



August 9, 2012

Ohio Department of Job & Family Services
Jay Easterling
Office of Contracts and Acquisitions
30 E. Broad Street
Columbus, Ohio 43215

RE: RFA # JFSR1213-07-0838
Ohio Integrated Care Delivery System (ICDS)

Dear Mr. Easterling:

On behalf of Carelink Health Plans, Inc., a subsidiary of Coventry Health Care, Inc. (Coventry), I am responding to your August 8, 2012 letter concerning RFA # JFSR1213-07-0838 Ohio Integrated Care Delivery System (ICDS). Pursuant to your request, Coventry is providing additional information for the following:

- 1) HCBS experience for the Missouri and Pennsylvania Medicaid lines of business in Appendix B, Part 1 – The attached documentation is contractually required by the Missouri and Pennsylvania Medicaid state agencies and demonstrates Coventry's experience in providing coverage of HCBS.
- 2) LTSS experience for the Florida Medicare line of business in Appendix D, Part A, D.1 Entry 3 – The attached Coventry Health Care of Florida, Inc. policy and procedure outlines the process for coordinating long term services and supports for the Florida Medicare Dual Eligible SNP members.

Thank you for the opportunity to provide additional information in response to RFA# JFSR1213-07-8038. Coventry looks forward to partnering with your office to meet the needs of Ohio ICDS members. If you have any questions regarding this application, please feel free to call me at (314) 705-2126.

Sincerely,

Claudia Bjerre
Senior Vice-President
Coventry Health Care, Inc.

Missouri Medicaid HCBS

PERSONAL CARE

PROGRAM DESCRIPTION

MO HealthNet Managed Care health plans are required to provide personal care services. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. Personal care services are tasks which assist an member in activities of daily living related to a stable chronic condition. Personal care services include basic personal care, advanced personal care, and authorized nurse visits. Personal care services are provided as a cost effective alternative to nursing home placement.

Basic Personal Care

Basic personal care services are services related to an member's physical requirements, such as assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. It also includes services essential to the health and welfare of the member, such as housekeeping chores like preparing meals, bed making, dusting, and vacuuming.

Examples of basic personal care services include but are not limited to:

- planning, preparation, and clean-up of meals;
- making beds and changing sheets;
- brushing, combing, and shampooing hair;
- giving bed baths and assisting with other baths; and
- brushing teeth and cleaning dentures.

Advanced Personal Care

Advanced personal care tasks are maintenance services provided to assist members when such assistance requires devices and procedures related to altered body functions.

Advanced personal care services are:

- routine personal care for members with ostomies and external, indwelling, and suprapubic catheters;
- removal of external catheters, inspection of skin and reapplication of same;
- administration of prescribed bowel programs;
- application of medicated lotions or ointments, and dry, non-sterile dressing to broken skin;
- use of a lift for transfer;
- assistance with oral medications;
- provision of passive range of motion; and
- apply non-sterile dressings to superficial skin breaks as directed by a

R.N.

Nurse Visits

Nurse visits provided by a RN or LPN in the personal care program are authorized to provide increased supervision of the aide, assessment of the member's health and the suitability of the care plan to meet the member's needs as well as referral and/or follow-up action. In addition, this service must include one or more of the following when appropriate to the needs of the member:

- fill a one week supply of insulin syringes;
- set up oral medication for an member who self-administers prescribed medications;
- monitor an member's skin condition when an member is at risk of skin breakdown;
- provide nail care for a diabetic or member with other medically contraindicating conditions;
- monthly assessments of the member's condition and the adequacy of the service plan for members receiving advanced personal care;
- provide task observation and certification to advanced personal care aides;
- other nursing services in other situations, subject to the needs of the member.

PROGRAM LIMITATIONS

Adults

Personal care services are provided as a cost effective alternative to nursing home placement. Federal law does not require that a physician prescribe personal care services. Personal care is available to an member who is assessed by the Department of Health and Senior Services, Division of Senior and Disability Services at a nursing home level of care. Members are considered eligible for personal care services when an initial in-home assessment completed on a DA-2 form scores 21 points or greater. The Service Plan (DA-3) and the Division of Senior and Disability Services , Home and Community Services map can be accessed through the MO HealthNet Division (MHD) web site by choosing the Personal Care Provider Manual. The map is included for use by the MO HealthNet Managed Care health plans when contacting the Division of Senior and Disability Services staff for assessments as discussed below.

MO HealthNet Managed Care health plans must provide all medically necessary personal care services. MO HealthNet Managed Care health plans must continue to provide personal care services to members who are receiving personal care services when they become enrolled in a MO HealthNet Managed Care health plan. It is at the option of the MO HealthNet Managed Care health plan to utilize the Division of Senior and Disability Services in performing assessments. MO

HealthNet Managed Care health plans can obtain a copy of the Client Assessment Form utilized by the Division of Senior and Disability Services by contacting the nearest office as indicated on the Home and Community Services map. MO HealthNet Managed Care health plans cannot reduce, discontinue or deny personal care services without an assessment performed by the Division of Senior Services Disability Services. In the event that the Division of Senior and Disability Services and the MO HealthNet Managed Care health plan disagree regarding the need or amount of personal care services, it will be the MO HealthNet Managed Care health plan's responsibility to present medical documentation, utilizing the DA-2 form, to the MHD medical review committee to support their finding. Service cannot be denied during the review period.

Maximum monthly payment for personal care services is limited to 100% of the average monthly fee-for-service cost for care in a nursing facility.

Children

Children under age 21 are determined to be in need of personal care services by medical necessity. Personal care needs for a child are demonstrated by their need for extra assistance in bathing, toileting, eating or other activities of daily living because of a medical condition. The fact that a child has a caretaker does not make him or her ineligible for personal care services. The primary caretaker may not be present to deliver the required services or may lack the time or ability to deliver the essential care.

The initial personal care plan for children is developed by a RN, unless the child is an member of the Department of Mental Health and has an Individual Habilitation Plan (IHP) which contains sufficient documentation of the need for personal care and the extent of the service required.

The following is a list of examples of medical problems that would meet the criteria for medical necessity for personal care services. This list is not exhaustive, and only provides a guideline of conditions.

Children who:

- have poorly controlled seizures, other than severe generalized tonic/clonic (grand mal) seizures;
- require assistance with orthotic bracing, body casts, or casts involving one full limb or more;
- are incontinent of bowel and/or bladder after age three;
- have persistent and/or chronic diarrhea, regardless of age;
- have significant central nervous system damage affecting motor control;
- have organically based feeding problems;
- require assistance with activities of daily living. This would apply to children unable to perform age appropriate functions of bathing,

maintaining a dry bed and clothing, toileting, dressing, and feeding. Children with a diagnosis of developmental delay or mental retardation may be eligible for personal care services;

- have immune deficiency diseases and metabolic diseases including AIDS.

MISCELLANEOUS

MO HealthNet Managed Care health plans may access the MO HealthNet Personal Care provider network to provide personal care services to eligible members.

The [Personal Care Program Provider Manual](#) , [Service Plan Supplement \(DA-3a\)](#), and Division of Senior and Disability Services, [Home and Community Services map](#) can be referenced online at the MO HealthNet Division website www.dss.mo.gov/mhd for additional information. [Special bulletins](#) may also be referred online for additional information.

Pennsylvania Medicaid HCBS

eliminated, implementation by the PH-MCO must be on the same day as the Department's, unless the PH-MCO is notified by the Department of an alternative implementation date. If the scope of services or consumers that are the responsibility of the PH-MCO is changed, covered services or the definition of eligible consumers is expanded or reduced, the Department will determine whether the change is sufficient that an actuarial analysis might conclude that a rate change is appropriate. If yes, the Department will arrange for the actuarial analysis, and the Department will determine whether a rate change is appropriate. The Department will take into account the actuarial analysis, and the Department will consider input from the PH-MCO, when making this determination. At a minimum, the Department will adjust the rates as necessary to maintain actuarial soundness of the rates. If the Department makes a change, the Department will provide the analysis used to determine the rate adjustment. If the scope of services or consumers that are the responsibility of the PH-MCO is changed, upon request by the PH-MCO, the Department will provide written information on whether the rates will be adjusted and how, along with an explanation for the Department's decision.

The Department has established benefit packages based on category of assistance, program status code, age, and, for some packages, the existence of Medicare coverage or a Deprivation Qualifying Code. In cases where the Member benefits are determined by the benefit package, the most comprehensive package remains in effect during the month the Consumer's category of assistance changes.

The PH-MCO may not arbitrarily deny or reduce the amount, duration or scope of a Medically Necessary service solely because of the Member's diagnosis, type of illness or condition.

2. In-Home and Community Services

The Pennsylvania Medicaid State Plan requires personal care services coverage for individuals under age 21. Personal care services may not be denied based on the member's diagnosis or because the need for assistance is the result of a cognitive impairment. The assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self.

A request for medically necessary in-home nursing services, home health aide services, or personal care services for a member under the age of 21 may not be denied on the basis that a live-in

caregiver can perform the task, unless there is a determination that the live-in caregiver is actually able and available to provide the level or extent of care that the member needs, given the caregiver's work schedule or other responsibilities, including other responsibilities in the home.

3. Program Exceptions

The PH-MCO is also required to establish a process, reviewed and approved by the Department, whereby a Provider may request coverage for items or services, which while included under the Recipient's benefit package, are not currently listed on the MA Program Fee Schedule. In addition to requests for items or services that are not on the MA fee schedule, the program exception process must be applied to requests to exceed limits for items or services that are on the fee schedule if the limits are not based in statute or regulation. These requests are recognized by the Department as a Program Exception and described in 55 Pa. Code 1150.63.

4. Expanded Benefits

The PH-MCO may provide expanded benefits subject to advance written approval by the Department. These must be benefits that are generally considered to have a direct relationship to the maintenance or enhancement of a Member's health status. Examples of potentially approvable benefits include various seminars and educational programs promoting healthy living or illness prevention, memberships in health clubs and/or facilities promoting physical fitness and expanded eyeglass or eye care benefits. These benefits must be generally available to all Members and must be made available at all appropriate PH-MCO Network Providers. Such benefits cannot be tied to specific Member performance. However, the Department may grant exceptions in areas where it believes that such tie-ins shall produce significant health improvements for Members. Previously approved tie-ins will continue to remain in effect under this Agreement, unless the PH-MCO is notified, in writing, by the Department, to discontinue the expanded benefit.

In order for information about expanded benefits to be included in any Member information provided by the PH-MCO, the expanded benefits must apply for a minimum of one full year or until the Member information is revised, whichever is later. Upon sixty (60)

Florida Medicare LTSS

Policy and Procedure

Policy Title:	Case Management	
Policy Number:	SNP.1000.301	Last Review Date: 7/30/2012
Business Unit:	Special Needs Plan (SNP)	
Organization:	<input checked="" type="checkbox"/> CHCFL <input checked="" type="checkbox"/> CHPFL <input checked="" type="checkbox"/> CSHP <input type="checkbox"/> CHLIC	
Product(s)/ Line(s) of Business:	<input type="checkbox"/> All Products <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial HMO <input type="checkbox"/> Commercial PPO <input type="checkbox"/> Healthy Kids <input type="checkbox"/> LTC <input checked="" type="checkbox"/> Other: <u>SNP</u>	

I. Policy Statement-

Case Management is a collaborative process by which the Health Plan facilitates coordination of care in the most cost-effective manner to ensure best possible outcome. Case Management process assesses, plans, implements, coordinates, monitors, and evaluates the services required to meet the client's health and human service needs. All members enrolled in the Special Needs Plan (SNP) will be enrolled in case management.

II. Purpose Statement

To identify, stratify, and manage SNP members to assure appropriate and timely coordination of services.

III. Definitions

SNP: Special Needs Plan
 HRA: Health Risk Assessment

IV. Procedure

All members enrolled into a SNP plan will be enrolled in case management

1. Monthly eligibility file will be uploaded into the case management system indicating new and terminated members
2. New members will be identified and queued for contact to complete a Health Risk Assessment (HRA)
3. Monthly data feed will be uploaded into the case management system containing:
 - Claims/encounter data
 - Hospital admission data
 - Pharmacy data.
 - Laboratory data

4. Member will be contacted to complete a telephonic evaluation via completion of the HRA that provides information on the individual's medical, physical, cognitive, psychological and functional needs. New members will be contacted within 90 days of enrollment
5. Annual reassessment is conducted through completion of an HRA.
6. A reassessment is conducted with any health status changes to compare changes from prior assessment(s).
7. Information obtained from the HRA along with clinical, claims, pharmacy, hospitalization, and lab data is input into the case management system for member stratification. An analysis is performed by a licensed nurse case manager to initiate an individualized care plan.
8. All member individualized care plans are presented to the Interdisciplinary Care Team for review and input.
9. Upon approval of the member's individualized care plan and based on tier level/stratification, a nurse case manager is assigned to a member. The nurse case manager establishes a relationship with the member, and/or the member's health care surrogate, treating physician(s), other providers and members of the interdisciplinary team. The nurse case manager becomes a care coach for the member; helping members navigate the health care system, assisting with benefit analysis, treatment options, referrals/authorizations, cost containment and health maintenance and promotions.
10. It is the responsibility of the nurse case manager to alert the interdisciplinary team of any changes to the member's health status in order to update the member's individualized care plan.
11. The nurse case manager documents interactions in the case management system.
12. The member's individualized care plan is maintained and updated in the case management system noting assessments, goals, interventions, and status (met/unmet), and any other applicable information
13. Member's primary care physician has access to member's individualized care plan via a secure web based portal.
14. Nurse case manager also identifies members who may qualify for disease case management and enrolls members into the appropriate disease management programs.
15. Nurse case managers will review benefit coverage to provide members with alternative resources where coverage issues arise or benefits are exhausted.

16. Social Worker is involved when implementing and coordinating case management activities relating to use of community resources and behavioral health issues.
17. If after 5 attempts member is unable to be reached telephonically, a letter is sent out to the member requesting to have him/her contact the SNP Case Management Department. An individualized care plan is created using the available information such as claims and/or encounter data, hospital admission data, pharmacy data, and laboratory data.

V. Policy History

- **Initial release date** – 3/1/2010
- **Reaffirmed date(s)** – 6/07/2012, 7/30/12
- **Revised date(s)** – 1/26/11
- **Retired date** – N/A

VI. Sources and References- None**VII. Related Procedures - None****VIII. Attachments-**

- **Sample Health Risk Assessment**
- **Sample Care Plan**

APPROVAL

[Signature of VP or higher]

Luisa Charbonneau

[Typed name of approver]

Approval Date: 3/1/2010