



Clinical Policy Guiding Document: Long Term Services and Support (LTSS) and Home and Community-Based Services (HCBS)

BACKGROUND

Medicaid is the primary payer across the nation for LTSS. Medicaid allows for the coverage of these services through several vehicles and over a continuum of settings, ranging from institutional care to community based long-term services and supports. CMS is working in partnership with states, consumers and advocates, providers and other stakeholders to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life. The programs and partnerships contained in this section are aimed at achieving a system that is:¹

- **Person-Driven:** Allows older people, and those with disabilities and/or chronic illness the opportunity to decide where and with whom they live, to have control over the services they receive and who provides the services, to work and earn money, and to include family/friends/other supports to help them participate in community life.
- **Inclusive:** Encourages and supports people to live where they want to live with access to a full array of quality services and supports in the community.
- **Effective and Accountable:** Offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners and includes personal accountability and planning for long-term care needs, including greater use and awareness of private sources of funding.
- **Sustainable and Efficient:** Achieves economy and efficiency by coordinating and managing a package of services that are appropriate for the beneficiary and paid for by the appropriate party.
- **Coordinated and Transparent:** Coordinates services from various funding streams to provide a coordinated, seamless package of supports, and makes effective use of health information technology to provide transparent information to consumers, providers and payers.
- **Culturally Competent:** Provides accessible information and services that take into account people's cultural and linguistic needs.

Approximately 11 million people receive LTSS; almost 60% are elderly and over 40% are age 18 to 65 with a physical and/or developmental disability. LTSS helps a Member achieve more independence as they may be able to continue living at home or another desired setting. The need for LTSS is expected to grow as the number of those over age 65 will double by 2050 – 70% of those will utilize LTSS at some point. The need for LTSS quadruples for those over age 85.² WellCare also serves pediatric members in New York through Medicaid Managed Care (MMC). Please see the New York specific section below for more information.

TYPES OF BENEFITS

Long-term services and supports (LTSS) are services and supports used by Members of all ages with functional limitations and chronic illnesses. LTSS helps those needing assistance to perform routine daily activities (e.g., bathing, dressing, meal preparation, administering medications). Types of LTSS benefits are noted below; Members should refer to their benefits package to determine eligibility.

- Adult Day Health Services
- Agency Providers such as RN, LPN, CNA and therapies. Housekeeping Level 1 is an LTSS benefit only (Personal Care Worker, Consumer Directed Personal Assistance Services).
- Homemaker Services
- Alcohol and Substance Use Rehabilitation Services
- Dental, Vision, Podiatry and Hearing (Managed Long Term Care [MLTC] benefit only)
- Electronic Home Response (e.g., EHR Installation [MARS], Personal Emergency Response System [NY])
- Exceptional Care
- Habilitation Services
- Individual Providers PA, RN, LPN, CNA and Therapies
- Licensed Clinical Professional Counselor (LCPC)
- Long Term Care – Intermediate; Recipient 22-64 in IMD not MI or MR; Skilled; Supportive Living Facility [Waivers]; SLF Dementia Care
- Mental Health Rehabilitation Option Services
- MPE Certification (Provider)
- Non-Emergency Transportation (NET)
- Other Behavioral Health Services
- Other HCFA Approved Services
- Psychologist Services
- Respite Care
- Social Day Care (MLTSS benefit only)
- Social Work Services
- Targeted Case Management Service (Mental Health)

Home and community-based services (HCBS) provide services to Medicaid beneficiaries with behavioral health conditions to receive services in their home or community. Types of HCBS benefits are noted below. To determine eligibility, Members should check their benefits package.

	HCBS ELIGIBILITY CATEGORIES						
	Persons who are Elderly	Persons with a Disability	Persons with HIV/AIDS	Persons with Brain Injury	Medically Fragile/Technology Dependent	Supportive Living Facility	Pediatric (NY Only)
Adult Day Services	X	X	X	X			
Adult Day Services Transportation	X	X	X	X			
Assisted Living						X	X
Behavioral Services – MA & PhD				X			
Environmental Accessibility Adaptations-Home		X	X	X	X		
Family Training					X		X
Habilitation Day				X			X
Home Delivered Meal		X	X	X			
Home Health Aid		X	X	X			X
Homemaker Services	X	X	X	X			
Individual Provider		X	X	X			
Nurse Training					X		X
Nursing – Intermittent		X	X	X			X
Occupational Therapy (OT)		X	X	X			X
Personal Emergency Response	X	X	X	X			

System (PERS)							
Physical Therapy (PT)		X	X	X			X
Placement Maintenance Counseling					X		
Prevocational Services				X			
Respite Care		X	X	X	X		X
Skilled Nursing – RN and LPN		X	X	X			X
Specialized Medical Equipment and Supplies		X	X	X	X		X
Speech Therapy (ST)		X	X	X			X
Supported Employment				X			

For market specific information, please see the *State Specific Criteria* below.

NATIONAL GUIDANCE

NCQA

Additional information on LTSS can be found on the National Council of Aging’s web site ([here](#)) regarding LTSS such as: Medicaid Home and Community Based Services; financing long term care; Duals Integration and Managed LTSS; information for caregivers; links to webinars; and ongoing national efforts.³

NCQA has also developed the *CM-LTSS Standards and Guidelines* that include the following elements:²

- LTSS 1: Program Description
- LTSS 2: Assessment Process
- LTSS 3: Person-Centered Care Planning and Monitoring
- LTSS 4: Care Transitions
- LTSS 5: Measurement and Quality Improvement
- LTSS 6: Staffing, Training and Verification
- LTSS 7: Rights and Responsibilities
- LTSS 8: Delegation of LTSS

State Specific Criteria .

FLORIDA

There are two different programs that make up the Statewide Medicaid Managed Care: **Long-Term Care (LTC) Managed Care Program** and the **Managed Medical Assistance (MMA) Program**. Medicaid recipients who qualify and become enrolled in SMMC LTC will receive long-term care services such as:⁴

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| Adult Companion | Medical Equipment & Supplies |
| Adult Day Care (Adult Day Health Care) | Medication Administration |
| Assistive Care Services | Medication Management |
| Assisted Living Facility Services | Nursing Facility Care |
| Attendant Care | Nutritional Assessment and Risk Reduction |
| Behavior Management | Occupational Therapy |
| Caregiver Training | Personal Care |
| Case Management | Personal Emergency Response System |
| Home Accessibility Adaptation | Physical Therapy |
| Home Delivered Meals | Respiratory Therapy |
| Homemaker | Respite Care |
| Hospice | Speech Therapy |
| Intermittent and Skilled Nursing | Transportation |

All of these services are available based on medical necessity, or they must be necessary in order to delay or prevent nursing facility placement. Individuals that meet the following criteria are eligible to receive services under SMMC LTC:⁴

- Age 65 and over and eligible for Medicaid
- Age 18 and over and eligible for Medicaid by reason of a disability
- Be determined by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) unit at the Department of Elder Affairs to be at nursing home level of care and meet one or more established clinical criteria.

For additional information on the Statewide Medicaid Managed Care Long-term Care (LTC) program, consult the Agency for Health Care Administration’s manual on Long-Term Care can be found [here](#).⁴

GEORGIA

Services are available in Georgia for Members through Medicaid Waivers managed by the State. WellCare refers candidates to the State for waiver consideration. If enrolled, the Member is termed from the health plan and moved to a Fee for Service (FFS) Medicaid plan. Dual Special Needs Population (DSNP) Members that receive benefits via Medicaid FFS and a WellCare Medicare plan may be eligible for services (or have access through the Georgia Long Term Care Insurance program). Services for the specific waiver are managed by the program through the State of Georgia, and are not coordinated by the health plan.

Long-term care (LTC) services range from home and community-based services to services provided in an assisted living or nursing facility. All services are designed to improve or maintain an individual's health and to maintain the individual in the least restrictive setting that ensures their health, safety, and welfare. Services and care:

- Can range from a few hours per week to around-the-clock care.
- Can be provided in the patient's home, at a community-based setting, or at a nursing facility.
- Are typically paid out of pocket or paid by private LTC insurance. For those individuals who become impoverished, Medicaid may assist with the cost of long-term care.

Types of LTC include:

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| Adult Day Health Care Center | Long-term Care Insurance |
| Adult Day Services | Private Duty |
| Certified Home Health Services | Nursing |
| Hospice | Nursing Facilities |
| Long-term Care | Respite Care |

For additional information about the types of LTC options, visit the Department of Community Health [here](#).⁵

HAWAII

The Long Term Services and Supports (LTSS) Program has been a RFP-required Service Coordination program since 2009. To determine if a Member’s eligibility for the Hawaii LTSS Program, the Member is assessed at their home setting by a RN Service Coordinator or a Licensed Social Worker (LSW) Service Coordinator. The State of Hawaii is highly prescriptive and requires the use of a State-mandated LTSS Assessment Tool, Service Plan, and Level Of Care Form (no. 1147) to determine a Member’s eligibility for Home and Community Based Services (HCBS). Cost share for requested HCBS is determined by completing the State of Hawaii’s Long Term Packet that details a Member’s income and assets. For an LTSS member to continue eligibility for ongoing services, they must renew Form 1147 annually. Options Counseling allows the Member to make an informed choice as to who should provide their care and where the care setting should be. The full array of HCBS services available to eligible Members can be found in the *Member Handbook* available [here](#).^{6,7}

ILLINOIS

The Managed Long Term Services and Supports (MLTSS) Program started in Illinois in 2016. The program operates in the Greater Chicago Region and is a mandatory program for Dual Eligibles receiving long term services and supports who opt out of the Medicare-Medicaid Alignment Initiative (MMAI). Individuals receiving HCBS on a Developmental Disabilities (DD) waiver or residing in a DD facility are excluded from the MMAI and MLTSS

programs.³ The State determines eligibility in this service program through performing a Determination of Need (DON) analysis and scoring for the member. Eligible Members are placed into a specific waiver program which defines the additionally covered alternate services. All LTSS services are coordinated through Managed Care Organizations Medical Management Programs. There are five different waiver programs a member can qualify for:

1. **Elderly Waiver:** Administered by the Illinois Department on Aging for Members age 60 or older, who are otherwise eligible for nursing facility as evidenced by a DON.
2. **Supported Living Facilities (SLF) Waiver:** Administered by the Illinois Department of Healthcare and Family Services (HFS) for Members age 65 and older, or persons with disabilities (as determined by the Social Security Administration) age 22 and older. Examples include: temporary nursing care; social/recreational programming; health promotion and exercise; medication oversight; ancillary services; 24-hour response/security; personal care; and laundry, housekeeping, and maintenance.
3. **Persons with Disabilities Waiver:** Administered by the Department of Rehabilitative Services (DRS) for Members age 0-59 with disabilities, or, those 60 or older who began services before age 60 and choose to continue using this waiver.
4. **Traumatic Brain Injury (TBI) Waiver:** DRS administers this waiver population for persons of any age with brain injury and functional limitations directly resulting from an acquired brain injury.
5. **Persons with HIV/AIDS Waiver:** DRS administers this waiver population for persons of any age diagnosed with HIV or AIDS.

In the MLTSS Program, the health plan only covers certain Medicaid services: non-Medicare long-term services and supports, non-Medicare behavioral health, and non-emergency transportation services. In addition, the Member's MLTSS health plan will cover the waiver services they receive at home, such as a personal assistant, homemaker, adult day care, or a home emergency response system. As a Dual Eligible participant, their medical benefits that are not covered by the MLTSS health plan are covered by Medicare or as Medicaid fee-for-service (Section 105.2.3).¹

The State of Illinois has altered its approach to providing Medicaid funding to members who require long term care services. Instead of providing care in institutions, such as nursing homes, hospitals or intermediate care facilities, the State of Illinois is providing more services and care in home or other community based settings. Certain Medicaid members are eligible for these alternate services not typically covered by Medicaid.

Service	Elderly Waiver	Disability Waiver	HIV/AIDS Waiver	Traumatic Brain Injury Waiver
Adaptive Equipment		X	X	X
Adult Day Service	X	X	X	X
Adult Day Service Transportation	X	X	X	X
Behavioral Services				X
Day Habilitation				X
Emergency Home Response System	X	X	X	X
Environmental Modification		X	X	X
Home Delivered Meals		X	X	X
Home Health Aide		X	X	X
Homemaker	X	X	X	X
Nursing, Intermittent		X	X	X
Nursing, Skilled		X	X	X
Occupational Therapy		X	X	X
Physical Therapy		X	X	X
Prevocational Services				X
Respite		X	X	X
Speech Therapy		X	X	X
Supported Employment				X

A Clinical Coverage Guideline (CCG) is also available – *Long Term Services and Supports: HS-325*. At the time of approval, the CCG is only applicable to the Illinois market.

Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

MISSOURI

Home and Community Based Services (HCBS) are designed to assist in meeting the unmet needs of the participant and provide the necessary assistance to remain in the least restrictive environment. As part of the development of a Person Centered Care Plan (PCCP), services shall be authorized which appropriately relate to the unmet needs of the participant, in accordance with provider availability and program eligibility. Individuals are not eligible to receive HCBS while residing in hospitals, Intermediate Care Facilities (ICF), or Skilled Nursing Facilities (SNF). HCBS are authorized for reimbursement through Medicaid for participants who meet specific program eligibility requirements. Medicaid funded HCBS are available through either State Plan services or through a Home and Community Based Waiver. States can choose to include certain HCBS in the State Plan Medicaid program or through a Waiver with the United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS).⁸

To view the Home and Community Based Services Manual, click [here](#).⁹

For information on the various types of waivers, click [here](#).¹⁰

NEW JERSEY

WellCare Health Plans Inc. has developed a comprehensive program to target prevention of long term institutionalization through identification of members at risk through; application of strategies aimed at prevention of institutionalization; and evaluation and measurement of program effectiveness in compliance with the State of New Jersey Managed Care and Quality Assurance & Performance Improvement (QAPI) activities. The current process shall not prohibit or delay a member’s access to nursing facility services when these services are medically necessary but is designed to support the member’s desire to remain in the community when appropriate.

Members at risk of institutionalization must meet at least 3 of the following:

- Prior history of nursing home placement in the last 5 years
- Reported impaired decision making
- Short term memory deficit
- Impaired ability to make self-understood or to understand
- Member exhibits behavioral issues (e.g., wandering, verbal abuse, physical abuse, inappropriate social behavior, resists care).
- Member requires assistance with Activities of Daily Living (ADLs).
- Member has had a decline in ADL status within the last 90 days.
- Member and/or family report bladder incontinence.
- Member requires assistance with ambulation or transfers.
- Wheelchair is the member’s primary mode of transportation.
- Member has a diminished ability to leave the house.
- Member has been diagnosed with Alzheimer’s disease.
- Member has a history of falling within last 90 days.

NOTE: Non-DDD members determined to be at-risk will be referred to MLTSS; please utilize the applicable internal referral form.

RISK OF INSTITUTIONALIZATION

Risk factors of institutionalization include the following:¹¹

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| <ul style="list-style-type: none"> • Cognitive Disorders • Developmental Disabilities • Progressive Neuromuscular Disorders • Multiple Co-Morbid Conditions • Non-Compliance with healthcare recommendations | <ul style="list-style-type: none"> • Frequent Emergency Department visits • Frequent Inpatient Admissions • Transfers to rehab facility • Frequent falls • Recent decline in health status • Caregiver stress and potential for burn out |
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- Lack of Social/Caregiver Support

Identification of Members at risk of institutionalization include:¹¹

- MLTSS Enrollees
 - Care manager (CM) assessment using the NJ Choice
 - Annually and when there is a change in condition
 - Triggers identified
 - Monitored through monthly report to keep aware
- For non-MLTSS enrollees
 - Risk Screen conducted at time of assessment for services
 - Every 6 months
 - Members at risk referred to MLTSS
- Member request for increase in services
 - For example, the Member's caregiver is hospitalized
- Identify Institutional Risk as a Problem on Care Plan
- Consider supports in place including:

○ Medical Day Care	○ PT/OT/ST
○ Emergency Response System (PERS)	○ DME (wheelchair, walker, bedside commode etc)
○ Caregiver Education and Training	○ Informal Supports
○ Caregiver Support Groups	○ Home-Based Supportive Care
○ Respite	

CLINICAL ASSESSMENT PROTOCOL (CAP)

A key aspect of interRAI assessment systems is written material designed to assist those involved in care planning to consider major issues triggered by the assessment. Typically these are referred to as “clinical assessment protocols,” or CAPs. Each assessment protocol has been produced by a team of expert authors, drawing on empirically tested strategies whenever possible. Assessment protocols help the clinician think through what is known about a given issue, how the problem is experienced by the individual, and why it is present. Assessment protocols also examine possible prevention and treatment options, and help the assessor evaluate whether a referral for further evaluation is needed. There are 27 individual CAPs organized by 4 categories: Functional Performance; Cognition and Mental Health; Social Life; and Clinical Issues).¹²

The interRAI assessment systems are person-centered assessment systems that inform and guide comprehensive care and service planning for specific settings and programs. Each assessment system consists of data collection form, user manual, Clinical Assessment Protocols (CAPs), CAP Triggers, and status and outcome measures. The assessment instruments enable Providers to identify, assess, and address key factors in the person's life, including function, health, social support, service use, and quality of life.¹²

NOTE: For New Jersey, the interRAI CAPs to guide Options Counseling (all assessors) and the Plan of Care (MCOs, PACE) will be used.¹²

NEW YORK

Medicaid Managed Care (MMC) provides a number of services for Members in addition to those received with a regular Medicaid plan. Services can be received without a referral from a PCP and include emergency care; family planning/HIV testing and counseling; and specific self-referral services. Types of services include:^{13,14}

- **Regular Medical Care** including office visits with a PCP, referrals to specialists, and vision/hearing exams
- **Preventive Care** such as well-baby and well-child care; immunizations/vaccines for children from birth through childhood; access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21 years; access to free needles and syringes; smoking cessation counseling; and HIV education and risk reduction

- **Maternity Care** including pregnancy care, provider/midwife and hospital services, newborn nursery care, and screening for depression during pregnancy and up to a year after delivery
- **Home Health Care** services are arranged by WellCare and include one medically necessary postpartum home health visit and additional visits as medically necessary for high-risk women. At least two visits are provided to high-risk infants (newborns). Other home health care visits are available as needed
- **Personal Care/Home Attendant/Consumer Directed Personal Assistance Services (CDPAS)** are arranged by WellCare. Services include assistance with bathing, dressing and feeding, help with preparing meals/housekeeping, plus home health aide and nursing tasks.
- **Personal Emergency Response System (PERS)** is an item worn by an individual in case of an emergency. To qualify for this service a Member must be receiving personal care/home attendant or CDPAS services.
- **Adult Day Health Care Services** are recommended by a PCP and can include: health education, nutrition, nursing and social services; help with daily living; rehabilitative therapy; pharmacy services; and referrals for dental and other specialty care
- **AIDS Adult Day Health Care Services** must be recommended by a PCP and include: general medical and nursing care; substance use supportive services; mental health supportive services; nutritional services; and socialization, recreational and wellness/health promotion activities.
- **Therapy for Tuberculosis** provides assistance in taking medication for TB and follow-up care
- **Hospice Care** helps Members and their families with their special needs that come during the final stages of illness and after death. Care is arranged by WellCare and provides support services and some medical services to Members expected to live for one year or less. Services are provided in the Member's home, a hospital, or nursing home. Children under age 21 who are getting hospice services can also receive medically needed curative services and palliative care.
- **Dental Care** is offered through a vendor specialized in providing high-quality dental services. Covered services include regular and routine dental services (e.g., preventive dental checkups, cleaning, X-rays, fillings) and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you.
- **Orthodontic Care** covers braces for children up to age 21 with a severe problem with their teeth (e.g., inability to chew food due to severely crooked teeth, cleft palate or cleft lip).
- **Vision Care** services are provided by an ophthalmologist, ophthalmic dispenser or optometrist. Coverage includes contact lenses, polycarbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Eye exams are generally provided every two years, unless medically needed more often. A new pair of glasses is offered every two years, or more often if medically needed. Specialist referrals are also given for eye diseases or defects.
- **Pharmacy** includes prescription drugs, over-the-counter (OTC) medicines, insulin and diabetic supplies, smoking cessation agents (including OTC products), hearing aid batteries, enteral formula, emergency contraception (6 per calendar year), and medical and surgical supplies.
- **Hospital Care** including inpatient and outpatient care, as well as lab, X-rays, and other tests
- **Emergency Care** services include procedures, treatments or services needed to evaluate or stabilize an emergency. Following an emergency, the Member may receive additional care (Post-Stabilization Services). Treatment may be received in the ER, an inpatient hospital room, or in another setting.
- **Specialty Care** includes services of other practitioners, including: occupational, physical and speech therapists; audiologists; midwives; cardiac rehabilitation; and podiatrists (for diabetic members).
- **Residential Health Care Facility Care (Nursing Home)** includes short-term, or rehab, stays and long-term care. Covered services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy, and speech-language pathology.

Related WellCare Guidelines

WellCare has a library of CPGs on a variety of behavioral, chronic, and preventive conditions including the following that relate to LTSS: *Cancer (HS-1034)*; *Fall Risk Assessment (HS-1033)*; *Frailty and Special Populations (HS-1052)*; *Managing Infections (HS-1037)*; *Neurodegenerative Disease (HS-1032)*; *Pain Management (HS-1064)*; *Palliative Care (HS-1043)*; *Pneumonia: HS-1062*; and *Traumatic Brain Injury (TBI) (HS-1066)*.

Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

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Disclaimer

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*Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
5/3/2018	<ul style="list-style-type: none"> • Approved by MPC. New.