

# Fallon Health products

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Fallon Health offers a commercial HMO product, as well as a variety of other targeted products designed to meet the changing needs of our members.

To view benefit summaries, which includes all exclusions for the plans, please click on the links below in blue.

## **HMO plans**

With our HMO plans, Fallon Health members choose a primary care physician (PCP) from the health care options described below. Their PCP helps manage the member's care and arranges for all of their health care needs, including referrals to specialists. The only differences between these options are the choice of physicians and hospitals.

### ***Direct Care***

Direct Care members must choose a PCP from within the Direct Care provider network. Members who choose a Reliant Medical Group PCP may self-refer to any Reliant Medical Group specialist\*. All other groups will follow the same referral procedures for Direct Care as they do for Select Care. Prior authorization from the plan is required for all specialty services performed outside of the Direct Care network.

Direct Care coverage options include:

*Coinsurance options* – coinsurance is applied to most services, however only copayments apply to office visits.

[\*Deductible options\*](#) – reduce your monthly premiums through the use of an annual deductible for certain services. The deductible must be met before the plan begins to provide benefits.

[\*Inpatient copayment options\*](#) – no deductibles, but there is a copayment on hospital admissions.

[\*Qualified high-deductible options\*](#) – plans that can be partnered with a health savings account to help pay for out-of-pocket costs, giving you even more flexibility when it comes to cost savings.

Every Direct Care product includes a rich core of benefits and include [It Fits!](#), [Oh Baby!](#), the [Peace of Mind Program™](#) and [Naturally Well.](#)

### ***Steward Community Care***

Steward Community Care members must choose a PCP from within the Steward Community Care provider network. Members will follow the same referral procedures for Steward Community Care as they do for Direct and Select Care. Prior authorization from the plan is required for all specialty services performed outside of the Steward Community Care network.

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Steward Community Care coverage options include:

*Coinsurance options* – coinsurance is applied to most services, however only copayments apply to office visits.

[Deductible options](#) – reduce your monthly premiums through the use of an annual deductible for certain services. The deductible must be met before the plan begins to provide benefits.

[Inpatient copayment options](#) – no deductibles, but there is a copayment on hospital admissions.

[Qualified high-deductible options](#) –plans that can be partnered with a health savings account to help pay for out-of-pocket costs, giving you even more flexibility when it comes to cost savings.

Every Steward Community Care product includes a rich core of benefits and include [It Fits!](#), [Oh Baby!](#), and [Naturally Well](#).

## **Select Care**

Select Care is Fallon’s largest HMO product network. Members choose a PCP from the Select Care network. Members who choose a Reliant Medical Group PCP may self-refer to any Reliant Medical Group specialist\*. Select Care members with any other PCP must obtain a PCP referral to receive specialty care.

Select Care coverage options include:

*Coinsurance options* – coinsurance is applied to most services, however only copayments apply to office visits.

[Deductible options](#) – reduce your monthly premiums through the use of an annual deductible for certain services. The deductible must be met before the plan begins to provide benefits.

[Inpatient copayment options](#) – no deductibles, but there is a copayment on hospital admissions.

[Qualified high-deductible options](#) –plans that can be partnered with a health savings account to help pay for out-of-pocket costs, giving you even more flexibility when it comes to cost savings.

Select Care products include a rich core of benefits and include [It Fits!](#), [Oh Baby!](#) and [Naturally Well](#), each of which is described below and on [www.fallonhealth.org](http://www.fallonhealth.org).

\* Specialty care providers include physicians, physician assistants, nurse practitioners and nurse midwives.

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## **Qualified high deductible plans**

Fallon Health is pleased to offer our members a wide variety of qualified high deductible health plan (HDHP) options. A qualified high-deductible health plan contains certain deductible and design requirements set by the IRS. This allows the participant in the qualified plan to participate in a health savings account (HSA), a tax-advantaged way to help pay for current or save for future medical expenses. All of Fallon Health's qualified high deductible plans fall under the name, "QHD" and are built off our existing products as product options. For example, a member participating in Direct Care with a qualified high deductible health plan option will be enrolled in 'Direct Care QHD'.

## **Tax-advantaged accounts**

There are several different types of tax-advantaged accounts approved by the IRS to help pay for qualified medical expenses. They include:

### ***Flexible Spending Accounts (FSA)***

Flexible Spending Accounts (FSAs) are the oldest type of tax-advantaged account. These accounts are owned by the Employer and typically funded by the employee with a pre-tax payroll deduction. Employees can use these funds to pay for qualified medical expenses. If the funds are not used during a specific time frame, they are no longer available for use by the employee. This is often referred to as the 'use-it-or-lose-it' provision to FSAs. There are no restrictions on the type of health plan a member must be enrolled in to open an FSA. Contribution limits are set by the employer.

### ***Health Savings Accounts (HSA)***

Health Savings Accounts (HSAs), introduced in 2004, are a form of tax-advantaged account. Members must be enrolled in a qualified high deductible health plan (HDHP) to be eligible to open an HSA. Both employers and employees can contribute to HSAs, however, the funds are owned by the employee and should they change jobs, are portable. Members can choose to use the funds for non-qualified medical expenses, however they must pay a 10% penalty in addition to taxes on the withdrawal amount. Funds do roll over from year to year and members who open a health savings account will receive tax advantages on contributions, withdrawals and any interest earned on the account. Contribution limits are set by the IRS and indexed annually. Fallon has partnered with Sovereign Bank as our preferred HSA vendor.

### ***Health Reimbursement Accounts (HRA)***

Health Reimbursement Accounts (HRA) are another form of tax-advantaged account. While members can open an HRA with any type of health plan, they are most commonly used in conjunction with a HDHP. These funds are owned and funded by the employer and the employer can choose what qualified medical expenses will be covered by the HRA. Funds can rollover from year to year.

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## Preferred Provider Organization (PPO)

### ***Fallon Preferred Care***

Fallon Preferred Care is a preferred provider organization (PPO) product that offers nationwide access to more than 1,000,000 providers through Multiplan and Fallon Health & Life Assurance Company (FHLAC). Members may self-refer to any provider, but prior authorization is required for the following:

- Nonemergency inpatient admissions
- Same-day surgeries
- Hospice services
- Infertility services
- Organ transplants
- Nonemergency transportation
- Prosthetic/orthotic devices and durable medical equipment
- Genetic testing
- Neuropsychological testing
- Speech therapy services
- Anesthesia for GI endoscopy procedures
- Habilitative or rehabilitative care, including but not limited to ABA therapy
- Therapeutic care
- Oral surgery (with the exception of the extraction of impacted teeth)
- Enteral formulas and special medical formulas
- High-tech radiology, including, but not limited to, all outpatient MRI/MRA, CT/CTA, PET and nuclear
- cardiology imaging studies
- Sleep study and/or sleep therapy
- Injections and injectables that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a plan provider
- Reconstructive and restorative services
- Oxygen
- Outpatient mental health services (including intermediate care), beyond eight sessions

All Fallon Preferred Care plan options include copayments, deductibles and coinsurance. Providers are contracted with FHLAC, which directly contracts with Fallon Preferred Care providers and facilities to make up the primary network in Massachusetts and Multiplan. The member benefits are explained in the Evidence of Coverage/Member Handbook. If a provider has a contract with both FHLAC and PHCS, the terms of the FHLAC agreement prevail unless otherwise specified in the individual provider contract.

Most medical management functions for Fallon Preferred Care will be managed by Fallon Health for Massachusetts residents and American Health Holdings for out of state residents. Members will be issued unique identification cards including the Multiplan logo. The Customer Service telephone number and the Medical Management telephone number for Massachusetts PPO members is 888-468-1541. The Customer Service telephone number for non-Massachusetts PPO members is 888-468-1541 and the Medical Management telephone number for non-Massachusetts PPO members is 866-353-1787.

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Fallon Preferred Care members must use the CVS/CAREMARK network. PPO members must follow the prescription drug formulary found online at [www.fallonhealth.org](http://www.fallonhealth.org). It is important to note, however, that Multiplan is not contracted with CVS/CAREMARK Specialty Services.

Therefore, drugs covered under the medical benefit, generally injectibles that are administered in a physician's office or under other professional supervision, must be obtained by the provider and then billed to Fallon Health & Life Assurance Company on a claim form from the provider rather than a specialty vendor. Claims should be sent to Fallon Health & Life Assurance Company, P.O. Box 15207, Worcester, MA 01615-0207.

Like our HMO products, Fallon Preferred Care has several plan design options available:

*Coinsurance options* – coinsurance is applied to most services, however only copayments apply to office visits.

*Deductible options* – reduce your monthly premiums through the use of an annual deductible for certain services. The deductible must be met before the plan begins to provide benefits.

*Inpatient copayment options* – no deductibles, but there is a copayment on hospital admissions.

*Qualified high-deductible options* – plans that can be partnered with a health savings account to help pay for out-of-pocket costs, giving you even more flexibility when it comes to cost savings.

Every Fallon Preferred Care product includes a rich core of benefits and include It Fits!, Oh Baby!, \$0 routine in-network physicals and Naturally Well.

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## **Bonus features**

With the exception of the Peace of Mind program, the following bonus features are available to Steward Community Care, Direct Care, Select Care and Fallon Preferred Care members. Please note that these features may also be available for other Fallon Health products on an exception basis and may vary by employer.

### ***It Fits!***

Eligible Fallon Health members (excludes members enrolled in MassHealth) can get reimbursed ) for participating in a variety of healthy activities: streaming fitness programs, Peloton subscriptions, membership at local fitness centers, aerobics, Pilates and yoga classes (by a certified instructor), certain home fitness equipment, Weight Watchers<sup>®</sup> programs, and local town and school sports programs for all ages (when they include an aerobic and instructional component). Reimbursement amount varies depending on the member's plan.

Members wishing to use this benefit must fill out a copy of the It Fits! reimbursement form. Proof of payment for all activities and memberships will be required and is explained on the reimbursement form.

### ***Oh Baby!***

Oh Baby! is a health and wellness program available at no additional cost to eligible members who are either expecting or adopting a child. The Oh Baby! program includes:

- Prenatal vitamins and information about prenatal care
- A convertible car seat
- A breast pump
- The American Academy of Pediatrics' book, Caring For Your Baby and Young Child: Birth to Age 5 or a temporal thermometer
- Reimbursement toward the cost of childbirth classes
- A home safety kit for childproofing your home
- Lactation support and counseling services reimbursement

Members who would like to learn more should call Customer Service at 1-800-868-5200. MassHealth ACO members should call MassHealth Customer Service at 1-800-341-4848.

### ***Naturally Well***

Naturally Well provides all Fallon members with discounts on acupuncture, chiropractic care (in addition to any chiropractic benefit their plan may have) and massage therapy from the American Specialty Health. (ASH) credentialed network of qualified providers. Health and wellness products also are available at a reduced rate through ChooseHealthy, an affiliate of ASH. The services and products are not covered benefits under their health plan coverage, but are instead offered as an extra value if they wish to use them. For more information, members can view the program at [www.choosehealthy.com/FCHP](http://www.choosehealthy.com/FCHP).

### ***Healthwise<sup>®</sup> Knowledgebase***

Fallon Health has introduced the Healthwise Knowledgebase to its website, [www.fallonhealth.org](http://www.fallonhealth.org). With this tool, for example, all your Fallon patients may research diagnosed conditions, medications and treatment options. The content is generated from a

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variety of reliable resources, including the National Cancer Institute, the National Organization of Rare Disorders and the American Self-Help Clearinghouse.

Healthwise<sup>®</sup> Knowledgebase is a reliable, comprehensive resource to help people be informed about their health care. Informed patients are more likely to understand their condition and take better care of themselves, as well as develop a more interactive relationship with their doctors.

## ***Peace of Mind Program***<sup>™</sup>

The Peace of Mind<sup>™</sup> Program allows Direct Care members access to specialty services at the following Boston area medical centers: Massachusetts General Hospital, Beth Israel Deaconess Medical Center, Brigham and Women's Hospital, Children's Hospital Boston, Dana-Farber Cancer Institute, Tufts Medical Center and Massachusetts General Hospital. Members must first see an in-network specialist for the same condition within the past three months. The PCP must request prior authorization from Fallon in order for the member to see a POM specialist. Additional details on the Peace of Mind<sup>™</sup> Program can be found within the member's Evidence of Coverage.

Direct Care members already have access to Tufts Medical Center, if they receive a referral from their PCP. However, if they do not receive a referral, they can still use their Peace of Mind benefit to access a second opinion and specialty care at Tufts Medical Center and the other five Boston facilities within the program.

The Peace of Mind Program is **not available** for members enrolled in MassHealth ACO, , Steward Community Care, Select Care, Fallon Preferred Care or Fallon Medicare Plus

The benefits listed here are standard for most Fallon Health HMO/ACO plan members. Some groups have exceptions, which may include varying levels of benefits and deductibles. The office visit copayments vary. View the Summary of benefits for our HMO products at: <http://fchp.org/employers/general-plan-information/benefit-summaries.aspx>

## ***Eyewear Discounts***

Fallon members (excluding MassHealth ACO) receive eyewear discounts at many of the EyeMed contracted optical centers listed online at <https://www.fchp.org/en/members/benefits-coverage/vision-care.aspx>. The discounts include 35% off frames and discounts on lenses when a pair of prescription glasses is purchased. Nonprescription sunglasses are discounted 20%. Members can also receive a 15% discount off regular pricing for LASIK procedures and 5% off promotional pricing for LASIK procedures.

MassHealth ACO members have the vision care component (non-medical component) covered by MassHealth. **Vision Care is defined as (non-medical component)** the prescription and dispensing of ophthalmic materials, including eyeglasses, contact lenses and other visual aids.



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## ***Summary of Benefits***

All of the Benefit Summaries and Summaries of Benefits and Coverage (SBCs) for Fallon Health's Commercial HMO and PPO plan designs can be found at:

<http://fchp.org/employers/general-plan-information/benefit-summaries.aspx>.

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## **Fallon Medicare Plus™ HMO (Medicare Advantage)**

Fallon Medicare Plus offers people with Medicare comprehensive products including plans with and without Part D prescription drug coverage. We have a number of plans to fit different needs. Below is an overview of the benefits for each of the Medicare Advantage HMO plan type for individual consumers.

Fallon Medicare Plus HMO plans for individuals have a range of premiums. The monthly plan premium and the level of benefit coverage vary by plan choice and by county. Our Fallon Medicare Plus Retiree Group premiums also vary by Group.

Our Medicare Advantage HMO plans offer comprehensive coverage and more benefits than member would get with Original Medicare alone. We offer two provider networks with our Medicare Advantage HMO plans:

- Fallon Medicare Plus and Fallon Medicare Plus Central

**Fallon Medicare Plus Central** is available only to residents of Worcester County. Members receive care and services from a tailored selection of providers based in the central part of the state.

**Fallon Medicare Plus** is available to all eligible plan members. This network includes all of our contracted providers throughout the state – from Boston to the Berkshires.

Our HMO plans for individuals are:

- Fallon Medicare Plus Central Orange HMO (Worcester county only)
- Fallon Medicare Plus Central Green HMO (Worcester county only)
- Fallon Medicare Plus Central Blue HMO (Worcester county only)
- Fallon Medicare Plus Orange HMO
- Fallon Medicare Plus Green HMO
- Fallon Medicare Plus Blue HMO
- Fallon Medicare Plus Super Saver HMO
- Fallon Medicare Plus Saver No Rx HMO

Fallon also offers Medicare Employer Group HMO plans for Medicare-eligible retirees/employees and their spouses. Our Fallon Medicare Plus Medicare Advantage Group Retiree premiums also vary by Group.

Our HMO plan for employer groups are:

- Fallon Medicare Plus Premier HMO
- Fallon Medicare Plus Central Premier HMO (Worcester County only)
- Fallon Medicare Plus Premier No RX HMO
- Fallon Medicare Plus Central Premier No RX HMO (Worcester County only)

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## ***Our HMO provider networks***

With our Fallon Medicare Plus (HMO) provider network, members can choose from thousands of doctors and facilities located across Massachusetts – from Boston to the Berkshires. With Fallon Medicare Plus Central (HMO) provider network, member receive care and services from a limited selection of providers in Worcester County. HMO members choose a primary care physician (PCP) from the network. The PCP coordinates all of the member’s care and provides referrals, if required, to see a specialist.

## ***Benefits overview***

Our HMO plans include:

- Benefit Bank – a card that can be used to pay for dental care, hearing aids, fitness membership and/or eyewear (not available with Super Saver HMO or Saver No Rx HMO)
- **Preventive and comprehensive dental care** with most plans - in addition to the Benefit Bank
- **Worldwide emergency coverage**
- **Free SilverSneakers®** gym membership with most plans – in addition to the Benefit Bank
- Free 13-consecutive week WW® (formerly Weight Watchers) membership
- **Vision care**, including \$150 toward eyeglasses, every year – in addition to the Benefit Bank
- **Free annual routine hearing exam** and hearing aid benefit – in addition to the Benefit Bank
- **Free preventive services including a routine annual physical exam**

*SilverSneakers® is a registered trademark of Tivity Health, Inc..*

Members of our Medicare Advantage Group HMO plans (Fallon Medicare Plus Premier HMO) also access the Fallon Medicare Plus and Fallon Medicare Plus Central (HMO) provider networks. Most employer group plans include enhanced drug coverage with no coverage gap and additional benefits that vary by group.

## ***Provider promotional activities & communications with Fallon Medicare Plus members on behalf of Fallon Health.***

Contact your provider relations representative in the event you would like to develop informational materials for FMP members or other Medicare beneficiaries. Such communications are subject to CMS review and approval in accordance with 42 CFR §422.80(a) – (c).

If you have any questions regarding the following activities, please call your provider relations representative to discuss the guidance provided in the current version of the Medicare Marketing Guidelines:

- 70.8 - Marketing/Sales Events
- 70.8.1 - Additional Guidance for Marketing Events in the Provider Setting
- 70.8.2 Plan Activities and Materials in the Health Care Setting
- 70.8.3 Provider-based Activities

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- 70.8.4 Provider Affiliation Information
- 70.8.6 Comparative and Descriptive Plan Information
- 70.8.7 Comparative and Descriptive Plan Information Provided by a Non-Benefit/Service Providing Third-Party
- 70.8.8 Providers/Provider Group Web Sites
- 70.5.1 - Specific Guidance on Third-party Contact
  - Leads from Providers strictly prohibited:
    - i. FALLON and Fallon contracted providers are responsible for following all Federal and State laws regarding confidentiality and disclosure of patient information to plan sponsors for marketing purposes.

This obligation includes compliance with the provisions of the HIPAA privacy rule and its specific rules regarding uses and disclosures of beneficiary information.

### ***Evidence of Coverage (EOC)***

An EOC is a booklet that we provide to members. It's part of their contract with us and it describes their complete benefits as well as how to use the plan.

Fallon Medicare Plus: <http://www.fchp.org/en/find-insurance/medicare/documents-forms.aspx>

Please contact Fallon Health for Medicare Group EOCs because the benefits vary by group.

### ***Fallon Medicare Plus™ Medicare Supplement***

Fallon Medicare Plus offer three Medicare Supplement plans, “Core” and “1” were launched in 2011, and “1A” was offered beginning January 1, 2020 in accordance with the Medicare Access and CHIP Reauthorization Act (MACRA) Federal regulations. Members pay a higher premium than our very popular Medicare Advantage HMO plans so that they have more flexibility. They pay little to nothing for health care expenses such as deductibles, coinsurance and other services that are not covered after Medicare has covered its portion of the costs. A brief summary of benefits is listed in the table below.

Our three Medicare supplement plans have different levels of coverage and premiums. With Medicare Supplement plans, there are no networks, members do not have to designate a PCP and they can see any Medicare provider without referrals. For more details about this product, call our Provider Services Department at 1-866-275-3247, prompt 4.

For more information, visit <http://www.fchp.org/find-insurance/medicare-supplement.aspx>

### ***Fallon Medicare Plus™ Freedom (WRAP)***

**Fallon Medicare Plus™ Freedom is our coast-to-coast health care coverage solution** for Medicare-eligible retirees, whether they live in Wellfleet or West Palm Beach.

With Fallon Medicare Plus Freedom, members get more benefits than they would with Original Medicare alone. And, with no provider network, plan members have the freedom to see any provider who accepts Medicare and is most convenient for them.

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Fallon Medicare Plus Freedom acts as a secondary payer for Medicare-approved services, and covers costs not paid by Medicare for services such as:

- Doctor office visits
- Tests and screenings, including X-rays and labs
- Hospital admissions
- Durable medical equipment, including wheelchairs and oxygen
- Emergency care inside and outside the U.S.

Fallon Medicare Plus Freedom plan options include those with and without prescription drug coverage.

Fallon Medicare Plus Freedom also includes the It Fits! Benefit – a **\$200 annual fitness reimbursement** that members can use for anything from streaming fitness programs and Peloton subscriptions to gym memberships of their choice, yoga classes, race fees and ski lift tickets.

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## **NaviCare®**

NaviCare is the product name for Fallon Health's Senior Care Options program. It provides coordinated care and coverage for seniors who are 65 or older, live in the service area and are eligible for MassHealth Standard. Plan benefits include all Medicare and Medicaid benefits, such as physician office visits, prescription and over-the-counter drugs as well as transportation to physician appointments. With NaviCare members receive a comprehensive package of medical, social and long term care services and there are no premiums, co-payments or coinsurance for the member. A team of doctors, nurses, social workers and other health care professionals work together to build a personalized care plan for each enrollee.

NaviCare® HMO SNP is for seniors who:

- Are 65 or older
- Live in the service area
- Have Medicare Parts A and B, and MassHealth Standard

NaviCare® SCO is for seniors who:

- Are 65 or older
- Live in the service area
- Have MassHealth Standard  
(and may have Medicare Parts A and B)

## ***NaviCare® resources***

- <http://www.fchp.org/providers/criteria-policies-guidelines/navicare-clinical-initiatives.aspx>
- <http://www.fchp.org/~media/Files/ProviderPDFs/adultimmunesched.ashx?la=en>

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## MassHealth ACO

Please review MassHealth Coverage Lists (starting on the following page) for more information:

Individuals enrolled with Fallon through the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS), are enrolled in one of the following Accountable Care Organizations (ACO); Berkshire Fallon Health Collaborative, Wellforce Care Plan, Fallon 365 Care; Descriptions and contact information for each of the ACOs are included later in this section.

Fallon Health members who are enrolled through MassHealth have some nonstandard benefits that provide additional coverage for some services through Fallon. Fallon also coordinates access to additional coverage through MassHealth.

### **Contact Information:**

The Fallon Health MassHealth Customer Service Department is available to assist members and member prospects with their servicing needs. The direct telephone number is 800-341-4848. TDD/TTY access for those who are hearing impaired is 877-608-7677.

Providers with questions should call the toll free provider service line at 866-ASK-FCHP (866-275-3247).

MassHealth contact numbers and hours of operation:

- MassHealth Member Customer Service Center 1-800-841-2900  
Hours of operation: 8AM-5PM
- MassHealth Dental Customer Service Center 1-800-207-5019  
Hours of operation: 8AM-5PM
- MassHealth Provider Services 1-800-841-2900  
Email: [providersupport@mahealth.net](mailto:providersupport@mahealth.net)  
Hours of operation: 8AM-5PM
- MassHealth Eligibility Verification System (EVS) Provider Help Desk  
1-800-462-7738

### **Verifying eligibility**

Fallon requires verifying the eligibility of MassHealth members. Please refer to the online eligibility tool at [www.fallonhealth.org](http://www.fallonhealth.org), or call the MassHealth Customer Service Department at 1-800-341-4848 (TDD/TTY: 1-877-608-7677).

Learn more at <https://www.mass.gov/how-to/check-member-eligibility>

### **MassHealth ACO**

Fallon has partnered with hospitals, health care providers and community health centers across the state to create three ACO Partnership Plans to better serve MassHealth patients:

- **Berkshire Fallon Health Collaborative**—a partnership with Berkshire Health Systems, Community Health Programs and several Berkshire County community physician practices. Learn more at [fallonhealth.org/Berkshires](http://fallonhealth.org/Berkshires).
- **Fallon 365 Care**—a partnership with Reliant Medical Group and other community providers. Learn more at [fallonhealth.org/365care](http://fallonhealth.org/365care).

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- **Wellforce Care Plan**—a partnership with Wellforce, which is made up of physicians and other health care providers from, or affiliated with: Circle Health; Floating Hospital for Children at Tufts Medical Center; Hallmark Health; Lawrence Memorial Hospital of Medford; Lowell Community Health Center; Lowell General Hospital; Lowell General Physician Hospital Organization; Melrose-Wakefield Hospital; New England Quality Care Alliance (NEQCA); and Tufts Medical Center. Learn more at [fallonhealth.org/wellforce](https://fallonhealth.org/wellforce).

## ***MassHealth covered services lists***

- [Fallon 365 ACO Covered Services](#)
- [Wellforce ACO Covered Services](#)
- [Berkshire ACO Covered Services](#)

## ***Access standards for MassHealth members***

### ***Geographic access standards***

Under contract with the EOHHS, Fallon must ensure adequate access to covered services for all MassHealth members and facilitate access to non-Fallon covered services. Adequate access shall include physical, telephone and geographic access including:

#### **a. Physical Health Services**

- Primary Care services - within 15 miles or 30 minutes travel time from an Enrollee's residence.
- Acute inpatient services—within 15 miles or 30 minutes travel time from an Enrollee's residence. MassHealth access standard requirement is 20 miles or 40 minutes.
- Rehabilitation hospital services—within 30 miles or 60 minutes travel time from an Enrollee's residence
- Urgent care services—within 15 miles or 30 minutes travel time
- Other Physical Health Services—shall meet the usual and customary community standards for accessing care

#### **b. Behavioral Health Services**

- Inpatient Services—within 60 miles or 60 minutes travel time from the Enrollee's residence, whichever requires less travel time.



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- All other services—within 30 miles or 30 minutes travel time from the Enrollee’s residence, whichever requires less travel time.
- For a listing of ESP and CSA locations, refer to the Managing Patient Care Section - Behavioral Health.

## **Waiting time standards**

<b>Accessibility of Service</b>	<b>Standard</b>
<b>A. Physical Health Service</b>	
1. Preventative and Primary Care- (Annual Physical or new patient examination)	1. Within 30 calendar days
2. Primary Care Services- Routine and Regular Care (Urgent Symptomatic, Non-Urgent Symptomatic and Non-Symptomatic Office Visit)	2. Within 48 hours of member’s request for urgent care; within 10 calendar days of member’s request for non-urgent symptomatic care; and within 45 calendar days of member’s request for non-symptomatic care
3. Specialty Care Services	3. Within 48 hours of member’s request for urgent care; within 30 calendar days of member’s request for non-urgent symptomatic care; and within 60 calendar days of member’s request for non-symptomatic care
4. Emergency Care*	4. Available 24 hours/days 7 days/week
5. After-Hours Care	5. 24 hours/day
6. After-Hours Telephone Response	6. Within 2 hours for the return call
7. For members newly placed in the care or custody of the Department of Children and Families (DCF)	7. DCF health care screening within 7 calendar days, and initial comprehensive medical examination within 30 calendar days

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All other services	8. In accordance with usual and customary community standards
<b>B. Behavioral Health Services</b>	
1. Emergency Services (Including Life Threatening Emergency Needs)	1. Immediately (24 hours/days 7days/week)
2. Non-life threatening emergency	2. Within 6 Hours
3. Emergency Service Programs (ESP)	3. 24/7
4. All other behavioral health services (including Routine and follow-up)	4. Within 10 business days
5. Behavioral Health URGENT Appointments	5. Less than 48 hours

*\*Emergency care defined by the “Prudent Layperson” definition.*

For enrollees newly placed in the care or custody of the Department of Children and Families (DCF), a DCF health care screening shall be offered within 7 days of receiving the request from a DCF case worker. Within 30 calendar days of receiving a request from a DCF case worker, a comprehensive medical examination, including all age appropriate screenings shall be offered at a reasonable time and place.

### **Fluoride varnish coverage for MassHealth members**

Effective October 1, 2008 physicians and other qualified health care professionals\* may apply fluoride varnish to eligible MassHealth members under age 21. It’s expected that this procedure would occur during a pediatric preventive care visit. The goal is to increase access to preventive dental treatment in an effort to prevent early childhood cavities in children at moderate to high risk for dental decay.

*\* Physicians, physician assistants, nurse practitioners, registered nurses and licensed practical nurses who complete the required training.*

### **Eligible members**

Fluoride varnish application is primarily intended for children up to age 3, but is allowed for children up to age 21 in those instances where the member doesn’t have access to a dentist. No more than one application every 180 days is recommended from first tooth eruption (usually at six months) to the third birthday. Members must meet the following three criteria to be eligible:

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- 1) The member is under the age of 21;
- 2) The member is eligible for dental services; and
- 3) The service is medically necessary as determined by a Caries Assessment Tool.

Providers must bill Fallon with CDT code D1206 on the CMS 1500 form. Please refer any MassHealth member who is without a dental provider to an appropriate dental service provider for ongoing preventive care. Please call us at the number below if you need assistance in locating a dental provider.

## **Required training**

We've approved the following training programs for providers who want to apply fluoride varnish to our eligible members. You may self-administer either the American Association of Pediatric Oral Health Group's online training on Cavity Risk Assessment at <http://www.aap.org/commpeds/dochs/oralhealth/cme> or the Smile for Life program at <http://www.stfm.org/oralhealth>. Providers must maintain proof of their completed training and provide Fallon with documentation upon request. If you have any questions about this MassHealth service, please contact Fallon Provider Relations at 1-866-275-3247, prompt 4.

## **Special formula (enteral-nutrition products)**

MassHealth and its contracted Accountable Care Organizations (ACO) have primary responsibility for payment of enteral-nutrition products (special formula) that are medically necessary and are not covered by the Massachusetts Department of Public Health's (DPH) Women, Infants and Children (WIC) nutrition program.

In an effort to provide a more streamlined and standardized process for requesting Prior Authorization (PA) for special formula, the MassHealth ACOs: Be Healthy Partnership, **Berkshire Fallon Health Collaborative (BFHC)**, BMC HealthNet Plan Community Alliance, BMC HealthNet Plan Mercy Alliance, BMC HealthNet Plan Signature Alliance, BMC HealthNet Plan Southcoast Alliance, Community Care Cooperative (C3), **Fallon 365 Care**, My Care Family, Partners HealthCare Choice, Steward Health Choice, Tufts Health Together with Atrius Health, Tufts Health Together with BIDCO, Tufts Health Together with Boston Children's ACO, Tufts Health Together with CHA, **Wellforce Care Plan**, have collectively adopted a standardized, slightly revised version of the [Combined MassHealth Managed Care Organization Medical Necessity Review For Enteral Nutrition Products \(Special Formula\)](http://www.fchp.org/~media/Files/FCHP/Imported/SpecialFormulaForm.pdf.ashx?la=en).  
<http://www.fchp.org/~media/Files/FCHP/Imported/SpecialFormulaForm.pdf.ashx?la=en>

In addition to Fallon's pharmacy network, enteral products can be obtained through various contracted Medical Supply Companies, please contact provider services to find out who is contracted at 1-866-275-3247, prompt 4.

To learn more about the Guidelines to Medical Necessity Determination for Enteral Nutrition Products, please access the following link:

<https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-enteral-nutrition-and-special>

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## **Overview**

EPSDT and PPHSD are, collectively, the preventive care and treatment services that Fallon covers for our MassHealth members under the age of 21. Fallon pays for these members to see their primary care doctors or nurses on a periodic schedule. At these visits, primary care doctors and nurses perform a series of health screenings. If the member screens positive, Fallon pays for further assessment, diagnosis, and treatment services. Fallon also pays for members under the age of 21 to visit their primary care doctor or nurse between periodic visits (interperiodically) any time there might be something wrong.

MassHealth ACO members are entitled to EPSDT services, Fallon pays for all medically necessary assessment, diagnosis, and treatment services that are covered by federal Medicaid law. If the services are not described in a contract, regulation, or procedure code covered for the MassHealth member's coverage type, please contact Care Services at 1-866-275-3247, prompt 3, to obtain plan prior authorization.

MassHealth has updated its EPSDT regulations and accordingly, Fallon providers must comply with these regulations. The changes and enhancements include:

- In addition to MassHealth Standard members under 21, MassHealth CommonHealth members under 21 are entitled to EPSDT services.
- Behavioral health (mental health and substance abuse) and developmental screenings in the list of screening services covered during an EPSDT or PPHSD visit.
- Mandate that primary care providers offer to conduct EPSDT and PPHSD screenings according to the EPSDT Periodicity Schedule, as described in the Fallon Provider Manual, and provide or refer such members to assessment, diagnosis and treatment services, as necessary.
- Providers requesting prior authorization for EPSDT services, for members enrolled in Fallon, should fax the completed Request For Preauthorization form to the Care Service Review Department at (508) 368-9700. Please refer to the Procedure Code Look-up Tool located on the Fallon website to determine if a procedure code/codes require preauthorization. Providers may also direct inquiries to the Fallon Provider Services line by calling 866-275-3247, select option #4.

The EPSDT Periodicity Schedule has been revised to update the procedures for conducting hearing, developmental and behavioral health screening, and the sources of anticipatory guidance provided at periodic and interperiodic EPSDT and PPHSD visits. This information can be found in the Fallon Provider Manual. The EPSDT/PPHSD Screening Services Codes have been revised to update the list of Current Procedural Terminology (CPT) codes that are reimbursable for laboratory services, hearing tests, and vision tests during a periodic or interperiodic EPSDT or PPHSD visit. A new mandated code has been added for the behavioral health screenings.

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## ***Mandate for Primary Care Providers to Offer to Conduct EPSDT/PPHSD Screenings and Refer Members for Further Diagnosis and Treatment***

Fallon is requiring all primary care providers to offer to conduct periodic and medically necessary interperiodic EPSDT and PPHSD screenings for Fallon MassHealth Standard and CommonHealth members under the age of 21 according to the EPSDT Periodicity Schedule. MassHealth is also requiring primary care providers to provide or refer members to needed assessment, diagnosis and treatment services.

Fallon is defining “primary care providers” as:

- General practitioners
- Family physicians
- Internal medicine physicians
- Pediatricians
- OB/Gyns
- Nurse practitioners

These providers must offer to conduct screenings when they practice in an individual or group practice, in the outpatient department of a hospital (acute or chronic and rehabilitation hospital) or in a community health center. Primary care services do not include emergency or post stabilization services provided in a hospital or other setting. Therefore, primary care providers are not required to offer to conduct screenings according to the EPSDT Periodicity Schedule, when practicing in those settings.

### Developmental and Behavioral Health Screenings

In particular, Fallon is expressly including developmental and behavioral health (mental health and substance abuse) screenings in the list of EPSDT/PPHSD screenings.

Fallon has incorporated the revised EPSDT Periodicity Schedule to require that providers choose a clinically appropriate behavioral health screening tool from a menu of approved, standardized tools when conducting a behavioral health screening at a periodic or interperiodic visit. These standardized behavioral health screening tools are described in more detail below.

### **Menu of Standardized Behavioral Health Screening Tools**

The menu of behavioral health screening tools that primary care providers must use during EPSDT and PPHSD visits is published below. These tools accommodate a range of ages while permitting some flexibility for provider preference and clinical judgment.

For your convenience, the menu of approved tools is reproduced in Table 1, “Behavioral Health Screening Tools,” along with a description of who completes the tool and the appropriate age group for the tool. Please note that Table 1 is for your information only. The EPSDT Periodicity Schedule controls the approved behavioral health screening tool.

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		Who completes the tool	Appropriate age group for the tool
BITSEA	Brief Infant and Toddler Social and Emotional Assessment <a href="http://harcourtassessment.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8007-352&amp;Mode=summary">http://harcourtassessment.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8007-352&amp;Mode=summary</a>	Parent	12 to 36 months
CBCL YSR ASR	Achenbach System: Child Behavior Checklist Youth Self-Report Adult Self-Report <a href="http://www.ASEBA.org">http://www.ASEBA.org</a>	Parent Youth Young Adult	1.5 to 18 years 11 to 18 years 18 to 59 years
CRAFFT			
M-CHAT	Modified Checklist for Autism in Toddlers <a href="http://www.dbpeds.org/media/mchat.pdf">http://www.dbpeds.org/media/mchat.pdf</a> (tool) <a href="http://www.dbpeds.org/articles/detail.cfm?TextID=377">http://www.dbpeds.org/articles/detail.cfm?TextID=377</a> Screening for autism	Parent	18 to 30 months
PEDS	Parents' Evaluation of Developmental Status <a href="http://www.pedstest.com">http://www.pedstest.com</a>	Parent	Birth to 8 years
PHQ-9	Patient Health Questionnaire-9 <a href="http://www.phqscreeners.com/">http://www.phqscreeners.com/</a> Screening for depression	Young Adult	18+
PSC Y-PSC			

### **How to Claim for the Standardized Behavioral Health Screening Tools**

Fallon will pay for the administration and scoring of the behavioral health tools listed in the EPSDT Services: Medical Protocol and Periodicity Schedule (Fallon Provider Manual)

when administered by:

- Physicians
- Nurse practitioners, and physician assistants under a physician's supervision

Fallon will reimburse for the administration of one standardized behavioral health screening tool per MassHealth member, per day, regardless of the number of behavioral health screening tools administered on the same day for a given member.

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Payment will be made to Primary Care Providers for the administration and scoring of the behavioral health screening tools in accordance with the EPSDT Periodicity Schedule. The provision of these services is considered separate from, and in addition to, the provision of periodic or interperiodic EPSDT and PPHSD visits. Primary Care Provider reimbursement will be made in accordance with his/her Fallon Provider Agreement. Claims for the behavioral health screening tool must be submitted using Current Procedural Terminology (CPT) service code 96110 (EPSDT/PPHSD Screening Services Codes).

The following provider types can submit claims for reimbursement for the standardized behavioral health screening tools:

- Physicians
- Hospital outpatient departments

Please note that distinct modifiers are required when billing the CPT code for the behavioral health screening tools. Effective July 1, 2011, failure to include the modifier will result in denial of the claim. These modifiers will allow Fallon to track the disposition of the screening so that Fallon will know the number of MassHealth members with a behavioral health need identified. These modifiers vary by provider type. Please see Table 2, “Modifiers for Use with CPT Code 96110,” for direction on the appropriate modifier to use.

<b>Table 2. Modifiers for Use with CPT Code 96110</b>		
<b>Servicing Provider</b>	<b>Modifier for Use When No Behavioral Health Need Identified *</b>	<b>Modifier for Use When Behavioral Health Need Identified *</b>
Physician, Outpatient Hospital Department (OPD)	U1	U2
Nurse Midwife employed by Physician or CHC	U3	U4
Nurse Practitioner employed by Physician	U5	U6
Physician Assistant employed by Physician	U7	U8

*\* Behavioral health needs includes needs in the area of behavioral health, social-emotional well-being, or mental health.*

The text of the CPT code and modifiers required to claim for the standardized behavioral health screening tools are listed in Table 3, “Text of CPT Code and Modifiers for Claiming the Standardized Behavioral Health Screening Tools.” Please note that this list of codes is for your information only. See the Fallon Provider Manual, [EPSDT/PPHSD Screening Service Codes](#), for the codes and modifiers that are required to claim for the administration and scoring of the behavioral health screening tool.

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<b>Code/Modifier</b>	<b>Text of Code/Modifier</b>
CPT 96110	Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report
U1	Physician, Nurse Practitioner, Outpatient Hospital Department (OPD), completed behavioral health screening with no behavioral health need identified
U2	Physician, Nurse Practitioner, Outpatient Hospital Department (OPD), completed behavioral health screening and behavioral health need identified
U5	Nurse Practitioner (SA) employed by Physician, completed behavioral health screening with no behavioral health need identified
U6	Nurse Practitioner (SA) employed by Physician, completed behavioral health screening and behavioral health need identified
U7	Physician Assistant (HN) employed by Physician, completed behavioral health screening with no behavioral health need identified
U8	Physician Assistant (HN) employed by Physician, completed behavioral health screening and behavioral health need identified

Training on How to Administer and Claim the Standardized Behavioral Health Screening Tools Fallon will be offering training opportunities for providers to learn more about how to administer and claim for administration of the standardized behavioral health screening tools listed in The EPSDT Periodicity Schedule and reproduced above in Table 1.

Training on how to administer the standardized behavioral health screening tools is available online. For more information, please visit the MassHealth Web site for child behavioral health at <https://www.mass.gov/childrens-behavioral-health-initiative-cbhi>. There is more information about this Web site below.

Training on how to claim for the administration of the standardized behavioral health screening tools is also available. You can contact the Fallon Provider Relations Department, 1-866-275-3247, press 4, for more information on these trainings.



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## ***Child Behavioral Health Initiative Information on the web***

The Children's Behavioral Health Initiative (CBHI) is an inter-agency initiative of the Commonwealth's Executive Office of Health and Human Services whose mission is to strengthen, expand and integrate Massachusetts state services into a comprehensive, community-based system of care, to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community.

Fallon Health provides a full range of Behavioral Health services including individual, group or family therapy, "diversionary" services such as partial hospitalization and inpatient care.

As part of the Children's Behavioral Health Initiative, Behavioral Health services for certain children and youth under the age of 21 have been expanded to include, when medically necessary, home- and community-based services including mobile crisis intervention, in-home therapy, in-home behavioral services, family support and training, therapeutic mentoring and Intensive Care Coordination.

For more information visit [www.fallonhealth.org](http://www.fallonhealth.org) or call Fallon's MassHealth Customer Service Department at 1-800-341-4848, or visit Beacon Health Options, Fallon Behavioral Health partner, at [www.beaconhealthoptions.com](http://www.beaconhealthoptions.com), or call 1-888-421-8861.

## ***Child Adolescent Needs and Strengths (CANS) tool***

Fallon in conjunction with its behavioral health partner, Beacon Health Strategies (Beacon) requires a uniform behavioral health assessment process that includes a comprehensive needs assessment employing the Child Adolescent Needs and Strengths (CANS) tool.

Two tasks must be completed in order for a Fallon/Beacon behavioral health clinician to obtain access to the CANS tool:

- (1) The clinician must become trained and certified in the use of CANS;
- (2) The clinician's provider organization must designate the clinician to the EOHHS Virtual Gateway as a user.

## ***The Child Adolescent Needs and Strengths Tool:***

Mass Health requires a uniform behavioral health assessment process that includes a comprehensive needs assessment employing the Child and Adolescent Needs and Strengths (CANS) tool for all Mass Health members under age 21, in specific levels of care. The CANS is intended to be used as a treatment decision support tool for providers. All Mass Health providers must be certified in the administration of the CANS, and must recertify themselves every two years. All CANS certified providers must have a Virtual Gateway account and a high-speed or satellite internet connectivity to access the CANS IT system. Providers must enter the CANS assessment into the Virtual Gateway upon initial completion or update. Providers are required to obtain member consent prior to entering member CANS information into the Virtual Gateway system. Should consent not be authorized by the family, guardian or emancipated minor, providers must still enter Serious Emotional Disturbance (SED) status via the Virtual Gateway.

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There are two forms of the Massachusetts CANS: There are two forms of the Massachusetts CANS:

- “CANS Birth through Four”: used until a child’s fifth birthday
- “CANS Five through Twenty”: used until an adolescent’s 21<sup>st</sup> birthday

Outpatient providers will be required to use the CANS as part of an initial behavioral health assessment and must update the CANS screening at least every 90 days.

Should a member be treated by more than one behavioral health provider, each provider must administer the CANS.

Inpatient or other 24-hour level of care providers will be required to use the CANS as part of discharge planning process.

Should you have questions about the CANS training or certification process, you can contact the CANS training group either by calling 508-856-1016 or on the web: [mass.cans@umassmed.edu](mailto:mass.cans@umassmed.edu).

Learn more at <https://www.mass.gov/service-details/cans-training-and-certification>

If you have questions regarding Fallon/Beacon’s expectations regarding the CANS tool, contact Deborah Kaegebein, PhD at Beacon Health Strategies at 1-781-994-7554 or via email at [Deborah.Kaegebein@beaconhs.com](mailto:Deborah.Kaegebein@beaconhs.com)

Each clinician who will be entering and viewing data in the CANS application will need to have a Virtual Gateway User ID in order to access the tool.

*Should you need assistance with the Virtual Gateway, please call Virtual Gateway Customer Service, Monday- Friday 8:30am-5:00p at:*

- 1-800-421-0938
- 617-988-3301 TTY

## **CANS forms**

The paper CANS form is located online. It can be found at: <https://www.mass.gov/service-details/cans-training-and-certification>. When you arrive on that website, choose “Information for Providers” and then click “CANS tools.”

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## **Summit ElderCare**

Summit ElderCare (SE), a Program of All-inclusive Care for the Elderly (PACE), provides comprehensive and coordinated services for adults frail enough to need nursing home level of care but prefer to remain living at home in the community.

For over 25 years, Fallon Health has operated this program which is a national model of health care for adults 55 and older, residing in in Hampden County, Worcester County and the communities of Easthampton, Granby, Hudson, Marlborough, South Hampton and South Hadley. The goal of Summit ElderCare is to provide the medical, insurance and social support systems to help frail seniors to remain at home in their community. It is a welcome alternative to a nursing home placement.

SE allows elders to maintain their independence while providing necessary support for both them and their caregivers.

SE offers the convenience and security of coordinated care. Most medical services are provided at the Summit ElderCare PACE Center by one team of clinical professionals who know participants' medical history. Participants do not have to be a member of Fallon Health to join. Any person age 55 and older who is able to live safely at home, who lives in Hampden County or Worcester County, and the communities of Easthampton, Granby, Hudson, Marlborough, South Hampton and South Hadley, and who is certified by the EOHHS's screening agent as meeting Medicaid nursing facility clinical criteria is eligible for SE.

An individualized care plan of services is developed and approved by the Interdisciplinary Team and may include:

- Primary medical and nursing care
  - Inpatient Hospital Services
  - Inpatient Skilled Nursing Facility and Nursing Facility Services
- Full prescription drug coverage including over-the-counter medications
- Medical supplies and equipment
- Physical, occupational, speech therapies
- Recreational therapies
- In-home care
- Summit ElderCare Day Center with a specialized unit for the memory- impaired
- Specialty care including podiatry, optometry, dental and audiology
- Round-trip transportation to the SE PACE center or contracted Adult Day Health Center and specialty appointments, when necessary
- Family caregiver support

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The Summit ElderCare team includes:

- Primary care Provider (physician, Nurse Practitioner or Physician Assistant)
- Nurses
- Home Care Coordinators
- Social workers
- Behavioral Health Specialists
- Health aides
- Rehabilitative therapists
- Recreational therapists
- Speech Therapists
- Nutritionists
- Transportation Coordinator

## ***Special features of Summit ElderCare***

There are several unique features of our program:

### ***1. Interdisciplinary team***

Care is planned and provided by a team of geriatric specialists. The team includes a primary care provider who is either a physician, a nurse practitioner, or a physician assistant, a primary registered nurse, social worker, rehabilitation and recreation therapists, health aides and others who will assist participants. Each team member's special expertise is employed to assess the participant's health care needs and to call upon additional specialists, if necessary. Together, with the participant and his/her family, we create a plan of care. All the services the participants receive are coordinated and arranged by the team.

### ***2. Authorization of care***

The SE Interdisciplinary team must review, approve and authorize all care and services, **except emergency services and urgent care**; and any changes in the participant's care plan, whether adding, changing or discontinuing a service. They will ensure that the participant is receiving the most appropriate care. The participant will get to know each of the members of their team very well. The team works closely with the participant so he or she can be as healthy and independent as possible. The team will reassess the participant's needs at least every six months, but more frequently, if necessary.

### ***3. Summit ElderCare centers***

Participants receive the majority of your health care services at our Summit ElderCare Adult Day Health Centers located at:

288 Grove Street  
Worcester, MA

108 Thompson Road  
Webster, MA

1085 Varnum Avenue  
Lowell, MA

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55 Cinema Boulevard  
Leominster, MA

101 Wason Ave.  
Springfield, Massachusetts

Summit ElderCare also contracts with other adult day programs in the community. We will work with the participant and his or her family to determine a schedule of attendance at the Summit ElderCare Day Center or any of our contracted facilities. Transportation to and from the Day Centers for medical care and adult day social programs is provided free of charge, when needed.

The Interdisciplinary Team may authorize services to be provided in the participant's home, in a hospital or a nursing facility. We have contracts with physician specialists, (such as cardiologists, urologists, and orthopedists), with pharmacies, laboratories, and X-ray services, and with hospitals and nursing facilities.

**We offer access to care on a 24-hour basis, 365 days of the year via after hours on call.**

**4. Primary Care Providers**

Summit ElderCare physicians, nurse practitioners, and physician assistants are solely responsible for the participant's health care.

**5. Coordinated, comprehensive care**

We have flexibility in providing care according to your needs. The interdisciplinary team will be able to determine the appropriate medical services for your care. In-home care will also be evaluated and provided by the team as determined by their assessment of your needs.

**6. Services are provided exclusively through Summit ElderCare**

The services offered by SE are available to participants because of a special agreement among Summit ElderCare, the Commonwealth of Massachusetts, MassHealth and the US Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS).

Once a participant has enrolled in SE, he or she agrees to receive services exclusively from the SE providers and the SE contracted providers. Otherwise, he or she may be fully and personally liable for the costs of unauthorized or out-of-SE program agreement services. Therefore, the participant will no longer be able to obtain services from other physicians or medical providers under his or her previous coverage (e.g. original) Medicare and Medicaid providers without prior approval of the SE interdisciplinary team.

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## ***Advantages of enrolling in Summit ElderCare***

Summit ElderCare was designed and developed specifically to maintain independence for adults 55 and over; the program offers comprehensive, coordinated medical, social and home support services through a single program. Because SE is a Program of All-inclusive Care for the Elderly (PACE) funded by the Center of Medicare and Medicaid Services, we are able to provide a full range of comprehensive medical, rehabilitative and financing arrangements with Medicare and Medicaid which allows us to provide flexible benefits and coordinated care. Most SE participants are Medicare- and Medicaid-eligible and pay no monthly cost for a fully-integrated program of Medicare and Medicaid benefits, including all prescriptions, rehabilitative services, and adult day social programs. Some participants pay a monthly share of cost for SE services.

Other advantages include:

- SE has operated in Massachusetts since the mid-1990's and is sponsored by Fallon Health
- Care is provided by dedicated on-site geriatric health care professionals
- Comprehensive medical and Part D prescription coverage
- In-Home support services
- Coordinated care 24 hours a day, 365 days a year
- Support for family caregivers
- Individualized care planning

## ***Benefits and coverage***

The following benefits are fully covered when approved by the Interdisciplinary Team and when provided by SE's providers or contractors at the SE PACE center or in contracted facilities.

Approval is not required for emergencies. Urgent care is covered and may be pre-approved or is deemed approved if SE does not respond to a request for approval within one hour of being contacted or cannot be contacted.

### ***1. Outpatient health services***

- a. Adult day health care
- b. Primary care, including consultation, routine care, preventive health care and physical examinations
- c. Medical specialty services including, but not limited to, services such as cardiology, gastroenterology, oncology, urology, rheumatology and dermatology, dental, audiology, podiatry, optometry
- d. Nursing care

### ***2. Personal care and supportive services***

- a. Social services

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- b. Physical, occupational and speech therapies
- c. Recreational therapy
- d. Nutrition counseling and education
- e. Laboratory tests, X-rays and other diagnostic procedures
- f. Prescription drugs (only if obtained from a pharmacy designated by ESP)
- g. Prostheses and durable medical equipment **when determined medically necessary by the Interdisciplinary Team.**
- h. Podiatry
- i. Vision care, including examinations, treatment and corrective devices such as eyeglasses
- j. Dental care (as defined in number 8 below)
- k. Psychiatry, including evaluation, consultation, diagnostic and treatment service
- l. Audiology evaluation, hearing aids, repairs and maintenance

### 3. Hospital inpatient care

- a. Ambulance
- b. Emergency room care and treatment room services
- c. Semi-private room and board, as available
- d. General medical and nursing services
- e. Medical, surgical, intensive care and coronary care unit, as necessary
- f. Laboratory tests, x-rays and other diagnostic procedures
- g. Other diagnostic procedures
- h. Drugs and biologicals
- i. Blood and blood derivatives
- j. Surgical care, including anesthesia
- k. Use of oxygen
- l. Physical, speech, occupational, respiratory therapies
- m. Social services

### 4. Home health care

- a. Skilled nursing services
- b. Provider visits
- c. Physical, speech and occupational therapies
- d. Social services
- e. Home health aide services

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- f. Homemaker/chore services
- g. Home-delivered meals with special diets, when deemed medically necessary
- h. Personal Emergency Response System
- i. Medical Supplies

## **5. Skilled nursing facility/nursing facility care**

### **6. End of life services**

End of life services are provided in a hospital, nursing facility, adult day health center, at home or on an outpatient basis.

### **7. Health-related services**

Health-related services may include transportation, homemaker/chore services, home delivered meals, translation services.

### **8. Dental care**

Our first priority for dental care is to treat pain and acute infection. Our second priority is to maintain dental functioning so that participants can chew as well as possible. The dentist and the Interdisciplinary Team provide dental care according to the need and appropriateness as determined. Participants will receive an initial dental assessment and exam within the first three months of their enrollment. After that, participants will have a yearly oral exam. Dental procedures that are considered aesthetic are not covered unless deemed medically necessary for reducing pain or maintaining proper nutrition (i.e., crowns, implants, etc.)

### **9. Interdisciplinary assessment and Care plan**

All participants receive an initial comprehensive assessment and care plan at the time of enrollment. All participants are reassessed on a semi-annual basis or more often if a participant's condition requires it. The care plan is revised and updated at the time of the reassessment.

The SE staff provides all primary care services through the PACE center and the in-home service program. SE has available a number of specialists and health care facilities for specialty care. Whenever the interdisciplinary team determines that participants need these services, they will make arrangements to provide that care. A list of the major contracted providers and facilities is available at the Summit ElderCare Center and will be provided to participants.

## **Eligibility**

Enrollees must be:

- At least 55 years of age.
- Capable of safely residing in the community setting without jeopardizing their health and safety.
- Living in the SE service areas of Hampden County, Worcester County and the communities of Easthampton, Granby, Hudson, Marlborough, South Hampton and South Hadley.
- Certified by the screening agent of the MassHealth program that they have met the level of care required for coverage of nursing facility services.



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## **Enrollment and effective dates of coverage**

Enrolling in Summit ElderCare is a five-step process:

1. Initial Intake/Home Visit
2. Intake Assessment
3. Enrollment
4. Final Approval
5. Continuation of Enrollment

Benefits coverage officially begins on the first day of the month after participants sign the Enrollment Agreement.

### **1. Initial take/Home Visit**

The home visit process begins when the applicant or someone on his or her behalf makes a call to SE. A SE representative will call you and provide a comprehensive overview of the program:

- a. How SE works
- b. The kinds of services it offers
- c. The answers to any questions applicant may have about us
- d. That when applicant enrolls he or she must agree to receive all his or her medical and health care exclusively from the SE, with the exception of emergency services
- e. Applicant's monthly payment, if any

After this overview, if the applicant is interested in enrolling in SE, we will arrange for a home visit by a member of our enrollment team (nurses). The enrollment staff member contacts the applicant within two business days of receiving the referral to obtain information on the applicant's needs and schedules a home visit.

At the **home visit**, the Enrollment Coordinator:

- Completes the Intake Sheet and Home Services form
- Obtains Consent for Release of Medical Records to SE and financial information.
- Determines the need for a Medicaid application.
- The Enrollment Coordinator completes the Minimum Data Set (MDS), or leveling form and the MassHealth Request for Services pgs. 1-2.

The **leveling assessment** documentation is entered into the State Virtual Gateway for review by MassHealth for clinical eligibility. MassHealth will notify SE of an acceptance or denial.

Upon **acceptance** by MassHealth the SE scheduler a) requests the applicant's medical record; b) schedules an in-home intake visit for the applicant and caregivers, as soon as possible; c) forwards a copy of the Enrollment Process forms to the appropriate SE team members (i.e., Social Worker and RN)

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## 2. *Intake assessment*

During the intake assessment process, the team will assess whether Summit ElderCare can meet the applicant's medical, nursing, psychological and social needs.

Within a few days, our team will have evaluated the applicant's situation. The team then will meet to share their findings and ideas for the applicant's care. At this meeting, they will decide whether the applicant meets the criteria for admission into the program, that is, whether the applicant's problems and needs appear to meet the MassHealth criteria for nursing facility level-of-care and whether you are found to be able to remain safely in your home or in the community.

A prospective participant may be denied enrollment because the team assesses that remaining in their home and or the community would jeopardize the individual's health and safety. In such cases, Summit ElderCare Interdisciplinary team **will provide written notification** (with prior approval by the State) to the prospect explaining the reason(s) for the denial and refer the individual to appropriate alternative services. **If you are denied enrollment, you have the right to appeal to MassHealth, Medicare or both.**

## 3. *Enrollment*

If the applicant has found his or her interactions with the SE team and visit to the center satisfactory and if the team believes that he or she is eligible, the applicant and his or her family will be invited to meet with the Social Worker. At that time, the Social Worker and a RN will review a Service Agreement outlining his or her participation and the service package being offered by Summit ElderCare before signing the Enrollment Agreement. At this meeting the applicant and his or her family member(s) will have an opportunity to discuss:

- a. Their input into the plan of care recommended by the team
- b. Ask questions about the monthly payment, if any
- c. The nature of the partnership between the caregiver(s) and Summit ElderCare

If the applicant decides to join Summit ElderCare, he or she will sign the Enrollment Agreement. Upon signing, the applicant will receive an Enrollment Packet that includes:

- a. A copy of the Enrollment Agreement Form
- b. The SE Enrollment Agreement
- c. SE membership card
- d. Stickers for enrollee's Medicare and Medicaid cards that identify him or her as SE participant
- e. Emergency contact information to post on enrollee's refrigerator or by the phone

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## ***Summit ElderCare quality management***

Summit ElderCare, maintains, evaluates, and implements an ongoing effective, data-driven Quality Improvement Program.

Summit ElderCare's quality program goal is to ensure that quality care is provided to all program participants. The quality program systematically designs, measures, monitors, evaluates and improves the performance of its PACE program.

## ***Quality Improvement Program***

The outcome-based quality management system reflects the scope of services provided by the PACE program and identifies opportunities for improvement by monitoring appropriate indicators, outcome measurements and the evaluation of the effectiveness of the program by site and overall.

The written Quality Improvement Program define the objectives, scope, structure, committees, and functions of the Summit ElderCare program. It is reviewed and updated annually and presented to the Fallon Health Board of Directors for approval.

## ***Grievances***

All Clinical and Administrative staff of SE share responsibility for assuring that participants and caregivers are satisfied with the care the participant receives. Participants and caregivers are encouraged to express any grievances at the time and place any dissatisfaction occurs.

Participants are provided with information regarding the grievance process and appeal rights upon enrollment, annually and when a service denial or concern is raised.

## ***Costs***

Some participants may have a monthly share of cost or premium based on income. Summit ElderCare is covered by Medicare and Medicaid (MassHealth) for eligible individuals, and is also available on a private pay basis. Many participants qualify for zero monthly cost share or zero premium based on income. In addition, all SE covered services are provided with no co-payments or out-of-pocket expense for program participants. Medicare beneficiaries not on Medicaid must continue to pay their Part B premium after enrollment in SE, along with the monthly premium. Participants in SE pay no additional co-payments or deductible for covered services.

## ***Your Rights as an Summit ElderCare (SE) Participant***

The rights of the individual to respect and nondiscrimination are fundamental to the basic philosophy of the PACE program. Within this context, as a participant in a federally-qualified PACE program, according to Federal PACE Regulations §460.112, you have certain rights and protections.

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## ***To be treated with respect.***

You have the right to be treated with dignity and respect at all times, to have all of your care kept private, and to get compassionate, considerate care. You have the right:

- To get all of your health care in a safe, clean environment.
- To be free from harm. This includes physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms or to prevent injury.
- To be encouraged to use your rights in the SE program.
- To get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes, and your civil and other legal rights.
- To be encouraged and helped in talking to SE staff about changes in policy and services you think should be made.
- To use a telephone while at the SE Day Center.
- To not have to do work or services for the SE program.

## ***You have a right to protection against discrimination***

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race / Ethnic Origin
- Religion
- Age
- Sex
- Sexual Orientation
- Mental or physical ability
- Source of payment for your health care (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at the SE Center to help you resolve your problem.

If you have any questions, you can call the Office for Civil Rights at 800-368-1019. TTY users should call 800-537-7697.

## ***You have a right to information and assistance.***

You have the right to get accurate, easy-to-understand information and to have someone help you make informed health care decisions. You have the right:

- To have someone help you if you have a language or communication barrier so you can understand all information given to you.
- To have the SE staff or a translation service interpret the information into your preferred language in a culturally competent manner, if your first language is not English and you cannot speak English well enough to understand the information being given to you.
- To receive marketing materials and SE rights in English and in any other frequently used language in your community. You can also get these materials in Braille, if necessary.

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- To get a written copy of your rights from the SE program. The SE program must also post these rights in a public place in the SE center where it is easy to see them.
- To be fully informed, in writing, of the services offered by the SE program. This includes telling you which services are provided by contractors instead of the SE staff. You must be given this information before you join, at the time you join, and when there is a change in services.
- To look at, or get help to look at, the results of the most recent review of your SE program. Federal and State agencies review all SE programs. You also have a right to review how the SE program plans to correct any problems that are found at inspection.

***You have a right to a choice of providers.***

You have the right to choose a health care provider within the SE network and to get quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

***You have a right to access emergency services.***

You have the right to get emergency services when and where you need them without the SE program's approval. A medical emergency is when you think your health is in serious danger—when every second counts. You may have a bad injury, sudden illness or an illness quickly getting much worse. You can get emergency care anywhere in the United States.

***You have a right to participate in treatment decisions.***

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf. You have the right:

- To have all treatment options explained to you in a language you understand, to be fully informed of your health status and how well you are doing, and to make health care decisions. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this will affect your health.
- To have the SE program help you create an advance directive. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.
- To participate in making and carrying out your plan of care. You can ask for your plan of care to be reviewed at any time.
- To be given advance notice, in writing, of any plan to move you to another treatment setting and the reason you are being moved.

***You have a right to have your health information kept private.***

You have the right to talk with health care providers in private and to have your personal health care information kept private as protected under state and federal laws. You also have the right to look at and receive copies of your medical records.

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There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. If you have any questions about the Health Insurance Portability and Accountability Act (HIPAA) privacy rule, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

## ***You have a right to file a complaint.***

You have a right to complain about the services you receive or that you need and don't receive, the quality of your care, or any other concerns or problems you have with the SE program. You have the right to a fair and timely process for resolving concerns with SE. You have the right:

- To a full explanation of the complaint process.
- To be encouraged and helped to freely explain your complaints to SE staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.
- To appeal any treatment decision by the SE program, staff, or contractors.

## ***You have the right to leave the program.***

If, for any reason, you do not feel that the SE program is what you want, you have the right to leave the program at any time.

## ***Additional Help***

If you have complaints about your SE program, think your rights have been violated, or want to talk with someone outside the SE program about your concerns, call 800-MEDICARE or 800-633-4227 to get the name and phone number of someone in your State Administering Agency.

You have the right to contact outside advocacy agencies to assist you in an appeal or grievance, including The Ombudsman Program at 855-781-9898, by videophone for ASL users at 339-224-6831, the Executive Office of Elder Affairs at (800) 243-4636, or the Medicare Rights Center at 888-HMO-9050.

If you are a MassHealth/Medicaid beneficiary, you may also request a fair hearing. The request may be mailed to the Office of Medicaid/MassHealth, Board of Hearings, 2 Boylston Street, Boston, MA 02116, or you may fax your request to 617-210-5820.

If you are concerned about the quality of the care you have received, you have the right to file a complaint with the Massachusetts Quality Improvement (Kepro) at 1-888-319-8452 or TTY:\* 711, Monday through Friday, 8 a.m. to 5 p.m.

You also have the right to contact the Office for Civil Rights at 800-368-1019 (TDD/TTY: 800-537-7697) if you have questions about your rights as a Summit ElderCare participant, or if you believe that your rights have been violated. You can also get copies of a brochure from the Centers for Medicare & Medicaid Services (CMS) about PACE program rights by calling 800-MEDICARE or 800-633-4227. TTY users should call 877-486-2048.