Proposed Regulation 101 CMR 350.00 Rates for Home Health Services

Written Public Comment

Submitted by: Home Care Alliance of Massachusetts

April 6, 2026

On behalf of over 200 home care, home health and hospice providers across the State who provide the vast majority of services delivered in the Commonwealth, the Home Care Alliance of Massachusetts (HCA) appreciates the opportunity to provide comments on the proposed amendments to 130 CMR 403.000 governing home health agency services.

HCA thanks MassHealth for its continued engagement with stakeholders and its efforts to ensure that home and community-based services meet the evolving needs of MassHealth members. We recognize the intent behind the proposed Value-Based Payment (VBP) service model to support more coordinated, outcome-focused care.

HCA offers the following comments and recommendations to support clarity, operational feasibility, and sustained access to high-quality home health services for MassHealth members. Our comments reflect direct input from member agencies and are informed by the practical realities of delivering care in the home setting.

Overview and General Comments

HCA appreciates MassHealth's efforts to advance a Value-Based Payment (VBP) approach within the home health benefit and its broader focus on strengthening care delivery in home and community-based settings. We support the goal of promoting high-quality, coordinated care for MassHealth members, particularly those with complex clinical and social needs.

At the same time, the proposed VBP service introduces a new care delivery and payment structure that represents a significant shift from existing home health frameworks. While MassHealth has provided additional context through stakeholder materials, key elements—including quality measurement methodology, performance thresholds, rate

determination, and operational expectations—are not sufficiently defined within the regulation itself.

As currently proposed, the VBP service raises important concerns related to clarity, implementation, and overall feasibility for home health providers. Providers are being asked to participate in a model that introduces new financial and operational risk without clear, codified expectations.

Home health agencies operate in a highly regulated environment with existing federal and state requirements, workforce constraints, and increasing administrative burden. The introduction of a new payment model without clearly defined expectations and alignment with existing frameworks may create unintended barriers to access, delays in care, and additional administrative complexity.

Given the scope and impact of this proposal, HCA strongly recommends that MassHealth provide additional detail and guidance on the VBP model and continue stakeholder engagement prior to implementation. Ensuring that the model is transparent, operationally feasible, and adequately resourced will be critical to its success and to maintaining access to home health services for MassHealth members across the Commonwealth.

Operational and Implementation Considerations

HCA has also received additional feedback from member agencies regarding the operational implications of implementing the VBP model.

Agencies note that implementing a new payment model requires significant operational changes, including configuring new payer structures within clinical and billing software, adapting workflows, and establishing processes to monitor a distinct VBP patient population. These changes require time, resources, and system modifications that may not be readily available across all providers.

HCA understands that agencies will not be responsible for verifying full member eligibility criteria (e.g., prior hospitalizations or emergency department utilization), but will instead attest that the member requires four or more skilled nursing and/or medication administration visits per week. MassHealth will then determine whether the member meets the broader eligibility criteria. While this approach reduces some burden on providers, additional clarity is needed regarding how and when eligibility determinations will be communicated to agencies.

Based on stakeholder discussions, HCA understands that services will initially be authorized and reimbursed under the traditional fee-for-service (FFS) model at the start of care. Once a provider identifies a member as potentially eligible for VBP and submits the required attestation, MassHealth will evaluate eligibility for transition into the VBP model. HCA requests clarification regarding the timing of this transition, including whether FFS billing will apply for an initial period (e.g., the first 60 days) and how payment reconciliation will be handled.

Member Participation and Enrollment Clarification

HCA requests clarification regarding how member participation in the VBP program will be operationalized, including whether members will have the ability to opt out of participation. Understanding whether enrollment is automatic or requires member consent, and how members will be informed of their participation, is important to ensure transparency and support both provider workflows and member choice.

HCA understands that prior authorization for VBP services may be issued for a 12-month period. However, it is not clear how prior authorization requirements will apply when there are changes to the plan of care, such as the addition of a new discipline or changes in service frequency. Clarification is needed to ensure that care delivery remains flexible and responsive to member needs without unnecessary administrative burden.

Finally, HCA seeks clarification regarding the role of telehealth within the VBP model, particularly as it applies to all disciplines—nursing, physical therapy, occupational therapy, speech therapy, and medical social work. Given the emphasis on care coordination and efficient service delivery under a PMPM structure, HCA assumes that telehealth may be appropriate in certain circumstances but recommends that MassHealth explicitly define allowable uses to ensure consistency across providers.

Quality Measurement Framework and Performance Methodology

MassHealth references quality measurements to define performance expectations under the VBP model. While HCA appreciates the intent to allow flexibility as measures evolve over time, the proposed regulation does not include sufficient detail regarding the specific measures, performance thresholds, or methodology used to determine provider compliance.

Based on stakeholder materials/meetings, MassHealth intends to evaluate performance using measures related to emergency department utilization, inpatient admissions, and total cost of care, and to apply a relative ranking methodology in which the top 75% of providers in two or more measures receive the compliant rate and the bottom 25% receive the non-compliant rate.

Given that performance on these measures will directly impact whether providers receive the compliant or non-compliant rate, greater transparency within the regulation is essential to ensure providers can fully understand program expectations and assess participation.

HCA has several concerns with this approach.

First, the use of a relative ranking methodology establishes a system in which a fixed percentage of providers will be designated as non-compliant each year, regardless of overall improvement in performance across providers.

Second, the identified measures rely on claims-based outcomes that are influenced by multiple factors beyond the control of home health agencies, including hospital practices, access to primary care, and social determinants of health. As a result, providers may be held accountable for outcomes that are not fully attributable to the care they deliver.

Third, the anticipated VBP population is relatively small, which may introduce variability in performance results and limit the reliability of comparisons across providers.

In addition, HCA has concerns regarding the inclusion of total cost of care (TCOC) as a performance measure within the VBP model. TCOC is a broad measure that reflects overall Medicaid spending and is influenced by multiple factors beyond the control of home health agencies, including hospital utilization, physician services, pharmacy costs, durable medical equipment (DME) and other system-level drivers.

HCA also notes that key components of total cost of care—particularly hospitalizations and emergency department utilization—are already included as separate quality measures. As a result, the inclusion of TCOC may effectively double weight these outcomes within the performance methodology.

Given the limited provider control over total cost of care and the potential duplication within the measurement framework, HCA recommends that MassHealth reconsider the use of TCOC as a performance measure within the VBP model.

HCA recommends that MassHealth:

- Include greater specificity within the regulation regarding quality measures and performance methodology;
- Provide clear definitions of how measures will be calculated and applied;
- Reconsider the use of a strictly relative ranking methodology; and
- Ensure appropriate risk adjustment and attribution methodologies are in place.

VBP Rate Structure and Consideration for High-Need Therapy Cases

HCA and its member agencies support MassHealth's movement toward a prospective, per member per month (PMPM) payment structure under the proposed VBP service. For the population identified, a PMPM model has the potential to support more flexible, patient-centered care delivery.

At the same time, HCA encourages MassHealth to consider the need for flexibility within the PMPM structure to account for outlier cases requiring higher-intensity services. While the target population for the VBP service may not routinely require extensive therapy or medical social work services, there are clinical scenarios—such as members with significant functional decline, behavioral health needs, or complex medical conditions—where short-term, intensive therapy services or medical social work intervention are medically necessary.

These members are often at increased risk for adverse events and hospital utilization, and may benefit from more intensive, time-limited therapy interventions to stabilize their condition and support safe care in the home. In these cases, a fixed PMPM rate may not adequately reflects the level of care required to achieve patient quality outcomes and creates challenges for providers in meeting member needs within the defined payment structure.

HCA recommends that MassHealth consider incorporating a mechanism for exceptions or add-on payments for high-need, therapy-intensive cases, with clearly defined criteria to ensure appropriate and consistent application.

Need for Additional Clarity on VBP Rate Methodology and Structure

HCA appreciates that MassHealth has provided additional detail regarding the overall rate setting process and reporting framework for the VBP model, including the use of an initial service year with a compliant rate, a baseline reporting year, and the use of prior calendar year claims data to assess performance in subsequent rate years.

MassHealth has also shared proposed compliant and non-compliant rate amounts and a general approach for determining provider performance.

However, additional clarity is still needed regarding how performance on quality measures will translate into payment.

As described, MassHealth intends to use a relative ranking methodology in which providers are compared to one another, with the top 75% receiving the compliant rate and the bottom 25% receiving the non-compliant rate.

HCA has concerns with this approach. Under a relative ranking model, a set percentage of providers will always fall into the non-compliant category, even if overall performance improves across all providers. In other words, even if all agencies reduce hospitalizations and emergency department visits, 25% of providers will still be assigned the lower rate.

In addition, providers serve different patient populations with varying levels of clinical complexity. Agencies caring for members with more complex medical or behavioral health needs may naturally see higher rates of hospital utilization, even when delivering high-quality care. Without clear information on how these differences are accounted for, providers may be disadvantaged based on the patients they serve rather than the quality of care they provide.

It is also unclear how performance results will be calculated, validated, and applied, including whether there will be opportunities for providers to review or appeal performance determinations.

Without this level of detail, providers are unable to fully assess the financial implications of participation or evaluate the sustainability of the model.

HCA strongly recommends that MassHealth provide additional transparency regarding the rate-setting methodology and how performance will be measured and applied to payment.

Additional Clarification Needed: Performance Review and Appeals Process

Comment:
HCA requests clarification regarding the process by which performance results under the VBP model will be calculated, shared, and finalized, including whether providers will have an opportunity to review and validate performance data prior to the application of payment adjustments.

Given that performance determinations will directly impact whether a provider receives the compliant or non-compliant rate, it is critical that providers have visibility into the data and methodology used to assess performance. This includes clarity regarding data sources, attribution of outcomes, and any risk adjustment applied.

In addition, HCA seeks clarification as to whether MassHealth will establish a formal process for providers to request review, reconsideration, or correction of performance results in cases where discrepancies or data inaccuracies are identified.

Without a defined process for data validation and appeal, providers may be subject to payment adjustments based on incomplete or inaccurate information, with limited ability to address potential errors.

Recommendation:
HCA recommends that MassHealth:

- Establish a clear and transparent process for sharing performance data with providers in advance of final rate determination;
- Provide providers with a defined opportunity to review and validate performance results; and
- Implement a formal appeals or reconsideration process to address data discrepancies, attribution concerns, or calculation errors prior to the application of payment adjustments.

Prior Authorization and Care Initiation Under VBP

HCA appreciates the additional clarification provided by MassHealth regarding the initiation of VBP services and the prior authorization process.

Based on stakeholder discussions, HCA understands that home health services will begin under the traditional fee-for-service (FFS) model at the start of care. Following initial clinical evaluation, the home health agency will determine whether the member will require ongoing services at a level of four or more skilled nursing and/or medication administration visits per week and may attest accordingly. MassHealth will then determine whether the member meets the eligibility criteria related to prior hospitalizations and emergency department utilization.

This approach helps to support timely initiation of care and appropriately places responsibility for eligibility determination with MassHealth.

However, several operational questions remain.

It is not clear how “hospitalizations” will be defined for purposes of VBP eligibility, including whether observation stays or overnight hospital encounters that do not result in formal inpatient admission will be included.

In addition, further clarity is needed regarding how and when providers will be notified of a member's transition from FFS to VBP, including how payment will be handled during this transition period. For example, it is not clear whether services will continue to be reimbursed under FFS for an initial defined period (e.g., 30–60 days) prior to transition into the VBP model, or how adjustments will be made once VBP eligibility is confirmed.

HCA also seeks clarification regarding prior authorization requirements once a member is enrolled in VBP, particularly in situations where there are changes to the plan of care, such as the addition of a new discipline or adjustments in service frequency.

HCA recommends that MassHealth provide additional guidance to ensure consistent implementation and to support providers in delivering timely, appropriate care under the VBP model.

403.410: Prior Authorization Requirements

(F) Home Health Agency VBP Service for VBP Members Not Enrolled in a Capitated Program

Prior Authorization 403.410(F)(3)(b)

Proposed Revision:
Delete section 403.410(F)(3)(b):
"Clinical criteria: documentation supporting the member's clinical eligibility in accordance with 130 CMR 403.414(B)."

Rationale:
Home health agencies do not have direct access to hospital or emergency department documentation needed to support clinical eligibility as outlined in 130 CMR 403.414(B), which requires evidence of either (1) at least two hospitalizations in the past 12 months, or (2) one hospitalization and at least two emergency department visits in the past 12 months.

Requiring agencies to submit documentation maintained by external providers—and not part of the home health agency's clinical record—is not operationally practical and creates unnecessary administrative burden. Obtaining this information would require outreach to hospitals or physician offices and may involve additional steps, including securing patient authorization under HIPAA, which can delay care and is outside the control of the agency.

It is HCA's understanding from prior stakeholder discussions that MassHealth or its designee would be responsible for determining and validating this eligibility criterion. Clarification is needed to ensure consistent implementation and to avoid placing responsibility on providers for information they do not reasonably have access to.

Prior Authorization 3.410(F)(3)(d)

Current Language:
"(d) attestation that they are seeking to confirm clinical eligibility for home health agency VBP service for the member identified."

Proposed Revision:
Revise section 403.410(F)(3)(d) to state:
"(d) attestation that the member requires at least four visits per calendar week of skilled nursing visits, medication administration visits, or a combination of both."

Rationale:
The current language is unclear and may be interpreted as requiring providers to attest to overall program eligibility as stated above. Home health agencies do not have access to this information and therefore cannot reasonably attest to full eligibility under 130 CMR 403.414(B).

However, providers can appropriately attest—based on their clinical assessment—to the member's need for ongoing services at a defined frequency.

Consistent with prior stakeholder discussions, HCA understands that the home health provider only needs to attest to the member requiring at least four visits per calendar week of skilled nursing visits, medication administration visits, or a combination of both.

MassHealth or its designee would confirm eligibility criteria related to hospitalizations and emergency department use. Aligning the attestation requirement with information available to providers will support clearer expectations and more consistent implementation of the VBP model.

403.414: Home Health Agency VBP Service for VBP Members Not Enrolled in a Capitated Program – Conditions of Payment

Comment:
HCA requests clarification regarding the prior authorization requirements and timing of initiation of VBP services as outlined in this section.

As written, subsection (A)(2) states that prior authorization must be obtained prior to home health agency VBP service delivery. However, based on stakeholder discussions, HCA understands that home health services will initially be provided under the traditional fee-for-service (FFS) model with standard prior authorization at the start of care. Following initial assessment and provider attestation, MassHealth will determine whether the member meets eligibility criteria for VBP and, if so, transition the member to the VBP service model.

The current regulatory language does not clearly reflect this process and may lead to confusion among providers regarding when VBP prior authorization is required and how the transition from FFS to VBP is operationalized.

Recommendation:
HCA recommends revising this section to clarify that:

- Home health services may be initiated under the traditional FFS model with standard prior authorization;
- Providers may submit attestation based on clinical assessment regarding service needs consistent with VBP criteria;
- MassHealth is responsible for determining eligibility based on hospitalization and emergency department utilization; and
- Members will transition to the VBP service model upon confirmation of eligibility.

Clarifying this process will support timely initiation of care and ensure consistent implementation of the VBP model.

HCA Recommendation: Exclude Dually Eligible Patients from the VBP Program

Recommendation:
MassHealth should exclude dually eligible Medicare–MassHealth members from the MassHealth Value-Based Payment (VBP) program.

Comment:

For home health agencies, including dually eligible patients in the VBP program creates a substantial and unsustainable administrative burden. When a patient's clinical condition changes and therapy is ordered for an individual who meets Medicare homebound criteria, the agency is required to transition that patient from the VBP program to Medicare-covered

home health services. This is not a simple payer change. It requires a new start of care under Medicare, including a qualifying face-to-face encounter and completion of a Start of Care OASIS by a Registered Nurse.

This process is exceptionally resource intensive. A Start of Care OASIS is lengthy, complex, and time consuming to complete, and it must be performed by limited RN staff who are already in short supply. Requiring agencies to open new Medicare episodes for dually eligible patients who move in and out of coverage status places significant strain on staffing, workflow, and clinical operations. It diverts scarce nursing resources away from direct patient care and further pressures an already constrained labor pool.

Some of these patients are older, medically complex, and more likely to experience changing care needs, rehospitalizations, and new therapy requirements that trigger repeated transitions between payer sources. In some situations, agencies may also be forced to submit demand billing to Medicare in order to obtain a formal denial when coverage is unclear, adding even more administrative work and compliance risk.

As a result, including dually eligible patients in the VBP program creates excessive workload, increases workforce strain, consumes valuable clinical resources, and heightens the risk of noncompliance with Medicare billing requirements. For home health agencies operating with limited staffing, these repeated transitions are operationally burdensome, inefficient, and difficult to sustain.

PMPM Payment Structure and Inpatient Stays – Clarification and Recommendation

HCA recommends that MassHealth clarify the application of the per-member-per-month (PMPM) payment during periods when a member is admitted to an inpatient setting. Specifically, MassHealth should establish a consistent policy that either:

- Allows the full PMPM payment to continue during inpatient stays, recognizing the home health agency's ongoing role in care coordination, discharge planning, and transition management; **or**
- Implements a clearly defined and transparent proration methodology that outlines how PMPM payments will be adjusted during periods of hospitalization.

In addition, HCA notes that, as currently structured, the VBP PMPM does not reflect a true population-based PMPM model. Traditional PMPM models rely on a balance of high- and low-utilizing members to offset overall costs. In contrast, the proposed VBP population appears to consist primarily of higher-acuity individuals who require consistent and often intensive services, with limited opportunity for lower-utilization cases to offset periods of higher need.

Within this context, inpatient hospitalizations may serve as one of the few natural offsets to periods of high service intensity in the community. Absent clear policy on PMPM application during inpatient stays, providers face uncertainty regarding how these fluctuations in utilization are accounted for, further complicating financial and operational planning.

Clear guidance is essential to ensure consistent implementation, mitigate the risk of retrospective recoupments, and align payment methodology with the clinical and operational realities of serving this population.

Telehealth Clarification – 403.414(A)(10)

Comment:
HCA requests clarification regarding the role and allowable use of telehealth within the VBP model.

While the regulation indicates that telehealth may be used for clinically appropriate and medically necessary services that do not require hands-on care, additional clarity is needed to support consistent implementation across providers.

Home health agencies are responsible for assessing member needs and determining the most appropriate and safe method of service delivery. Telehealth, when delivered via audio-visual technology, can support clinically appropriate care across multiple disciplines when used in accordance with clinical judgment and patient needs.

For example, telehealth may be used for therapy-related services such as pain assessment, instruction in functional mobility and safety, and guidance on individualized exercise programs. Medical social work services, including psychosocial assessment, care coordination, and patient and caregiver support, may also be appropriately delivered via telehealth when clinically indicated.

However, the regulation does not specify which disciplines may deliver services via telehealth or provide sufficient parameters around appropriate use. This lack of specificity may result in inconsistent interpretation and potential compliance concerns across providers.

Recommendation:
HCA recommends that MassHealth clarify:

- the types of services that may be delivered via telehealth; and
- which disciplines are allowed to provide services via telehealth.

Discharge Timing Requirements Under VBP

HCA has concerns regarding the proposed requirement that a VBP member be discharged at the end of the month in which the member received a PMPM.

This requirement may limit clinical flexibility and does not fully align with how care needs evolve in the home setting. Discharge decisions are based on clinical judgment and member needs, which may not correspond to a fixed monthly timeframe. A fixed monthly discharge requirement may not align with how care needs change in the home and could create challenges in making timely, clinically appropriate discharge decisions.

403.420 (E) Face- to- Face Encounter Requirements

Comment:

HCA proposed that MassHealth revise its face-to-face encounter regulation for home health 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 to home health.

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 home health 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 home health services.

The most important change that should be reflected clearly in the revised regulation is this: the face-to-face encounter does not need to be performed by the certifying provider, and it does not need to be performed 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, so long as the encounter 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 an acceptable Face-to-Face encounter:

For example, if a beneficiary is referred to home health for wound care by a wound care specialist, the specialist may perform the face-to-face encounter, even if that specialist is not the certifying physician.

Example of what would NOT be acceptable:

It would not be appropriate for a practitioner who specializes in optometry to certify a patient for home health services needed for orthopedic reasons.

MassHealth should therefore revise its regulation to align with the updated federal regulation and remove the phrase “directly admitted from acute/post-acute care”

Recommendation:

HCA recommends MassHealth replace the language for 130 CMR 403.420 (E) to align with the updated regulatory language in the Federal Conditions of Participation as written below in red

403.420 (E) Face- to- Face Encounter Requirements

(1) A face-to-face encounter between the member and an authorized practitioner is required for initial orders for home health services. A face-to-face encounter is not required when the plan of care is reviewed and revised as required at 130 CMR 403.420(C) or at resumption of home health services.

(2) A face-to-face patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was performed by 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) a physician;

(b) a nurse practitioner;

(c) a clinical nurse specialist;

(d) a physician assistant; or

(e) 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.

Additional Regulatory Clarifications and Technical Recommendation

Deletion of Fiscal Soundness Requirement

Comment:

HCA supports the proposed deletion of the fiscal soundness requirement under 130 CMR 403.405(E).

The removal of this provision meaningfully reduces administrative burden for home health agencies and eliminates a requirement that has been largely duplicative and of limited practical value. Agencies are already subject to multiple financial oversight mechanisms, and this requirement has not provided additional program integrity benefit commensurate with the burden imposed.

HCA appreciates MassHealth's recognition of this issue and its efforts to streamline requirements that do not directly contribute to quality or access to care

403.402: Definitions

Medication Administration Visit (MAV) Definition (130 CMR 403.402)

Summary of Proposed Change
MassHealth proposes to revise the definition of a medication administration visit (MAV) by replacing the term "sole purpose" with "primary purpose" of medication administration.

HCA Comments
HCA recommends reconsideration of the proposed change from "sole" to "primary." The

current definition establishes a clear and limited scope for medication administration visits, allowing clinicians to focus specifically on medication administration, patient response, and related education.

From a clinical and workforce perspective, this change introduces unnecessary ambiguity. The term "primary" inherently raises questions for clinicians—if medication administration is the primary purpose, what is considered secondary, and to what extent must additional issues be assessed, addressed, or documented during the visit?

HCA recognizes that this change may be intended to allow limited flexibility for clinicians to address additional patient needs during a medication administration visit. However, as proposed, the revised language does not establish clear parameters for what constitutes allowable secondary activities, creating uncertainty for providers.

HCA also requests clarification regarding the intent of this change. Several members have raised questions about whether this revision signals an expectation for broader assessment or the provision of additional services during medication administration visits. Greater clarity from MassHealth will support consistent clinical practice, appropriate documentation, and alignment in how these visits are delivered across providers.

Medication administration visits are typically high-frequency encounters, often provided to members with behavioral health or substance use disorders. Clinicians have developed efficient and consistent documentation practices aligned with the current definition. Introducing ambiguity into the scope of these visits may disrupt established workflows and increase cognitive burden for nurses managing complex caseloads.

Given ongoing workforce challenges, clear expectations are especially important. Uncertainty in documentation may lead to clinician frustration and variation in practice.

This change may:

- Create confusion for clinicians regarding documentation expectations during MAV visits;
- Lead to inconsistent interpretation of what must be addressed or documented beyond medication administration;
- Increase documentation burden on an already strained workforce; and
- Blur the distinction between medication administration visits and skilled nursing visits, which have different documentation and prior authorization requirements.

Recommendation

HCA recommends that MassHealth retain the current term "sole purpose" in the definition

of a medication administration visit. Maintaining this language preserves clarity for clinicians, supports consistent documentation practices, and avoids introducing unnecessary burden in an already strained workforce environment.

Clarification of Respite Services Definition

Comment:

HCA recommends removing the definition of "Respite Services" from the regulation.

Respite services are not a covered benefit under the MassHealth home health program. Including a definition for a non-covered service may create confusion among providers regarding allowable services and billing practices.

To promote clarity and alignment with covered benefits, HCA recommends removing the definition of "Respite Services" from the regulation.

Conclusion

HCA appreciates the opportunity to provide feedback on the proposed VBP model and recognizes MassHealth's efforts to advance care for members with complex needs.

The success of this model will depend on ensuring that it is transparent, operationally feasible, and aligned with the realities of home health care delivery.

HCA recommends that MassHealth provide additional clarity within the regulation—particularly related to quality measurement, performance methodology, and payment structure—and continue to engage stakeholders prior to implementation to support a model that improves outcomes while maintaining access to care.

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