Department of Health Care Services (DHCS)
Long-Term Care At Home
Continuum of Care Attachment

Introduction: As part of DHCS' implementation efforts relative to the Long-Term Care at Home benefit, this document is intended to serve as a reference tool, which is designed to help interested parties better understand the interplay and interconnectedness between various DHCS programs, services, and benefits, as well as those of other State departments. This tool can also help in making determinations where there are potential areas for duplication of services and benefits across program areas, thus allowing interested parties to more clearly understand what programs, benefits, and services can be offered simultaneously with Long-Term Care at Home benefit versus not.

Program/ Benefit	Long-Term Care at Home	Community-Based Adult Services (CBAS)	Multipurpose Senior Services Program (MSSP)	Assisted Living Waiver (ALW)	Home and Community-Based Alternatives (HCBA) Waiver	California Community Transitions (CCT)/ Money Follows the Person (MFP)	In-Home Supportive Services (IHSS)	Program of All-inclusive Care for the Elderly (PACE)	Hospice	SNF	Home Health Services	Palliative Care Services
Overlap with Long-Term Care at Home Benefit	NA	Provided under the 1115 waiver. Has overlapping services; managed care plans have a process to provide individual, unbundled CBAS services.	Provided under a 1915(c) home and community based (HCBS) waiver program. Due to many overlapping services, the state does not allow participation in more than one 1915(c) or (i) program at the same time.	Provided under a 1915(c) HCBS waiver program. Due to many overlapping services, the state does not allow participation in more than one 1915(c) or (i) program at the same time.	Provided under a 1915(c) HCBS waiver program. Due to many overlapping services, the state does not allow participation in more than one 1915(c) or (i) program at the same time.	CCT provides transition services and some ongoing supports. LTC at Home will leverage the transition services on a one-time basis, paid under a separate rate. A CCT participant may still receive the non-transition LTC at Home services for ongoing supports.	Complementary service; IHSS hours will be coordinated with the Long-Term Care at Home benefit in a similar manner used by Regional Centers for services and the hospice benefit.	PACE and Long-Term Care at Home services are duplicative so a beneficiary who is eligible for both would have to choose to participate in one or the other.	Requires MD certification for life expectancy of 6 months or less; overlapping services thus individual would have to cease Long-Term Care at Home services if Hospice is elected to avoid service duplication.	Requires level of care determination; Long-Term Care at Home can be provided as an alternative to a short-term or long-term stay.	Home Health Services and Long-Term Care at Home are duplicative with the exception of home assessment and evaluation; beneficiaries who are eligible for both would have to choose to participate in one or the other.	Palliative Care Services can be adjusted as needed to avoid duplication with and Long-Term Care at Home.
Operating Department/ Lead Entities	DHCS	DHCS/CDA	CDA	DHCS	DHCS	DHCS	CDSS	DHCS	DHCS	DHCS	DHCS	DHCS
Provider Types	DHCS and Medi-Cal managed care plan enrolled providers	CBAS Centers	Contracted MSSP Sites	Care Coordination Agencies (CCAs) Residential Care Facilities for the Elderly (RCFE), and Adult Residential Facilities (ARF).	Case Management Nurse Evaluators in 7 counties not covered by the contracted waiver agency. Contracted HCBA Waiver Agencies (WAs) in 51 counties.	CCT Lead Organizations (LOs)	IHSS Providers	PACE Organizations	DHCS and Medi-Cal managed care plan enrolled hospice providers	DHCS and Medi-Cal managed care plan enrolled skilled nursing facility providers	DHCS and Medi-Cal managed care plan enrolled home health providers	DHCS and Medi-Cal managed care plan enrolled palliative care providers
Federal Authority	1915 (i)	1115 Waiver	1915 (c)	1915 (c)	1915 (c)	Deficit Reduction Act	1915 (j) /1915 (k)	Balanced Budget Act	1905 (a) State plan benefit	1905(a) State Plan benefit	1905(a) State Plan benefit	HSC § 1747.3
Target Population/ Eligibility	Full-scope Medi-Cal; and individuals 21 years of age or older who are Medicare Part A, Medicare Part B, or both.	Full-Scope Medi-Cal; Aged, Disabled, 18 and older	Full-Scope Medi-Cal; Aged 65 and older, Nursing Facility Level of Care	Full-Scope Medi-Cal; Aged, Disabled, 21 and over, Nursing Facility Level of Care	Full-Scope Medi-Cal; Aged, Disabled, all ages, Nursing Facility Level of Care	Full-Scope Medi-Cal; Aged, Disabled, residing in an institutional setting for 90 consecutive days, all ages	Full-Scope Medi-Cal; Aged 65 and older, blind and disabled	Aged, Disabled, 55 and older living in a PACE service area, Nursing Facility Level of Care	Medi-Cal eligible with physician certification; self-elected by beneficiary.	Physician certification regarding need for level of care.	Medi-Cal eligible recipients; Covered when prescribed by a physician and provided at the recipients home in accordance with a treatment plan.	Covered for any beneficiary that meets the criteria in Provider Manual and APL
Service Area	Statewide	Operating in 27 counties	46 counties	15 Counties	Statewide	Statewide	Statewide	16 counties; specific zip codes covered	Statewide	Statewide	Statewide	Statewide
Where Services Are Provided	In the home	CBAS Center	In the home	Residential Care Facilities for the Elderly, Adult Residential Facilities and Public Subsidized Housing	In the home, a Congregate Living Health Facility (CLHF), or Intermediate Care Facilities for Individuals with Developmental Disabilities – Continuous Nursing (ICF/DD-CN)	Provided to individuals while in an institutional setting for transfer to Residential Facilities and in the home	In the home	PACE Center and in the home	In the home or hospice agency.	Skilled Nursing Facility	In the patient's residential setting	Inpatient, Outpatient, and in the home

Department of Health Care Services (DHCS)
Long-Term Care At Home
Continuum of Care Attachment

Program Term	State Plan benefit; no end date	Authorized until 12/31/2020	Waiver term ends 6/30/2024	Waiver term ends 2/29/2024	Waiver term ends 12/31/2021	Authorized until 9/30/2021; Transitions will end 12/31/2021	State Plan benefit, no end date	Optional State Plan benefit; no end date	State Plan benefit, may be reauthorized in 6 month increments, based on patient status	State plan benefit; authorized based on continued level of care need	As needed based on physician prescription	Based on individual needs of the patient
Current Enrollment/ Capacity	N/A	Enrollment: >32,000 No enrollment limit Waitlist: No	Enrollment: >11,000 Capacity: 11,789 Waitlist: Yes	Enrollment: 4,685 (as of March 2020) Capacity: 5,744 Waitlist: Yes	Enrollment: 4,688 (as of March 2020) Capacity: 8,500 Waitlist: Yes	No enrollment limit Waitlist: No	Enrollment: >600,000	Current enrollment ≈11,000	No enrollment limit	No enrollment limit	No enrollment limit	Data unavailable
Services Provided	Proposed 1. Physician services 2. Nursing services 3. Physical, occupational, and speech therapy services 4. Social worker services 5. Medical equipment 6. Medical supplies 7. Personal care and homemaker services 8. Short-term respite for caregivers 9. Assistive and medical technology 10. Dietary counseling and nutrition services 11. Services for Mild-to-Moderate mental health conditions 12. Family/Caregiver training 13. Personal Emergency Response Systems 14. Laboratory services	1. Professional nursing services 2. Physical, occupational and speech therapies 3. Mental health services 4. Therapeutic activities 5. Social services 6. Personal care 7. Hot meals and nutritional counseling 8. Transportation to and from the participant's residence	Coordinates: 1. Care Management 2. Respite Care 3. Supplemental Homemaker Services 4. Supplemental Personal Care 5. Adult Day Care 6. Assistive Technology 7. Communication: Device 8. Communication: Translation/Interpretation 9. Community Transition Services 10. Consultative Clinical Services 11. Counseling and Therapeutic Services: 12. Minor Home Repairs and Maintenance 13. Non-Medical Home Equipment 14. Nutritional Services 15. Supplemental Protective Supervision 16. Transportation	1. Assisted Living Services - Homemaker; Home Health Aide; Personal Care 2. Care Coordination 3. Residential Habilitation 4. Augmented Plan of Care Development and Follow-up 5. Nursing Facility Transition Coordination	1. Case Management 2. Habilitation Services 3. Home Respite 4. Waiver Personal Care Services (WPCS) 5. Community Transitions Services 6. Comprehensive Care Management 7. Continuous Nursing and Supportive Services 8. Developmentally Disabled-Continuous Nursing Care (DD-CNC), Non-Ventilator Dependent Services 9. DD-CNC, Ventilator Dependent Services 10. Environmental Accessibility Adaptations 11. Facility Respite 12. Family/Caregiver Training 13. Medical Operating Expenses 14. Personal Emergency Response System (PERS) - Installation and Testing 15. PERS - Monthly Service Charge 16. Private Duty Nursing - Including Home Health Aide and Shared Services 17. Transitional Case Management (TCM)	1. Transition Coordination 2. Habilitation 3. Family and Informal Caregiver Training 4. Personal Care Services 5. Home Set-up 6. Home Modification 7. Vehicle Adaptations 8. Assistive Devices	1. Accompaniment to Alternative Resources 2. Accompaniment to Medical Appointments 3. Ambulation 4. Bathing, Oral Hygiene/ Grooming 5. Bowel and/or Bladder Care 6. Care and Assistance with Prosthesis Domestic 7. (Housework) 8. Dressing 9. Feeding 10. Heavy Cleaning 11. Meal Cleanup 12. Menstrual Care Move In/Out of Bed 13. (Transfer) 14. Other Shopping and Errands 15. Paramedical Services 16. Prepare Meals 17. Protective Supervision 18. Removal of Ice and Snow 19. Rub Skin and Repositioning 20. Respiration Assistance 21. Routine Bed Baths 22. Routine Laundry 23. Shopping for Food 24. Teaching and Demonstration 25. Yard Hazard Abatement	1. All Medicare-covered items and services. 2. All Medicaid-covered items and services, as specified in the State's approved Medicaid plan. 3. Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.	1. Nursing service 2. PT/OT 3. Speech language pathology 4. Medical social services, home health aide, and home maker/attendant services, medical supplies and appliances 5. Drugs and biologicals 6. Physician services 7. Short term inpatient care 8. Counseling	1. Physician services 2. Nursing services, including wound care 3. Specialized rehabilitative services 4. PT/OT/ST, 5. Standard and customized wheelchair 6. Medically-related social services 7. Pharmaceutical services 8. Dietary services 9. Emergency dental services 10. Room and bed maintenance services 11. Routine personal hygiene items and services	1. Part time or intermittent skilled Nursing services 2. PT/OT/ST 3. In-home medical care 4. Medical social services 5. Medical supplies and other biologicals 6. DME 7. Home heath aid services 8. Other home health services	1. Advanced care planning 2. Palliative care assessment and consultation 3. Pain and symptom management 4. Plan of care 5. Care coordination 6. Nursing services 7. Home Health aide 8. Psychosocial services 9. Discharge planning 10. PT/OT 11. Palliative care team
Transition Services	Yes	No	Yes	Yes	Yes.	Yes.	No	No	No	No	No	No