Aging Services Access Point (ASAP) Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☐ Fallon Medicare Plus, Fallon Medicare Plus-Central (Medicare Advantage)
☐ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☐ Fallon Health Weinberg PACE
☐ Community Care (Commercial/Exchange)

Policy

Organized under Massachusetts law, an Aging Services Access Point (ASAP) is a non-profit agency under contract with the Executive Office of Elder Affairs to coordinate the delivery of community-based long term care services for eligible elderly residents in Massachusetts. Senior Care Options (SCO) plans may enter into contracts with ASAPs to manage and coordinate the provision of home and community-based services for their eligible members.

Fallon Health (the Plan) reimburses contracted ASAPs for the coordination and delivery of certain home and community-based services provided by the ASAP or by a Vendor under contract with the ASAP (Purchased Services).

Geriatric Support Services Coordinator (GSSC) Requirements
Senior Care Options (SCO) plans must provide a Geriatric Support Services Coordinator (GSSC) to members requiring certain Long-Term Services and Supports (LTSS) services through a contract with one or more ASAPs that complies with M.G.L. c. 118E, § 9D. A GSSC must meet the standards established by the Executive Office of Elder Affairs in designating ASAPs as qualified to serve as a GSSC. The GSSC is responsible for all of the activities set forth in M.G.L. c. 118E, § 9D, which consist of:

- Arranging, coordinating and authorizing the provision of Long-term Services and Supports (LTSS) and community long-term care and social support services, based on the member's needs assessment and Individual Care Plan (ICP) and with the agreement of other Care Team providers designated by the Fallon Health;
- Coordinating non-covered services and providing information regarding other elder services, including, but not limited to, housing;
- Monitoring the provision and outcomes of community long-term care and support services, according to the member's ICP, and making periodic adjustments to the member's ICP as deemed appropriate by the Interdisciplinary Care Team;
- Tracking a member's transfer from one setting to another;
- Scheduling periodic reviews of member ICPs and assessment of progress in reaching the goals of a member's ICP, and
- Documenting activities in the Fallon Health Centralized Enrollee Record within one (1) business day.

Deficiencies in ASAP Performance
Fallon Health follows the process as outlined by Executive Office of Health and Human Services (EOHHS) in the SCO Contract, should the Plan identify any of the following deficiencies with the contracted ASAP's performance:

- the ASAP does not meet its responsibilities relating to the performance of GSSC functions and GSSC qualifications established by Fallon Health; or
- the ASAP does not satisfy clinical or administrative performance standards, based on a performance review evaluation by Fallon Health according to Operational Guidelines and subsequent failure by the ASAP to correct documented deficiencies, or
- if Fallon Health is unable to execute a contract with an ASAP, or determines that it shall terminate a GSSC contract with an ASAP (noting if the ASAP is the only ASAP that operates in that specific the service area), Fallon Health will notify EOHHS in writing, within five (5) business days of the triggering event, with detailed, specific findings of fact that document the deficiencies.

ASAP Operational Guidelines

- The ASAP is required to be actively participating, during the time of member care transition.
- The ASAP meets monthly with Fallon Health staff to include: GSSC staff, Fallon Health leadership, Fallon Health Clinical Nurses (RN), the member's, designated Navigator, and Behavioral Health staff.
- The ASAP must respond within three (3) business days to Plan-issued requests verifying continued Centralized Enrollee Record (CER) access for agency staff.
- The ASAP will meet with Fallon Health on an as needed basis when a member's situation warrants further collaboration and ICP update.
- The ASAP will assist with MassHealth redetermination paperwork for members as needed.
- Additionally, Bi-Annual Joint Operating CommitteeCommittees (JOC) Meetings are scheduled and must be attended by both ASAP leadership and Fallon Health staff, to include representatives from the Network Development and Contracting Department and Care Team leadership.
- Member Assessments are required to be completed within thirty (30) days of onboarding new members. Should the assessments not be completed within this period, the Fallon Health Care Team, will initiate an ASAP Corrective Action Plan (CAP).
- The ASAP will coordinate services with their respective vendors based upon thresholds. Should the member require further services, it will be under the direction of the Fallon Health Care Team. If further services are not approved by the Plan, they will not be reimbursed.
- The ASAP is required to participate on the Massachusetts Health Information Exchange (Mass Hiway)
- The ASAP is required to complete the NaviCare Annual Model of Care training before the assigned due date.
- For those ASAPs required to annually review Fallon Health's Corporate Compliance policy, the review must be completed within two (2) weeks' time of the assignment date.

Definitions

Aging Services Access Point (ASAP) – Non-profit agency\ies organized under Massachusetts General Law (M.G.L.) c.19A §4B that contract with the Executive Office of Elder Affairs to manage the Home Care Program Services in Massachusetts and perform case management, screening, and authorization activities for certain long-term care services.

Community-Based Long Term Care Services – As defined, such services include but are not limited to Home Care Program Services; Adult Day Health (ADH); Adult Foster Care (AFC); Group Adult Foster Care (GAFC)/Assisted Living (AL); Program for All-inclusive Care for the Elderly (PACE) 1115 Demonstration Waiver services and Pre-PACE for purposes of Nursing Facility level of care determinations; Persona lEmergency Response System (PERS); 2176 Home and Community-Based Waiver services (for the frail elderly); and Home Health Services.

Geriatric Support Services Coordinator (GSSC) - A member of the NaviCare Interdisciplinary Care Team who is employed by an Aging Services Access Point (ASAP), is qualified to conduct and is responsible for arranging, coordinating, and authorizing the provision of appropriate community long-term care and social support services.

Home Care Program Services- Include, but are not limited to: Homemaker, Personal Care, Laundry, Home-delivered Meals, Interdisciplinary Case Management, Chore, Home Health, Transportation, Social Day Care Services, Adult Day Health, Dementia Day Care, Adaptive Housing, Personal Emergency Response,Grocery Shopping / Delivery, Companion, Emergency Shelter, Respite Care and other Home Care Program Services as outlined in 651 CMR 3.01, and established by Elder Affairs.

Individualized Care Plan (ICP) - The plan of care developed between the member and the member's Interdisciplinary Care Team. The plan of care outlines the scope, frequency, type, amount, and duration of all covered services to be provided by Fallon Health to the member.

Interdisciplinary Care Team (ICT) - A team consisting of at least the member's PCP and a GSSC and/or Registered Nurse conducting required assessments, the care team is responsible for effective coordination and delivery of care for plan members. The team is responsible for working with the member to develop, implement, and maintain their care plan. In NaviCare, this may also be referred to as the Primary Care Team or Care Team.

Long-Term Services and Supports (LTSS) - These services help certain members meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities.

Purchased Services - Any service directly provided by a vendor under contract with the ASAP agency.

Vendor - An entity which has entered into a contract with an ASAP agency to provide one or more Home Care Program Services or community-based long-term care services.

Reimbursement

The Plan reimburses contracted ASAPs for coordination and delivery of services provided by the ASAP itself and\or the ASAP's contracted Vendor. Payment will be in accordance to contracted terms and services.

The Plan's standard claim submission threshold is one hundred twenty (120) days. In certain exceptional conditions, which must be approved by the Plan, a claim may be submitted up to two hundred forty (240) days from the date of service.

The Plan will only reimburse for Adult Day Health (ADH) transportation billed by the ASAP. All other non-emergent transportation must be coordinated through the designated transportation vendor by calling 1-833-824-9440 or by contacting the member's Interdisciplinary Care Team.

Referral/notification/prior authorization requirements

NaviCare

TheNaviCare model of care is based on member care coordination, therefore, the ASAP agencyis required to contact the member's Interdisciplinary Care Team (ICT) prior to coordinating and/or rendering services or adding services to the member's care plan.

Summit Elder Care (Eldercare PACE)

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the Interdisciplinary Team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the Interdisciplinary Team.

Billing/coding guidelines

To be eligible for reimbursement, the following processes and coding must be used by the ASAP to submit Per Member Per Month (PMPM) Care Management claim information. PMPM Care Management, as indicated per contract, are invoice-billed, and are to be sent on a monthly basis.

- **Invoice:** The following data elements are to be submitted through secure email to the Plan's designated recipient, in a PDF document:
  - Member Full Name
  - Member's Plan Identification Number (13 digits)
  - Member's Date of Birth
  - Service Date Span (start date and end date).
  - Total Monthly PMPM Due
  - ASAP National Provider Identifier (NPI) number
- For invoice billing, no CPT or HCPCS codes are included with PMPM Care Management.

Purchased Services and/or Assessments are to be submitted as follows, as applicable per contract and all billed codes must be Executive Office of Elder Affairs (EOEA) approved and coded into the State's database system.

Appropriate codes and modifiers (if applicable) are defined by associated service descriptions and frequency of service type as outlined in the following table.

HCPCS or CPT Code	Modifier	Description	Service Category	Unit Type
S5102		Adult Day Health – Basic – Over 3 hours	Adult Day Health	Per Diem
S5102	TG	Adult Day Health – Complex – Over 3 hours	Adult Day Health	Per Diem
S5101		Adult Day Health – Basic – Up to 3 Hours	Adult Day Health	Partial Per Diem
S5101	TG	Adult Day Health – Complex – Up to 3 Hours	Adult Day Health	Partial Per Diem
T2003		Nonemergency transportation; non-wheelchair transportation; encounter/trip (All transportation services must be billed as one-way trips.)	Adult Day Health	Encounter/Trip
T2003	U6	Nonemergency transportation; wheelchair transportation; encounter/trip (All transportation services must be billed as one-way trips).	Adult Day Health	Encounter/Trip
S5140		Foster care, adult; per diem; AFC Level I	Adult Foster Care	Per Diem
S5140	TF	Foster care, adult; per diem; AFC Level I Alternate Caregiver Day	Adult Foster Care	Per Diem
S5140	TG	Foster care, adult; per diem; AFC Level II	Adult Foster Care	Per Diem

S5140	U5	Foster care, adult; per diem; AFC Level II Alternate Caregiver Day	Adult Foster Care	Per Diem
S5140	U6	Foster care, adult; per diem; AFC Level I Medical Leave of Absence Day	Adult Foster Care	Per Diem
S5140	TG U6	Foster care, adult; per diem; AFC Level II Medical Leave of Absence Day	Adult Foster Care	Per Diem
S5140	U7	Foster care, adult; per diem; AFC Level I Non-Medical Leave of Absence Day	Adult Foster Care	Per Diem
S5140	TG U7	Foster care, adult; per diem; AFC Level II Non-Medical Leave of Absence Day	Adult Foster Care	Per Diem
T1028		Assessment of home, physical, and family environment, to determine suitability to meet patient's medical needs (Use this code to bill for adult foster care intake and assessment services rate; one-time payment per member per provider.)	Adult Foster Care	Occurrence
S5120		Chore services; per 15 minutes	Chore	Per 15 Minutes
S5135		Adult companion care; per 15 minutes	Companion	Per 15 Minutes
T2022		Case management per month. Use this code to bill administrative (per member per month). Bill code on the first of month. During a transfer, both PCM agencies may bill for the month the transfer took place (one-month limit).	Personal Care Attendant Services (Self-directed PCA)	Monthly
T2022	U1	Case management per month. Use this code to bill for required quarterly comprehensive (in person) functional skills training (FST) visits during the first year of approved PCA services. (Bill on the date FST was delivered.) (Bill code once in each calendar year quarter only.) Cannot be billed on the same date as T2022 U2, U3, U4, U5, or another unit of T2022 U1 was billed.	Personal Care Attendant Services (Self-directed PCA)	Quarterly

T2022	U2	Case management per month. Use to bill for required annual comprehensive (in person) functional skills training (FST) (limit one per year). (Bill on date FST was delivered.) Cannot be billed on the same date as T2022 U3, U4, U5, or another unit of T2022 U2 was billed.	Personal Care Attendant Services (Self-directed PCA)	Annual
T2022	U3	Case management per month. Use to bill for functional skills training (FST) (in person) within ten days of identifying a new surrogate. (Bill on date FST was delivered.) Cannot be billed on same date as T2022 U1, U2, U3, U4, or another unit of T2022 U5 was billed. May bill only once during a calendar year, regardless of multiple surrogate changes. This code does not apply to administrative proxy changes.	Personal Care Attendant Services (Self-directed PCA)	Occurrence
T2022	U4	Case management per month. Use this code to bill for issue-focused (in person) functional skills training (FST). (Bill on date FST was delivered.) Cannot be billed on same date as T2022 U1, U2, U5, or another unit of T2022 U3 was billed.	Personal Care Attendant Services (Self-directed PCA)	Occurrence
T2022	U5	Case management per month. Use this code to bill for issue-focused (telephone contact) functional skills training (FST). (Bill on date FST was delivered.) Cannot be billed on same date as T2022 U1, U2, or U5 was billed.	Personal Care Attendant Services (Self-directed PCA)	Occurrence
S5160	U8	*Cellular Network* Emergency Response System; installation and testing	Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS)	Occurrence

S5161	RR U8	*Cellular Network* Emergency Response System: service fee, per month (excludes installation and testing)	Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS)	Monthly
S5165		Home modifications, per service	Environmental Accessibility Adaptations	Occurrence
S5121		Grocery Shopping & Delivery	Grocery Shopping & Delivery	Per Diem
S5111		Home care training, family; per session	Alzheimer's/Dementia Coaching (Habilitation Therapy)	Per Session
S5170		Home delivered meals, including preparation; per meal	Home Delivered Meals	Per Meal
G0299		Direct skilled nursing services of a registered nurse (RN) in the home health setting (one through 30 calendar days)	Home Health Services	Per Visit
G0300		Direct skilled nursing services of a licensed practical nurse (LPN) in the home health setting (one through 30 calendar days)	Home Health Services	Per Visit
G0299	UD	Direct skilled nursing services of a registered nurse (RN)in the home health setting (31+ calendar days)	Home Health Services	Per Visit
G0300	UD	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health setting (31+ calendar days)	Home Health Services	Per Visit
T1502		Administration of oral, intramuscular, and/or subcutaneous medication by health care agency/professional per visit (RN or LPN) (Use only for medication administration visit.)	Home Health Services	Per Visit
T1503		Administration of medication other than oral, intramuscular, and/or subcutaneous medication by health care agency/professional per visit (RN or LPN) (Use only	Home Health Services	Per Visit

		for medication administration visit.)		
99058		Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service (use for emergency office services)	Home Health Services	Per Visit
G0151		Services performed by a qualified physical therapist in the home health setting	Home Health Services	Per Visit
G0152		Services performed by a qualified occupational therapist in the home health setting	Home Health Services	Per Visit
G0153		Service performed by a qualified speech/language pathologist in the home health setting	Home Health Services	Per Visit
G0156		Services of home health aide in the home health setting	Home Health Services	Per 15 Minutes
G0156	UD	Services of home health aide in the home health setting for ADL support	Home Health Services	Per 15 Minutes
G0493		Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition provided every 60 days to members utilizing home health aide services for ADL support	Home Health Services	Per Visit
S5130		Homemaker service, NOS; per 15 minutes	Homemaker (*to the extent not covered under Home Health*)	Per 15 Minutes
S5175		Laundry service, external, professional; per order	Laundry Service	Per Order
A9279		Monitoring feature/device, standalone or integrated, any type, includes all accessories, components and electronics, not otherwise classified (use to bill for medication dispensing system; monthly)	Medication Dispensing System	Monthly
T5999		Supply, not otherwise specified (use to bill for	Medication Dispensing System	Occurrence

		medication dispensing system; installation)		
T1019		Personal care services; per 15 minutes	Personal Care (*to the extent available through an Agency Model rather than through the Self-Directed PCA Model*)	Per 15 Minutes
S5160		Emergency Response System; installation and testing	Personal Emergency Response System	Occurrence
S5161	RR	Emergency Response System: service fee, per month (excludes installation and testing)	Personal Emergency Response System	Monthly
S5101		Day care services, adult; per half day	Supportive Day Care (to the extent *not covered under Adult Day Health or Day Habilitation*)	Per Half Day
S5125		Attendant care services; per 15 minutes	Supportive Home Care Aide (to the extent n*ot covered under home Health*)	Per 15 Minutes
T1013		Sign Language or oral interpretive services; per 15 minutes	Translation/Interpreting Services	Per 15 Minutes
T2003		Nonemergency transportation; non-wheelchair transportation; encounter/trip (All transportation services must be billed as one-way trips.)	Transportation (*to the extent not covered under non-emergency medical transportation)*	Encounter/Trip
T2029	UB U1	Assistive Technology	Electronic Services	Month
T2029	UB U1	Assistive Technology – Electronic Comfort Pets	Electronic Services	1 Item
A0425		Ground mileage, per statute mile	Transportation (*to the extent not covered under non-emergency medical transportation)*	Encounter/Trip
H2021		Community-based wrap-around services; per 15 minutes (use for orientation and mobility services; per 15 minutes)	Orientation and Mobility Services	Per 15 Minutes

Place of Service (POS)

This Policy applies to services rendered in ASAP settings (POS 12), remotely (POS 02) and transportation settings (POS 41).

Policy history

Origination date:	04/01/2015
Previous revision date(s):	07/01/2015 – Introduced policy. 11/01/2015 – Updated Appendix A to reflect ICD-10 code change. 05/01/2016 - Annual review. 05/01/2017 - Annual review.
Connection date & details:	May 2017 – Updated prior authorization section. July 2018 – Updated reimbursement section, added coding to purchased services. October 2019 – Updated reimbursement section and coding table. May 2020 – Update Policy and Biling and Coding sections related to COVID-19 temporary retainer payments. July 2020 – Updated termination date of COVID-19 retainer payments August 2020 – Updated reimbursement and coding section for COVID-19 expanded services. Removed retainer payments. October 2020 – Updated reimbursement and coding sections for COVID-19 ADH services. January 2025 – Updated Policy, Reimbursement and Billing/coding guidelines sections.

The criteria listed above apply to Fallon Health Plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.