***Commonwealth of Massachusetts***
***Executive Office of Health and Human Services***
***Office of Medicaid***
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# Nursing Facility Bulletin 201

**DATE:** July 2026

**TO:** Nursing Facilities Participating in MassHealth

**FROM:** Ryan Schwarz, Assistant Secretary for MassHealth

**RE:** **Updates to Instructions for Nursing Facility Fee-for-Service Payments: MDS 3.0 Assessments**

## Introduction

This bulletin updates and supersedes Nursing Facility Bulletin 197 (January 2026) as of July 1, 2026. Bulletin 197 explained how the various types of MDS assessments are used to determine payment; described the responsibilities of nursing facilities when completing and submitting assessments; outlined a process to initiate a selected review of the MDS level of care in certain circumstances; and described the MDS audit process.

This bulletin includes the following updates:

- adds a new section titled, "MassHealth Retro-Eligibility and Modified MDS Assessments" on page 5;
- under "MDS Audit Structure and Expectations" on page 6, adds another item to the list of documentation requirements: In addition to the previous three items, "the facility will [now] be required to provide up to 100% of admission, quarterly and annual assessments, with a focus on modified assessments not previously audited that result in higher PDPM scores than the original assessment for any paid claims with service dates on or after 10/1/2023"; and
- adds information to the section titled, "Clinical Review and Documentation" on page 7 about audits of MDS assessments for members with paid claims for the behavioral indicator add-on.

## General Instructions

Nursing facilities must follow the Minimum Data Set (MDS) assessment schedules, instructions, and submission requirements as outlined in the CMS 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, as determined by the MDS assessment, to establish payment rates for MassHealth nursing facility fee-for-service claims. To receive payment for the defined period, facilities must reassess residents according to the timetable in Table 1.

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 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, MassHealth will continue paying claims if the facility has submitted 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:<br>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:<br>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:<br>The ARD must be no later than 366 days from the ARD of the most recent OBRA comprehensive | 03 | This assessment will be used to pay claims from first day of next assessment quarter which is |

| OBRA Assessment Types Used for MassHealth Payment | Identifier | Effective Date for MassHealth Payment |
|---|---|---|
| assessment and no later than 92 days after the ARD of the most recent assessment. | | based on the level of care end date of the prior assessment. |
| Significant Change in status (Comprehensive):<br>The ARD and completion date must be within 14 days after determination that a significant change in resident's status occurred. A Significant Change in Status 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 correction to prior Comprehensive in status (Comprehensive):<br>The ARD and completion date must be within 14 days of the identification of a significant 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 correction assessment will be used to pay claims starting from the ARD on the significant correction 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:<br>The ARD and completion date must be within 14 days of the identification of a significant error in prior comprehensive assessment. A Significant Correction of a Prior Comprehensive assessment includes full MDS and CAAs and resets the | 06 | This significant correction assessment will be used to pay claims starting from the ARD on the significant correction 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. | | |
| 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. |

## MassHealth Provider ID and Member ID Must Be 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 submits an MDS assessment without the MassHealth provider ID and MassHealth member ID, the nursing facility must submit a modified MDS assessment. For full instructions on how to submit a correcting 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)".

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 must verify that accurate MDS assessment data is imported into MMIS. 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 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 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 MDS Data Review Request provided and then email it to Institutionalprograms@mass.gov.

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

## MassHealth Retro-Eligibility and Modified MDS Assessments

If an MDS assessment is required for payment purposes for a newly approved MassHealth member and is beyond CMS's two-year MDS assessment submission

deadline, the provider must submit the following documentation to mdsaudit@masshealthltss.com within 90 days of receiving the Notice of MassHealth financial eligibility:

- a copy of the MassHealth notice of financial eligibility verifying the date the notice was issued and MassHealth Long-term care financial eligibility start date; and
- a copy of the original MDS assessment and validation of timely submission to CMS via the IQIES system.

Requests submitted more than 90 days from the date of the MassHealth financial eligibility notice will not be accepted and the associated MDS level of care will not be updated within the POSC system.

## MDS Audit Structure and Expectations

According 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 records and the facility's premises for these audits.

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

The facility will be required to provide up to 100% of admission, quarterly and annual assessments, with a focus on the following:

- assessments with high PDPM scores;
- assessments for members with claims that billed for the behavioral indicator add-on (focused on behavioral health sections of the MDS assessment)
- 100% of significant change assessments; and
- modified assessments not previously audited that result in higher PDPM scores than the original assessment for any paid claims with service dates on or after 10/1/2023.

The MDS assessments to be audited will be determined from paid claims with service dates on or after 10/1/2023 and their associated completed MDS assessments for MassHealth members.

Non-compliance with the *RAI Manual* (e.g., 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 the Executive Office of Health and Human Services (EOHHS).

Monthly Licensed Nursing Summaries will not be required for MassHealth payment effective for dates of service on or after 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*.

## Clinical Review and 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*, outlined in the Minimum Data Set (MDS) 3.0 *Resident Assessment Instrument (RAI) Manual*.

### *Supporting Documentation*

In addition to the MDS assessments, facilities will be required to provide supporting documentation for EOHHS to review during the audit. This documentation includes, but is not limited to:

- care plans;
- physician's orders, progress notes, and history and physical (H&P);
- admission or transfer documentation;
- Medical Administration Records (MAR), Treatment Administration Records (TAR);
- all clinical assessments (respiratory, ulcers, wounds, Section GG assessments);
- nurses' notes, clinicians' notes, MDS notes;
- occupational therapy (OT), physical therapy (PT), speech language pathologist (SLP) documentation, nursing restorative notes;
- dietician notes, assessments;
- pharmaceutical reviews;
- mental health specialist notes, social service notes;
- treatment and medication consent from the member or their guardian; and
- certified nursing assistant (CNA) documentation.

This is not an exhaustive list. Any additional documentation within a member's medical record that EOHHS requests must be provided for review during the audit.

The member's entire medical record must be made available if requested by EOHHS at the time of the audit. The nursing facility must ensure that the medical record supports the coding of the MDS assessment and the resulting PDPM Nursing HIPPS Code, with particular focus on the questions in the MDS assessment that factor into the PDPM Nursing HIPPS Code as outlined in Chapter 6 of the *RAI Manual*. If the medical record does not align with the MDS assessment, the PDPM Nursing HIPPS Code will need to be

adjusted. In this scenario, nursing facilities will be required to submit a correcting MDS to update the MDS assessment to document the appropriate PDPM Nursing HIPPS Code.

The audit will ultimately determine whether the documentation within the medical record validates the Nursing Function Score in Section GG and the resulting PDPM Nursing HIPPS Code. 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."

***MDS Assessments for Paid Claims for Behavioral Indicator Add-on***

For MDS assessments selected for audit for members with paid claims for the behavioral indicator add-on, the audit will validate whether the documentation within the medical record supports the behaviors coded in Section E (behavioral health) of the MDS assessment. The audit will validate whether:

- documentation within the medical record supports the behaviors coded as 2 or 3 in Section E of the MDS assessment within the allowable 7-day look-back period;
- the care plan includes specific references to the behaviors coded as 2 or 3 for items E0200A, E0200B, E0200C, E0800, and E0900 and identifies related interventions to care for the member;
- nursing documentation specifies behaviors, frequency, interventions, and outcome of interventions; and
- when rejection/decline of care (E0800) is first identified, the team then investigates and determines the rejection/decline of care is really a matter of resident's choice and that the team then provides education and the member's choice becomes part of the care plan so that on future assessments, the behavior will not be coded in this item.

If the medical record documentation does not support the behaviors coded in Section E of the MDS assessment, MassHealth will review behavioral indicator add-on claims paid based on the assessment and recover any overpayments.

***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 Asthma, Chronic Obstructive Pulmonary Disease, or other chronic lung 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 the following:
    - 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 that addresses 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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