



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

Nursing Facility Bulletin 194

DATE: July 2025

TO: Nursing Facilities Participating in MassHealth

FROM: Mike Levine, Undersecretary for MassHealth

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

Introduction

This bulletin updates and supersedes [Nursing Facility Bulletin 190: Updates to Transition to CMS OBRA MDS 3.0 Assessments for Nursing Facility Fee for Service Payments](#) (January 2025) as of July 1, 2025. In October 2023, MassHealth transitioned from using the Management Minutes Questionnaire (MMQ) policies to policies from the Centers for Medicare & 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 are 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 on the following occasions:

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

MassHealth uses 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 1 to be paid by MassHealth for the defined time period.

As outlined in the *RAI Manual*, MDS assessments are due to CMS within 92 days of the last MDS assessment. For example, if a member's MDS admission assessment had an assessment reference date of January 1, 2025, the next MDS quarterly assessment submitted to CMS should have an assessment reference date of April 3, 2025 (i.e., the 92nd day following January 1, 2025). For claims payment purposes, MassHealth will accept as timely assessments that have an assessment reference date within 21 days of the 92-day deadline. For example, if the member's MDS admission assessment had an assessment reference date of January 1, 2025, in order for MassHealth to continue paying claims, the facility must submit an MDS quarterly assessment that falls within 21 days of April 3, 2025, (i.e., between March 13, 2025 and April 24, 2025).

Table 1. 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	"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.

OBRA Assessment Types Used for MassHealth Payment	Identifier	Effective Date for MassHealth Payment
schedule for the next annual and quarterly assessments.		
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 an MDS assessment without the required MassHealth provider ID and MassHealth member ID, the nursing facility must submit a modified MDS assessment. Please refer to the *RAI Manual*, “Chapter 5.7: Correcting errors in MDS records that have been accepted into the CMS Internet Quality Improvement and Evaluation System (IQIES)” for full instructions on how to submit a correcting MDS assessment.

MassHealth imports MDS assessment data daily directly from 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 (ELG-402)**: 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 (ELG-404)**: Providers should use this report to review MDS assessments that were not accepted into MMIS due to errors, such as a missing or incorrect MassHealth member ID. Providers must submit a modified MDS assessment to address any errors. Please refer to the *RAI Manual*, “Chapter 5.7: Correcting errors in MDS records that have been accepted into IQIES” for full instructions on how to submit a modified 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 should first refer to their MDS Submission Success and Error reports to ensure that the MDS assessment has been received by the POSC system and that the member’s information was completed correctly within the MDS assessment.

To request review, the facility must complete the [MassHealth DS Data Review Request](#) and then email it to Institutionalprograms@mass.gov.

Upon receipt of the complete MassHealth MDS Data Review Request, MassHealth will conduct a review of the documentation. Within 15 business days of receiving the request for review, MassHealth will return the spreadsheet with updates and comments.

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 do not need to submit Management Minutes Questionnaires (MMQs) for dates of service on or after 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 accurate 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 before October 1, 2023, Licensed Nursing Summaries will be required to accompany that MMQ.

MDS Audit Structure and Expectations

Pursuant to 130 CMR 446.420(C), MassHealth or its designee may periodically audit medical records to ensure that the nursing facility's documentation supports the *per diem* case-mix classification rating. A facility must permit MassHealth or its designee to access the facility's premises and records for these audits.

All facilities will be audited twice a year on a random schedule.

A. Sample Size and Error Rate

The facility's audit sample size will depend on the error rate from the facility's previously completed MDS audit ("error rate").

Facilities with an error rate less than 3% will have an MDS audit of the following sample size:

- Up to 40% 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 indicator add-on (focused on the behavioral health sections of the MDS assessment).

Facilities with an error rate between 3% and 10% will have an MDS audit of the following sample size:

- Up to 70% 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 indicator add-on (focused on the behavioral health sections of the MDS assessment).

Facilities with an error rate greater than 10% will have an MDS audit of the following sample size:

- Up to 90% 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 indicator add-on (focused on the behavioral health sections of the MDS assessment).

Facilities that have undergone a CHOW (change of ownership) will be audited in the same manner as facilities with an error rate between 3% and 10% and will have an MDS audit of the following sample size:

- Up to 70% 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 indicator add-on (focused on the behavioral health sections of the MDS assessment).

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.

The sample of MDS assessments will be pulled from the previous three months of paid claims and their associated completed MDS assessments for MassHealth members. The earliest sample of MDS assessments will be pulled from claims with dates of service beginning on October 1, 2023.

Non-compliance with the *RAI Manual* (for example, no patient interviews, missing or late assessments) may lead to a Corrective Action Plan, referral to the Department of Public Health (DPH), overpayment recovery, sanction, or other enforcement action by EOHHS.

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 including but not limited to 105 CMR 150.007(H): *Nursing Review and Notes*.

A nursing facility may request reconsideration of MassHealth's audit findings in accordance with 130 CMR 456.421: *Reconsideration of MassHealth-assigned Case-mix Classification Rating*.

If the results of the audit determine that any member's case-mix classification rating is higher than what the medical record documentation supports, the facility must adjust the corresponding Minimum Data Set (MDS) assessment(s) accordingly. The facility must correct and submit the associated MDS assessment(s) to the Centers for Medicare & Medicaid Services (CMS) within 30 days of the MDS audit date or, if a reconsideration is requested, within 30 days of the notice of the reconsideration determination.

B. Clinical Review & Documentation

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 and assessment,
- Mental health specialist notes, social service notes, and
- 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 the *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.

C. Clarification of necessary documentation for “shortness of breath when lying flat”

Shortness of breath is a serious medical condition and may be an indication of a change in condition that requires further assessment and care planned interventions. When a member’s MDS assessment reports “shortness of breath when lying flat,” documentation demonstrating an assessment of shortness of breath must be present in the member’s medical record. The assessment of shortness of breath must meet the following requirements:

- There must be documentation by the member’s physician or nurse practitioner in the member’s medical record that identifies the active diagnosis of Chronic Obstructive Pulmonary Disease.
- The assessment of shortness of breath must be documented by a licensed nurse, physician, nurse practitioner, or respiratory therapist with a correlating note or documentation other than the MDS assessment detailing shortness of breath while lying flat, within the look-back period.
- The assessment of shortness of breath must include documented evidence that the member experiences shortness of breath when the member attempts to lie flat, or that the member avoids lying flat because of shortness of breath.
- The sources of data used for the assessment of shortness of breath must include, at a minimum:
 - Interviews with the member, family members or significant other (if appropriate) and facility staff from all shifts.
 - Observations of the member during various activities, sitting at rest, and when in bed.
 - A review of the member’s medical history including any diagnoses or conditions that may affect respiratory status.
 - Documentation addressing the following questions:
 - Was the onset of shortness of breath sudden or gradual?
 - Are there certain activities that make the shortness of breath better or worse?
 - Does the member use any medications that may affect respiratory function?
 - Is the member’s shortness of breath accompanied by a fever, cough, abnormal lung sounds, or chest pain?
- The assessment of shortness of breath must include a care plan that addresses both 1) a measurable goal of treatment and 2) the interventions used to decrease symptoms of shortness of breath.

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](#)

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