

**Administrative Services Agreement Between
Managed Long Term Care Plan and Health Homes
APPENDIX A**

Managed Long Term Care Plan Covered Services (Covered by the Capitation ^{1,2}, Services Provided as Medically Necessary)	Check Needed Services	Managed Long Term Care Plan Non-Covered Services (Excluded From The Capitation; Can Be Billed Fee-For-Service)	Check Needed Services
Nursing Home Care	<input type="checkbox"/>	Inpatient Hospital Services	<input type="checkbox"/>
Home Care a. Nursing <input type="checkbox"/> b. Home Health Aide <input type="checkbox"/> c. Physical Therapy (PT) <input type="checkbox"/> d. Speech Pathology (OT) <input type="checkbox"/> e. Medical Social Services <input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Adult Day Health Care	<input type="checkbox"/>	Outpatient Hospital Services	<input type="checkbox"/>
Personal Care	<input type="checkbox"/>	Physician Services including services provided in an office setting, a clinic, a facility, or in the home. ³	<input type="checkbox"/>
DME, including Medical/Surgical Supplies*, Enteral and Parenteral Formula#, and Hearing Aid Batteries, Prosthetics, Orthotics and Orthopedic Footwear**	<input type="checkbox"/>	Laboratory Services	<input type="checkbox"/>
Personal Emergency Response System	<input type="checkbox"/>	Radiology and Radioisotope Services	<input type="checkbox"/>
Non-emergent Transportation	<input type="checkbox"/>	Emergency Transportation	<input type="checkbox"/>
Podiatry	<input type="checkbox"/>	Rural Health Clinic Services	<input type="checkbox"/>
Dentistry	<input type="checkbox"/>	Chronic Renal Dialysis	<input type="checkbox"/>
Optometry/Eyeglasses	<input type="checkbox"/>	Mental Health Services	<input type="checkbox"/>
PT, OT, SP or other therapies provided in a setting other than a home. Limited to 20 visits of each therapy type per calendar year, except for children under 21 and the developmentally disabled. MLTC Plan may authorize additional visits.	<input type="checkbox"/>	Alcohol and Substance Abuse Services	<input type="checkbox"/>
Audiology/Hearing Aids	<input type="checkbox"/>	OPWDD Services	<input type="checkbox"/>
Respiratory Therapy	<input type="checkbox"/>	Family Planning Services	<input type="checkbox"/>

Nutrition	<input type="checkbox"/>	Prescription and Non-Prescription Drugs, Compounded Prescriptions	<input type="checkbox"/>
Private Duty Nursing	<input type="checkbox"/>	Assisted Living Program	<input type="checkbox"/>
Private Duty Nursing	<input type="checkbox"/>	All other services listed in the Title XIX State Plan:	<input type="checkbox"/>
Consumer Directed Personal Assistance Services	<input type="checkbox"/>		
Home Delivered or Congregate Meals	<input type="checkbox"/>		
Social Day Care	<input type="checkbox"/>		
Social and Environmental Supports	<input type="checkbox"/>		

¹ The capitation payment includes applicable Medicare coinsurance and deductibles for benefit package services

² Any of the services listed in this column, when provided in a diagnostic and treatment center, would be included in and covered by the capitation payment.

³ Includes nurse practitioners and physician assistants acting as “physician extenders”.

Enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism

** Prescription footwear and inserts are limited to use in conjunction with a lower limb orthotic brace, as part of a diabetic treatment plan, or if there are foot complication in children under age 21.