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| **Part 2: Care Management Service Plan for Partial MLTC Plans and Health Homes** |
|  | **Covered Services, When Provided, Would Be Covered by the Capitation.** 1, 2 (**Services Provided as Medically Necessary)** | √ | **For Each Service, Indicate The Respective Roles of MLTC Care Coordinator and the Health Home Care Manager** |
|  | Nursing Home Care |  |  |
|  | Home Care |  |  |
|  | 1. Nursing
 |  |  |
|  | 1. Home Health Aide
 |  |  |
|  | 1. Physical Therapy (PT)
 |  |  |
|  | d. Occupational Therapy (OT) |  |  |
|  | e. Speech Pathology (SP) |  |  |
|  | f. Medical Social Services |  |  |
| Adult Day Health Care  |  |  |
| Personal Care |  |  |
| DME, including Medical//Surgical Supplies, Enteral and Parenteral Formula#, and Hearing Aid Batteries, Prosthetics, Orthotics and Orthopedic Footwear |  |  |
| Personal Emergency Response System |  |  |
| Non-emergent Transportation |  |  |
| Podiatry |  |  |
| Dentistry |  |  |
| Optometry/Eyeglasses |  |  |
| 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.** |  |  |
| Audiology/Hearing Aids |  |  |
| Respiratory Therapy |  |  |
| Nutrition |  |  |
| Private Duty Nursing |  |  |
| Consumer Directed Personal Assistance Services |  |  |
| Home Delivered or Congregate Meals |  |  |
| Social Day Care |  |  |
| Social and Environmental Supports |  |  |

[[1]](#footnote-1)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

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| **Managed Long Term Care Plan Non-Covered Services** |
| **Excluded From The Capitation; Can Be Billed Fee-For-Service**  | √ | **For Each Service, Indicate The Respective Roles of MLTC Care Coordinator and the Health Home Care Manager** |
| Inpatient Hospital Services |  |  |
| Outpatient Hospital Services |  |  |
| Physician Services including servicesprovided in an office setting, a clinic, a facility, or in the home.3 |  |  |
| Laboratory Services |  |  |
| Radiology and Radioisotope Services |  |  |
| Emergency Transportation |  |  |
| Rural Health Clinic Services |  |  |
| Chronic Renal Dialysis |  |  |
| Mental Health Services |  |  |
| Alcohol and Substance Abuse Services |  |  |
| Family Planning Services |  |  |
| Prescription and Non Prescription Drugs, CompoundPrescriptions |  |  |
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|  |  |  |
| All other services listed in the Title XIX State Plan: (list) |  |  |
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| Other community supports: (list) |  |  |
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1. [↑](#footnote-ref-1)