Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Nursing Facility Bulletin 181 (Corrected)
September 2023

TO: Nursing Facilities Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: **Transition to CMS OBRA MDS 3.0 Assessments for Nursing Facility Fee for Service Payments**

Introduction

Effective October 1, 2023, MassHealth will transition from using the Management Minutes Questionnaire (MMQ) to using the Centers for Medicare and Medicaid Services (CMS) Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS) 3.0 assessments ("MDS assessments") to determine resident acuity for payment of MassHealth nursing facility Fee for Service claims. This bulletin

- explains how the various types of MDS assessments will be used to determine payment;
- describes the responsibilities of nursing facilities when completing and submitting assessments;
- outlines a process to initiate a selected review of the MDS Level of Care in certain circumstances; and
- describes the MDS audit process.

General Instructions

Nursing facilities must follow MDS assessment schedules and submission requirements as outlined in the CMS MDS 3.0 Resident Assessment Instrument manual (RAI Manual). Instructions and requirements for submitting the MDS assessments can be found in the RAI Manual at Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual. Under these guidelines, facilities are required to submit MDS assessments for each resident

- upon their admission;
- quarterly;
- annually; and
- upon any significant change, as defined by the RAI Manual.

MassHealth will use each resident's Patient Driven Payment Model (PDPM) nursing case mix category resulting from the MDS assessments to determine the rate of payment of MassHealth nursing facility Fee for Service claims. Facilities must reassess residents according to the timetable in Table A on the next page to be paid by MassHealth for the defined time period.

Table A: Timetable for MDS Assessments for MassHealth Nursing Facility Payments

OBRA Assessment Types Used for MassHealth Payment	Identifier	Effective Date for MassHealth Payment
Admission OBRA Assessment/PPS 5-day Scheduled Assessment: Must be submitted within 14 days of admission	"01"	This assessment will be used to pay claims from day of admission or from the first noncovered Medicare day until the last day of the quarter.
Quarterly Non-comprehensive: The Assessment Reference Date (ARD) must be no later than 92 days after the ARD of the most recent OBRA assessment	"02"	This assessment will be used to pay claims from first day of next assessment quarter which is based on the level of care end date of the prior assessment.
Annual OBRA Assessment: The ARD must be no later than 366 days from the ARD of the most recent OBRA comprehensive assessment and no later than 92 days after the ARD of the most recent assessment	"03"	This assessment will be used to pay claims from first day of next assessment quarter which is based on the level of care end date of the prior assessment.
Significant Change in status (Comprehensive): The ARD and completion date must be within 14 days of the identification of a major, uncorrelated error in prior comprehensive assessment. A Significant Correction of a Prior Comprehensive assessment includes full MDS and Care Area Assessments (CAAs) and resets the schedule for the next annual and quarterly assessments.	"04"	This significant change assessment will be used to pay claims starting from the ARD on the significant change assessment. This assessment will interrupt the current payment quarter schedule and will restart a new quarter based on the ARD of this assessment.
Significant Change in prior Comprehensive in status (Comprehensive): The ARD and completion date must be within 14 days of the identification of a major, uncorrelated error in prior comprehensive assessment. A Significant Correction of a Prior Comprehensive assessment includes full MDS and CAAs and resets the schedule for the next annual and quarterly assessments.	"05"	This significant change assessment will be used to pay claims starting from the ARD on the significant change assessment. This assessment will interrupt the current payment quarter schedule and will restart a new quarter based on the ARD of this assessment.
Significant Correction in Prior Quarterly: The ARD and completion date must be within 14 days of the identification of a major, uncorrelated error in prior comprehensive assessment. A Significant Correction of a Prior Comprehensive assessment includes full MDS and CAAs and resets the schedule for the next annual and quarterly assessments.	"06"	This significant change assessment will be used to pay claims starting from the ARD on the significant change assessment. This assessment will interrupt the current payment quarter schedule and will restart a new quarter based on the ARD of this assessment.
Discharge Assessment – Return not anticipated	"10"	This assessment may be combined with a quarterly assessment and may pay through the date of discharge. If a resident readmits, a new assessment schedule is started.
Discharge Assessment – Return anticipated	"11"	This assessment may be combined with a quarterly assessment and may pay through the end of the quarter. It may restart the assignment schedule.
Medicare PPS Discharge Assessment	"10/11"	This assessment will not impact payments.
Entry Tracking – not combined with any other assessment	"01"	This assessment will not impact payments.
Death in Facility Entry Tracking	"12"	This assessment will not impact payments.

Requirement to Include MassHealth Provider ID and MassHealth Member ID on MDS Assessments

To receive MassHealth payment for a resident, the nursing facility must include both the MassHealth provider ID and the MassHealth member ID on all MDS assessments. If a facility has submitted a MDS assessment without the required MassHealth provider ID and MassHealth member ID, the nursing facility must submit a correcting MDS assessment. Please refer to RAI Manual, "Chapter 5.7: Correcting errors in MDS records that have been accepted into IQIES"[1] for full instructions on how to submit a correcting MDS assessment.

MassHealth will import MDS assessment data daily directly from the CMS Internet Quality Improvement and Evaluation System (IQIES) into MassHealth's Provider Online Service Center (POSC) and Medicaid Management Information System (MMIS). Nursing facilities are responsible for verifying that MDS assessment data has been imported into MMIS and is accurate. Two reports, listed below, are available for nursing facility providers to verify MDS data within MMIS. These reports will be available every Wednesday and will report on the prior week's MDS assessment submissions.

- MDS Submission Success Report: Providers should use this report to confirm that appropriate MDS assessments were received by MassHealth for MassHealth members within their facility.
- MDS Submission Error Report: Providers should use this report to review MDS assessments that were not accepted into MMIS due to errors, such as missing or incorrect MassHealth member ID. Providers must submit a correcting MDS assessment to address any errors. Please refer to RAI Manual, "Chapter 5.7: Correcting errors in MDS records that have been accepted into IQIES"[2] for full instructions on how to submit a correcting MDS assessment.

Nursing Facility–Initiated Review of MDS Level of Care

Nursing facilities may initiate a review of the MDS Level of Care if the facility believes an MDS Level of Care is incorrect in MMIS or is not present within MMIS. This review will only be conducted if there has been a technical error that has resulted in MMIS not accurately capturing an MDS Level of Care, namely:

- MMIS lists an MDS Level of Care that does not match the third digit of the Health Insurance Prospective Payment System (HIPPS) code on an MDS assessment; or
- MMIS does not list an MDS Level of Care even though a valid MDS assessment has been completed and submitted to CMS via the IQIES system with the facility's MassHealth provider ID and the member's MassHealth ID. Before submitting for this type of review, facilities must first refer to the MDS Submission Error report to ensure that the member's information wasn't incorrectly filled out on the MDS assessment.

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[1] Source: CMS RAI MDS 3.0 User's Manual, Page 5-9, Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual.
[2] Source: CMS RAI MDS 3.0 User's Manual, Page 5-9, Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual.

To request review, the facility must submit the "Nursing Facility–Initiated Review of MDS Level of Care" provided in Appendix A at the end of this bulletin to mdsaudit@masshealthltss.com. Nursing facilities submitting this request must follow all instructions in Appendix A, including attaching the required supporting documentation. Upon receipt of the complete request, MassHealth will conduct a review of the documentation.

A request for review must be initiated by the nursing facility and must contain the following information:

- Completed Nursing Facility–Initiated Review of MDS Level of Care Request form (see Appendix A);
- Reason for the request to review, either:
    - MMIS lists an MDS Level of Care that does not match the third digit of the HIPPS code on an MDS assessment; or
    - MMIS does not list an MDS Level of Care, and a valid MDS assessment has been completed and submitted to CMS via the IQIES system with the facility's MassHealth provider ID and the member's MassHealth ID;
- Copy of the completed MDS Assessment form along with validation that the MDS assessment was submitted and accepted into the CMS IQIES system;
- Status Change form (SC-1) and Notice of Clinical Eligibility;
- Member's HIPPS code and MDS Level of Care and their effective dates; and
- Attestation that copies of the facility's request and MDS assessment supporting documentation are available for review at the facility.

Within 15 business days of receiving the request for review, MassHealth will review the provided documentation and will notify the facility if the MassHealth member's MDS Level of Care needs to be updated. MassHealth's decision will be final.

Please note: Nursing facilities may not initiate a review of the MDS Level of Care if the MDS Level of Care is the result of a MassHealth MDS Audit.

Key Information on Transition from MMQ to MDS

Nursing facilities will not need to submit Management Minutes Questionnaires (MMQs) for dates of service beyond October 1, 2023. For all dates of service on or after October 1, 2023, MassHealth payment will be based on MDS assessments.

MMQ turnarounds will still be due for July, August, and September 2023 to allow for appropriate payment to nursing facilities. If a nursing facility resident converts to MassHealth on or before September 30, 2023, nursing facilities will still need to submit MMQ data for payment purposes.

Nursing facilities will not need to complete Licensed Nursing Summaries for dates of service on or after October 1, 2023. However, if an MMQ is submitted for dates of service prior to October 1, 2023, Licensed Nursing Summaries will be required to accompany that MMQ.

MDS Audit Structure and Expectations

All facilities will be audited twice yearly on a random schedule. Each audit will review, *at a minimum,* the following sample of MDS assessments:

- 25% of quarterly and annual assessments (with a focus on assessments with high PDPM scores);
- 100% of significant change assessments; and
- 100% of assessments for members with claims that billed for the Behavioral Health add-on (focused on Behavioral Health sections of the MDS assessment).

This sample of MDS assessments will be pulled from the previous three months of completed MDS assessments for MassHealth members. The earliest sample of MDS assessments will be pulled from dates of service beginning on October 1, 2023.

MDS assessments must be completed and submitted in accordance with CMS RAI guidelines. The submission of Significant Change MDS assessments must meet criteria as described in the RAI Manual, which can be found at Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual.

At a minimum, the following documentation will be reviewed during the audit:

- Care Plans
- Physician's orders/progress notes/History and Physical (H&P)
- Medical Administration Records (MAR)/Treatment Authorization Request (TAR)
- All assessments (respiratory, ulcers/wounds)
- Nurses' notes/clinicians' notes/MDS notes
- Occupational Therapy (OT)/Physical Therapy (PT) /Speech Language Pathologist (SLP) documentation, Nursing Restorative notes
- Dietician notes/assessment
- Mental Health Specialist notes, Social Service notes
- Certified Nursing Assistant (CNA) documentation

The above is not an exhaustive list. Any additional documentation within a resident's medical record may be reviewed and considered during the audit.

The medical record, in its entirety, may be subject to review during the audit and must be made readily available upon request at the time of the audit. The medical record must support the coding of the MDS assessment and the resulting Nursing Payment Grouper Category, with particular focus on the questions in the MDS assessment that factor into the Nursing Payment Grouper as outlined in Chapter 6 of the RAI Manual. If the medical record does not align with the MDS assessment, the Nursing Payment Grouper Category will need to be adjusted accordingly. In this scenario, nursing facilities will be required to submit a correcting MDS to update the MDS assessment to document the appropriate Nursing Payment Grouper Category.

The audit will ultimately determine whether the documentation within the medical record validates the Nursing Function Score in Section GG of the MDS assessment. Facilities should refer to RAI Manual, page GG-15, "Steps for Assessment" to ensure accurate completion of Section GG. Here is a key excerpt from that page:

> "Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period."[3]

If the first audit of a facility results in an error rate that is greater than the average error rate for all facilities' first audits, that facility's second audit will review an increased number of quarterly and annual assessments in addition to reviewing 100% of significant change assessments and 100% of assessments for members with claims that billed for the Behavioral Health add-on.

Any errors discovered in an audit that resulted in an incorrect payment amount will count toward the facility's error rate. For example, the submission of a significant change assessment for a reason that is not allowed by the RAI Manual and results in an incorrect payment amount would be counted as an error.

Issues that do not affect payment but are still out of compliance with the RAI Manual (e.g., no patient interviews, missing or late assessments) may lead to a Corrective Action Plan and may be referred to the Department of Public Health (DPH).

Monthly Licensed Nursing Summaries will not be required for MassHealth payment effective for dates of service as of October 1, 2023. Nursing facilities are still required to follow all DPH regulations inclusive of 105 CMR 150.007(H).

A nursing facility may request reconsideration of MassHealth's audit findings in accordance with 130 CMR 456.420(1).

Additional Resources

Nursing facilities should also refer to the following documents for additional information:

- Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual
- 101 CMR 206.00: Standard Payments to Nursing Facilities
- 130 CMR 456.000: Long Term Care Services

MassHealth Website

This bulletin is available on the MassHealth Provider Bulletins web page.

Sign up to receive email alerts when MassHealth issues new bulletins and transmittal letters.

Questions

If you have questions about the information in this bulletin, please email your inquiry to InstitutionalPrograms@mass.gov.

[3] Source: CMS RAI MDS 3.0 User's Manual, Page GG-15, Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual.

Appendix A: Nursing Facility–Initiated Review of MDS Level of Care

Date of Request: _____

Name of Nursing Facility Contact:	Nursing Facility Contact Email:
Nursing Facility Provider Name:	Nursing Facility Provider ID:
MassHealth Member Name:	MassHealth Member ID:

In certain circumstances, nursing facilities may initiate a review of the MDS Level of Care listed in MMIS. This review will only be conducted if a technical error results in MMIS not accurately capturing the MDS Level of Care. **This review process may not be used to appeal or change the MDS Level of Care.**

Reason for Request (check one):

☐ MMIS lists an MDS Level of Care that does not match the third digit of the HIPPS code on a given MDS assessment.

☐ MMIS does not show an MDS Leve of Care, and a valid MDS assessment has been completed and submitted to CMS via the IQIES system with the facility's MassHealth provider ID and the member's MassHealth ID included.

Please complete the information in this table.

MDS Assessment Type (check one)	Assessment Reference Date	HIPPS Code	MDS Level of Care	Effective Dates of Level of Care*
☐Admission				
☐Quarterly				
☐Annual				
☐Significant Change in Status				
☐Significant Correction				

**Please list exact dates applicable for the MDS assessment in review.*

The following documentation has been included:

- Complete copy of MDS assessment that pertains to the Level of Care being reviewed;
- Validation that MDS assessment has been submitted and accepted into IQIES; and
- MassHealth member's most recent Status Change form (SC-1) and corresponding Notice of Clinical Eligibility.

By signing below, I hereby certify under the pains and penalties of perjury that the information in this Appendix A and in the attached documentation is true and correct. I further attest that copies of the submitted MDS assessment and all supporting clinical documentation are available for review at the nursing facility.

Signature: _____
Date:_____

Please email these two pages, the MDS assessment and validation, the SC-1, and the Notice of Clinical Eligibility to mdsaudit@masshealthhltss.com.