



***Comments on Proposed Regulation 130 CMR 438.000 Continuous Skilled Nursing
Agency Services***

Written Public Comment

Submitted by: Home Care Alliance of Massachusetts (HCA)

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Introduction

On behalf of more than 200 home care, home health, and hospice providers across the State who deliver the vast majority of services in the Commonwealth, The Home Care Alliance of Massachusetts (HCA) appreciates the opportunity to comment on the proposed amendments to 130 CMR 438.00, which governs Continuous Skilled Nursing Services.

Appreciation is extended for MassHealth's continued engagement with stakeholders and for its efforts to ensure that home and community-based services meet the evolving needs of MassHealth members receiving services through the Continuous Skilled Nursing Program.

The Home Care Alliance of Massachusetts respectfully offers the following comments and recommendations to support clarity, operational feasibility, patient safety, and continued access to high-quality care.

These comments reflect the importance of aligning any changes with applicable nursing regulations and ensuring care is delivered in a manner consistent with the established scope of practice for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs).

Overview and General Comments

HCA appreciates MassHealth's efforts to examine strategies to address workforce shortages in the home health sector, including consideration of an expanded role for Licensed Practical Nurses (LPNs). We recognize the significant staffing challenges facing providers across the industry and support thoughtful approaches that help strengthen access to care for MassHealth members.

At the same time, changes to care delivery expectations must remain consistent with Board of Nursing regulations at [244 CMR 3.00: Registered Nurse and Licensed Practical Nurse](#).

HCA's comments on the proposed amendments to 130 CMR 438.00, related to Complex Care Assistant (CCA) supervision and the expanded role of LPNs, are guided by these foundational principles. Our recommendations reflect the importance of ensuring that any expansion of responsibilities within the home health setting remains consistent with Board of Nursing regulations, respects the established scope of practice for LPNs and RNs, and supports safe, high-quality care for MassHealth members.

438.402: Definitions

Proposed Definition of Complex Care Assistant Supervisor (CCA Supervisor) (130 CMR 438.402)

Recommendation:

HCA recommends that MassHealth delete the proposed definition of Complex Care Assistant Supervisor (CCA Supervisor), defined as “a registered nurse or licensed practical nurse who is familiar with the member and the member’s plan of care as described at 130 CMR 438.416”, and retain the definition of Registered Nurse (RN) Supervisor – “a person who is familiar with the member and the member’s plan of care as described at 130 CMR 438.416”

HCA Comments:

The proposed definition blurs the distinction between administrative oversight and clinical supervision. **That distinction is critical.** The Massachusetts Board of Registration in Nursing has clarified in [Advisory Ruling 98-02: The Licensed Practical Nurse in the Charge or Supervisor Nurse Role](#) that the LPN charge or supervisory role is administrative in nature, and distinct from clinical functions such as delegation and oversight of patient care

The Board further explains that the “non-clinical, administrative functions” of the charge/supervisor role differ from the “clinical function of delegation,” in Table 1 of Advisory Ruling 98-02. The Advisory Ruling identifies patient care assignment as an administrative function and delegation as a clinical function.

The proposed CCA Supervisor definition is problematic because CCA supervision is not limited to staffing or assignment functions. Supervision of the CCA requires observation and assessment of care delivery in the home. That is not merely administrative oversight; it is the oversight of the delivery of health-related services to medically complex members. These are inherently clinical functions involving judgment and accountability.

The Board of Nursing’s regulations at [244 CMR 3.00: Registered Nurse and Licensed Practical Nurse](#) reinforce why this distinction matters.

- **244 CMR 3.01** states the RN “holds ultimate responsibility for direct and indirect nursing care.”
- **244 CMR 3.02 (1)** states the RN bears “full and ultimate responsibility” for the quality of nursing care.

- **244 CMR 3.04 (2)** describes the LPN role in participatory terms: the LPN “participates in direct and indirect nursing care” and “participates in” analysis, planning, and evaluation.

While **244 CMR 3.04 (1)** permits an LPN, with education and experience, to delegate nursing activities to unlicensed persons in accordance with **244 CMR 3.05**, that delegation authority does not erase the broader regulatory framework that reserves ultimate nursing responsibility to the RN.

Supervision of the CCA services under **130 CMR 438.415(C)(5)(a), (b), and (c)**, states observation of care, assessment of whether health-related tasks are being performed safely, evaluation of member-specific competency, identification and follow-up of deficiencies, and oversight of care delivered to medically complex members in the home. Decisions about whether a deficiency exists, whether retraining or remediation is required, and whether a CCA may safely continue providing member-specific care are closely tied to quality oversight and evaluation of care.

Those functions are most appropriately carried out by an RN and are consistent with **244 CMR 3.05**, which places direct responsibility on the licensed nurse for the nature and quality of care rendered under that nurse’s direction. Accordingly, HCA recommends that responsibilities under **130 CMR 438.415(C)(5)(b)** and **(c)** remain under RN oversight.

Complex Care Assistant services are part of the CSN framework for medically complex MassHealth members. MassHealth defines CCA services as medically necessary services as described at **130 CMR 438.000** and identified in the plan of care delivered to complex care members. These services include enhanced care tasks such as enteral G-tube or J-tube feedings, routine tube care, oxygen therapy, oral suctioning of superficial oral secretions, ostomy care, catheter care, and management of respiratory equipment, including CPAP, BiPAP, and oxygen.

Because these are delegated, health-related tasks performed for a high-acuity population, supervision cannot be reduced to administrative oversight. The supervising nurse must be able to observe and assess how care is being provided, determine whether the member’s plan of care is being followed safely, identify any deviations from proper technique, and decide when retraining or escalation is required. That level of oversight fits the RN role, not a generalized LPN supervisory model.

It should be noted that Medicare-certified home health agencies participating in the MassHealth CSN program are required to comply with the Federal Conditions of Participation for home health agencies. Under the Federal Conditions of Participation governing supervision of home health aides, the supervisory role is assigned to a **registered nurse or other appropriate skilled professional**. An LPN is not defined as a

professional authorized to conduct these supervisory visits. See **42 CFR § 484.80(h)(1)(i)(A)** and **42 CFR § 484.80(h)(2)(i)(A)**.

Allowing LPNs to supervise aides under the MassHealth CSN program would therefore create ambiguity and uneven standards across agencies. A Medicare-certified home health agency would still have to follow the federal CoPs, while a non-Medicare-certified agency could be held to a different state standard.

For these reasons, the proposed definition of CCA Supervisor is overly broad. In practice, it would place LPNs in a role that extends beyond the Board's characterization of LPN supervision as administrative and extends to oversight of clinical and health-related services for medically complex members in the home.

Retaining an RN-specific definition of supervisor preserves a clear line of accountability for delegated care delivered by unlicensed personnel to medically complex members. It also avoids ambiguity over whether agencies may substitute lower-licensure oversight for functions that require assessment, judgment, remediation, and escalation.

130 CMR 438.415(C)(5)(a): 60-day Supervisory Visits

Recommendation:

HCA recommends retaining the current biweekly (every 14 days) RN supervisory visit requirement as written in the existing regulation, as it better supports patient safety and quality oversight.

If MassHealth proceeds with the proposed 60-day supervisory visit standard, HCA recommends strengthening the requirement by retaining the prior expectation that the RN "observe and assess the assistant while they are performing care," thereby requiring the CCA to be present during at least one supervisory visit

HCA Comments:

HCA recognizes that many Complex Care Assistant (CCA) services are often provided by family members or other caregivers who have delivered daily care for an extended period and are often deeply familiar with the member's usual care routines and needs.

We acknowledge the commitment of these caregivers and the critical role they play in supporting members in the home. However, that day-to-day familiarity does not eliminate the need for regular, clinically appropriate supervision by a Registered Nurse. Because CCA services include complex medical and health-related tasks, they require ongoing clinical oversight to ensure that services are delivered safely, appropriately, and in accordance with the member's plan of care.

Caregivers often manage significant physical and emotional stress, and their close involvement in daily care may make it more difficult to identify subtle yet clinically meaningful changes in the member's condition, technique, or adherence to member-specific instructions.

For this reason, HCA does not believe a 60-day supervisory interval is sufficient for the medically complex population receiving CCA services. Extending the timeframe for supervisory visits reduces opportunities to identify patient decline, caregiver error, equipment-related concerns, unsafe workarounds, or deviations from the plan of care before they result in harm.

We recommend that the CCA be present during the 60-day supervisory visit, which, as stated in the regulations, must occur "no less frequently than every 60 days." Removing this requirement eliminates an important safeguard for maintaining patient safety. Ultimately, agencies providing this care are responsible for the quality and safety of the care delivered. If the CCA is not required to be present for the 60-day supervisory visit, the agency may go an extended period without directly observing the CCA perform assigned tasks in the patient care setting. An agency cannot meaningfully assess a CCA's proficiency without direct observation of that performance.

This concern is heightened where the proposal would also permit a lower licensure level to perform the supervisory function. In HCA's view, the combination of less frequent oversight and a change in the level of licensure responsible for that oversight weakens an important safeguard in the delivery of CCA services.

HCA recognizes the workforce challenges facing providers and appreciates the need to consider operationally feasible alternatives. If MassHealth determines that a modification to the current standard is necessary, a 30-day RN supervisory interval would be a more appropriate approach to help address staffing pressures while preserving patient safety and meaningful clinical oversight.

It is also important to note that if a Medicare-certified home health agency provides CSN services to a MassHealth member, it must comply with the federal Conditions of Participation for home health agencies. Under **42 CFR § 484.80(h)(1)(i)**, patients receiving skilled services are subject to a 14-day supervisory standard, while the 60-day standard is reserved for patients who are not receiving skilled nursing, physical therapy, occupational therapy, or speech-language pathology services.

HCA is concerned that changing the 14-day supervision requirement could create confusion in cases where a member receives CCA services from both a Medicare-certified agency and a non-Medicare-certified agency. Applying different supervisory standards to agencies serving the same member may create ambiguity for members, families, and providers and may undermine consistent oversight expectations. It may also encourage

members to prefer services from non-Medicare-certified agencies because those agencies would be subject to less frequent supervisory visits.

130 CMR 438.415(C)(6): CCA 12-Month Evaluation

Recommendation:

HCA supports the addition of the CCA 12-Month Evaluation, but proposes revising the language in 130 CMR 438.415 (C)(6) from **“A 12-month enhanced care evaluation must be conducted by an RN or LPN employed by the CSN agency”** to **“A 12-month enhanced care evaluation must be conducted by an RN.”**

HCA Comment:

As with the other proposed changes related to the delegation and supervision of CCA services, HCA believes the annual enhanced care evaluation should remain under RN oversight. The evaluation requires a review of the member-specific tasks performed by the CCA, an assessment of continued proficiency, and a determination of whether additional training is necessary. Because these determinations involve clinical judgment regarding the competency and quality of care for medically complex patients, they are more appropriately made by an RN. And for all the other reasons stated above.

130 CMR 438.416 (F) Face-to-Face Encounter Requirements

HCA Comment:

HCA proposes that MassHealth revise its face-to-face encounter regulation for CSN services to align with the updated federal Medicare home health certification standard, effective January 1, 2026. CMS revised 42 CFR 424.22(a)(1)(v) in the CY 2026 Home Health PPS final rule to clarify that the face-to-face encounter may be performed by any physician, nurse practitioner, clinical nurse specialist, physician assistant, or certified nurse-midwife authorized by law, and CMS removed the prior restriction tying the encounter to the certifying practitioner or to the acute/post-acute practitioner **“from the facility from which the patient was directly admitted from”**.

MassHealth’s current regulation limits the face-to-face encounter to the ordering provider, the acute/post-acute attending provider from the facility of direct admission, or certain non-physician practitioners working under that older structure. That approach no longer reflects the revised federal Medicare certification framework. Aligning MassHealth’s regulation with the updated federal standard would reduce confusion, promote consistency across payers, and eliminate unnecessary administrative barriers that delay access to medically necessary services.

The most important change that should be clearly reflected in the revised regulation is this: the face-to-face encounter need not be performed by the certifying provider, nor by the physician or practitioner from the acute or post-acute setting from which the patient was directly admitted.

Under the updated federal Medicare rule, the encounter may instead be performed by any of the authorized practitioner types listed in the regulation, provided it is timely, related to the primary reason the patient requires home health services, and properly documented in the medical record.

Example of what **would** be acceptable:

If a MassHealth member is referred for continuous skilled nursing services due to tracheostomy dependence, ventilator support, or other complex respiratory needs, the practitioner who has evaluated and is actively treating those conditions may appropriately complete the face-to-face encounter for CSN services, even if that practitioner is not the member's primary care provider.

Example of what would **NOT** be acceptable:

It would not be appropriate for a practitioner whose involvement is unrelated to the member's need for continuous skilled nursing services to complete the face-to-face encounter. For example, a practitioner treating a member for a limited dermatologic condition should not certify the need for CSN services requested for tracheostomy care, gastrostomy tube management, or seizure monitoring.

Recommendation:

HCA recommends that MassHealth replace the language for 130 CMR 438.416 (F) to align with the updated regulatory language in the Federal Conditions of Participation, as written below:

438.416 (F) Face- to- Face Encounter Requirements

(1) A face-to-face encounter between the member and an authorized practitioner is required for initial orders for CSN agency services. A face-to-face encounter is not required when the plan of care is reviewed and revised as required at 130 CMR 438.416(C) or at resumption of CSN agency services

(2) A face-to-face patient encounter, which is related to the primary reason the patient requires CSN agency services, occurred no more than 90 days prior to the start of care date or within 30 days of the start of CSN Services and was performed by a physician or non-physician practitioner defined below. The certifying physician or certifying allowed practitioner must also document the date of the encounter as part of the certification.

(3) The face-to-face encounter may be performed by any of the following practitioners, acting within the scope of practice permitted under applicable law:

- a physician;
- a nurse practitioner;
- a clinical nurse specialist;
- a physician assistant; or
- a certified nurse-midwife, as authorized by state law.

(4) The face-to-face encounter is not required to be performed by the certifying or ordering provider and is not required to be performed by a practitioner who cared for the member in an acute or post-acute care facility from which the member was directly admitted to home health. Any allowed practitioner may perform the face-to-face encounter, provided that the encounter satisfies the timing, practitioner-type, and clinical relevance requirements of this section, and the certifying or ordering provider has sufficient information to certify or order home health services.

(5) The face-to-face patient encounter may occur through telehealth, in compliance with State and Federal law.

130 CMR 438.411(E): Prior Authorization Requirements

130 CMR 438.419 (H) Complex Care Assistant (CCA) Intake Visits

Comment:

HCA respectfully requests clarification regarding when CSN agencies can request and bill for CCA Intake visits.

As written, proposed regulations **438.411(E)** and **438.419(H)** appear inconsistent. Section **438.411(E)** states “**MassHealth will authorize up to two hours (8 units) for CCA intake visits at the beginning of a new prior authorization period. CSN agencies may not request more units for CCA intake visits.**” whereas section **438.419(H)** states “**CSN agencies may submit claims for CCA intake visits when a MassHealth member begins to receive CCA services from the agency. CSN agencies may not submit claims for CCA intake visits that take place after a member has already begun to receive CCA services.**” This inconsistency should be resolved so that agencies have clear direction regarding when CCA intake visits may be requested and billed.

130 CMR 438.418(A)(2): Transfers and Discharge Planning – Discharge for Cause

HCA appreciates MassHealth’s recognition that there are circumstances in which a CSN agency may be unable to safely provide care in the home due to disruptive, abusive, or uncooperative behavior. Protecting the safety of nurses and other staff is critically important, and we support the inclusion of discharge-for-cause provisions in the regulation.

Although this language is not new, HCA is raising it intentionally given continued concerns from providers regarding staff safety and the practical application of the 14-day notice requirement.

However, we have concerns with the requirement that agencies provide advance notice of a planned discharge “within 14 days” in situations where safety is already compromised.

In practice, there are circumstances in which the safety risk to staff is immediate or escalating, and a fixed 14-day notice period may not be appropriate or feasible. Requiring agencies to continue providing services during this period could place nurses at continued risk, particularly in situations involving threatening or unsafe behavior in the home.

HCA recommends that MassHealth revise this section to allow for greater flexibility in cases where there is a documented risk to staff safety. Specifically, we suggest:

- Allowing for shortened or immediate discharge when the agency determines that continued service delivery would pose a risk to staff; and
- Clarifying that the 14-day notice expectation applies only when it is safe and appropriate to do so, based on the circumstances.

We support the remaining provisions requiring notification, documentation of efforts to resolve issues, and assistance with identifying alternative providers, as these are important protections to ensure continuity of care. However, these requirements should not override the need to ensure staff safety in urgent or high-risk situations.

Clarifying this distinction would better align the regulation with real-world care delivery and support both patient access and workforce protection.

130 CMR 438.419 (I): CSN Training time:

Recommendation:

HCA recommends removal of the proposed language at 438.419(l)(2)(b) “**another CSN provider who is familiar with the member’s care;**” and (c) “**the member’s natural caregiver or other family member who is familiar with the member’s care.**”

Comment:

Providers should be responsible for training their own nurses in accordance with the agency’s established quality standards and should not have their agency nurses trained by nurses employed by another CSN agency.

An agency is responsible for the care delivered under its license and would not reasonably train a nurse who is not its employee due to liability considerations and the inability to assess that individual’s competency and proficiency. Similarly, agencies cannot ensure the quality or consistency of training provided by another CSN agency or rely on another agency’s assessment of competency.

In addition, a member’s family member or natural caregiver should not be responsible for training a nurse, particularly when skilled care is involved. While family members and caregivers are often familiar with the member’s care needs and can be a valuable support in the training process, HCA’s position is that the safest approach is for a new agency nurse to be trained by a licensed nurse employed by the CSN agency. HCA supports reimbursement for this training time. This approach reflects best practice by ensuring that training is delivered by a qualified professional and is consistent with the quality standards established by the CSN agency.

Conclusion

HCA appreciates the opportunity to provide comments on the proposed amendments to **130 CMR 438.00**. We thank MassHealth for its continued engagement with stakeholders

and for the opportunity to offer feedback on these important proposed regulations affecting continuous skilled nursing services.

In conclusion, HCA respectfully recommends that MassHealth revise the proposed amendments to **130 CMR 438.00** to better protect patient safety, preserve clear clinical accountability, and avoid unnecessary operational confusion for providers.

The testimony highlights significant concerns regarding reduced supervisory standards, the expansion of LPN oversight into areas requiring RN clinical judgment, conflicting provisions related to CCA intake visits, and training standards that should remain under the control of the agency responsible for the member's care.

These revisions are critical to ensuring that the final regulations are clear, workable, and protective of the medically complex members who rely on continuous skilled nursing.

Respectfully submitted,

Jake Krilovich
Chief Executive Officer
Home Care Alliance of Massachusetts
75 Kneeland Street Ste. 709
Boston, MA 02111