



Group Adult Foster Care Clinical Coverage Criteria

Description

Group Adult Foster Care (GAFC) is a MassHealth-covered personal care service provided in the member's residence by qualified non-live-in staff. GAFC includes daily ADL and related IADL assistance, nursing oversight, and care management based on the member's assessed needs and plan of care.

RELEVANT DEFINITIONS:

Clinical Assessment- A comprehensive GAFC provider assessment that documents the member's medical, cognitive, behavioral, and functional status; each qualifying ADL; the assistance or supervision required; the proposed interventions and frequency; the living setting; and the basis for the plan of care and prior authorization request.

Family Member- A spouse, parent of a minor child, or legal guardian of the member.

Uniform Core Assessment (UCA): A standardized assessment used to evaluate a member's functional status, support needs, and community-based service requirements. Information from the UCA may be considered during medical necessity review but does not replace the provider's current service-specific assessment, plan of care, or required supporting documentation.

Policy

This Policy applies to the following Fallon Health product:

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

Authorization Requirements

- Prior authorization is required.
- For NaviCare members, effective January 1, 2027, the AFC provider must submit complete authorization and reauthorization requests directly to Fallon Health and monitor authorization expiration dates.
- PACE- No PA Required for GAFC Services

Fallon Health Clinical Coverage Criteria

GAFC is medically necessary when:

- the member has a medical, cognitive, or behavioral health condition requiring daily hands-on assistance or cueing and supervision throughout at least one qualifying ADL;
- the member resides in an eligible GAFC setting;
- the provider's clinical assessment supports the required assistance and planned interventions;
- services are included in the member's person-centered plan of care; and

- GAFC does not duplicate another personal-care service.

Qualifying ADLs

- Bathing: Assistance with full-body bathing or personal hygiene. Assistance limited to grooming, oral care, shaving, or similar hygiene tasks alone does not qualify.
- Dressing: Assistance with upper and lower body dressing. Assistance limited to shoes, socks, buttons, or zippers alone does not qualify.
- Toileting: Assistance with toileting, incontinence care, catheter care, colostomy care, or related toileting routines.
- Transferring: Physical assistance to move between positions, such as bed, chair, or wheelchair.
- Mobility (Ambulation): Physical assistance, steadying, or guidance during mobility, or assistance with wheelchair mobility when the member cannot self-propel independently.
- Eating: Ongoing supervision, cueing, or physical assistance during meals. Assistance limited to meal preparation or setup does not qualify.

Documentation Required for Prior Authorization

1. Completed authorization request.
2. Current PCP order or other acceptable clinical documentation supporting the need for GAFC.
3. Current GAFC clinical assessment identifying the qualifying ADL needs, required assistance, relevant conditions, interventions, service frequency, and living setting.
4. Current plan of care and planned service schedule.
5. Documentation of the eligible GAFC living setting.
6. For reauthorization, updated information supporting continued eligibility and any relevant changes.
7. For provider transfers or service changes, applicable transition and member-notification documentation.
8. Additional clinical documentation reasonably necessary to determine medical necessity.

Note: Eligibility for Related Services

Members may receive GAFC concurrently with Adult Day Health or Day Habilitation services when independently eligible for each service and when services are coordinated and nonduplicative.

Medicare Variation

N/A

MassHealth Variation

N/A

Exclusions

GAFC is not covered when:

- the member does not require daily assistance with at least one qualifying ADL;
- the request is based only on IADL needs;
- prior authorization was not obtained;
- the provider, direct-care worker, or setting does not meet applicable requirements;
- the service duplicates another personal-care program;
- the member resides in an excluded institutional or provider-operated setting; or
- the requested amount represents rent, room and board, housing charges, or personal-care supplies.

Evidence Summary

N/A

Analysis of Evidence (Rationale for Determination)

N/A

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

CPT/HCPCS Codes

Code	Description
H0043	Supported Housing, per diem

References

1. 130 CMR 408.00 MassHealth Adult Foster Care program regulations
<https://www.mass.gov/doc/130-cmr-408-adultfoster-care/download>
2. 101 CMR 351.00 MassHealth Adult Foster Care rate regulations
<https://www.mass.gov/doc/101-cmr-351-rates-forcertain-adult-foster-care-services/download>
3. 42 CFR 441.301(c)(4) related to home- and community-based services (HCBS)
<https://www.ecfr.gov/current/title42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301>
4. MassHealth Guidelines for Medical Necessity Determination for Adult Foster Care (AFC)
<https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-adult-foster-care-afc/download>

5. Policy history

Origination date: 01/01/2026
Review/Approval(s): Technology Assessment Committee: N/A
Utilization Management Committee: 10/21/2025 (origination, approved as written), 09/15/2026 (Revision date: 01/01/2027 – Aligned with the GAFC Payment Policy and current MassHealth GAFC requirements; clarified medical necessity, clinical assessment, documentation, reauthorization, provider oversight, nonduplication, housing transition, NaviCare, PACE IDT, exclusions, and corrected coding to H0043).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in

accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.