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

Nursing Facility Bulletin 205

DATE: November 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: Minimum Data Set (MDS) 3.0 Assessments**

Introduction

This bulletin updates and supersedes Nursing Facility Bulletin 201 (July 2026) as of October 1, 2026.

This bulletin includes the following updates.

- Updates to MassHealth payment requirements for MDS items I6200 and J1100C relating to "shortness of breath while lying flat."
- Updates to MassHealth payment requirements for behavioral indicator add-on claims, specifying that member-based eligibility will be based on the behavioral indicator scores from the original MDS assessment only.
- Removing the requirement to submit a modified MDS assessment solely because of a MassHealth audit finding.

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 member on the following occasions.

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

MassHealth uses each member'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 members according to the timetable in Table 1.

As outlined in the *MDS 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: 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):	04	This significant change assessment will be used to pay

OBRA Assessment Types Used for MassHealth Payment	Identifier	Effective Date for MassHealth Payment
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.		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): 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: 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.	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.
Discharge Assessment – Return not anticipated	10	This assessment may be combined with a quarterly assessment and may pay through

OBRA Assessment Types Used for MassHealth Payment	Identifier	Effective Date for MassHealth Payment
		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 Requirements for MassHealth Payment

To receive MassHealth payment for a member, 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 corrected MDS assessment. For full instructions on how to submit a corrected MDS assessment, please refer to the *MDS 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. The two reports listed 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 corrected MDS assessment to address any errors. Refer to the *MDS RAI Manual*, "Chapter 5.7: Correcting errors in MDS records that have been accepted into IQIES" for full instructions on how to submit a corrected 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 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 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 the MassHealth Long-term care financial eligibility start date.
- 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.

MDS Audit Structure and Expectations

According to 130 CMR 456.420(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.

Upon request, 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 *MDS 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 the Executive Office of Health and Human Services (EOHHS).

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*.

Effective October 1, 2026, MassHealth will no longer require nursing facilities to submit a modified MDS assessment solely because of a MassHealth MDS audit finding.

This policy also applies to MDS audits completed before October 1, 2026, for which the nursing facility has not yet submitted a modified MDS assessment in response to the audit findings. In such cases, the nursing facility is not required to submit a modified MDS assessment solely because of a MassHealth MDS audit finding. This does not alter a nursing facility's responsibility to modify an MDS assessment as required by the *MDS RAI Manual*.

Clinical Documentation Required for MassHealth Payment

MassHealth will audit facilities to determine whether the MDS information reported by facilities is supported by clinical documentation for the purpose of MassHealth payment. Documentation supporting PDPM Nursing classifications will be evaluated in accordance with both the applicable *MDS RAI Manual* requirements and the MassHealth supporting documentation requirements described in this bulletin. If the medical record does not support the MDS information used to determine the PDPM Nursing classification used for MassHealth payment, MassHealth will adjust its applicable PDPM Nursing HIPPS code for the affected payment quarter.

Therefore, in addition to the MDS assessments, upon request, facilities will be required to provide supporting documentation for EOHHS to review during an 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 audit will determine whether documentation in the member's medical record supports the Section GG responses used to calculate the Nursing Function score and the

resulting PDPM Nursing HIPPS Code. Facilities must assess and code Section GG in accordance with "Chapter 3: MDS Items, Section GG: Functional Abilities" of the *MDS RAI Manual*. Additionally, for MassHealth payment purposes, any MDS item used to determine the PDPM Nursing HIPPS Code must be supported by documentation in the member's medical record, independent of the MDS assessment, that substantiates the condition, service, function, or other factors reported on the assessment during the applicable assessment period.

If the audit determines that member's medical record does not support the MDS assessment coding used to determine MassHealth payment, notwithstanding the MDS assessment, MassHealth will notify the facility that it will adjust the applicable PDPM Nursing HIPPS code for the affected payment quarter in MMIS to reflect the coding supported by the medical record. MassHealth will make the adjustment no earlier than 31 calendar days after the completion of the reconsideration process under 130 CMR 456.421, if applicable.

MDS Assessments and Paid Behavioral Indicator Add-on Claims

For purposes of validating member eligibility for paid behavioral indicator add-on claims, MassHealth will review 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 has investigated and determined the rejection/decline of care is really a matter of the resident's choice. If so, education is provided and the resident's choices become part of the plan of care and on future assessments, rejection/decline of care is not coded in this item, consistent with the guidance for E0800 on page E-14 in "Chapter 3, Section E" of the *MDS RAI Manual*.

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

Modified MDS Assessments and Payment of Behavioral Indicator Add-on Claims

Effective October 1, 2026, member eligibility for MassHealth payment of behavioral indicator add-on claims will be determined based on the value listed in items E0200A, E0200B, E0200C, E0800, or E0900 of the original MDS assessment only. A modified MDS assessment that updates items E0200A, E0200B, E0200C, E0800, or E0900 to a value of 2 or 3 from an original value of 0 or 1 will be disregarded for purposes of determining eligibility for payment of behavioral indicator add-on claims. This payment policy does not alter a nursing facility's responsibility to modify an MDS assessment when required under "Chapter 5, section 5.7" of the *MDS RAI Manual*.

MassHealth Payment Requirements for Clinical Documentation Supporting Coding of MDS Items I6200 ("Active Diagnosis") and J1100C ("Shortness of Breath While Lying Flat")

Nursing facilities must complete and code MDS items I6200 and J1100C in accordance with the applicable *MDS RAI Manual*, under "Chapter 3, Section I and Section J" respectively.

For payment purposes, MassHealth will determine whether the medical record supports the coding on MDS assessment items I6200 and J1100C by reviewing relevant clinical documentation, as follows.

Active Diagnosis (I6200)

For MassHealth payment, when the MDS Assessment codes a member for item I6200, the member's medical record must include documentation supporting an active diagnosis of asthma, chronic obstructive pulmonary disease (COPD), or other chronic lung disease.

Shortness of Breath When Lying Flat (J1100C)

For MassHealth payment, when the MDS assessment codes a member for item J1100C, clinical documentation in the member's medical record must support the presence of shortness of breath or trouble breathing when lying flat during the applicable 7-day look-back period. The documentation must demonstrate that the member experiences shortness of breath when attempting to lie flat or avoids lying flat because of shortness of breath.

In determining whether the medical record sufficiently supports MassHealth payment for J1100C, relevant documentation must include the following.

- Documentation by a licensed nurse, physician, nurse practitioner, respiratory therapist, or physician assistant describing the member's shortness of breath or trouble breathing when lying flat.
- Information obtained through interviews with the member, facility staff, and, when appropriate, family members or significant others.
- Observations of the member during relevant activities, at rest, and when in bed;
- Review of the member's medical history, including diagnoses or conditions that may affect respiratory status.
- Relevant clinical factors, including onset of symptoms, activities or positions that improve or worsen symptoms, medications that may affect respiratory function, and associated symptoms such as fever, cough, abnormal lung sounds, or chest pain.
- Care-planning documentation addressing underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath. Measurable goals and interventions used to manage shortness of breath must be included in care plan.

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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