**CALIFORNIA DEPARTMENT OF AGING**
**Community-Based Adult Services Branch**
1300 National Drive, Suite 200
Sacramento, CA 95834
www.aging.ca.gov
TEL 916-419-7545
FAX 916-928-2507
TTY1-800-735-2929

**ACL 20-11**

Date: May 13, 2020

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

From: California Department of Aging (CDA) CBAS Branch

Subject: New Participant Enrollment during CBAS Temporary Alternative Services (TAS)

## Purpose

This letter provides guidance to providers regarding expectations for enrolling new participants during this period of CBAS TAS.

## Background

During the time of transition from CBAS congregate services to CBAS TAS, and since, providers have been challenged by the enrollment of new participants – some who were already in the process and were at varying levels of readiness to begin services and some who are brand new and for whom enrollment has yet to begin.

By referencing existing requirements under traditional CBAS, new realities with COVID-19, and rules for CBAS TAS, this ACL addresses both categories of participants - those for whom enrollment is near complete or underway and those for whom enrollment has yet to begin.

The requirements and guidance in this ACL provide a standard approach for providers to enroll new participants, to document enrollment steps, and to allow for CDA monitoring of CBAS TAS for participants not previously served by traditional CBAS.

## CBAS TAS New Participant Enrollments

Requirements for enrollment of new participants in CBAS TAS will be modified but generally follow requirements for traditional CBAS[1]. **Traditional CBAS requirements include**:

- A written request of a physician for CBAS participation
- Multidisciplinary team assessment, including:
    - A physician's history, physical, and tuberculosis screening
    - Assessments by the RN, social worker, activities coordinator, physical and occupational therapists, and the registered dietician, speech therapist, and psychiatric/psychological consultant as needed
    - An assessment of the home environment
- An Individual Plan of Care (IPC)
- A signed participation agreement
- Authorization by the managed care plan (MCP) for managed care participants or Department of Health Care Services (DHCS) for fee-for-service participants

**Enrollment of new participants to CBAS TAS will address each of the requirements above as follows:**

### Physician's Request

- Providers must obtain the physician's written request and include it in the participant's health record. The physician's request for services is often included with the history and physical information, but if it is not, providers must be sure to obtain a separate, clear request for services. NOTE: A request in the form of a prescription is acceptable.

### Multidisciplinary Team Assessment

Physician's History and Physical

- Providers must obtain the history and physical from the participant's primary care provider (PCP) and include it in the participant's health record[2].

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[1] References: WIC §14529, §14526.1, Title 22, CCR, §54203, §54205, §54207, §54211, §78303, §78317.

- If the provider is unable to obtain a history and physical from the PCP in a timely manner, alternate sources may be used such as urgent care, other physician specialists the participant sees, hospital records, or the provider's staff physician[3].
- Core medical record elements that must be obtained include diagnoses, conditions, medications, any medications to which the participant is allergic, and dietary restrictions.
- Evidence of TB clearance is required before participants may be served in person inside their home or in the center.
- Providers must work with their MCP(s) regarding approval to proceed with completion of assessments.

CBAS TAS Team Member Assessments

- Per ACL 20-07, the minimum required staff who must conduct assessments of new participants are the RN and social worker. Other team members that should conduct assessments are those participating in service delivery per the provider's CBAS TAS Plan of Operation.
- The assessment team must determine and document that medical necessity criteria are met.[4]
- Assessments may be conducted telephonically using self-reported information by participants and/or caregivers.

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[2] Title 22, CCR, §78303 requires the provider to obtain "a written assessment of the participant which has been completed within 90 days by the participant's physician or staff physician." A physical exam of the participant by their primary health care provider is not required within the 90 days prior to admission. If the form is completed and signed by the physician within the previous 90 days of admission, the center has met the requirement outlined.

[3] WIC §14528.1 and Title 22, CCR, §54319 and §54321 address roles of the personal and staff physicians and the provider's responsibility to maintain close liaison with participants' personal health care provider(s). If a participant does not have a personal health care provider or one is not available during the initial assessment process, the staff physician may conduct the initial history and physical. However, the provider must make all reasonable efforts to establish and maintain communication with a personal health care provider(s) and document those efforts in the health record.

[4] Refer to the Medi-Cal 1115(a) Demonstration Waiver, entitled California Medi-Cal 2020, Special Terms and Conditions (STC) for medical necessity criteria.

- Home assessments must be completed and include the following, per Title 22, CCR, §54207:
    - Living arrangements
    - Relationship with family or other person
    - Facilities available such as heat, bath, toilet, stove
    - Existence of environmental barriers such as stairs or other features not negotiable by the impaired individual
    - Access to transportation, shopping, church, or other needs of the individual

  NOTE: Since home visits are not advised, the assessment of the home environment may take the form of a doorstep "check-in" or drive by or be completed telephonically. If other sources of information are available, such as past home assessments by other agencies, they can be substituted or supplement the provider's assessment.

**Authorization and IPCs**

Authorization for services is the purview of the MCPs and DHCS. Providers must work with their contracting MCP(s), or DHCS for fee-for-service participants, regarding processes for submission of authorization requests and other requirements necessary for enrollment of new.

The processes and documentation requirements set forth in this ACL reflect minimum standards required by CDA for CBAS TAS providers enrolling new participants.

- All IPC boxes for which the assessing disciplines are able to gather the information are to be completed. Any boxes that cannot be completed in part or whole, must be described in Box 16.
- Box 13, the care plan, should be written to reflect how the provider anticipates delivering services to meet participant needs and goals. Frequency of services may be left blank as appropriate based on expectation of evolving participant needs during this time of COVID-19 emergency.
- The IPC should include baseline information obtained from the physician's health assessment, from other medical records the provider has accessed, and information obtained through the team's assessment such as medication reconciliation, ADLs/IADLs, risk factors, and equipment used.
- Minimum signatures required are those required by CBAS TAS – the RN, SW, and program director – and any other team members conducting assessments and participating in service delivery per the provider's CBAS TAS Plan of Operation.

- Guidance for completion of Boxes 15 and16 may be found in ACL 20-09. Boxes 15 and 16 for new participants must include the medical necessity and level of need for TAS that support the number of days requested.
- The days of service requested for new participants, as with traditional CBAS, should be based on the medical necessity of the participant as determined during the assessment process. Considerations include those listed in the Medi-Cal Provider Manual and additional risks related to COVID-19, the participant's living situation, social isolation, transitions out of other health facilities such as the hospital or nursing home, etc.

**Participation Agreement**

The ADHC/CBAS Participation Agreement (CDA 7000) form required for traditional CBAS will continue to be required at this time for newly enrolling participants, with some minor modifications which include:

- The first sentence on the form notes how many days per week the participant plans to attend the center. Providers may note here the minimum number of days necessary to provide anticipated weekly CBAS TAS contacts or services.
- The participant signature is not required. The provider shall note on the "Participant or Participant Authorized Representative Signature" line the name of the individual with whom the participation agreement was discussed and the date.

Providers shall share the information in the CDA 7000 with the enrolling participant or caregiver telephonically, sign, date, and mail a hard copy of the form and any other enrollment forms to the participant, and file originals in the participant's health record.

**Health records for each newly enrolled participant must, at a minimum, document the above actions and information.**

## Questions

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