

Group Adult Foster Care Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

- ☐ Fallon Medicare Plus
- ☐ MassHealth ACO
- ☒ NaviCare HMO SNP
- ☐ Summit ElderCare PACE
- ☐ Fallon Health Weinberg PACE
- ☐ Community Care

Policy

This policy applies to Fallon Health NaviCare line of business only.

For Summit ElderCare PACE, please see ***Per Diem, Residential Support Services Payment Policy***.

This policy applies to Group Adult Foster Care (GAFC) services. GAFC is a MassHealth-covered personal care service delivered in the member's residence, including an eligible Assisted Living Residence (ALR) or other qualified GAFC setting, by a non-live-in direct care aide employed or contracted by the GAFC provider. GAFC includes daily assistance or cueing and supervision with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), nursing oversight, and care management. GAFC does not include rent, room and board, or personal-care supplies.

The GAFC provider is responsible for arranging and documenting the authorized daily personal care, nursing oversight, care management, and multidisciplinary team services required by 130 CMR 408.505 and the member's GAFC plan of care. Services must be individualized to the member's needs and furnished in accordance with applicable MassHealth requirements and provider guidance.

To qualify for GAFC, a NaviCare member must meet the clinical eligibility requirements in the Fallon Health Group Adult Foster Care Clinical Coverage Criteria and applicable MassHealth requirements, including a documented medical or behavioral health condition requiring daily hands-on assistance or cueing and supervision throughout at least one qualifying ADL. The requested service must be medically necessary, nonduplicative, and appropriate to the member's living setting.

Definitions

The GAFC per diem reimburses the provider for authorized personal care, nursing oversight, care management, and related GAFC program responsibilities furnished in the member's living setting. The GAFC per diem does not reimburse rent, room and board, or supplies required to perform personal care.

Covered GAFC activities may include authorized assistance or supervision with bathing, dressing, toileting, transferring, mobility, eating, meal preparation and cleanup, housekeeping, laundry, shopping, transportation coordination, medication management, and maintenance of adaptive equipment, consistent with the plan of care and 130 CMR 408.505.

NaviCare: Effective January 1, 2027, contracted GAFC providers must submit initial, renewal, reauthorization, extension, significant-change, and provider-transfer requests directly to Fallon Health before services begin or the current authorization expires. The provider must monitor authorization dates. Submission does not extend an authorization.

Reimbursement

The Plan reimburses GAFC services at the applicable per diem rate when the services are medically

necessary, authorized by Fallon Health, actually delivered, properly documented, and billed in accordance with applicable contract terms and billing requirements.

The Plan does not reimburse a day on which the member does not receive GAFC, except an authorized and otherwise payable medical or nonmedical leave-of-absence day within applicable limits. Payment ends when eligibility or medical necessity ends, services stop, the authorization expires, or another payment condition is no longer met, whichever occurs first.

GAFC is not payable when authorization is absent or expired; required personal care is not delivered; the claim duplicates PCA, AFC, agency personal care, home health aide, supportive home care aide, or substantially similar ADL/IADL services; the member is in an inpatient or institutional setting except an authorized payable leave day; the provider, staff, or setting requirements are not met; or the claim is undocumented, incorrectly coded, untimely, or otherwise excluded by law, regulation, benefit, or contract.

Noncovered or Nonpayable Services

The GAFC provider must meet 130 CMR 408.504 and maintain qualified staff, required policies, clinical oversight, care management, emergency planning, member records, and quality-management processes. Admission, ongoing visits, and any limited telehealth use must follow applicable MassHealth requirements and current provider guidance, including Adult Foster Care Bulletin 34 when applicable.

Referral/notification/prior authorization requirements

Prior authorization is required before GAFC services are delivered to NaviCare members. Effective January 1, 2027, contracted GAFC providers must submit complete initial authorization, renewal, reauthorization, extension, significant-change, and provider-transfer requests directly to Fallon Health before services begin or the current authorization expires. The provider is responsible for monitoring authorization effective and end dates. Submission of a request does not extend an existing authorization.

Authorization requests must include, at a minimum:

- Fallon Health's standardized prior authorization request form completed by the GAFC provider;
- A provider clinical assessment completed within six months of the request that identifies the qualifying ADL need, the medical, cognitive, or behavioral health condition causing the functional limitation, the assistance required, and the planned frequency of services;
- A PCP order and/or PCP Summary Form completed within six months of the request;
- The current GAFC plan of care and, for reauthorization requests, updated documentation supporting continued medical necessity and any change in functional status; and
- Documentation or attestation that the requested services do not duplicate other authorized personal care or IADL services.

For a provider transfer or service change, the provider must submit required member-signed transfer or discontinuation documentation and planned effective dates.

For continuity-of-care requests, the provider must submit documentation of the prior insurer's approval or authorization, when applicable.

Fallon Health may request additional clinical records, evaluations, assessments, or other documentation needed to complete the medical necessity review.

Services furnished after an authorization expires may not be reimbursed when continued authorization has not been obtained, subject to applicable law, the provider agreement, and Fallon Health requirements.

Prior authorization is not a guarantee of payment. Payment remains subject to member eligibility and coverage on the date of service, service delivery and documentation, authorization terms, correct coding, timely filing, coordination of benefits, and applicable provider contract requirements.

Billing/coding guidelines

Services must be submitted in the following manner, or per contract terms:

Code	Description
H0043	Supported Housing, per diem

Place of service

This policy applies to services rendered in POS 12.

Policy history

Origination date: 03/01/2017
Previous revision date(s): N/A
Connection date & details: May 2017 – Introduced policy.
November 2017 – Added language regarding Medical and Non-Medical Leave of absence payments/limits.
October 2018 – Clarified services are still covered when the member elects hospice.
October 2019 – Added language regarding room and board payment responsibility.
April 2020 – Annual review. Updated criteria.
January 2027 – Updated prior authorization submission, provider responsibility, documentation, and reimbursement requirements for GAFC services.

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.