only to CBAS participants. "CBAS participant" means an individual who:
	• has been determined eligible for CBAS by their managed care plan (MCP) or DHCS (for fee-for-service participants); **and**
	• has the following in place prior to initiation of ERS supports and services:
	  ○ A completed person-centered care plan and treatment authorization request (TAR)/authorization request for CBAS approved by their managed care plan or DHCS; **and**
	  ○ A signed CBAS Participation Agreement in place at the CBAS center
	
	NOTE: CBAS ERS is available only when CBAS participants meet all ERS emergency criteria and the CBAS provider follows all required ERS policy and processes.
		❖ STC 5.1
		❖ Welf. & Inst. Code section 14530
		❖ 22 CCR sections 54131, 54203
		❖ ACL 22-04 (Rev)
		❖ APL 22-020 (Rev)

3. Who May Provide CBAS ERS?	To provide ERS, CBAS providers must: 1. have an ADHC license in good standing, including having "Emergency Remote Services" added to their ADHC license by the California Department of Public Health, and be open and operating; 2. be CBAS-certified by CDA; 3. have a signed contract(s) with a Medi-Cal MCP(s); 4. have no administrative sanctions by the Medi-Cal program, including but not limited to provider number withhold or suspension; and	❖ STC 5.4.d ❖ SOPs A and B ❖ 22 CCR section 78347 ❖ ACL 22-04 (Rev) ❖ APL 22-020 (Rev)

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	5. have received approval from CDA for provision of CBAS ERS. **Additionally**: CDA reserves the right to determine ERS eligibility for CBAS providers that are subject to an enrollment ban or that are under a "Significantly Out-of-Compliance" status. **NOTE**: CBAS providers are required by state law and regulation, and MCPs are required under the 1115 Waiver, to coordinate care of CBAS participants, including in the event of emergencies, regardless of whether ERS is authorized.	
4. When May CBAS ERS Be Provided and at What Frequency?	ERS may be provided according to individual participant needs, in accordance with authorized days of service on a participant's person-centered plan, whenever a CBAS participant: 1. experiences one of the public or personal emergencies that prevent or restrict their receiving services, in-person, at the center; 2. requires medically necessary services and/or supports determined by the CBAS Multi-Disciplinary Team members and the participant's MCP or DHCS* to ensure all the following: a. essential continuity of care is maintained; b. assessed clinical and non-clinical needs and service/supports gaps are addressed; c. ERS supports and services: i. promote return to center-based services and/or aid in a transitional period to/from the center; and	❖ STCs 5.3 and 5.4 ❖ ACL 22-04 (Rev) ❖ APL 22-020 (Rev) ❖ ACL 22-06 (Rev) ❖ ACL 22-08 (Rev)

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	ii. are not knowingly duplicative; and 3. is informed by the CBAS provider of service options and chooses ERS. **NOTE:** Providers initiating ERS for a participant must complete and transmit the required CBAS ERS Initiation Form (CEIF) (CDA-4000) to CDA* and the participant's MCP no more than three (3) working days after the start of ERS for personal emergencies or within seven (7) working days for public emergencies [reference Items 7 and 9 below]. Providers must ensure that all criteria for ERS are met and must coordinate with the MCP to ensure that continuation of ERS is appropriate during the participant's currently authorized TAR/authorization period and, as necessary and/or required by the participant's MCP, for reauthorization into a new TAR/authorization period. [Reference Items 2 and 10] *For FFS participants, CDA will review CEIFs submitted by providers and address any possible needs for coordination with DHCS.	
5. What Types of Emergency Events May Result in the Need for ERS?	Two types of "unique circumstances" listed in the Waiver STCs that may result in need for ERS: 1. **Public Emergencies**, such as state or local disasters, regardless of whether formally declared; 2. **Personal Emergencies**, such as illness, injury, crises, or care transitions. Emergencies may include but are not limited to:	❖ STC 5.3.a.i ❖ STC 5.3.a.ii ❖ 22 CCR section 78427 ❖ ACL 22-04 (Rev) ❖ APL 22-020 (Rev) ❖ ACL 22-08 (Rev)

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	State or Local Disasters such as: • earthquakes • floods • fires • power outages • epidemic/infectious disease outbreaks such as COVID, Tuberculosis, Norovirus, etc. *Personal Emergencies such as:* • serious illness or injury* • crises** • care transitions such as to/from nursing facility, hospital, home*** ***Serious Illness or Injury** means that the illness or injury is preventing the participant from receiving CBAS within the facility AND providing medically necessary services and supports are required to protect life, address or prevent significant illness or disability, and/or to alleviate pain. ****Crises** mean that the participant 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 Transition** refers to transitions to or from care settings, such as returning to home or another community setting from a nursing facility or hospital. ERS provided during care transitions should address service gaps and participant/caregiver needs and	

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	not duplicate responsibilities assigned to intake or discharging entities. **A participant emergency alone does not warrant provision of ERS. The participant must experience a public or personal emergency AND need the array of CBAS services offered under ERS.** Considerations regarding the initial need and/or duration of ERS **may** include but are not limited to: • medical necessity – meaning that services and supports are necessary to protect life, address or prevent significant illness or disability, or to alleviate severe pain. Since CBAS participants are determined to meet medical necessity criteria for **center-based services** during the eligibility determination and TAR/authorization approval processes, ERS must address needs when center-based care plan services are prevented or restricted; • hospitalization; • restrictions set forth by the participant's primary/personal health care provider due to recent illness or injury; • participant's overall health condition; • extent to which other services or supports meet the participant's needs; • personal crises, as defined above, such as sudden loss of caregiver or housing that threaten the participant's health, safety, and welfare.	

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6. What are the Basic Supports and Services Required By ERS?	CBAS participants shall continue to receive supports and services specified in their authorized person-centered care plans as appropriate and feasible during the time of emergency.
	
	Additionally, ERS supports and services to be provided include:
	• Regular communication with the participant, including the following performed by a center multidisciplinary team member at least weekly during provision of ERS:
	  ○ Review and update of the ERS participant's health and functional status based on emerging needs
	  ○ Review of the care plan for ERS and adjustments made as indicated.
	• Phone and email access for participant and family support six hours daily, Monday through Friday.
	• Assessment of participants' and caregivers' current and emerging needs
	• Response to needs through targeted interventions
	• Communication and coordination with participants' networks of care supports
	• Identification of equipment/technology needs and assistance with telehealth
	• Delivery of services and visits in-person if barriers to telehealth exist
	• Delivery of/arranging for delivery of food, medications, and/or supplies. Meal delivery limited to no more than two meals per day
	
	NOTE: ERS may be provided only for the number of days the participant needs during the emergency and may not exceed
		❖ STC 5.4.d.i-viii
		❖ Welf. & Inst. Code section 14529(d)(3)
		❖ ACL 22-04 (Rev)
		❖ APL 22-020 (Rev)

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	the number of days currently authorized. ERS days of service are billable only when supports and services are provided: • **As specified on the participant's authorized person-centered care plan, as appropriate and feasible during the emergency; and** • **As specified on the participant's CEIF (CDA 4000) and any subsequent ERS care plan(s)**	
7. What Steps Must CBAS Providers Follow to Initiate and Coordinate ERS?	A CBAS provider shall do the following whenever it initiates ERS: 1. Assess/evaluate the participant/caregiver's **current** status and **emerging** needs. Upon start of ERS, the registered nurse and/or social worker (per scope of practice) shall determine: a. participant's status relative to their existing person-centered plan at time of emergency; b. participant's need for specific supports and services at time of emergency; and c. whether the CBAS provider can meet the participant's needs and/or if additional services and supports are needed*. 2. Inform the participant/caregiver of services and supports needed, including by agencies other than the CBAS provider, and obtain consent for ERS if the participant chooses.	❖ STC 21 ❖ SOP H.13 ❖ 22 CCR section 54411 ❖ ACL 22-04 (Rev) ❖ APL 22-020 (Rev)

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	3. Complete the standardized CEIF (CDA 4000) per CDA instructions (*additional information in Documentation section below [reference Item 9]*). 4. Send a copy of completed CEIF (CDA 4000) to participant's MCP (or DHCS for fee-for-service participants) no more than three (3) working days after the start of ERS for personal emergencies or within seven (7) working days for public emergencies. Note: For FFS participants, CDA will review CEIFs submitted by providers and address any possible needs for coordination with DHCS. 5. Follow guidelines established by the MCP to coordinate the participant's ERS including: a. processes for CEIF (CDA 4000) submission and communication established by the MCP; b. any conditions for/duration of ERS; c. need for alternative or additional services and supports during the emergency; and d. conclusion of ERS when emergency conditions cease, and participant is able to receive necessary services at the center and/or when the participant requires discharge from the center. *[reference Item 10 below]* ***NOTE**: When criteria for ERS are met, CBAS providers are required to provide ERS if feasible and appropriate. If the CBAS provider determines that it cannot meet a participant's needs during	

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	an emergency that would otherwise indicate the need for ERS, or if the participant's MCP determines that ERS is not appropriate, the CBAS provider must coordinate with the participant's MCP or DHCS for fee-for-service participants and make referrals to alternative service providers and/or discharge the participant if necessary.	
8. What are the MCP Responsibilities for Coordination of ERS?	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 participant needs when participants are restricted or prevented from receiving services at the center. This includes but is not limited to: Developing processes that: • address CEIF (CDA 4000) submission to the MCP that are in addition to requirements established in this ERS policy document (reference Items 7 and 9); • support timely review of the CEIF (CDA 4000) and communication regarding participant care that comport with expedited timelines for rapid response; • ensure consideration of need for additional or alternative supports and services during the emergency*, including clear communication with providers regarding such determinations **NOTE**: CBAS providers and MCPs are required to use billing codes established to distinguish ERS days of service, including those	❖ STC 5.5.c ❖ ACL 22-04 (Rev) ❖ APL 22-020 (Rev) ❖ APL 22-014 Medi-Cal Inpatient/Outpatient Provider Manual: Billing Codes and

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	ERS days that meet criteria for reporting under rules for Electronic Visit Verification (EVV). See detail in Item 13 below. *CBAS participants who are MCP members are eligible to receive Enhanced Care Management (ECM) if they meet the Population of Focus criteria established for ECM by DHCS. Additionally, participants may be able to receive Community Supports if offered by their MCP.	
9. What are the Documentation and Reporting Requirements for ERS?	The CBAS provider shall complete the following documentation whenever a CBAS participant receives ERS: 1. The CEIF (CDA 4000), which includes: a. date of emergency and date of participant/caregiver consent for ERS; b. nature of emergency; and c. participant's identified needs and ERS care plan that addresses supports and service needs specified in STC 22.d.i-viii and demonstrate that the participant meets ERS criteria. The CEIF (CDA 4000) is to be completed per CDA reporting requirements and sent to the participant's MCP (or DHCS for fee-for-service participants): • within three (3) working days of initiation of ERS for personal emergencies and seven (7) for public emergencies*;	❖ SOP H.13 ❖ 22 CCR section 54411 ❖ ACL 22-04 (Rev) ❖ APL 22-020 (Rev) ❖ ACL 22-06 (Rev) ❖ ACL 22-08 (Rev) ❖ ACL 22-09 Medi-Cal Provider Manual Instructions – CBAS IPC, TAR and H&P Form Completion

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	• at least one-week prior to continuation of ERS, or on a timeline specified by the MCP, for any participant whose emergency indicates a need for extending ERS beyond three months; • for a participant whose ERS timeframe crosses over a TAR/authorization period, providers are to attach the CEIF (CDA 4000) to the participant's renewing TAR/authorization request and follow any additional specifications set by the MCP. ***NOTE**: additional time for completion of the CEIF (CDA 4000) may be allowed in cases of widespread emergency affecting multiple participants at a CBAS center. Providers are to coordinate with their contracting MCP partners. 2. Monthly reporting of ERS data, including: • <u>CBAS Monthly ERS Report:</u> Each time a provider submits a CEIF (CDA 4000) a corresponding Event ID is assigned in the Peach Portal. The provider is responsible to submit each participant's ERS attendance dates for a corresponding emergency via the Peach Portal. ERS attendance dates are defined as dates the participant received CBAS services in a setting other than the CBAS center. This report is due by the 10th day of the following month ERS was provided. For example, if the participant receives ERS during the month of October, the corresponding attendance dates are due no later than November 10th. The provider will report this information each month until the participant returns to in-center	

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	services, at which time the provider will close the ERS Event in the Peach Portal. • Monthly Statistical Summary Report (MSSR): ERS days of service data summarized on the MSSR, reflect both in-center attendance and ERS days of service that providers are required to maintain daily for all days on which services are provided. Detailed instructions for reporting ERS attendance dates can be found in the ERS Portal instructions on the Emergency Remote Services – Forms and Instructions page. 3. All customary CBAS documentation, maintained in the health record, such as Individual Plans of Care (IPC), * ongoing assessments, progress notes, and notes reflecting services provided. *IPC Documentation in Boxes 15 and 16 for reauthorization must: • Specify dates for any ERS initiated during the TAR/authorization period set to expire, and, if ERS concluded within the expiring TAR/authorization period, the date ERS concluded. • Include other information relevant to provision of ERS during the expiring TAR/authorization period and pertaining to continuation of ERS if crossing over the TAR/authorization period.	

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10. What is the timeframe for the provision of ERS to a participant?	ERS is intended to be temporary and time-limited. Specifically: • **Short-term:** Participants may receive ERS for an emergency occurrence for up to three consecutive months. Providers and MCPs must coordinate [reference Items 7 and 8] to ensure duration of ERS is appropriate during the participant's current TAR/authorized period and, as necessary, for reauthorization into a new period. • **Beyond Three Consecutive Months**: ERS for an emergency occurrence may not exceed three consecutive months, either within or crossing over a TAR/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 [reference Items 7 and 8] on requests for authorization of ERS that exceed three consecutive months. • **ERS End Date:** An ERS incident ends when: o The precipitating emergency is resolved, and the participant can return to the center to receive care plan services and supports. o The participant's MCP determines ERS is no longer appropriate and/or that the participant requires alternative supports and services. o The participant's existing CBAS authorization expires without reauthorization.	❖ STC 5.3 ❖ ACL 22-04 (Rev) ❖ APL 22-020 (Rev)

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	NOTE: Participants may choose to cease receipt of ERS at any time.	
11. Are CBAS Providers and MCPs Required to Provide ERS?	When criteria for ERS are met, CBAS providers are required to provide ERS if feasible and appropriate. **CBAS providers** are NOT allowed or required to provide ERS under the following circumstances: • Provider is NOT approved for provision of ERS by CDA due to certification status. • Provider is approved but unable to meet the participant's identified needs during the emergency. **NOTE**: If the CBAS provider cannot deliver ERS to a participant in need for reasons stated above, the CBAS provider and MCP must communicate and coordinate to ensure participant's needs are addressed. **MCPs** are required to cover ERS as part of the CBAS benefit when participants meet the criteria established in ERS policy, ERS is determined to be the appropriate service for the participant and their situation, and the CBAS provider meets the criteria specified above.	❖ STC 5.3 ❖ STC 5.4 ❖ STC 5.5.c ❖ Title 22 CCR sections 54323(a)(5), 54329(a)(5), 54329(a)(8) ❖ ACL 22-04 (Rev) ❖ APL 22-020 (Rev)
12. What Oversight and Monitoring Measures Will CDA Establish for ERS?	CDA has done and will continue to do the following to promote clear understanding and ongoing implementation of ERS to maintain program integrity: • Develop ERS policy requirements in alignment with waiver Special Terms and Conditions (STCs) and Standards of Participation (SOPs).	

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	• Develop ERS policy guidance in collaboration with stakeholders, including state and MCP partners and provider representatives. • Develop standardized ERS forms and reporting processes. • Establish metrics for measuring and reporting on ERS program quality under the 1115 Demonstration Waiver. • Incorporate ERS data surveillance and service delivery monitoring into CDA certification and survey processes. • Establish close coordination and data/report sharing protocols with DHCS and MCP partners. • Establish ERS best practice and quality improvement sharing strategies and conduct regular provider training.	
13. How Will the State, CBAS Providers, and MCPs Comply with Electronic Visit Verification (EVV) for ERS?	ERS care plan supports and services provided in participants' homes are subject to Electronic Visit Verification (EVV) requirements per 1115 Waiver STC 25. EVV is a federally mandated telephone and computer-based system for electronically verifying services provided to Medi-Cal beneficiaries' in their homes. The program is intended to reduce fraud, waste, and abuse. When a Medi-Cal provider delivers specified Personal Care Services (PCS) and Home Health Care Services (HHCS) in the home, they must verify with the CalEVV system the service performed, the individual receiving the service, the date and location of the service, and the time the service begins and ends. ERS is a required service under the CBAS benefit and includes delivery of services in participants' homes when needed and	❖ STC 5.7 ❖ APL 22-014 Medi-Cal Inpatient/Outpatient Provider Manual: Billing Codes and Reimbursement Rates

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	feasible. Because CBAS providers must be prepared to deliver services in participants' homes, all CBAS providers are subject to ERS EVV requirements. Services subject to ERS EVV reporting requirements include: • Personal care services provided in the participant's home (supervision or assistance with activities of daily living and instrumental activities of daily living, meals (if prepared and/or assisted with) in the home, and physical and occupational therapy maintenance program services). • Home health care services provided in the participant's home (professional nursing services, restorative physical and occupational therapies, and speech therapy. Any time a CBAS provider delivers an EVV personal care service (PCS) or home health care service (HHCS) in the home, required data for that service must be entered into the CalEVV system. All claims submitted to the participant's MCP or DHCS for an ERS EVV service must be billed with the appropriate billing codes posted in the Medi-Cal Provider Manual as follows. S5136 – CBAS ERS personal care service in home Q5001 – CBAS ERS home health care service in home CBAS providers will use the S5102 CR or SC† code and modifier to identify a CBAS ERS visit, then ADD code S5136 (PCS) or Q5001 (HHCS) with modifier CR or SC† with revenue code 3103 on the claim to identify a CBAS ERS EVV service. In addition to using S5102 CR or SC† (published FFS rate of $76.27 or rate otherwise contracted between provider and managed care plan),	

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	the $0.01 will be added to the reimbursement for codes S5136 and Q5001. CBAS providers are now required to submit claims for ERS days of service that do NOT include EVV services with the modifiers listed in the revised Billing Codes section of the Medi-Cal Provider Manual and as follows: Public Emergency S5102 CR Personal Emergency S5102 SC†	

CBAS Special Terms and Conditions (STCs) for Emergency Remote Services

(Excerpts from 1115(a) "CalAIM" Demonstration Waiver)

21. Remote CBAS Services- Emergency Remote Services (ERS). Under certain unique circumstances, CBAS ERS may be provided in response to the individual's person-centered needs. CBAS ERS (i.e., professional nursing care; personal care services; social services; behavioral health services; speech therapy; therapeutic activities; registered dietician-nutrition counseling; physical therapy; occupational therapy; meals) shall be provided in alternative service locations (e.g., community setting or participant's home) and/or, as appropriate, telephonically, via telehealth, live virtual video conferencing, as clinically appropriate.

a. These unique circumstances are limited to the following:
    i. Qualified emergencies - state or local disasters such as wildfires and power outages (to allow for services prior to the official declaration of a formal PHE as determined by the Department of Health Care Services or its contractor(s)); and,
    ii. Personal emergencies - time-limited illness/injury, crises, or care transitions that temporarily, on a time-limited basis, prevent or restrict enrolled CBAS participants from receiving services, in-person, at the CBAS center (subject toapproval by the beneficiary's managed care plan, or by the Department of Health Care Services or its contractor(s) for beneficiaries exempt from managed care).
b. These special circumstances are time-limited and vary based on the unique circumstances and identified needs of the participant as documented in the participant's individual care plan. 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.

22. CBAS Provider Specifications. CBAS center staff shall include licensed and registered nurses; licensed physical, occupational, and speech therapists; licensed behavioral health specialists; registered dieticians; social workers; activity coordinators; and a variety of other non-licensed staff such as program aides who assist in providing services.

a. Licensed, registered, certified, or recognized staff under California State scope of practice statutes shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.

b. All staff shall have necessary experience and receive appropriate on-site orientation and training prior to performing assigned duties. All staff will be supervised by CBAS center or administrative staff.

c. The Department of Healthcare Services maintains Standards of Participation for all CBAS providers are found in Attachment H to these STCs. These Standards of Participation are hereby incorporated by reference and can be found on the Department of Health Care Services and California Department of Aging (CDA) websites. Any changes in the CBAS Provider Standards of Participation must be approved by CMS.

d. CBAS providers, approved for provision of CBAS Emergency Remote Services must:
   i. Maintain regular communication with the participant via phone email, other electronic device, or in-person visits in order to assess need related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.
   ii. 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.
   iii. 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.
   iv. Respond to needs and outcomes through targeted interventions and evaluate outcomes.
   v. Communicate and coordinate with participants' networks of care supports based on identified and assessed need.
   vi. CBAS providers will work with individual participants to ensure they have the proper support they need in the event of equipment/technology failure including, but not limited to, arranging for alternative tools/equipment, evaluation of the existence or availability of back-up power sources, alarms, additional person(s) to assist, etc.
   vii. The CBAS provider will be required to identify back-up telehealth modality service delivery options or in-person/in-home visits in the instance that equipment/technology failure prevents the provision of services through telehealth.
   viii. 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. Note: Meals are limited to no more than two meals per day.

e. Medi-Cal certification requires that a CBAS provider adhere to federal and state laws and regulations regarding the confidentiality, security, and unauthorized disclosure ofprotected health information. The role of the provider in remote service delivery is to:

i. Explain privacy requirements and appropriately document in the individual's clinical records that the individual and/or the legal representative, when appropriate, has consented to receive CBAS services via telehealth.
ii. Confirm that the provider and the individual will use two-way, real-time communication technology that meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that the equipment is adequately suited for the individual's needs in order for remote service delivery.

25. **HCBS Electronic Visit Verification System**. For any in-home services provided to CBAS beneficiaries under the CBAS Emergency Remote Services, the state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by and home health services in accordance with section 12006 of the 21st Century CURES Act.