

CALIFORNIA DEPARTMENT OF AGING  
COMMUNITY-BASED ADULT SERVICES BRANCH  
1300 NATIONAL DRIVE, SUITE 200  
SACRAMENTO, CA 95834  
Internet Home Page www.aging.ca.gov  
TDD 1-800-735-2929  
TEL (916) 419-7545  
FAX (916) 928-2507



**ACL 19-02**

Date: March 19, 2019

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

From: California Department of Aging (CDA) CBAS Branch

Subject: Implementation of New CBAS Individual Plan of Care (IPC) – **AMENDED**

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## **Purpose**

This All Center Letter is to inform CBAS providers that the new CBAS Individual Plan of Care (IPC) form (DHCS 0020) (Rev 03/2019) and instructions have been published and are approved by the California Department of Health Care Services (DHCS) for implementation.

## **IPC Implementation Date and Process**

CBAS providers are required to begin implementing the new CBAS IPC form starting **June 1, 2019**.

Implementation will occur on a roll-out basis as each CBAS participant's IPC comes up for review and renewal, and new Treatment Authorization Requests (TARs) are submitted. All TARS submitted for effective dates of service beginning June 1, 2019, must be accompanied by the new IPC. These include initial, reauthorization and change TARs.

CBAS center staff in collaboration with the CBAS participant and/or the participant's authorized representative shall review and update the CBAS participant's IPC at least every six months or more frequently when there is a change in the participant's condition or circumstances requiring a change in CBAS services.

CBAS providers are to determine the eligibility of CBAS participants for receipt of CBAS at least every six months through the treatment authorization or reauthorization process,

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or up to every twelve months for individuals determined by the managed care plan to be clinically appropriate.

**Note:** For Medi-Cal fee-for-service beneficiaries, the CBAS provider shall submit the new IPC to DHCS with the TAR as supporting documentation for the participant's level of service determination. For Medi-Cal managed care plan beneficiaries, the CBAS provider shall contact the participant's managed care plan for instructions about the TAR process and submission of the new IPC.

The CBAS provider must have assessment and care planning policies and procedures in place to ensure proper implementation of the new CBAS IPC and must always maintain a copy of the current IPC in the participant's health record.

### **Where to Find New IPC Forma, Instructions, and CBAS Sections of the Medi-Cal Provider Manual**

The new CBAS IPC form, IPC instructions, and blank Word templates of IPC Boxes 12, 13 and 14 are posted on the CDA website at the following link:

[https://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/Eligibility\\_and\\_Service\\_Authorization/](https://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/Eligibility_and_Service_Authorization/)

**Note:** The link above will take you to "CBAS Forms and Instructions-Eligibility and Service Authorization" page. Click on "Individual Plan of Care (IPC) (DHCS 0020) (Rev 03/2019)."

The revised CBAS sections of the DHCS Medi-Cal Provider Manual are posted at the following link:

[http://files.medi-cal.ca.gov/pubsdoco/manuals\\_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp)

**Note:** The link above will take you to the DHCS Medi-Cal "Provider Manuals" Publications page. Go to the "Inpatient/Outpatient" category and click on "Community-Based Adult Services (formerly Adult Day Health Care Centers)." Scroll down to the sections titled "Community-Based Adult Services (CBAS)."

### **Training**

The CBAS Branch provided a webinar training on the new CBAS IPC form and instructions on October 3, 2018, for CBAS providers, managed care representatives,

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software vendors and other interested stakeholders. The webinar recording, slides and Frequently Asked Questions (FAQ) are posted on the CDA website at the following link:

[https://www.aging.ca.gov/programsproviders/adhc-cbas/CBAS\\_Training/Default.aspx](https://www.aging.ca.gov/programsproviders/adhc-cbas/CBAS_Training/Default.aspx)

**Note:** The link above will take you to the “CBAS Training” webpage. Click on “Eligibility and Service Authorization” then “10/03/2018 - Individual Plan of Care (IPC) (DHCS 0020).”

After the October webinar training, the terms “Transgender Male” and “Transgender Female” were added to the IPC form for “Gender” options on page one. No other revisions were made to the IPC after this training.

### **Background on the New IPC Form**

The new CBAS IPC and standardized Participation Agreement (a companion document to the IPC) were developed to support CBAS center compliance with the federal Home and Community-Based (HCB) Settings and Person-Centered Planning requirements. These federal requirements are specified by the Centers for Medicare & Medicaid Services (CMS) in the CBAS provisions of California’s 1115(a) Demonstration Waiver, entitled “Medi-Cal 2020.”

CDA and DHCS facilitated a year-long stakeholder workgroup from June 2015 through June 2016 to develop the new IPC and Participation Agreement. The work group was comprised of CBAS providers, managed care plans and advocates. After June 2016, the CBAS Branch provided opportunities for additional stakeholder input on the draft IPC and instructions.

The IPC is a written plan of care developed by the CBAS center’s multidisciplinary team (MDT) in collaboration with the CBAS participant and/or the participant’s authorized representative(s) through a person-centered planning process. The IPC is designed to identify the CBAS participant’s treatment services to address his/her assessed and expressed needs, preferences, choices and abilities.

The CBAS Participation Agreement (CDA 7000) is to be signed by the participant or the participant’s authorized representative at the time of admission to the CBAS center and at a minimum every 12 months or more frequently if there is a significant change in the participant’s condition requiring a change in the IPC and requested number of attendance days. The signed Participation Agreement indicates consent by the participant to attend the ADHC/CBAS center and receive services identified in his/her IPC. Refer to All Center Letter (ACL) #17-01, dated January 31, 2017, for more information about the CBAS Participation Agreement.

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## **Relevant Federal and State Requirements**

### **California's 1115(a) Demonstration Waiver ("Medi-Cal 2020")**

#### **CBAS Special Terms and Conditions (STCs)**

##### **STC 48(c) (EXCERPT)**

"The state must ensure that home and community-based settings have all the qualities required by 42 CFR 441.301(c)(4), and other such qualities as the secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan."

### **California's 1115(a) Demonstration Waiver ("Medi-Cal 2020")**

#### **CBAS Special Terms and Conditions (STCs), STC 49(c)**

"The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request.

The whole person-centered planning project will comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying:

1) How the plan will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the plan will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the plan will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

The IPC is prepared by the CBAS center's multidisciplinary team based on the team's assessment of the beneficiary's medical, functional, and psychosocial status, and includes standardized components approved by the State Medicaid Agency.

Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports. Person-Centered Planning includes consideration of the current and unique bio-psycho-social-cultural and medical needs and history of the individual, as well as the person's functional level, support systems, and continuum of care needs. CBAS center

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staff, the beneficiary, and his/her support team shall review and update the beneficiary's IPC at least every six months or when there is a change in circumstance that may require a change in benefits. Such review and updates must include an evaluation of progress toward treatment goals and objectives, and reflect changes in the beneficiary's status or needs. The IPC shall include at a minimum:

- i. Medical diagnoses.
- ii. Prescribed medications.
- iii. Scheduled days at the CBAS center.
- iv. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis.
- v. Elements of the services that need to be linked to individual objectives, therapeutic goals, and duration of service(s).
- vi. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities.
- vii. Participation in specific group activities.
- viii. Transportation needs, including special transportation
- ix. Special diet requirements, dietary counseling and education, if needed.
- x. A plan for any other necessary services that the CBAS center will coordinate.
- xi. IPCs will be reviewed and updated no less than every six months by the CBAS staff, the enrollee, and his/her support team. Such review must include a review of the participant's progress, goals, and objectives, as well as the IPC itself."

**Federal Home and Community-Based Settings Requirements for Non-Residential Settings, Code of Federal Regulations (CFR), Title 42, Section 441.301(c)(4)(i) through (v)**

"Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered service plan:

- i. The setting is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCB Services;
- ii. The setting is selected by the individual among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences and for residential services, resources available for room and board.

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- iii. (The setting) ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.
- iv. (The setting) optimizes individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, the physical environment and with whom to interact.
- v. (The setting) facilitates individual choice regarding services and supports, and who provides them."

**Federal Person-Centered Planning Requirements for Non-Residential Settings, Code of Federal Regulations (CFR), Title 42, Section 441.301(c) (1) through (3)**

(1) Person-Centered Planning Process.

"The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

- i. Includes people chosen by the individual.
- ii. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
- iii. Is timely and occurs at times and locations of convenience to the individual.
- iv. Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.
- v. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
- vi. Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.
- vii. Offers informed choices to the individual regarding the services and supports they receive and from whom.
- viii. Includes a method for the individual to request updates to the plan as needed.

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- ix. Records the alternative home and community-based settings that were considered by the individual.

(2) The Person-Centered Service Plan.

The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope and services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

- i. Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
- ii. Reflect the individual's strengths and preferences.
- iii. Reflect clinical and support needs as identified through an assessment of functional need.
- iv. Include individually identified goals and desired outcomes.
- v. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.
- vi. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
- vii. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.
- viii. Identify the individual and/or entity responsible for monitoring the plan.
- ix. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
- x. Be distributed to the individual and other people involved in the plan.
- xi. Include those services, the purpose or control of which the individual elects to self-direct.
- xii. Prevent the provision of unnecessary or inappropriate services and supports.

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(3) Review of the Person-Centered Service Plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by §441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.”

**Welfare and Institutions Code (WIC), Division 9, Chapter 8.7,**

**Section §14529. “Multidisciplinary Health Team”**

[Welfare and Institutions Code \(WIC\) §14529.](#)

**Title 22, California Code of Regulations (CCR), Division 3, Chapter 5, Section § 54207. “Multidisciplinary Team Assessment”**

[Title 22, California Code of Regulations \(CCR\) § 54207](#)

**Title 22, California Code of Regulations (CCR), Division 3, Chapter 5, Section § 54211. “Multidisciplinary Team”**

[Title 22, California Code of Regulations \(CCR\) § 54211.](#)

## **Questions**

For questions about this letter, please contact the CBAS Branch at (916) 419-7545 or email us at [cbascda@aging.ca.gov](mailto:cbascda@aging.ca.gov).