MISSISSIPPI DIVISION OF MEDICAID

# Public Comments

# State Plan Amendment (SPA) 18-0001

# Long-Term Care (LTC) Updates

January 26, 2018

Elizabeth G. Hooper
Wise Carter Child & Caraway
Jackson Office
401 E. Capitol St, Heritage Bldg., Suite 600
Jackson, MS 39201

Re: Providers' Comments in Response to Proposed State Plan Amendment 18-0001 and Request for Oral Proceeding on behalf of South Central Regional Medical Center and Neshoba County General Hospital

Dear Ms. Wilson:

We are writing on behalf of our clients South Central Regional Medical Center, which owns and operates Comfort Care Nursing Center and Jones County Rest Home and Neshoba County General Hospital, which owns and operates Neshoba County Nursing Home (collectively the "Providers") to provide our clients' comments in response to the Division of Medicaid's Public Notice dated December 28, 2017, in which the Division submitted State Plan Amendment 1B-0001, Long-Term Care ("LTC") Updates, Transmittal No. 18-0001 (the "SPA").

Procedurally, we believe the SPA fails to meet the requirements of the Mississippi Administrative Procedures Law because the Division of Medicaid has failed to file the proposed rulemaking with the Mississippi Secretary of State as required by Miss. Code Ann. § 25-43-3.103. Further, the SPA's Public Notice fails to provide a description of how persons may demand an oral proceeding on the proposed rulemaking; such a description is required is also required by§ 25-43-3.103. The Providers believe that the proposed SPA will result in a greater than $100,000 cost to them, but the Division has failed to attach the economic impact statement required under Miss. Code Ann. § 25-43-3.105. Though the Division has include a statement as to federal and state expenditures, the Providers believe this falls short of the requirement of the statute.

The Providers believe that the notice is not a proper filing for rulemaking. However, to the extent that the Division moves forward with the Notice and SPA, the Providers, are each political subdivisions of the State of Mississippi under the Mississippi Community Hospital Act. Therefore, the Providers are entitled to request an oral proceeding on the *SPA,* which the Division is required to provide at their request pursuant to Miss. Code Ann. § 25-43-3.104. The name and contact information for the Providers is included at the conclusion of this letter.

Regarding the substance of the proposed changes in the SPA, we have the following comments:

• In Section 3(a) of the Public Notice pages, the Division attempts to characterize its revisions to the State Plan Attachment 4.19-D regarding the cost allocations, including certain assessments, by hospital-based LTCs as a clarification. As discussed below, the language proposed by the Division drastically alters the hospital-based cost allocation system that has been in place for many years. The Division is not clarifying its position, but rather attempting to adopt a new rule.

• On Page 66 of Attachment 4.19-D, the Division proposes to include respiratory therapy expenses in the per diem rate for all LTC facilities. We support the Division's efforts to reimburse facilities for therapy costs since the facilities must provide such services to a patient in need of these services. Historically, the Division has had no mechanism to reimburse for these services in LTC facilities.

• On Pages 49 and 58 of Attachment 4.19-D, the Division fails to provide guidance on what year fees should be claimed if a case settles. We believe that the intent is that all accounting or legal costs should be claimed in the year that an appeal actually settles, but it is unclear from the language of the SPA.

• On Page 58 of Attachment 4.19-D, the Division's attempts to make certain legal fees non-allowable. The final sentence states that legal fees in an appeal are not allowable, but then goes on to state that the provider should not claim them until the provider has prevailed in final litigation. If the Division's intent is actually to make legal *fees* for appeals against the Division of Medicaid non-allowable, we strongly disagree with this proposed revision as it is aimed at discouraging providers from appealing decisions of the Division and exercising due process rights. A state agency should not be permitted to take such actions. If the Division's intent is to make costs non-allowable until all litigation has concluded, we also disagree with this revision and departure from Section 2183 of the Provider Reimbursement Manual 15-1. Litigation from administrative appeal to final decision may at times last for years and this change would also discourage providers from appealing decisions of the Division and exercising due process rights, which we contend is an inappropriate actions for a state agency to take. It would also discourage providers from ever settling any matters with the Division because allegal fees incurred would become non-allowable. There is no rational basis to alter the existing rule.

• On Page 60 of Attachment 4.19-D, the Division proposes to cap the allowable costs for officers of a nursing home as owner's salaries and the salaries of their immediate

family members are currently capped. We disagree with this proposal because this limitation serves no obvious public interest. Nursing homes have no incentive to pay more than fair market value compensation to an officer, except in cases where a familial relationship may be present. The Providers providing this comment are political subdivisions of the state of Mississippi and paying employees greater than fair market value compensation would potentially violate the Mississippi Constitution prohibiting gratuities.
Placing an arbitrary limit on the allowable cost for compensation of an officer disadvantages nursing facilities from attracting the most qualified candidates. The current rules for allowable costs require that expenses be reasonable and necessary. Reasonableness should be based on what the market demands, not a cap created by the Division. Additional restrictions are not necessary, and the Division has not placed such restrictions on any other Medicaid providers. The Division should not single out LTCs for such a policy.

• On Page 67 the Division proposes that costs incurred for providers to pay for the education of employees are allowable only upon the employee acquiring an undergraduate or graduate degree. However, nursing home employees regularly have to obtain training andjor certifications that they must pay for, but which do not lead to a terminal degree. Providers have no incentive to provide reimbursement for such training unless it is beneficial to patient care. Such expenses are reasonable and necessary and should remain allowable as described in the Provider Reimbursement Manual, 15-1.

• On Pages 69 and 76 of the Attachment 4.19-D, the Division proposes to drastically alter the hospital based cost allocation system that has been in place for many years. The Division proposes to make the allocation of a portion of the hospital assessment to a hospital-based nursing home non-allowable. Such an action is in conflict with the step-down allocation method required by Provider Reimbursement Manual 15-1, which has been adopted by the Division in the State Plan Attachment 4.19-D. Allocating portions of costs from hospitals, including the hospital assessment, to hospital-based nursing homes recognizes the services provided by the hospitals, such as Providers, to their hospital-based nursing homes. These allocated costs represent actual benefit to patient care in the L TCs and are related to patient care. Therefore, they should remain allowable. Chapter 23 of the Provider Reimbursement Manual 15-1, published by CMS in order to administer Medicare costs and adopted by the Division of Medicaid throughout the State Plan, intentionally established a basic cost allocation methodology that is neither overly burdensome nor unwieldy while allowing providers at their own discretion to opt for more complex methods. The Division is proposing a change to that system that will be overly burdensome and expensive to providers and result in a significant financial impact to hospital-based provider LTC, such as those owned by the Providers. Further, there is no existing form or substance under the State Plan or PRM 15-1 by which the Providers can implement the proposed changes.

• On Page 76 of the Attachment 4.19-D, the Division of Medicaid singles out those LTC facilities that are not contiguous to the hospital without providing any rationale for this position. This proposal indicates the Division of Medicaid has a fundamental lack of understanding of how departments of a hospital, including LTCs, operate and

share scarce resources such as overhead, across an integrated healthcare system. Such facilities need not be contiguous to be integrated. The purpose of integration is the create economies of scale and geographic location does not prevent providers from attaining economies of scale.

As mentioned above, we believe the Notice of SPA 18-0001 was procedurally deficient. Further, *we* believe that the majority of the revisions proposed by the Division of Medicaid other than the reimbursement for respiratory therapy costs are unnecessary and will create a lack of efficiency in the Medicaid Program as it relates to long-term care facilities. Further as political subdivisions of the State of Mississippi, the Providers request an oral proceeding on SPA 18-0001. The contact information for the Providers follows:

South Central Regional Medical Center
ATTN: James T. Canizaro, Jr., CFO
P.O. Box 607
Laurel, MS 39440
601-426-4506
tcanizaro@ls~rmc.com

Neshoba County General Hospital-Nursing Home
ATTN: Scott McNair, CFO
1001 Holland Avenue
Philadelphia, MS 39350
601-663-1233
smcnair(filneshoba-hospital.com

Respectfully submitted,

Elizabeth G. Hooper

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January 26, 2018

Diana S. Mikula, Executive Director
Department of Mental Health
239 North Lamar Street
1101 Robert E. Lee Building
Jackson, MS 39201

Re: Comments Regarding Proposed State Plan Amendment (SPA) 18-0001

Dear Ms. Wilson:

We would like to take this opportunity to comment on the changes proposed by the Division of Medicaid in the aforementioned Mississippi State Plan Amendment (SPA). We trust that the Division will consider the following comments in a thoughtful manner.

**General**

- Division of Medicaid (DOM) did not file proposed changes with the Secretary of State in accordance with the Administrative Procedures Act (APA). Failure to follow the protocols of the APA precludes the implementation of the proposed changes.
- The required economic impact analysis was not provided with the SPA. The only impact analysis provided was the impact on the state and federal budget. No consideration was provided regarding the impact on providers, patients and other incidental entities.

**Changes to selected cost considered allowable**

- Pages 57 & 58 - accounting and legal fees

  Clarification should be provided concerning which year costs associated with certain lawsuits should be claimed considering recent audits by the Division have scrutinized invoice dates with the related cost report year. One may suppose that DOM intends that the fees be claimed the year in which the case is successfully settled, though this is not clearly stated. DOM simply states the trigger (successful settlement of suit) as the prerequisite for claiming the cost but does not specify for which cost report year the costs should be claimed.

- Page 60 - Officer compensation limits

  The application of owner compensation limits to individuals unrelated to owners serves no obvious public interest considering that there is no perverse incentive for an owner to pay more than market value compensation to an unrelated officer. Placing arbitrary reimbursement limits on the amount owners can claim for compensation paid to unrelated officers inherently disadvantages owners from attracting the most qualified candidates to their facility. Current reimbursement regulations require that all expenses, including officer compensation, be reasonable and necessary. Additional restrictions are neither necessary nor rational. In fact, such policies inflict long term negative consequences on long term care facilities by fostering reimbursement policy that restricts their ability to pay market rates for qualified officers. Considering that such restrictions are not placed on any other Medicaid providers, long term care facilities should not be singled out.

- Page 67- Educational Costs

  DOM's restriction on the reimbursement for educational training courses does not recognize the inherent benefits of educational expenses other than those associated with the attainment of a degree. We find DOM's departure from the Provider Reimbursement Manual (PRM) ill- informed as to the various educational and training needs of employees of LTC facilities. Frequently, employees are in need of various certifications (including new certifications) offered by various educational institutions for which there is no degree issued at the completion of the educational course set. These certifications and specific educational training sessions yield benefits to the residents of the facility irrespective of whether a degree is issued at the end of the education course curriculum. DOM should consider that a facility does not have an inherent interest in expending funds on education activities that are not

otherwise beneficial to the residents of the facility. The Provider Reimbursement Manual rightly recognizes these aforementioned realities and avoids the restrictions that DOM is proposing.

**Changes allocated cost requirements**

- Pages 69 & 76 - Allocation of Hospital overhead including tax assessments paid

  While we concur with DOM that intergovernmental transfers (IGTs) are not an allowable cost, we do not concur with DOM's departure from the PRM in regards to allocation of overhead from the hospital that is reasonable and necessary in nature. Chapter 23 of the PRM intentionally established a basic cost allocation methodology that is not overly burdensome or unwieldy while allowing providers, at **their discretion**, to opt for a more complex cost accounting methodology subject to the approval of the Medicare Administrative Contractor (MAC). CMS understood that setting forth a comprehensive but basic cost allocation methodology struck the correct balance between workability and objectivity while avoiding mandates for overly complex models that would inherently increase the cost to providers. This particular proposal by DOM seems to do the exact opposite of the PRM intent. In their departure from the tested precedence of the PRM, DOM creates a direct conflict in how facilities would report cost to the Medicare program compared to cost reporting to Medicaid. This conflict creates unfair reimbursement implications for providers, added administrative costs of compiling Medicaid cost reports, and a material conflict with the PRM. While DOM indicates they are not mandating these allocation changes and thereby allowing providers to continue to comply with Chapter 23 of the PRM, providers will not be allowed to claim the cost allocated in accordance with Chapter 23 of the PRM without meeting these newly imposed restrictions by DOM. DOM appears to not realize that some entities lack the capability to componentize, subscript and otherwise maintain a more complex accounting system than the one long recognized as adequate by the PRM. In addition, DOM seems to not acknowledge that, even those providers who have the capacity for these additional DOM imposed requirements, a change is not allowed to the allocation methodology unless approved by the MAC. Where the MAC does not approve of the allocation change, DOM's proposal puts the SPA in direct opposition to the PRM resulting in the provider penalized through no fault of their own. In such cases, the provider is required to make such allocations to the nursing home (depriving itself of reimbursement for such cost in other areas of the hospital) only to have DOM refuse to allow the reimbursement in the nursing home. Consequently, DOM should not implement a policy in direct contradiction to the PRM.

- Page 76 - Contiguous restrictions

  DOM singles out LTC facilities that are not contiguous to the hospital for specific allocation restrictions without providing any rationale for their position. Since DOM does not define their interpretation of contiguous, presumably a facility located across the parking lot or across the street from the hospital would preclude itself for being able to allocate costs similarly to a facility that is affixed to the hospital, despite the fact that services and overhead cost are commingled and

delivered in exactly the same way. It is unclear how this would apply to allocation of shared overhead of LTC facilities that have multiple locations. Absent rationale provided by DOM, this could presumably restrict how shared overhead is allocated in such situations as well. This portends a fundamental lack of understanding in how departments (including LTC units) of multi-location facilities, including hospitals, operate and share scarce resources such as overhead. We encourage DOM to ensure consideration is given to hospital and multi-location operations prior to proposing such severe changes that will at least produce inefficiencies in how overhead services are provided.

**Respiratory Therapy Reimbursement Changes**

- We applaud DOM's effort to reimburse facilities for respiratory therapy costs since this is a required service that facilities provide in accordance with patient need, but historically been no reimbursement mechanism in the Medicaid program to reimburse facilities for the cost of these services. This proposed **change** will rectify this inequity.

We appreciate your sincere consideration of the above perspectives

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January 26, 2018

Copeland, Cook, Taylor & Bush, P.A.
Thomas L. Kirkland, Jr.
Copeland, Cook, Taylor & Bush
JACKSON I RIDGELAND
600 Concourse, Suite 100
1076 Highland Colony Parkway
Ridgeland, Mississippi 39157

**Re: Medicaid State Plan Amendment 18-0001 Long Term Care (LTC) Updates**

Dear Ms. Wilson:

Copeland, Cook, Taylor and Bush represents Methodist Specialty Care Center ("Methodist"); and we have been asked to provide written comments concerning the Medicaid State Plan ("Plan") Amendment 18-0001 Long Term Care (LTC) Updates ("SPA 18-0001") which impacts, among other things, nursing facility allowable and non-allowable costs and hospital-based nursing facility cost allocation.

Methodist, a hospital-based nursing facility owned by Methodist Rehabilitation Center ("MRC"), is currently involved in an administrative appeal before Medicaid concerning Medicaid's decision to disallow certain costs allocated to Methodist by MRC-specifically at issue is MRC's allocation of a portion of the Mississippi Hospital. Assessment as required by PRM 15- 1, Chapter 23. Despite the pendency of this appeal, SPA 18-0001 will specifically prohibit such allocations, rendering any ruling made by the Administrative Hearing Officer

or the Executive Director moot. In addition to this inequitable undermining of the administrative appeal process, Methodist also takes issue with other proposed amendments impacting the allowable costs for nursing facilities. Methodist therefore opposes SPA 18-0001 for the reasons more specifically outlined below.

Medicaid is an "Agency" pursuant to Miss. Code Ann. §25-43-1.102 that is required to comply with the Mississippi Administrative Procedures Law ("APA"), the purpose of which is to ". . . increase public accountability of administrative agencies;. . . to increase public access to governmental information; and to increase **public participation in the formulation of administrative rules."** (emphasis added). So as to avoid any questions of the Law's applicability to Medicaid, Miss. Code Ann. §43-13-137, specifically states, "[t]he division is an agency as defined under Section 25-43-3 and, therefore, must comply **in all respects with the Administrative Procedures Law**, Section 25-4 3-1, et seq." (emphasis added). Therefore, "[a]t least twenty-five (25) days before the adoption of a rule an agency shall cause notice of its contemplated action **to be properly filed with the Secretary of State for publication in the administrative bulletin…**" Miss. Code Ann. §25-43-3.103(1)(emphasis added). Medicaid has made no such filing regarding SPA 18-0001, and thus has not complied with the Law. This failure to provide notice as prescribed by Miss. Code Ann. §25-43-3.103(1) will invalidate SPA 18-0001 should Medicaid continue to move forward with the proposed amendment.

In addition to its failure to comply with the APA by refusing to file SPA 18-0001 with the Secretary of State's Office, Medicaid has also failed to conduct an adequate financial impact study. As stated above, Medicaid is required to comply with the APA which requires that

> . . . each agency proposing the adoption of a rule or significant amendment of an existing rule imposing a duty, responsibility or requirement on any person shall consider the economic impact the rule will have on the citizens of our state and the benefits the rule will cause to accrue to those citizens. For purposes of this section, a 'significant amendment' means any amendment to a rule for which the total aggregates cost to all persons required to comply with that rule exceeds One Hundred Thousand Dollars ($100,000.00).

Miss. Code Ann. §25-43-3.105

The only financial impact analysis conducted by Medicaid regarding SPA 18-0001 related to the amendment's impact on the federal and state budget. Absolutely no consideration was given to the impact the proposed amendments would have on the provider community-which will certainly exceed the $100,000.00 threshold.

**1. Medicaid is inappropriately mandating a change in cost allocation methodologies.**

As mentioned previously, Methodist is currently engaged in an administrative appeal before the Division of Medicaid. This appeal challenges Medicaid's decision to disallow the allocated portion of the Mississippi Hospital Tax Assessment ("Assessment") on the

Methodist cost report. Methodist contends that such allocations are required by the PRM, specifically Chapter 23, Section 2306. This section specifically states in part, Although nonrevenue-producing cost centers do not directly produce patient care revenue, they contribute indirectly to patient care revenue generated by "serving" as a service to the revenue-producing centers and also to other nonrevenue- producing centers. **Therefore, for the purpose of proper matching of revenue and expenses, the cost of the revenue-producing center should include both its direct expenses and its proportionate share of the costs of each nonrevenue-producing center** (indirect costs) based on the amount of services received.

(Emphasis added)

Methodist-a revenue producing cost center of MRC-must then share a proportionate amount of the nonrevenue-producing cost centers; one of which is the Administrative and General ("A&G") cost center. Therefore, Methodist must receive an allocated portion of MRC's A&G costs based upon "accumulated costs"-which includes an allocation of the Assessment costs. The allocated A&G costs are then included in Methodist's cost report.

Despite adopting the PRM standards allowable costs1, Medicaid now seeks to adopt an exception to those rules which would disallow a proportional allocation of the Assessment by a hospital to its hospital-based nursing facility. This departure from the PRM guidelines is unnecessary and it creates an undue burden for hospital-based nursing facilities like Methodist.

Medicaid has elected to utilize the cost-allocation methodology outlined in the PRM. Regarding this issue, Section 2306 of the PRM intentionally establishes a basic cost allocation methodology that is not overly burdensome or unwieldy. This "step-down" method is a comprehensive cost allocation methodology that strikes the correct balance between workability and objectivity, while eliminating the potential for cost report adjustments that vary with the subjectivity of individual auditors. Because the step-down method is the preferred model, in accordance with Chapter 23 if a provider chooses to utilize any other method of cost allocation, it must receive approval from the Medicare Administrative Contactor ("MAC"). Because these other methods of cost allocation are more complex and onerous, the provider must initiate the request and provide the MAC with its rationale for departing from the step-down method. The MAC is under no obligation to approve these requests.

While Medicaid may not dictate to providers which cost allocation method must be utilized, the implementation of SPA 18-0001 will do precisely that. SPA 18-0001 will prohibit providers from stepping down A&G costs and will instead require providers to componentize their A&G costs-meaning the facility will have to separate out *each cost* identified as A&G and estimate the likelihood that the individual cost will pass Medicaid's subjective "applicable to services rendered" test, before it may be allocated to cost centers. SPA 18-0001 offers zero guidance on how a cost qualifies as "applicable to the LTC facility for which services were rendered." As opposed to providing a clear and concise rule, Medicaid will subjectively allow allocated costs based upon each individual auditor's preferences. In apparent effort to window dress SPA 18-0001, Medicaid specifically states that providers are not required to componentize its costs; however, under SPA 18-0001 a provider will not be paid unless they officially componentize or unofficially componentize by recasting costs for purposes of the Medicaid cost

report. Either way, the departure from the step-down method of cost allocation in SPA 18-0001 is not at the discretion or desire of the providers, but instead at the mandate of Medicaid.

Medicaid either fails to realize-or simply does not care-that there are providers that are not able to depart from the accounting system that has long been recognized and accepted by CMS. These facilities are unable to implement and maintain a more complicated accounting system that is capable of componentization and subscription, and they should not be asked to do so when their existing accounting models have been deemed adequate and acceptable by CMS. Medicaid further fails to acknowledge that unilaterally mandating this cost allocation methodology change remains subject to approval of the MAC. Should the MAC not approve a change in the cost allocation, SPA 18-0001 places providers in direct opposition with the requirements of the PRM. In such cases, the provider will be punished by a situation that is not of their making. MRC will be required to make A&G cost allocations to Methodist and thus deprive itself of reimbursement for such cost in other areas of the hospital-only to have Medicaid refuse to allow the allocation and thereafter deny reimbursement. SPA 18-0001 is part of a continued attempt by Medicaid to place undue influence and hardship on hospital-based nursing homes and the hospitals that operate them.

SPA 18-0001's changes regarding cost allocation will have the most detrimental impact to hospital-based nursing facilities and specifically hospital-based nursing facilities that are non-contiguous. Without reason or rationale, Medicaid places heightened restrictions on these "non-contiguous" nursing facilities; however, Medicaid does not bother to define what constitutes a "non-contiguous" nursing facility. Therefore, a facility that is located on the same campus as its hospital but separated by a parking lot would be prohibited from allocating costs in same manner as a nursing facility that is affixed to the hospital-even though services and overhead costs are commingled and delivered in the same manner. This portends a fundamental lack of understanding in how hospital departments (which includes nursing homes) operate and share scare resources such as overhead.

In the event that Medicaid institutes SPA 18-0001 as proposed, a corresponding SPA revising Attachment 4.19-A will be necessary. Otherwise, Attachment 4.19-A and 4.19-D will have conflicting standards and policies regarding cost allocation, while requiring providers to utilize the same Medicare cost reporting worksheets-namely worksheets B and B 1. This will inevitably lead to hospitals allocating overhead costs to the nursing facility where such costs could be disallowed by Medicaid, thus causing the both the nursing facility and the hospital to lose reimbursement for those expenses. However, with a corresponding amendment to Attachment 4.19-A, Medicaid will provide hospitals with a better understanding of when costs should be allocated and to what specific cost centers those allocations should be made. This is especially true for the allocation of the A&G cost center, as any lost reimbursement in the area will have a direct impact on the Medicaid Disproportionate Share payment that a hospital might otherwise receive.

**2. Allowability of Accounting and Legal Fees**

SPA 18-0001 amends sections 2-1(A)(1) and (9) of the Plan regarding accounting and legal fees. Specifically, this amendment will now only allow accounting fees that result

from actions against federal and state agencies administering the Medicaid Program if the provider prevails in their appeal or litigation. Further, SPA 18-0001 will not allow nursing facilities to claim accounting and legal costs incurred in such actions until all appeal remedies have been exhausted and the provider has prevailed in their appeal or litigation. As Medicaid is well aware, if a provider incurs accounting and legal fees as a result of challenging the actions of Medicare, such fees are allowable regardless of the outcome. To do otherwise, would obviously discourage providers from exercising their right to undertake such actions regardless of the likelihood of success on appeal. Methodist would encourage Medicaid not to create additional barriers in what is already perceived to be an exceedingly inequitable appeal process.

Alternatively, given the likelihood that Medicaid will institute these amendments, Methodist would ask that Medicaid reword the proposed changes in SPA 18-0001 with regard to accounting and legal fees, as the present language is contradictory and ambiguous. Methodist offers the following suggested language on this issue:

> Accounting fees resulting from suits against federal and or state agencies administering the Medicaid program are not allowable costs unless the provider has prevailed in their appeal or litigation. The provider may not claim such costs until all appeal remedies have been exhausted. All accounting fee costs incurred in such an appeal or litigation should be included in the cost report for the year in which the appeal was concluded or settled.
>
> Legal fees resulting from suits against federal and or state agencies administering the Medicaid program are not allowable costs unless the provider has prevailed in their appeal or litigation. The provider may not claim such costs until all appeal remedies have been exhausted. All legal fee costs incurred in such an appeal or litigation should be included in the cost report for the year in which the appeal was concluded or settled.

Given that SPA 18-0001 may not be applied retroactively, the limitations contained therein should only be applied to appeals filed after SPA 18-0001 has been approved by CMS.

**3. Allowability of Owners' and Officers' Salaries**

SPA 18-0001 unnecessarily places salary limits on officers while serving no obvious public interest. SPA 18-0001 presumes that there is some sort of incentive for an owner to pay more than market value compensation to an unrelated officer-this is simply not the case. Conversely, placing arbitrary reimbursement limits on the amount owners can claim for salaries paid to unrelated officers of nursing facilities inherently creates a disadvantage for owners as it will create a hardship for owner's in attracting the most qualified candidates to their facility. Current reimbursement regulations require that all expenses, including officer compensation, be reasonable and necessary; therefore, additional restrictions are not necessary. Such digressive policies will inflict long term negative consequences on such long-term care facilities alone given that such restrictions regarding officer compensation are not placed on any other Medicaid providers.

**4. Allowability of Training and Education Costs**

SPA 18-0001 added two new sections to the Plan, one for training costs and another for education costs. The amendment also adopted the majority of PRM Section 416.3 as the basis for allowing education costs. However, Methodist opposes Medicaid's proposal that would require providers to capitalize and amortize these training and education costs over the period required to obtain a degree or the continued employment period-whichever is longer.

Medicare utilizes an accrual basis of accounting for training and educational costs and allows these costs to be claimed in the year such costs are incurred; therefore, offsetting the costs incurred even in the event the employee does not complete the course or the employment relationship is terminated. To do otherwise, discourages providers from allowing employees to undertake such training and education courses and thus, ignores the various education and training needs of nursing facility employees.

Methodist opposes the above referenced portions of SPA 18-0001 and would ask that Medicaid revisit the SPA to address the concerns outlined herein. Further, Methodist would request that a public hearing be held prior to the submission of this SPA to CMS for review and approval. We appreciate the opportunity to share these concerns with you. If you have any questions, please call my office at 601-898-2745 or, Tammy Voynik, General Counsel to Methodist or Mark Adams, its CEO at 601-98 1-2611.

Enclosed herewith is a copy of this comment letter. Please file stamp and return the copy to me via our runner for our records.

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January 25, 2018

Leslie Morris, Reimbursement Manager
Jefferson Davis Community Hospital
Forrest Health

RE: MS SPA 18-0001 Long Term Care (LTC) Proposed Changes

To Whom It May Concern:

Jefferson Davis ECF is submitting the following comments concerning the proposed changes to Long Term Care Facilities outlined in SPA 18-0001 Long-Term Care (LTC) Updates, Transmittal #18-0001.

The required economic impact was not provided with the SPA. The impact analysis in regards to the providers, patients, and other incidental entities was not provided by the Division of Medicaid (DOM).

The update does not clearly state when accounting and legal fees associated with certain appeals should be claimed. Additional clarification should be provided concerning which year the cost associated with certain appeals should be claimed. We suppose that the fees should be claimed in the year in which the case is successfully settled. However, the update simply states the successful settlement of an appeal as the prerequisite for claiming the cost. We do support the effort to reimburse the LTC facilities for respiratory therapy cost. This may be a required service for the facility based upon the patient's needs. Historically, there has been no reimbursement mechanism in the Medicaid program to reimburse facilities for the cost of this service.

We disagree with the restriction on the reimbursement for educational training courses, specifically where it departs from the Provider Reimbursement Manual (PRM). We find the departure from the PRM short sighted and ill-informed as to the various educational and training needs of employees of the LTC facilities. Frequently, employees are in need of various certifications (including new certifications) offered by various educational institutions for which there is no degree issued at the completion of the educational course. These certifications and specific educational training sessions yield benefits to the residents of the facility irrespective of whether a degree is issued at the end of the education course curriculum. Consideration should be given that a facility does not have an inherent interest in expending funds on educational activities that are not otherwise beneficial to the residents of the facility. The Provider Reimbursement Manual rightly recognizes these aforementioned realities and avoids the restrictions that are unwisely being proposed.

The following discusses the allocation of the proposed changes in the hospital overhead including the paid tax assessments. We concur that intergovernmental transfers (IGTs) are not an allowable cost in that they do not meet the requirements for allowable cost set forth in the PRM. We do not concur with the departure from the PRM in regards to the reasonable and necessary allocation of overhead from the hospital. Chapter 23 of the PRM intentionally established a basic cost allocation methodology that is not overly burdensome while allowing providers, at **their discretion,** to opt for a more complex cost accounting methodology subject to an approval from the Medicare Administrative Contractor (MAC). CMS understood that setting forth a comprehensive basic cost allocation methodology struck the correct balance between workability and objectivity while avoiding mandates for overly complex models that would inherently increase the cost on providers. The Department of Medicaid (DOM) does the exact opposite of the PRM. In their departure from the tested precedence of the PRM, they create a direct conflict in how facilities would report cost to Medicare compared to cost reporting to Medicaid. This conflict creates a reimbursement loss as well as added administrative costs of compiling Medicaid cost reports that materially conflict with the PRM. In an apparent effort to window dress the changes, DOM politely points out that they are not mandating these allocation changes and are kindly allowing providers continue to allocate cost in accordance with Chapter 23 of the PRM except the provider will not be allowed to claim the cost allocated in compliance with Chapter 23 of the PRM unless it meets these newly imposed restrictions by DOM. DOM fails to realize that some entities lack the capability to componentize, subscript, and otherwise maintain a more complicated accounting system than the one long recognized as adequate by the PRM. In addition, DOM fails to acknowledge that even the providers who have the capacity for these additional DOM imposed requirements, no such change is allowed to their allocation methodology unless approved by the MAC. Where the MAC does not approve of the allocation

change, DOM's proposal puts the SPA in direct opposition to the PRM with the provider being penalized through no fault of their own. In such cases, the provider is required to make such allocations to the nursing home (depriving itself of reimbursement for such cost in other areas of the hospital) only to have DOM refuse to allow the reimbursement in the nursing home. Consequently, DOM should not depart from long established PRM regulations. DOM singles out LTC that are not contiguous to the hospital for specific allocation restrictions without providing any rationale for their position. Since DOM does not define their interpretation of contiguous, presumably a facility located across the parking lot or across the street from the hospital would preclude itself for being able to allocate costs similarly to a facility that is affixed to the hospital despite the fact that services and overhead cost are commingled and delivered in exactly the same way. This portends a fundamental lack of understanding in how departments (including nursing homes) of hospitals operate and share scarce resources such as overhead. We encourage DOM to attain a better understanding of hospital operations including those with nursing homes prior to proposing such changes that will only produce inefficiencies in how overhead services are provided.

As a Long-Term Care Facility, we strive to deliver the most efficient patient care in the most cost efficient manner possible which includes the sharing of resources with the hospital. We feel the proposed changes would have a negative impact on our facility. Therefore, we would appreciate the DOM's consideration on these comments concerning the proposed changes to the Long-Term Care Facilities.

Sincerely,

Leslie Morris
Reimbursement Manager

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January 23, 2018

Re: Comments Regarding Proposed State Plan Amendment {SPA) 18-0001

Ms. Wilson:

We would like to take this opportunity to comment on the changes proposed by the Division of Medicaid in the aforementioned Mississippi State Plan Amendment {SPA). We trust that the Division consider the following comments in a thoughtful manner.

**General**

• Division of Medicaid (DOM) failed to file proposed changes with the Secretary of State in accordance with the Administrative Procedures Act {APA). Failure to follow the protocols of the APA precludes the implementation of the proposed changes.

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• Pages 57 & 58- accounting and legal fees
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The application of owner compensation limits to individuals unrelated to owners serves no obvious public interest considering that there is no perverse incentive for an owner to pay more than market value compensation to an unrelated officer. Placing arbitrary reimbursement limits on the amount owners can claim for compensation paid to unrelated officers inherently disadvantages owners from attracting the most qualified candidates to their facility. Current reimbursement regulations require that all expenses including officer compensation be reasonable and necessary. Additional restrictions are neither necessary nor rationale. In fact, such policies inflict long term negative consequences on long term care facilities by fostering reimbursement policy that restricts their ability to pay market rates for qualified officers. Considering that such restrictions are not placed on any other Medicaid providers, long term care facilities should not be singled out with such digressive policy.

• Page 67- Educational Costs
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**Changes allocated cost requirements**

• Pg 69 & 76 - Allocation of Hospital overhead including tax assessments paid
While we concur with DOM that intergovernmental transfers (IGTs) are not an allowable

cost, we do not concur with DOM's departure from the PRM in regards to allocation of overhead from the hospital that is reasonable and necessary in nature. Chapter 23 of the PRM intentionally established a basic cost allocation methodology that is not overly burdensome or unwieldy while allowing providers, at **their discretion,** to opt for a more complex cost accounting methodology subject to the approval of the Medicare Administrative Contractor (MAC). CMS understood that setting forth a comprehensive but basic cost allocation methodology struck the correct balance between workability and objectivity while avoiding mandates for overly complex models that would inherently increase the cost to providers. This particular proposal by DOM does the exact opposite of the PRM intent. In their departure from the tested precedence of the PRM, DOM creates a direct conflict in how facilities would report cost to the Medicare program compared to cost reporting to Medicaid. This conflict creates unfair reimbursement implications for providers, added administrative costs of compiling Medicaid cost reports, and a material conflict with the PRM. While DOM politely indicates they are not mandating these allocation changes and thereby allowing providers to continue to comply with Chapter 23 of the PRM, providers will not be allowed to claim the cost allocated in accordance with Chapter 23 of the PRM without meeting these newly imposed restrictions by DOM. DOM fails to realize that some entities lack the capability to componentize, subscript and otherwise maintain a more complex accounting system than the one long recognized as adequate by the PRM. In addition, DOM fails to acknowledge that even those providers who have the capacity for these additional DOM imposed requirements that no such change is not allowed to the allocation methodology unless is it approved by the MAC. Where the MAC does not approve of the allocation change, DOM's proposal puts the SPA in direct opposition to the PRM resulting in the provider penalized through no fault of their own. In such cases, the provider is required to make such allocations to the nursing home (depriving itself of reimbursement for such cost in other areas of the hospital) only to have DOM refuse to allow the reimbursement in the nursing home. Consequently, DOM should not implement a policy in direct contradiction to the PRM .

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DOM singles out LTC that are not contiguous to the hospital for specific allocation restrictions without providing any rationale for their position. Since DOM does not define their interpretation of contiguous, presumably a facility located across the parking lot or across the street from the hospital would preclude itself for being able to allocate costs similarly to a facility that is affixed to the hospital despite the fact that services and overhead cost are commingled and delivered in exactly the same way. It is unclear how this would apply to allocation of shared overhead of LTC facilities that have multiple locations. Absent rationale provided by DOM, this could presumably restrict how shared overhead is allocated in such situations as well. This portends a fundamental lack of understanding in how departments (including LTC units) of multi-location facilities including hospitals operate and share scarce resources such as overhead. We encourage DOM to attain a better understanding of hospital and multi-location operations prior to proposing such draconian changes that will only produce inefficiencies in how overhead services are provided.

**Respiratory Therapy Reimbursement Changes**
• We applaud DOM's effort to reimburse facilities for respiratory therapy costs since this is a

required service facilities provide in accordance with patient need, however, there has historically been no reimbursement mechanism in the Medicaid program to reimburse facilities for the cost of these services. This proposed **change** will rectify this inequity.
We appreciate your sincere consideration of the above perspectives.

Sincerely,

G. Bennett Hubbard, Jr.
President & CEO

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JOHN L. MAXEY II
S. MARKWANN
MARJORIE S. SELF
WILLIAM H. HUSSEY
KELLY HOLLINGSWORTH STRINGER
ELLIOTT V. HALLER

January 19, 2018

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Re: Pursuant to 42.C.F:R, Section 447.205 public notice is hereby given to the submission of a Medicaid State Plan Amendment (SPA). Effective January 1, 2018, the Division of Medicaid, in the Office of the Governor, is submitting SPA 18~0001 Long-Term Care (LTC) Updates, Transmittal #18-0001.

Dear Ms. Wilson,

This firm represents the Mississippi Health Care Association. The following comments are in response to the public notice publishing proposed amendments.

**Changes to selected cost considered allowable**

• Pages 57 & 58 - accounting and legal fees

Clarification should be provided concerning which year costs associated with certain suits should be claimed considering' recent audits by the Division, have scrutinized invoice dates with the related cost report year. One may suppose that DOM intends that the fees be claimed the year in which the case is successfully settled though this is not clearly stated. DOM simply states the trigger (successful settlement of suit) as the prerequisite for claiming the cost but does not specify which cost report year that the costs should be claimed.

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Yours sincerely,

Maxey Wann PLLC
John L. Maxey II

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January 17, 2018

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Re: Comments Regarding Proposed State Plan Amendment (SPA) 18-0001

Dear Ms. Wilson:

We would like to take this opportunity to comment on the changes proposed by the Division of Medicaid in the aforementioned Mississippi State Plan Amendment (SPA). We trust that the Division considers the following comments in a thoughtful manner.

General

• Division of Medicaid (DOM) failed to file proposed changes with the Secretary of State in accordance with the Administrative Procedures Act (APA). Failure to follow the protocols of the APA precludes the implementation of the proposed changes.

• The required economic impact analysis was not provided with the SPA. The only impact analysis provided was the impact on the state and federal budget. No consideration was provided in regards to the impact on providers, patients and other incidental entities.
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Partner, Healthcare Services