Adult Foster Care
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☐ Fallon Medicare Plus (Medicare Advantage)
☐ MassHealth ACO
☒ NaviCare HMO SNP
☐ Summit Eldercare PACE
☐ Fallon Health Weinberg PACE
☐ Community Care (Commercial/Exchange)

Policy

This policy applies to Adult Foster Care (AFC) services.

This policy does not apply to Group Adult Foster Care. Please refer to the Plan's Group Adult Foster Care payment policy.

AFC is a program that pays for personal care services for NaviCare HMO SNP and NaviCare SCO members that live in a qualified setting (home environment) as described in the Commonwealth of Massachusetts Provider Manual Series – Adult Foster Care Manual – Section 408.402.

In order to qualify for this program, the Plan member must be deemed "nursing home certifiable" as noted on the Minimum Data Set Home Care (MDS HC) form completed by the Care Team and approved by the Executive Office of Health and Human Services (EOHHS). The NaviCare Nurse Case Manager determines the member's eligibility for this program.

AFC services may be provided by contracted AFC Providers which includes Aging Services Access Points (ASAPs) for AFC services provided by the ASAP or by a vendor under contract with the ASAP (purchase services).. The AFC Provider is responsible for ensuring compliance with the MassHealth Adult Foster Care Manual 130 CMR 408.000 and other applicable MassHealth guidance including Bulletins and Transmittals.

Scope of Adult Foster Care (AFC) Services
The AFC Provider must ensure the delivery of direct care to members in a qualified setting, as described in 130 CMR 408.435, by a qualified AFC Caregiver, as described in 130 CMR 408.434, who lives in the residence and is paid by the AFC Provider. AFC must be ordered by a PCP and delivered by a qualified AFC Caregiver under the oversight of the registered nurse and the AFC Multidisciplinary Team (MDT) in accordance with each member's written plan of care. Direct care includes 24-hour supervision, and daily assistance with ADLs and IADLs as defined in 130 CMR 408.402.

The AFC provider must provide nursing oversight by a registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, who is not related to the member, and who is licensed in Massachusetts. Nursing oversight services must be individualized to meet the needs of each member in accordance with the member's AFC plan of care and must include all of the activities described in 130 CMR 408.415 (B), including nursing on-site visits with each member at the qualified setting.

Care management must be provided by a qualified AFC Care Manager, as described in 130 CMR 408.433(C)(3)(a), who is not related to the member, and who is responsible for coordinating care and monitoring the needs of the member in conjunction with the registered nurse. Care management performed by the AFC Care Manager must include all the activities described in 130 CMR 408.415 (C), including on-site visits with each member at the qualified setting.

An AFC Community Support Specialist who is qualified as described in 130 CMR 408.433(D)(1), who is not related to the member, and who has the responsibilities described in 130 CMR 408.433(D)(2) may conduct on-site visits of the member at the qualified setting in place of the nurse or care manager if determined appropriate by the AFC Multidisciplinary Team (MDT) in accordance with 130 CMR 408.433(B).

Adult Foster Care Bulletin 34
In August 2025, MassHealth issued Adult Foster Care Bulletin 34. This Bulletin provides updated guidance for AFC providers related to admission and monthly visit requirements. The purpose of this bulletin is to provide flexibility for AFC and GAFC providers' multidisciplinary team as it relates to the cadence of admission and monthly visit requirements. However, this flexibility is subject to the specific needs of the member.

- With respect to admission visits, for both AFC level I and level II services, an RN, LPN, or care manager must make the initial visit. If the RN or LPN do not make the initial visit, then an RN or LPN must do so within the first five working days of admission (Adult Foster Care Bulletin 34 August 2025).
- With respect to monthly visits, for both AFC level I and level II services, the RN or LPN must conduct on-site visits every other month, or more often if necessary. These visits alternate with the required visits by the care manager to ensure that the member receives one visit from either the nurse or the care manager every month, as determined by the multidisciplinary team (MDT). A community support specialist may conduct up to three nonconsecutive onsite visits per 12-month period, per calendar year (Adult Foster Care Bulletin 34 August 2025).

Definitions

AFC Alternative Caregiver - A person who meets all of the qualifications of an AFC Caregiver and provides AFC to the member in a qualified setting in the absence of the AFC Caregiver.

AFC Alternative Caregiver Days - A short-term period during which a member receives AFC in a qualified setting from an alternative caregiver when the AFC Caregiver is temporarily unavailable or unable to provide care.

AFC Caregiver - A person who lives with the AFC member and paid by the AFC provider for the provision of direct care in accordance with 130 CMR 408.415 (A).

AFC Intake and Assessment Services - Preadmission services provided to a member seeking admission to an AFC program for AFC as described in 130 CMR 408.431(A)(2).

AFC Level I Service Payment - A rate established by the MassHealth agency for members who meet the requirements of 130 CMR 408.419(D)(1).

AFC Level II Service Payment - A rate established by the MassHealth agency for members who meet the requirements of 130 CMR 408.419(D)(2).

AFC Multidisciplinary Team (MDT) – As describerd in 130 CMR 408.433 (B) and (C), the MDT is employed or contracted by the AFC provider, and includes, but is not limited to, a program director, a registered nurse or a licensed practical nurse; and an AFC care manager; and which may also include an AFC community support specialist, who works in conjunction with the AFC caregiver.

AFC Provider - An organization that meets the requirements of 130 CMR 408.404 and contracts with MassHealth as the provider for AFC.

Qualified Setting. A location for the provision of AFC that meets all of the standards described in 130 CMR 408.435.

Medical Leave of Absence (MLOA) - A short-term absence from an AFC-qualified setting, during which a member does not receive AFC services because the member is temporarily admitted to a hospital, nursing facility, or other medical setting.

Nonmedical Leave of Absence (NMLOA) - A short-term absence from an AFC-qualified setting, during which a member does not receive AFC services for nonmedical reasons.

Plan of Care - A person-centered, written plan based on clinical and psychosocial evaluations, describing activities to meet a member's medical, physical, emotional, and social needs and goals for AFC.

Reimbursement

The Plan reimburses the AFC Provider a daily (per diem) rate for an eligible member who receives AFC authorized by the Plan. The AFC Provider reimburses the AFC Caregiver.

An AFC Provider may not bill for non-service days and the Plan does not pay for any day during which an eligible member does not receive AFC, with the exception of a medical leave of absence (MLOA) or nonmedical leave of absence (NMLOA) days.

Payment for AFC is subject to the conditions, exclusions, and limitations set forth in 130 CMR 408.000.

Payment to an AFC Provider ends on the date on which a member no longer meets the clinical coverage criteria for AFC described in 130 CMR 408.416, is no longer receiving AFC, or no longer has a prior authorization in effect, whichever comes first.

Any residence where AFC is provided must be qualified by the AFC Provider and meet the setting requirements of 130 CMR 408.435.

The Plan reimburses an AFC Provider for AFC services only if:

1. The member receiving AFC is eligible under 130 CMR 408.403, and
2. The member meets clinical eligibility criteria for AFC in accordance with 130 CMR 408.416, and
3. The AFC provider has obtained prior authorization for AFC in accordance with 130 CMR 408.417, and
4. The member resides in an AFC-qualified setting in accordance with 130 CMR 408.435, and
5. The AFC provider bills at the payment level authorized by the Plan; and
6. The AFC provider is not billing for days that are non-covered days under 130 CMR 408.437.

Reimbursement for Intake and Assessment Services
Intake and assessment services are preadmission services provided to a member seeking admission to an AFC Program. The Plan will reimburse an AFC Program for intake and assessment services performed in accordance with 130 CMR 408.431 (A). .

Intake and assessment requires prior authorization and is reimbursable only once per member per AFC Provider.

If a member changes from one AFC Provider to another AFC Provider, a new assessment is required and the new AFC Provider must obtain prior authorization. The previous AFC Provider must continue to provide AFC to the member while the new AFC provider is obtaining prior authorization and until the member is admitted and receiving services from the new AFC Provider. The previous AFC Provider must discharge the member from its AFC program before the new AFC Provider may bill the Plan for AFC. The Plan will pay only one AFC Provider per day for the provision of AFC to a member.

Reimbursement for AFC Level I and Level II Services
AFC payments are made as follows:

(1) AFC Level I Service Payment - The Plan will reimburse the AFC level I Service Payment rate for a member who is authorized by the Plan to receive AFC level I Services.

(2) AFC Level II Service Payment - The Plan will reimburse the AFC level II Service Payment rate for a member who is authorized by the Plan to receive AFC level II Servces.

The Plan does not reimburse an AFC Provider for any days during which a member does not receive AFC, with the exception of a Medical Leave of Absence (MLOA) or Nonmedical Leave of Absence (NMLOA).

Medical Leave of Absence and Non-Medical Leave of Absence
The Plan will reimburse the AFC Provider for up to 40 days each calendar year for MLOA and up to 15 days each calendar year for NMLOA. Any unused leave-of-absence days follow the member when changing from one AFC provider to another AFC provider. MLOA and NMLOA days cannot be used interchangeably.

Alternative-Caregiver Days
An AFC Provider may bill for up to 14 alternative-caregiver days per member per calendar year. Any unused alternative caregiver days follow the member when changing from one AFC provider to another AFC provider.

The Plan reimburses for both the daily primary AFC rate and the alternative placement AFC per diem rate utilizing the appropriate modifiers for the same date of service, up to but not exceeding the 14 days per calendar year per 130 CMR 408.419.

Non-Covered Days
The Plan does not reimburse AFC for any day a member is also receiving any personal care/personal care attendant services or home health aide services.

The Plan does not reimburse AFC on any day a member is a resident or inpatient of a hospital, nursing facility (with the exception of MLOA days), rest home, ICF/IID, ALR, or any other residential facility subject to state licensure or certification.

The Plan does not reimburse AFC for any day that has not received prior authorization from the Plan.

Referral/notification/prior authorization requirements

As a requisite for payment, the AFC Provider must obtain prior authorization from the Plan prior to delivering any AFC services.

Intake and assessment services require prior authorization and must be approved by the NaviCare Care Team prior to intake and assessment occurring.

Prior authorization determines the medical necessity for AFC and the service level for payment (i.e., level I or level II).

If a member changes from one AFC Provider to another AFC Provider, a new assessment is required and the new AFC Provider must obtain prior authorization.

Billing/coding guidelines

AFC must be billed using the following Service Codes and Modifiers.

Service Code	Modifier	Service Description
S5140		Foster care, adult; per diem (AFC Level I)
S5140	TG	Foster care, adult; per diem (AFC Level II)
S5140	TF	Foster care, adult; per diem (AFC Level I alternativecaregiver day)
S5140	U5	Foster care, adult; per diem (AFC Level II alternative caregiver Day)
S5140	U6	Foster care, adult: per diem (AFC Level I MLOA day)
S5140	TG U6	Foster care, adult: per diem (AFC Level II MLOA day)
S5140	U7	Foster care, adult: per diem (AFC Level I NMLOA day)

S5140	TG U7	Foster care, adult: per diem (AFC Level II NMLOA day)
T1028		Assessment of home, physical, and family environment, to determine suitability to meet patient's medical needs (adult foster care intake and assessment services rate; one-time payment per member per provider)

Telehealth Services

Pursuant to MassHealth Adult Foster Care Bulletin 34 (August 2025), under extraordinary circumstances AFC Providers may use telehealth to conduct a visit or provide other AFC required services that can be directly addressed through telehealth. Extraordinary circumstances may include, but is not necessarily limited to, staffing shortages due to illness and/or medical leave (such as Family Medical Leave Act absences).

Such use of telehealth to address extraordinary circumstances cannot be used for caregiver or direct-care aide assistance with activities of daily living or instrumental activities of daily living, including cueing and supervision of such activities.

In these limited, permissible instances, the AFC Program Director must document the approved temporary telehealth use. Further, for each such use, the AFC Provider must document:

- the extraordinary circumstance,
- the timeframe during which the extraordinary circumstances necessitated the telehealth visits,
- which types of visits are permitted to be conducted by telehealth, and
- how the use of telehealth is narrowly tailored to address this extraordinary circumstance.

Such documentation must be made available upon request by the Plan. The AFC Provider must also document in the relevant member record each visit that occurred via telehealth. If telehealth use extends beyond three months, the AFC provider must contact the Plan for approval and must provide a deadline by which the use of telehealth for extraordinary circumstances will conclude.

Providers must bill the same procedure codes for services delivered via telehealth as appropriate for services delivered in person.

Place of service (POS)

This policy applies to services rendered in POS 12.

Policy history

Origination date:	04/01/2015
Previous revision date(s):	07/01/2015 – New policy became effective. 11/01/2015 - Updated reimbursement section to align with new MassHealth regulations regarding alternative placement days. 05/01/2016 - Annual review.
Connection date & details:	May 2017 - Added instructions to bill MassHealth directly for specific codes. July 2018 – Added language regarding duplicate service verification. Clarified reimbursement section April 2019 – Clarified Alternative Placement reimbursement and coding. January 2026 – Under Policy, added new section for Scope of Adult Foster Care (AFC) Services and Adult Foster Care Bulletin 34 which updates guidance for AFC providers related to admission and monthly visit requirements; added new definitions to the Definitions section; under Reimbursement, added new sections for Intake and Assessment Services and AFC Level I and Level II Services, clarified reimbursement for Medical Leave of Absence and Nonmedical Leave of Absence, and Alternative Caregiver Days; under Billing/coding guidelines, updated Service

Descriptions and added new section for Telehealth Services pursuant to MassHealth Adult Foster Care Bulletin 34 (August 2025).

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.