130 CMR 438.000: CONTINUOUS SKILLED NURSING AGENCY SERVICES

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438.401: Introduction

130 CMR 438.000 states the requirements for the payment of continuous skilled nursing (CSN) services and complex care assistant (CCA) services provided by a CSN agency. All CSN agencies participating in MassHealth must comply with MassHealth regulations including, but not limited to, 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

438.402: Definitions

The following terms used in 130 CMR 438.000 have the meanings given in 130 CMR 438.402, unless the context clearly requires a different meaning. The reimbursed services defined in 130 CMR 438.402 are not determined by these definitions, but by the application of regulations elsewhere in 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

Accountable Care Organization (ACO). An entity that enters into a population-based payment model contract with the Executive Office of Health and Human Services (EOHHS) as an ACO, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans, Primary Care ACOs, and managed care organization (MCO)-administered ACOs.

Branch Office. A location or site from which a CSN agency provides services within a portion of the total geographic area served by the parent CSN agency. The parent CSN agency must provide supervision and administrative control of any branch office on a daily basis.

Calendar Week. Seven consecutive days beginning Sunday at 12:00 A.M. and ending Saturday at 11:59 P.M.

Capitated Program. An integrated care organization (ICO), senior care organization, ACO, or Program of All-inclusive Care for the Elderly (PACE) organization, or any other entity that, according to a contract with EOHHS, covers home health and other medical services for members on a capitated basis.

Care Management. A function performed by the MassHealth agency or its designee that assesses and reassesses the medical needs of complex care members and authorizes or coordinates long-term services and supports (LTSS) that are medically necessary for such members to remain safely in the community.

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Certification Period. A period of no more than 60 days for which the member's physician has certified that the plan of care is medically appropriate and necessary.

Clinical Manager. A registered nurse (RN) employed by the MassHealth agency or its designee, who performs the in-person assessment of a member for MassHealth coverage of CSN services and, if it is determined that CSN services are medically necessary, coordinates authorization of medically necessary LTSS for the member.

Complex Care Assistant. A person who is employed or contracted by a CSN agency and meets the qualifications of a complex care assistant to perform certain health-related services as described at 130 CMR 438.415(C).

Complex Care Assistant Services. Medically necessary services as described at 130 CMR 438.000 and identified in the plan of care delivered to complex care members.

Complex Care Assistant Supervisor (CCA Supervisor). 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 is deignated by the CSN agency as a supervisor of CCA service delivery.

Continuous Skilled Nursing (CSN) Agency. A public or private organization that provides CSN services, or CSN agency services to complex care members within the members' homes.

Continuous Skilled Nursing (CSN) Agency Services. CSN services and CCA services as described at 130 CMR 438.402 and delivered to MassHealth-eligible members.

Continuous Skilled Nursing (CSN) Services. Skilled nursing care provided by a licensed nurse to complex care members who require more than two continuous hours of nursing services per day, including any CSN training time as described at 130 CMR 438.410(H).

Co-vending. An arrangement through which a member's CSN services are provided by more than one CSN agency or independent nurse, with each provider obtaining its own MassHealth prior authorization to provide CSN services to the member.

Home Health Agency. A public or private organization that provides nursing and other therapeutic services to individuals whose place of residence conforms to the requirements of 42 CFR 440.70(c). Home health agency providers are governed by MassHealth regulations at 130 CMR 403.000: *Home Health Agency*. Home health agencies providing CSN services must also comply with 130 CMR 438.000 for the provision of those services.

Household. A place of residence where two or more people are living that is:

(1) a group home, a residential care home, or another group living situation;

(2) at the same street address if it is a single-family house that is not divided into apartments or units; or

(3) at the same apartment number or unit number if members live in a building that is divided into apartments or units.

Independent Nurse. A licensed nurse who independently enrolls as a provider with MassHealth to provide CSN services. Independent nurse providers are governed by 130 CMR 414.000: *Independent Nurse Services*.

Integrated Care Organization (ICO). An organization with a comprehensive network of medical care, behavioral health care, and LTSS providers that integrates all components of care, either directly or through subcontracts, and has contracted with EOHHS and the Centers for Medicare & Medicaid Services (CMS), and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrolled members with the full continuum of Medicare- and MassHealth-covered services.

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Long-term Services and Supports (LTSS). Certain MassHealth-covered services intended to enable a member to remain in the community. Such services include, but are not limited to, home health, durable medical equipment (DME), oxygen and respiratory equipment, personal care attendant (PCA), and other health-related services as determined by the MassHealth agency or its designee.

LTSS Needs Assessment. The standardized assessment the MassHealth agency or its designee uses to determine a member's eligibility for CSN services and if found eligible, quantifies the medically necessary CSN, CCA services, and other LTSS services.

Managed Care Organization (MCO). Any entity with which the MassHealth agency contracts under its MCO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), and is organized primarily for the purpose of providing health care services.

Marketing. Any communication from a CSN agency provider, or its agent, to a member, or their family or caregivers, that can reasonably be interpreted as intended to influence the member's choice of CSN agency provider, whether by inducing that member

(1) to retain that CSN agency provider to provide CSN agency services to the member;
(2) not to retain CSN agency services from another CSN agency provider; or
(3) to cease receiving CSN agency services from another CSN agency provider.

Medical History. A component of the member's medical record that provides a summary of all health-related information about the member. A history includes, but is not limited to, medical and nursing-care histories as well as summaries of physician physical examination and nursing-assessment results.

Medical Record. Documentation, maintained by the CSN agency, that includes medical history, nursing progress notes, the member's plan of care, and other information related to the member.

Medical Records Release Form. A signed authorization from the member or the member's parent or legal guardian, if the member is a minor, that allows the designated release to access the member's confidential health information from other health care providers.

Member with Medical Complexity. An individual who is a MassHealth member and whose medical needs, as determined by the MassHealth agency or its designee, are such that they require a nurse visit of more than two continuous hours of nursing services to remain in the community.

Nurse. A person licensed as an RN or licensed practical nurse (LPN) by a state’s board of registration in nursing.

Nursing Services. The assessment, planning, intervention, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse.

Ordering Non-physician Practitioner. A nurse practitioner, physician's assistant, or clinical nurse specialist who is licensed in the state of Massachusetts to perform and order medical services according to their scope of practice and who has a collaborative practice agreement with a physician. Ordering non-physician practitioners are also allowed to conduct face-to-face encounters.

Primary Natural Caregiver. The individual, other than the nurse, who is primarily responsible for providing ongoing care to the member and is also connected to the member in some other way, such as a parent, spouse, other family member, or close friend.

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Program of All-inclusive Care for the Elderly (PACE). PACE, as described at 42 CFR 460 and 130 CMR 519.007(C): *Program of All-inclusive Care for the Elderly (PACE)*.

Senior Care Organization (SCO). An MCO that participates in MassHealth under a contract with the MassHealth agency to provide coordinated care and medical services through a comprehensive network to eligible members 65 years of age or older. SCOs are responsible for providing enrolled members with the full continuum of MassHealth-covered services, and for dual eligible members, the full continuum of MassHealth- and Medicare-covered services.

Unfair or Deceptive Acts or Practices. Any unfair or deceptive acts or practices, as that term is defined in M.G.L. c. 93A, § 2, and the regulations promulgated thereunder by the Massachusetts Attorney General.

438.403: Eligible Members

(A)(1) MassHealth Members. The MassHealth agency covers CSN agency services provided by CSN agencies only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations at 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*. 130 CMR 450.105: *Coverage Types* specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, *see* 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

438.404: Provider Eligibility

To participate in MassHealth as a MassHealth CSN agency provider, an agency must

(A) be accredited or certified as

(1) a provider of home health services by a CMS-approved accrediting organization including one of the following: Accreditation Association for Ambulatory Health Care, Accreditation Commission for Health Care, Community Health Accreditation Partner, the Joint Commission on Accreditation of Healthcare Organizations, and meet all requirements of the CMS-approved accrediting organization; or

(2) a provider of home care services by the Accreditation Commission for Health Care or the Community Health Accreditation Partner and meet all requirements of this accrediting organization; or

(3) a provider of home health services under the Medicare program by the Massachusetts Department of Public Health and meet all requirements within the Medicare Conditions of Participation for home health agency services;

(B) obtain a MassHealth provider number before providing CSN agency services;

(C) participate in, and be in compliance with, other MassHealth enrollment requirements that may include, but are not limited to, provider site visit requirements;

(D) accept MassHealth payments as payment in full for all CSN agency services;

(E) agree to comply with all the provisions of 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*, and all other applicable MassHealth rules and regulations;

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(F) meet all provider participation requirements described at 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*;

(G) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 438.000;

(H) participate in any CSN agency provider orientation required by the EOHHS;

(I) submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the CSN agency provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 438.000 and as specified in 130 CMR 438.415(E);

(J) except as provided in 130 CMR 438.404(K) regarding change in scope of service or business, notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract* including, but not limited to, change of ownership, change of address, change in status of accreditation and/or reaccreditation or Medicare certification, and additional CSN agency branch office;

(K) notify the MassHealth agency, its designee, and MassHealth members in writing at least 60 days in advance of any change in the CSN agency's scope of business or services (for example, if a provider decides to no longer provide certain services or if a CSN agency will be disenrolling as a MassHealth provider); and

(L) An out-of-state provider must also
(1) provide services to a member in accordance with 130 CMR 450.109: *Out-of-state Services*; and
(2) participate in the Medicaid program in its state.

438.408: Services Provided under Contract

(A) Introduction. A CSN agency may provide CSN agency services directly or through contractual arrangements made by the CSN agency. Whether the services are provided directly or through contracts, the CSN agency is responsible for submitting claims for services and for meeting the requirements in 130 CMR 438.000 and all other applicable state and federal requirements.

(B) Contract Requirements.
(1) If the CSN agency contracts with another provider participating in MassHealth (*e.g.*, hospital, nursing facility, a home health agency, another CSN agency, or hospice), a written contract must document the services to be provided and the corresponding financial arrangements.
(2) If the CSN agency contracts with a provider that does not participate in MassHealth, the written contract must include
(a) a description of the services to be provided;
(b) the duration of the agreement and how frequently it is to be reviewed;
(c) a description of how personnel are supervised;
(d) a statement that the contracting organization will provide its services in accordance with the plan of care established by the member's physician in conjunction with the CSN agency's staff;
(e) a description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and in-service training;
(f) a description of the method of determining reasonable costs and payments by the home health agency for the specific services to be provided by the contracting organization; and
(g) an assurance that the contracting organization will comply with Title VI of the Civil Rights Act and all relevant MassHealth provider requirements.

438.409: Administrative Requirements

Whether services are provided by the CSN agency directly or through contractual arrangements made by the agency, the agency must

(A) accept the member for treatment in accordance with its admission policies;

(B) maintain a complete medical record as defined at 130 CMR 438.402 relating to all services provided in accordance with 130 CMR 438.415(D)(3);

(C) obtain from the physician or ordering non-physician practitioner the required certifications and recertifications of the plan of care in accordance with 130 CMR 438.416(C); and

(D) ensure that the CSN agency's staff review the medical necessity of services and the physician or ordering non-physician practitioner certification on a regular basis.

438.410: Clinical Eligibility Criteria for CSN Agency Services

(A) Clinical Criteria for Nursing Services.

(1) A nursing service is a service that must be provided by an RN or LPN to be safe and effective, considering the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

(2) Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only an RN or LPN can safely and effectively provide the service.

(3) When a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct intervention of an RN or LPN, the service is not considered a nursing service, unless there is no one trained and able to provide it.

(4) The CSN agency must assess the member to ensure that continued nursing services are necessary.

(5) Medical necessity of services is based on the condition of the patient at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period.

(6) A member's need for nursing care is based solely on their unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

(B) Clinical Eligibility for CSN Services. A member is clinically eligible for MassHealth coverage of CSN services when all of the following criteria are met.

(1) There is a clearly identifiable, specific medical need for a nursing visit to provide nursing services, as described at 130 CMR 438.410(A), of more than two continuous hours;

(2) The CSN services are medically necessary to treat an illness or injury in accordance with 130 CMR 438.410; and

(3) Prior authorization is obtained by the CSN agency in accordance with 130 CMR 438.411.

(C) Clinical Eligibility for Complex Care Assistant (CCA) Services. A member is clinically eligible for MassHealth coverage of CCA services when

(1) they are found eligible for CSN services as described at 130 CMR 438.410(B);

(2) services described at 130 CMR 438.415(C)(3)(a)2. may be safely performed by a CCA; and

(3) services are not duplicative of other services the member is receiving.

(D) Member Must Be under the Care of a Physician or Ordering Non-physician Practitioner. The MassHealth agency pays for CSN agency services only if the member's physician or ordering non-physician practitioner certifies the medical necessity for such services on an established individual plan of care in accordance with 130 CMR 438.419(C). A member may receive CSN agency services only if the member is under the care of a physician or ordering non-physician practitioner. The physician or ordering non-physician practitioner providing the certification of medical necessity must not be a physician or ordering non-physician practitioner on the staff of, or under contract with, the CSN agency or related home health agency.

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(E) Safe Maintenance in the Community. The member's physician, ordering non-physician, and CSN agency must determine that the member can be maintained safely in the community with medically appropriate CSN agency services.

(F) Multiple-patient Care for CSN Services. The MassHealth agency pays for one nurse to provide CSN services simultaneously to more than one member, but not more than three members, if

(1) the members have been determined by the MassHealth agency or its designee to meet the criteria listed at 130 CMR 438.410(A);

(2) the members receive services in their place of residence and during the same time period;

(3) the MassHealth agency or its designee has determined that it is appropriate for one nurse to provide nursing services to the members simultaneously; and

(4) the CSN agency has received a separate prior authorization for each member as described at 130 CMR 438.411.

(G) Limitations on Covered Services. The MassHealth agency pays for CSN agency services to a member who resides in a non-institutional setting, which may include, without limitation, a homeless shelter or other temporary residence or a community setting. The MassHealth agency does not pay for CSN agency services when a member is under the direct care of a hospital or emergency room, nursing facility, intermediate care facility, or any other institutional facility providing medical, nursing, rehabilitative, or related care. The MassHealth agency pays for CSN agency services when the CSN agency must accompany the member in transport to and from an institutional setting to ensure medical stability.

(H) Clinical Eligibility for Continuous Skilled Nursing (CSN) Training Time. A MassHealth member is eligible for CSN Training time when a nurse employed by the CSN agency is newly assigned to the member to provide CSN services and requires training for the member's specific care needs.

438.411: Prior Authorization Requirements

(A) Prior authorization must be obtained from the MassHealth agency or its designee as a prerequisite for payment for CSN agency services and before services are provided to the member. Without such prior authorization, CSN agency services will not be paid by the MassHealth agency.

(B) Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

(C) The MassHealth agency or its designee will conduct the assessment of need for CSN agency services, including CSN services and CCA services, and coordinate other MassHealth LTSS for the member, as appropriate. When the MassHealth agency or its designee conducts an assessment of need for CSN agency services and authorizes CSN agency services for the member, the member will select the CSN agency or agencies that will be responsible for providing CSN agency services. The MassHealth agency or its designee will provide written notification of its assessment to the member and, if applicable, the CSN agency or agencies selected by the member.

(D) At the request of the MassHealth agency or its designee, CSN agencies are required to provide a signed plan of care under 130 CMR 438.416 and supporting clinical documentation including, but not limited to, nursing progress notes, CCA progress notes, medication records, and clinical logs to the MassHealth agency or its designee for all members authorized for CSN agency services.

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(E) The MassHealth agency or its designee will specify on the prior authorization for CSN agency services the number of CSN hours, including CSN training hours, and CCA hours, including CCA supervision and intake visits, as applicable, that have been determined to be medically necessary and that are authorized for the provider to provide to the member per calendar week and the duration of the prior authorization. MassHealth will authorize up to two hours (eight 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. Any CSN hours or CCA hours provided to the member by the CSN agency that exceed what the MassHealth agency or its designee has authorized in a calendar week are not payable by MassHealth, except as described at 130 CMR 438.411(F).

(F) If there are unused hours of CSN and/or CCA services in a calendar week, they may be used at any time during the remainder of the current authorized period.

(G) MassHealth members and/or primary natural caregivers will determine when authorized CSN hours and CCA hours will be used in order to best support the member's needs. This can include scheduling authorized service hours in increments of less than two hours in order to meet the member's needs and best utilize authorized hours.

(H) If the frequency of the member's CSN agency services needs to be adjusted because

(1) the member's medical needs have changed from current authorization, the CSN agency must contact the MassHealth agency or its designee to request an adjustment to the prior authorization;

(2) there is a change in other nursing and health care services or care from current authorization (for example, PCA services, changes in adult day health or day habilitation schedules, adult foster care services), the CSN agency or the member may contact the MassHealth agency or its designee to request a review of the prior authorization.

(I) The MassHealth agency or its designee may authorize additional medically necessary CSN agency services on a temporary three-month basis if the member meets the clinical criteria for nursing services and the primary natural caregiver is unavailable because they

(1) have an acute illness, have been hospitalized, or have a suspected illness;
(2) have abandoned the member or have died within the past 30 days;
(3) have a high-risk pregnancy that requires significant restrictions;
(4) have given birth within the four weeks prior to a request for additional services;
(5) require surgery and/or are recovering from surgery in the hospital, in a rehabilitation facility, or at home; or
(6) are required to be away from the MassHealth member for an extended period.

This temporary increase in authorized units will be evaluated at the end of the three-month period in order to determine whether additional authorization is needed.

(J) Prior authorization for CSN services may be approved for more than one CSN agency or independent nurse, or both, provided that

(1) each provider is authorized only for a specified portion of the member's total hours; and
(2) the sum total of the combined hours approved for co-vending providers does not exceed what the MassHealth agency or its designee has determined to be medically necessary and authorized for the member per calendar week.

438.412: Notice of Prior Authorization and Clinical Eligibility Determination

(A) Notice of Approval. For all approved prior authorization requests for CSN agency services, the MassHealth agency or its designee sends written notice to the member and the CSN agency, if applicable, specifying the frequency and duration of care authorized, and the effective date of the authorization.

(B) Notice of Modification and Right of Appeal.

(1) For all modified prior authorization requests, the MassHealth agency or its designee notifies the member of the modification, reason, member's right to appeal, and appeal procedure. The CSN agency receives the information about the modification and the reason from the MassHealth agency or its designee.

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(2) A member may request a fair hearing from the MassHealth agency if the MassHealth agency or its designee modifies a prior authorization request. The member must request a fair hearing in writing within 30 days after the date of the modification. The Office of Medicaid Board of Hearings conducts the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(C) Notice of Discontinuation and Right of Appeal.

(1) For members who no longer meet clinical criteria for CSN agency services, the MassHealth agency or its designee notifies the member and the CSN agency provider of the discontinuation and the reason for discontinuation. The member also receives notification of the member's right to appeal, and the appeal procedure.

(2) A member may request a fair hearing from the MassHealth agency if the MassHealth agency or its designee discontinues authorization of CSN agency services. The member must request a fair hearing in writing within 30 days after the date of the discontinuation. The Office of Medicaid Board of Hearings conducts the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

438.413: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary CSN agency services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services: Introduction*, with prior authorization.

438.414: Administrative Care Management

For complex care members, as defined in 130 CMR 438.402, the MassHealth agency or its designee provides administrative care management that includes service coordination with CSN agencies as appropriate. The purpose of administrative care management is to ensure that a complex care member is provided with a coordinated LTSS package that meets the member's individual needs and to ensure that the MassHealth agency pays for nursing, CCA services, and other community LTSS only if medically necessary in accordance with 130 CMR 450.204: *Medical Necessity*. The MassHealth member eligibility verification system identifies complex care members.

(A) Care Management Activities.

(1) Enrollment. The MassHealth agency or its designee automatically assigns a clinical manager to members who may require a nurse visit of more than two continuous hours of nursing and informs such members of the name, telephone number, and role of the assigned clinical manager.

(2) LTSS Needs Assessment. The clinical manager performs an in-person visit with the member to evaluate whether the member meets the criteria to be a complex care member as described at 130 CMR 438.402 and 438.410(B). If the member is determined to meet the criteria as a complex care member, the clinical manager will complete an LTSS needs assessment. The LTSS needs assessment will include input from the member; the member's caregiver, if applicable; LTSS providers; and other treating clinicians. The LTSS needs assessment will identify

(a) skilled and unskilled care needs within a 24-hour period;
(b) current medications the member is receiving;
(c) DME currently available to the member;
(d) services the member is currently receiving in the home and in the community; and
(e) any other case management activities in which the member participates.

(3) Service Record. The clinical manager

(a) develops a service record, in consultation with the member, the member's primary natural caregiver, and where appropriate, the CSN agency and the member's physician or ordering non-physician practitioner, that

1. lists those LTSS services that are medically necessary, covered by MassHealth, and required by the member to remain safely in the community, and to be authorized by the clinical manager;

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2. describes the scope and duration of each service;
3. lists other sources of payment (*e.g.*, third-party liability, Medicare, Department of Developmental Services, adult foster care); and
4. informs the member of their right to a hearing, as described at 130 CMR 438.414.

(b) provides the member with copies of
1. the service record, one copy of which the member or the member's primary natural caregiver is requested to sign and return to the clinical manager. On the copy being returned, the member or the member's primary natural caregiver should indicate whether they accept or reject each service as offered and that they have been notified of the right to appeal and provided an appeal form; and
2. the LTSS needs assessment.

(c) provides information to the CSN agency about services authorized in the service record that are applicable to the CSN agency.

(4) Service Authorizations. The MassHealth agency or its designee will authorize those LTSS in the service record, including nursing and CCA services, that require prior authorization and that are medically necessary, as provided in 130 CMR 438.412, and coordinate all nursing services and CCA services; any applicable home health agency services; and any subsequent changes with the CSN agency, home health agency, or independent nurse prior authorization, as applicable. The MassHealth agency or its designee may also authorize other medically necessary LTSS including, but not limited to, PCA services, therapy services, DME, oxygen and respiratory therapy equipment, and prosthetics and orthotics.

(5) Discharge Planning. The clinical manager may participate in member hospital discharge-planning meetings as necessary to ensure that medically necessary LTSS necessary to discharge the member from the hospital to the community are authorized and to identify third-party payers.

(6) Service Coordination. The clinical manager will work collaboratively with any other identified case managers assigned to the member.

(7) Clinical Manager Follow-up and Reassessment. The clinical manager will provide ongoing care management for members to

(a) determine whether the member continues to meet the definition of a complex care member; and

(b) reassess whether services in the service record are appropriate to meet the member's needs.

(B) CSN Agency Care Management Activities. The CSN agency must closely communicate and coordinate with the MassHealth agency's or its designee's clinical manager about the status of the member's nursing and CCA needs, in addition, but not limited to

(1) The amount of authorized CSN and CCA hours the agency is able and unable to fill upon agency admission, and periodically with any significant changes in availability;

(2) Any recent or current hospitalizations or emergency department visits, including providing copies of discharge documents, when known;

(3) Any known changes to the member's nursing needs and services that may affect the member's CSN agency service needs;

(4) Needed changes in the agency's CSN agency PA; and

(5) Any incidents warranting an agency submitting to the MassHealth agency or its designee an incident or accident report. *See* 130 CMR 438.415(D)(2).

438.415: Provider Responsibilities

In addition to meeting all of the qualifications set forth in 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*, CSN agencies must meet all of the following requirements.

(A) Policies and Procedures. Each CSN agency must develop comprehensive policies and procedures governing the delivery of CSN agency services. The agency must maintain the policies and procedures, review/update them, comply with them, and make them available to members, in part or in their entirety, on request. At a minimum, the policies and procedures must contain the following:

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(1) administrative policies and procedures including, but not limited to,
(a) human resource and personnel;
(b) staff and staffing requirements;
(c) backup staff in the event coverage is required due to illness, vacation, or other reasons;
(d) staff education and training;
(e) CSN agency staff evaluation and supervision;
(f) emergencies including fire, safety and disasters, including notifying the fire department and police in emergencies;
(g) MassHealth member rights;
(h) human rights and nondiscrimination;
(i) incident and accident reporting;
(j) staff and member grievances;
(k) staff cultural competency;
(l) quality assurance and improvement;
(m) emergency services and plans for members;
(n) recognizing and reporting abuse (physical, sexual, emotional, psychological), neglect, self-neglect, and financial exploitation;
(o) Health Insurance Portability and Accountability Act (HIPAA);
(p) procedures to be followed if a member is missing or lost; and
(q) member complaint resolution protocol.

(2) clinical policies and procedures including, but not limited to,
(a) clinical evaluations;
(b) privacy and confidentiality;
(c) documentation of visits and progress notes;
(d) medication management;
(e) infection control and communicable disease;
(f) discharge criteria;
(g) coordination of CSN agency services with other services the member is receiving, including co-vending;
(h) coordination of CSN agency services with other CSN providers. CSN providers must include how the provider ensures documentation is accessible to family and other providers;
(i) medical record management in the member's home;
(j) first aid and cardiopulmonary resuscitation requirements;
(k) prevention of workplace fatigue for direct-care nursing staff; and

(3) any additional administrative or clinical policies the agency chooses to implement.

(B) Nurse Teaching Activities. During a CSN services visit and established in the plan of care, the nurse may teach the member, family member, or unpaid caregivers how to manage the member's treatment regimen as applicable. Ongoing teaching should occur when there is a change in the procedure or the member's condition. All teaching activities must be documented in the member's record.

(C) Complex Care Assistant (CCA) Service Delivery.

(1) Complex Care Assistant Qualifications. CSN agencies providing CCAs and submitting reimbursement to the MassHealth agency for CCA services must ensure CCAs meet the following qualifications:
(a) be legally authorized to work in the United States;
(b) be at least 18 years old;
(c) not be on the List of Excluded Individuals and Entities as provided by the Office of Inspector General of the U.S. Department of Health and Human Services, or other applicable lists excluding individuals or entities from participating in MassHealth under state or federal law;
(d) meet reading and writing comprehension standards sufficient to effectively communicate and report on the member's CCA services; and
(e) complete training requirements for CCA services as described at 130 CMR 438.415(C)(3).

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(2) CCA Payment and Assignment.

(a) Payment. The CSN agency is required to directly pay CCAs at least 65% of the reimbursement rate established for CCA services under 101 CMR 361.00: *Rates for Continuous Skilled Nursing Agency and Independent Nursing Services*.

(b) Member Assignment. CCAs are assigned to serve a specific member by the CSN agency. CCAs may only serve members they have been specifically trained to care for.

(3) CCA Training Requirements.

(a) CSN agencies providing CCA services and submitting reimbursement to the MassHealth agency for these services must ensure all CCAs complete a competency training and comprehension program that:

1. meets the home health aide qualification standards set forth in 42 CFR 484.80(a); and

2. provides, through hands-on practical training, education on how to perform the following activities that do not require the skills of a nurse, as ordered for a specific complex care member the assistant is being trained to serve:

a. enteral G-tube/J-tube feedings
b. skin care including application of OTC products or routine G-tube/J-tube care
c. oxygen therapy
d. oral (dental) suction to remove superficial oral secretions
e. ostomy and catheter care
f. modified meal preparation
g. equipment management and maintenance (wheelchair, CPAP/BiPAP, oxygen and respiratory) and paperwork
h. braces, splints, and/or pressure stockings
i. transportation to medical providers / pharmacy (by driving the member or going alone)
j. incidental services

(b) The training and comprehension program must document the training provided and evaluate the CCA's proficiency in safely performing the activities listed in 130 CMR 438.415(C)(3)(a)2.

(c) CCAs who are evaluated and have documented competency and proficiency in safely performing the activities listed in 438.415(C)(3)(a) are exempt from completing the full training program. They are, however, required to complete any elements for which they are evaluated and not determined to be competent and proficient.

(4) Member Care Instructions. The CCA supervisor must prepare written member care instructions that are specific to the complex care member's needs and follow the member's plan of care as ordered by their physician or non-physician ordering practitioner.

(5) CCA Service Supervision. CCA services must be assessed regularly by the CCA supervisor described at 130 CMR 438.415(C)(4) to ensure quality and safe care delivery.

(a) 60-day Supervisory Visits. The CCA supervisor must make an on-site visit to the member's home no less frequently than every 60 days to assess the quality and safety of the CCA services provided. The CCA does not need to be present during these supervisory visits. The supervisory visit must be documented and maintained in the member's medical record and be clearly identified as a CCA supervisory visit note. The visit may be concurrent with the CSN agency's recertification of the plan of care.

(b) Identifying Deficiencies. If the CCA supervisor notes an area of concern in CCA services during a supervisory visit, then the CCA supervisor must make another on-site visit to observe and assess the CCA while they are providing CCA services to the member.

(c) Addressing Deficiencies. If the CCA supervisor verifies a deficiency in CCA services during an on-site visit, then the CSN agency must conduct, and the CCA must complete, reeducation and training to address the specific deficiency. Documentation of satisfactory completion of reeducation and training must be maintained in the CCA's employment file and in accordance with 130 CMR 438.415(D).

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(6) CCA 12-month Evaluation. A 12-month enhanced care evaluation must be conducted by an RN or LPN employed by the CSN agency. The evaluation must review the member-specific enhanced care tasks the CCA performs according to the applicable member's care instructions. The CCA's proficiency must be evaluated and new training provided as necessary. The CSN agency must document the 12-month evaluation and any additional training that demonstrates the CCA's continued proficiency in performing the enhanced care tasks.

(D) Recordkeeping.

(1) Administrative Records. CSN agencies must maintain administrative records in compliance with the record retention requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. All records including, but not limited to the following, must be accessible and made available on site for inspection by the MassHealth agency:

(a) payroll and staff records, including any CCA's satisfactory completion of the competency training and comprehension program in the CCA's employment file, as well as any other evidence of completed staff orientation and training;

(b) financial records;

(c) staffing levels;

(d) complaints and grievances;

(e) contracts for subcontracted services, including a description of how the CSN agency will supervise the subcontracted services;

(f) contracts for independent contractor services; and

(g) job descriptions that include titles, reporting authority, qualifications, and responsibilities.

(2) Incident and Accident Records. CSN agencies must maintain an easily accessible record of member and staff incidents and accidents. The record may be kept within the individual member medical record or employee record or within a separate, accessible file.

(a) The CSN agency must submit to the MassHealth agency or its designee an incident or accident report within five days under the following circumstances:

1. an incident or accident that occurred during a CSN agency service visit that results in serious injury to the member;

2. an incident or accident resulting in the member's unexpected death even if the CSN agency was not involved in the incident or accident;

3. an incident of abuse or neglect involving a staff member of the CSN agency and the member; or

4. an incident of abuse or neglect committed by another provider supporting the member (if known).

(b) The incident or accident report must include at least the following information:

1. general information including, but not limited to, member's name and members MassHealth ID number;

2. general nature of incident or accident; and

3. any action that was taken as a result of the incident or accident including all outcomes.

(3) Member Records. In order for a medical record to completely document a service to a member, the record must describe fully the nature, extent, quality, and necessity of the care furnished to the member. When the information contained in a member's record does not provide sufficient documentation for the service, the MassHealth agency may disallow payment (*see* 130 CMR 450.205: *Recordkeeping and Disclosure*).

(a) The record maintained by a CSN agency for each member must conform to 130 CMR 450.000: *Administrative and Billing Regulations*. Payment for CSN agency services described at 130 CMR 438.000 requires complete documentation in the member's medical record. The CSN agency must maintain records for each member to whom services are provided and a copy of the member's complete medical record must be maintained in the member's home.

(b) The CSN agency must maintain an up-to-date medical record of services provided to each member. The medical record must contain at least the following in addition to the information defined at 130 CMR 438.415(D):

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1. the member's name, address, phone number, date of birth, and MassHealth ID number;
2. the name and phone number of the member's primary care physician or ordering non-physician practitioner;
3. the primary natural caregiver's name, phone number, and relationship to the member;
4. the name and phone number of the member's emergency contact person;
5. a copy of all verbal orders, properly authenticated;
6. accessible and legible progress notes for each visit, signed by the person providing the service, that include the following information:
   a. the full date of service and time that each visit began and ended;
   b. for CSN services, all treatments and services ordered by the physician or ordering non-physician practitioner included in the member's plan of care and documentation of which treatments and services were provided during the visit and the member's response;
   c. for CCA services, documentation of the treatments and services in the plan of care, and written in the member care instructions described at 130 CMR 438.415(C)(4), that were provided during the visit, as well as the member's response;
   d. any additional treatment or service not included in the member's plan of care provided, as well as the member's response, including, for CSN services, documentation of medication administration as described at 130 CMR 438.415(D)(3)(b)7;
   e. any service or treatment the member may have declined during visit and explanation of denial;
   f. the member's vital signs and any other required measurements, as appropriate;
   g. progress toward achievement of goals as specified in the plan of care including, when applicable, an explanation of why goals are not achieved as expected;
   h. a pain assessment, as appropriate;
   i. the status of any equipment maintenance and management, as appropriate; and
   j. any contacts with physicians or other health care providers about the member's needs or change in plan of care, as applicable.
7. a current medication administration list or other documentation, such as nursing notes, that includes the timing of administration as ordered, drug identification and dose, route of administration, the member's response to the medication being administered, and the signature of the person administering the medication;
8. any clinical tests and their results, as applicable;
9. a signed medical records release form, as applicable;
10. the number of authorized nursing hours for their agency per calendar week for the member;
11. the number of authorized CCA hours for the CSN agency per calendar week for the member, as applicable;
12. the names and telephone numbers of all the providers involved in co-vending care; the number of nursing hours; and, as applicable, the number of CCA hours approved for each provider by the MassHealth agency or its designee, to the best of the agency's ability;
13. a copy of the CSN agency's current prior authorization; and
14. a discharge summary, if applicable, including the reason for discharge and any activities by the CSN agency related to the discharge.

(4) Access to Records Maintained in Member's Home. The CSN agency must maintain a copy of the member's medical record in the member's home as described at 130 CMR 438.415(D)(3). The copy of the member's medical record maintained in the member's home must be provided to the member, and also the CSN agency must make every attempt to coordinate care and/or change in shifts with other CSN providers and, as applicable, CCAs.

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(5) Copies of Records. Upon the request of the member or the member's representative, the CSN agency must provide a copy of the medical record free of charge to the person or entity that the member or the member's representative designates. Additionally, upon request of the MassHealth agency or its designee, the CSN agency must provide a copy of the member's complete medical record.

(E) Statement of Fiscal Soundness.

(1) Submission Requirements. Under 130 CMR 438.404(I), CSN agencies must submit to the MassHealth agency or its designee annually and at enrollment a statement of fiscal soundness attesting to the financial viability of the CSN agency. To satisfy the fiscal soundness requirement, the CSN agency must demonstrate a cash reserve sufficient to meet one month of financial obligations in the operation of the provider's CSN agency program including, but not limited to, timely payment of staff wages and the agency's general and professional liability insurance coverage and workers' compensation insurance coverage. If using a line of credit to meet the cash reserve requirement, the agency must demonstrate the line of credit has been approved by a financial institution.

(2) Submission Due Date. The CSN agency must submit to the MassHealth agency or its designee a statement of fiscal soundness annually and by the end of May each year.

(3) Attestation. The CSN agency must attest that its available cash reserve will meet the average monthly cost at all times during the subsequent year.

(4) Noncompliance. For CSN agencies that fail to meet the fiscal soundness requirement pursuant to 130 CMR 438.404(I) and 438.415(E), the MassHealth agency may take further action, such as imposing sanctions in accordance with 130 CMR 450.238: *Sanctions*: *General* including, but not limited to, termination of the provider as a MassHealth CSN agency.

(F) Annual Staffing Report.

(1) Submission Requirements. CSN agencies must annually submit to the MassHealth agency or its designee a record of the gross hourly wage the CSN agency paid to all employee nurses the previous calendar year. The staffing report must include the median, average, and range of all direct-care nurse salaries and account for all wage differentials paid, licensure, other factors the CSN agency uses to determine nurse wages, and additional requirements issued by the EOHHS.

(2) Submission Due Date. The CSN agency must submit its staffing report to the MassHealth agency or its designee by the end of February each year.

(3) Attestation. The staffing report must include an attestation confirming, under the penalty of perjury, that the information provided in the report is accurate and complete for the previous calendar year. The attestation must be signed by the appropriate personal representative who is responsible for the CSN agency's operation in the state.

(4) Noncompliance. CSN agency providers that fail to submit the annual staffing report may be subject to sanctions in accordance with 130 CMR 450.238: *Sanctions: General*, including, but not limited to, termination as a MassHealth CSN agency.

(G) Member Complaint Resolution.

(1) Member Complaint Resolution Protocol. The CSN agency must have a member complaint resolution protocol that is maintained in its Policy and Procedure Manual described at 130 CMR 438.415(A). CSN agencies without an implemented member complaint resolution protocol may be subject to administrative sanction under 130 CMR 450.000: *Administrative and Billing Regulations*.

(a) The CSN agency must investigate complaints made by a member, the member's representative (if any), and the member's caregivers and family, including, but not limited to, complaints on the following topics:

1. treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and

2. mistreatment; neglect; verbal, mental, sexual, or physical abuse, including injuries of unknown source; and/or misappropriation of member property by anyone furnishing services on the CSN agency's behalf.

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(2) Content of Member Complaint Resolution Protocol. The member complaint resolution protocol must

(a) detail how the CSN agency will generally manage received member complaints;

(b) specify the agency employee(s) responsible for managing member complaint resolution; and

(c) indicate how the CSN agency will ensure a written response to all member complaints within two business days of the received complaint.

(3) Recordkeeping and Documentation. The CSN agency must document and maintain record of all received complaints (whether provided in person; by phone; or in writing in email, letter, or text), and the documentation must at least include

(a) the name, address, and telephone number of the member;

(b) the name, address, and telephone number of the person filing the complaint (if not the member);

(c) a summary of the complaint;

(d) the date the provider received the complaint;

(e) the name of the person receiving the complaint;

(f) a summary of any investigation or actions taken by the CSN agency to resolve the complaint; and

(g) if the CSN agency determined that an investigation of the complaint or further action was not necessary, the name of the person making this decision and the reason for the decision.

438.416: Plan of Care Requirements

All CSN agency services must be provided under an individualized plan of care developed for the member. The physician or ordering non-physician practitioner must sign the plan of care before services are provided to the member.

(A) Providers Qualified to Establish a Plan of Care.

(1) The member's physician or ordering non-physician practitioner in consultation with the CSN agency must establish a written plan of care and the physician or ordering non-physician practitioner must recertify, sign, and date the plan of care every 60 calendar days.

(2) The CSN agency may establish an additional nursing plan of care, when appropriate, that may be incorporated into the physician or ordering non-physician practitioner's plan of care, or be prepared separately. The additional plan of care does not substitute for the physician or ordering non-physician practitioner's plan of care.

(3) If a CSN agency is co-vending a case with other CSN providers or home health agency providers, each provider is responsible for establishing a separate plan of care signed by the member's physician or ordering non-physician practitioner.

(B) Content of the Plan of Care. The orders on the plan of care must specify the total number of CSN hours and CCA hours, as applicable, that the MassHealth agency or its designee has authorized to be provided to the member. The physician or ordering non-physician practitioner must sign and date the plan of care before the CSN agency submits its claim for those services to the MassHealth agency for payment. Alternatively, the physician or ordering non-physician practitioner must comply with the verbal order provisions at 130 CMR 438.416(D). Any increase in the total number of CSN hours and CCA hours, as applicable, must be requested in advance by the physician or ordering non-physician practitioner with verbal or written orders and authorized by the MassHealth agency or its designee. If the member is enrolled in the Primary Care Clinician (PCC) Plan, the CSN agency must communicate with the member's PCC both when the goals of the care plan are achieved and when there is a significant change in a member's health status. The plan of care must also include

(1) the member's name and date of birth;

(2) all pertinent diagnoses, including the member's mental, psychosocial, and cognitive status;

(3) types of medical supplies and DME required;

(4) the member's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments;

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(5) the total number of nursing hours requested by the CSN agency, if different from the total number of CSN hours authorized by the MassHealth agency or its designee;
(6) the total number of CCA hours requested by the CSN agency, if different from the total number of CCA hours authorized by the MassHealth agency or its designee, as applicable;
(7) any teaching activities to be conducted by the nurse to teach the member, family member, or caregiver how to manage the member's treatment regimen (ongoing teaching may be necessary where there is a change in member's condition or treatment);
(8) a description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors;
(9) a plan for medical emergencies;
(10) goals toward discharge planning from CSN agency services when appropriate; and
(11) any additional items the CSN agency or physician or ordering non-physician practitioner chooses to include.

(C) Certification Period. The plan of care required under 130 CMR 438.416(A)(1) must be reviewed, signed, and dated by a physician or ordering non-physician practitioner at least every 60 days, unless the provider follows the verbal order provisions at 130 CMR 438.416(D).

(D) Verbal Orders.
(1) Notwithstanding the requirements of 130 CMR 438.416(A), services that are provided from the beginning of the certification period (*see* 130 CMR 438.416(C)) and before the ordering physician or ordering non-physician practitioner signs the plan of care are considered to be provided under a plan of care established and approved by the physician or ordering non-physician practitioner if
(a) the clinical record contains a documented verbal order from the ordering physician or ordering non-physician practitioner for the care before the services are provided; and
(b) the physician or ordering non-physician practitioner signature is on the 60-day plan of care either before the claim is submitted or within 90 days after submitting a claim for that period.
(2) If the member has other health insurance (whether commercial or Medicare), the provider must comply with the other insurer's regulations for physician or ordering non-physician practitioner signature before billing the MassHealth agency.

(E) Corrections to the Plan of Care. When correcting errors on a paper plan of care before it is signed by the physician or ordering non-physician practitioner, the CSN agency staff must cross out the error with a single line and place their initials and the date next to the correction. The use of correction fluid or correction tape on a plan of care is not permitted.

(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) CSN agencies must comply with the face-to-face patient encounter requirements established under 42 CFR 424.22(a)(1)(v).
(3) Documenting the Face-to-face Encounter in the Member's Record.
(a) The face-to-face encounter must be documented in the member's record either on the plan of care or in other medical notes sufficient to make the link between the individual's health conditions, the services ordered, an appropriate face-to-face encounter, and actual service provision.
(b) The ordering or acute/post-acute care attending physician or ordering non-physician practitioner may serve as the physician writing the plan of care. When the acute/post-acute care attending physician or ordering non-physician practitioner writes the plan of care, such attending practitioners must document that the face-to-face encounter is related to the primary reason the patient requires CSN agency services and that the encounter with an authorized practitioner occurred within the required timeframes. The plan of care or the medical notes must include which authorized practitioner conducted the encounter and the date of the encounter.

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(c) If the face-to-face encounter was not provided by the ordering physician or ordering non-physician practitioner, the authorized practitioner who did conduct the face-to-face encounter is required to communicate the clinical findings of the face-to-face encounter to the ordering physician or ordering non-physician practitioner. This requirement is necessary to ensure that the ordering physician or ordering non-physician practitioner has sufficient information to determine the need for CSN agency services in the absence of conducting the face-to-face encounter himself or herself.

(d) The CSN agency must maintain a copy of the face-to-face documentation.

(G) MassHealth Members Enrolled in the Primary Care Clinician (PCC) Plan. If a member is enrolled in the PCC Plan, the CSN agency must provide the PCC with a copy of the member's plan of care for each certification period.

438.417: Quality Management, Utilization Review, and Reporting Requirements

(A) A CSN agency must participate in any quality management and program integrity processes as required by the MassHealth agency and EOHHS including making any requested data available and providing access to visit the CSN agency's place of business upon request by the MassHealth agency or its designee.

(B) A CSN agency must submit requested documentation to the MassHealth agency or its designee for purposes of utilization review and provider review and audit, within the MassHealth agency's or its designee's time specifications. The CSN agency must provide the MassHealth agency or its designee with any supporting documentation the MassHealth agency or its designee requests, in accordance with M.G.L. c. 118E, § 38 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) A CSN agency must provide the MassHealth agency or its designee any requested documentation for purposes of a member's medical necessity review for CSN agency services. The requested documentation must be submitted to the MassHealth agency or its designee within the MassHealth agency's or its designee's time specifications.

438.418: Transfers and Discharge Planning

(A) A CSN agency provider can discharge a MassHealth member upon the member's request or when the agency cannot reasonably continue to serve the member, such as under the following conditions:

(1) if the member no longer meets the clinical eligibility for CSN agency services;
(2) if the member selects another service that is duplicative of CSN agency services;
(3) if the member transitions all CSN agency services to another CSN provider; or
(4) if the CSN agency ceases operations.

(B) A member may be discharged by the CSN agency provider if the CSN agency cannot safely serve the member in the home due to the member or other persons in member's home being disruptive, abusive, or uncooperative to the extent that delivery of care is seriously impaired. Prior to discharge the CSN agency must

(1) notify the member, representative, ordering physician, and the MassHealth agency or its designee that a discharge for cause is being considered;

(2) notify the member, representative, ordering physician, and the MassHealth agency or its designee at least 14 days in advance that a discharge is planned to ensure member or provider safety. If a CSN agency has documented that the continued provision of CSN services poses significant risks to provider safety, a CSN agency may discontinue services and discharge the member immediately;

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(3) make diligent efforts to solve the problem(s) present and document these efforts in the member's clinical records;
(4) provide the member and/or caregiver contact information for alternative CSN agency providers; and
(5) document the discharge and CSN agency activity related to the discharge in the member's clinical record.

(C) A CSN agency may not discharge a MassHealth member in violation of any discrimination provisions established in state or federal law.

(D) When a CSN agency makes the determination that a member no longer meets the clinical eligibility for CSN agency services and would like to proceed with discharge as described at 130 CMR 438.418(A)(1), the CSN agency must consult with the MassHealth agency or its designee at minimum 14 days prior to discharge planning to allow the MassHealth agency or its designee to perform a reassessment of the member's medical necessity for CSN services as described at 130 CMR 438.414(A)(7).

(E) When a CSN agency ceases operations, they must provide notification to the MassHealth agency, its designee, and any MassHealth members and/or caregivers it serves in accordance with 130 CMR 438.404(K). In addition, the CSN agency must
(1) provide the member and/or caregiver the number of non-billed units remaining on the prior authorization; and
(2) make diligent efforts to transfer the member's care to another CSN provider.

(F) If, upon discharging a member, the CSN agency is unable to transfer the member to another CSN provider, the CSN agency must
(1) provide the members and/or caregivers contact information for alternative CSN agency providers; and
(2) work with the MassHealth agency or its designee to assist in the transfer of members' care to another CSN provider.

438.419: Conditions of Payment

The following conditions for payment apply to all CSN agency services, in addition to conditions of payment described throughout 130 CMR 438.000.

(A) Place of Service. The MassHealth agency pays for CSN agency services provided to a member who meets the clinical criteria in 130 CMR 438.410 and resides in a noninstitutional setting, which may include, without limitation, a homeless shelter or other temporary residence or a community setting. The MassHealth agency does not pay for CSN agency services provided in a hospital, nursing facility, intermediate care facility, or any other institutional setting providing medical, nursing, rehabilitative, or related care. The MassHealth agency will pay for CSN agency services when the CSN agency must accompany the member in transport to and from an institutional setting to ensure medical stability during transitions in and out of the institutional setting. The MassHealth agency does not pay for CSN agency services provided to a member under the direct care of a hospital or emergency room, a nursing facility, an intermediate care facility, or any other institutional setting providing medical, nursing, rehabilitative, or related care.

(B) Medical Necessity Requirement. In accordance with 130 CMR 450.204: *Medical Necessity*, the MassHealth agency pays for only those CSN agency services that are medically necessary.

(C) Plan of Care. The MassHealth agency pays only for CSN agency services that are provided according to a plan of care authorized by a physician or a non-physician practitioner and meet the plan of care requirements at 130 CMR 438.416.

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(D) Prior Authorization. The MassHealth agency pays for CSN agency services only when prior authorization has been obtained from the MassHealth agency or its designee, in accordance with 130 CMR 438.411.

(E) Members for Whom Services Are Approved. The MassHealth agency does not pay for CSN agency services provided to any individual other than the member who is eligible to receive such services and for whom such services have been authorized by the MassHealth agency or its designee.

(F) Multiple-patient Care and CSN Services. The MassHealth agency pays for one nurse to provide CSN services in the same household and during the same time period to more than one member, but not more than three members, if

(1) the members have been determined by the MassHealth agency or its designee to meet the criteria listed at 130 CMR 438.410(A) and (B);

(2) the members receive services in the same household and during the same time period;

(3) the MassHealth agency or its designee has determined that it is appropriate for one nurse to provide nursing services to the members simultaneously; and

(4) the CSN agency has received a separate prior authorization from the MassHealth agency or its designee for each member as described at 130 CMR 438.411.

(G) Complex Care Assistant 60-day Supervisory Visits. The MassHealth agency only pays for the 60-day CCA supervisory visit described at 130 CMR 438.415(C)(5)(a). The 60-day nurse reassessment visit may be made in conjunction with the supervisory visit.

(H) Complex Care Assistant (CCA) Intake Visits. The MassHealth agency will reimburse CSN agencies for CCA intake visits conducted by a registered nurse (RN) or licensed practical nurse (LPN) at the start of CCA services. 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.

(I) CSN Training Time. The MassHealth agency will reimburse for CSN training time when the following conditions are met:

(1) A nurse(s) employed by the CSN agency has been newly assigned to a MassHealth member and requires training to manage the member's treatment regimen;

(2) The agency nurse(s) receives in-home, member-specific training from

(a) another nurse employed by the same CSN agency who is familiar with the member's care;

(b) another CSN provider who is familiar with the member's care; or

(c) the member's natural caregiver or other family member who is familiar with the member's care.

(3) The CSN agency uses the CSN training time units during the first six weeks after the agency nurse's first shift working with the member; and

(4) The member and/or their natural caregiver or legal guardian have provided verbal consent for a new agency nurse to receive in-home, member-specific training.

CSN training time units must be used only for training a nurse to serve a specific member and may not be used for general training education or competency testing for agency nurses.

438.420: Maximum Allowable Fees

CSN agencies must accept MassHealth payment in full for CSN agency services in accordance with the rates and regulations established by EOHHS as set forth in 101 CMR 361.00: *Rates for Continuous Skilled Nursing Agency and Independent Nursing Services*. Payments are subject to the conditions, exclusions, and limitations set forth in 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

438.421: Denial of Services and Administrative Review

(A) A failure or refusal by a CSN agency to furnish services that have been ordered by the member's attending physician or ordering non-physician practitioner and are within the range of payable services, constitutes a violation of 130 CMR 438.000 for which administrative sanctions may be imposed, with the exception of instances where the CSN agency does not have nursing availability to provide services.

(B) When a CSN agency believes that services ordered by the attending physician or ordering non-physician practitioner are not payable under 130 CMR 438.000, the CSN agency must refer the matter to the MassHealth agency for a payment decision. If and to the extent the MassHealth agency determines that the ordered services are payable, the CSN agency must provide those services.

438.422: Prohibited Marketing Activities

A CSN agency provider must not

(A) with the knowledge that a member is enrolled in a capitated program, engage in any practice that would reasonably be expected to have the effect of steering or encouraging the member to disenroll from the capitated program in order to obtain services on a fee-for-service basis;

(B) offer to a member, or their family or caregivers, in person or through marketing any inducement to retain the CSN agency provider to provide CSN agency services, such as a financial incentive, reward, gift, meal, discount, rebate, giveaway, or special opportunity;

(C) pay a "finder's fee" to any third-party in exchange for referring a member to the CSN agency provider; or

(D) engage in any unfair or deceptive acts or practices in connection with any marketing.

438.423: Providing Continuous Skilled Nursing Agency Services out of State

The MassHealth agency does not reimburse CSN agencies to provide CSN agency services outside Massachusetts unless all of the following conditions are met:

(A) The CSN agency has a current prior authorization to provide CSN agency services as described in 130 CMR 438.411; and

(B) For CSN services, the CSN agency nurse who will be providing the services has an active nursing license in the state where the member is present or that the member plans to travel to.

REGULATORY AUTHORITY

130 CMR 438.000: M.G.L. c. 118E, §§ 7 and 12.

NON-TEXT PAGE