PUBLIC NOTICE

June 28, 2018

Pursuant to 42 C.F.R. Section 447.205, public notice is hereby given to the submission of a Medicaid State Plan Amendment (SPA) 18-0005 Long-Term Care (LTC) Updates #2. The Division of Medicaid, in the Office of the Governor, will submit this proposed SPA to the Centers for Medicare and Medicaid Services (CMS) effective July 1, 2018, contingent upon approval from CMS, our Transmittal #18-0005.

1. Mississippi Medicaid 18-0005 Long-Term Care (LTC) Updates #2 (1) revises the number of allowed therapeutic leave days for nursing facilities (NFs) and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), (2) implements a Minimum Data Set (MDS) penalty, (3) removes stock transactions as a change in ownership assets, (4) clarifies the provider appeals process to include reconsideration prior to an administrative appeals request, (5) removes MDS submissions as appealable, and (6) restricts providers from entering or modifying hospital and therapeutic leave days via the web portal after the corresponding quarter close cutoff.

2. The expected annual aggregate expenditures of:

   (a) Revising the therapeutic leave days is estimated to be an annual savings of $10,000 based on the number of residents that exceeded forty-two (42) therapeutic leave days in state fiscal year's (SFY's) 16 and 17. The federal financial impact is estimated to be a savings of $1,875 for FFY 2018 and $7,500 for FFY 2019. The state financial impact is estimated to be a savings of $2,500 for SFY 2019 and a savings of $2,500 for SFY 2020.

   (b) The MDS penalty is an estimated annual savings of $2,635,958 based on the percent of unsupported MDS reviews by the Division of Medicaid in SFY 17. The federal financial impact is estimated to be $498,525 for FFY 2018 and $1,994,102 for FFY 2019. The state financial impact is estimated to be $641,856 for SFY 2019 and $641,856 for SFY 2020.

   (c) All other clarifications are anticipated to have no economic impact.

3. The Division of Medicaid is submitting this proposed SPA to be in compliance with 42 C.F.R. § 430.12 which requires that if the Division of Medicaid amends the state plan a SPA must be submitted. Therapeutic leave days are being revised as required by Senate Bill 2836 passed during the 2018 legislative session and CHOW revision is to be in compliance with 42 C.F.R. § 489.18.

4. A copy of the proposed SPA will be available in each county health department office and in the Department of Human Services office in Issaquena County for review. A hard copy can be downloaded and printed from www.medicaid.ms.gov, or requested at 601-359-2081 or by emailing at Margaret.Wilson@medicaid.ms.gov.

5. Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or Margaret.Wilson@medicaid.ms.gov for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.

6. A public hearing on this SPA will not be held.

L. Failure to File a Cost Report

Providers that do not file a required cost report within six (6) months of the close of the reporting period will be subject to sanctions as described in Sanctions, Chapter 1 Section 7-C.

M. Change of Ownership

For purposes of this plan, a change of ownership of a facility includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility operations. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer - seller relationship.

Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset whether by acquisition or merger for which any payment has previously been made shall not be considered reasonable in the provision of health care services and, therefore, shall not be included in allowable costs. These costs include, but are not limited to, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies.

F. Credit Balances

A credit balance, or negative balance, on a provider's account is an amount which is due to the Division of Medicaid. The credit balance is treated as an overpayment by the Division of Medicaid and is subject to the rules described above for overpayments.

1-7 Appeals and Sanctions

A. Appeal Procedures - Desk and Field Reviews

Long-term care providers who disagree with an adjustment to their allowable costs made as a result of a desk review or an audit may request a reconsideration in writing and must include the reason for the reconsideration and any supporting documentation, and must be made within thirty (30) calendar days after receipt of the notification of the adjustment. If the provider disagrees with the reconsideration decision, the provider may file a request for an administrative hearing to the Division of Medicaid. The hearing request must be in writing, must include the reason for the appeal and any supporting documentation, and must be made within thirty (30) calendar days after receipt of the notification of the final reconsideration letter. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the reconsideration request or administrative hearing request. If the provider does not request a reconsideration, the Division of Medicaid will consider the provider’s nonresponse as acceptance of the adjustments made. Therefore, no administrative hearing request will be considered.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, or (b) if by hand delivery, on the date delivered.

Long-term care providers who disagree with an adjustment to the Minimum Data Set (MDS) that changes the classification of the resident to a different MDS RUG IV group than the MDS RUG IV group originally determined by the facility may request a reconsideration in writing and must include the reason for the reconsideration, and must be made within thirty (30) calendar days after the date of the notification of the final case mix review findings report. This request must contain the specific classification adjustment(s) in dispute and the reason(s) the provider believes his/her documentation complies with the Mississippi Supportive Documentation Requirements. If the provider disagrees with the reconsideration decision, the provider may file a request for an administrative hearing to the Division of Medicaid. These adjustments may have been made by either a desk review or an on-site visit. The hearing request must be in writing, must contain the reason for the appeal, and must be made within thirty (30) calendar days after the provider was notified of the final reconsideration letter. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the reconsideration request or administrative hearing request. If the provider does not request reconsideration, the Division of Medicaid will consider the provider’s nonresponse as acceptance of the final case mix review findings report. Therefore, no administrative hearing request will be considered.

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The provider may appeal the decision of the Division of Medicaid in matters related to cost reports, including, but not limited to, allowable costs and cost adjustments resulting from desk reviews and audits in accordance with Medicaid policy.

The provider may appeal the decision of the Division of Medicaid in matters related to the Minimum Data Set (MDS) including but not limited to reviews and classifications in accordance with Medicaid policy. Final Roster Reports upon the close of the quarter are not subject to an informal reconsideration or an appeal.

10. Other Non-Allowable Costs. The cost of any services provided for which residents are charged a fee is a non-allowable cost. In addition, the amount paid for any item subject to direct reimbursement by the Division of Medicaid is a non-allowable cost.

11. Penalties and Sanctions. All penalties and sanctions assessed to the facility are considered non-allowable costs. These include, but are not limited to, delinquent cost report penalties, Internal Revenue Service penalties, civil money penalties, Minimum Data Set (MDS) penalties, delinquent bed assessment penalties, late payment fees and insufficient check charges.

12. Television. The cost of providing television service to residents is a non-allowable cost if residents are charged a fee for this service.

13. Vending Machines. The cost of providing vending machines is a non-allowable cost. If a cost finding is not submitted with the cost report, the vending machine revenues will be offset against allowable costs.

Each facility must establish and follow a written bed-hold and resident return policy which conforms to requirements of the Medicaid State Plan and other state and federal regulations. Hospital leave days may not be billed if the facility refuses to readmit the resident under their resident return policy. Repayment will be required of a facility which bills Medicaid for fifteen (15) consecutive days of hospital leave, discharges the resident, and subsequently refuses to readmit the resident under their resident return policy when a bed is available. Leave days must be billed in accordance with the applicable Mississippi Division of Medicaid Provider Billing Handbook and Administrative Code.

B. Home/Therapeutic Leave

The Division of Medicaid will reimburse long-term care facilities for home/therapeutic leave days with limits per resident, per state fiscal year (July 1 - June 30), as determined by the Mississippi State Legislature. Nursing Facility residents are allowed forty-two (42) days per state fiscal year in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. ICF/IID residents are allowed sixty-three (63) days per state fiscal year in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. PRTF residents are allowed eighteen (18) days per state fiscal year. Leave days must be determined, authorized and billed in accordance with the applicable Mississippi Division of Medicaid Provider Billing Handbook and Administrative Code.

A. Submission of MDS Forms and Bed Hold Days Information.

Assessments of all residents must be submitted electronically in accordance with CMS requirements. Bed hold day information must be submitted electronically to the Division of Medicaid’s designee.

Data processing on all assessments and bed hold days started within a calendar quarter will be closed on the fifth (5th) day of the second (2nd) month following the quarter, e.g., the MDS's with start

dates between July 1, 1996 and September 30, 1996 will be closed out for the final calculations on November 5, 1996. This allows a full month for the submission and correction of all MDS's begun in a calendar quarter and the submission of bed hold day information. Assessments and bed hold day information for a specific quarter which are received after the file has been closed will not be entered for previous quarterly calculations except as a result of a Division of Medicaid case mix review. If the quarter close date is on a weekend, a state of Mississippi holiday, or a Federal holiday, the data must be submitted on or before the first business day following such weekend or holiday. Final Roster Reports upon the close of the quarter are not subject to an informal reconsideration or an appeal.

The submission schedule may be extended as deemed necessary by the Division of Medicaid for extenuating circumstances.

B. Assessments Used to Compute a Facility's Average Case Mix Score.

All resident assessments completed per a calendar quarter will be used to compute the quarterly case mix average for a facility. These will include the last assessment from the previous calendar quarter. Bed Hold days, which are therapeutic leave and hospital leave days, will be calculated

at the lower of the case mix weight as computed for the resident on leave using the assessment being utilized for payment at the point in time the resident starts the leave, or a case mix score of 1.000. Assessments used will affect the case mix computation using the start date of the assessment except for new admissions and reentries. The computation of the facility's case mix score will use the date of admission for new admissions or residents that are reentered after a discharge from the facility. In computing a facility's average case mix, the dates of admission or reentry will be counted and the dates of discharge will not be counted in the computation.

C. Medicaid Reviews of the MDS. The accuracy of the MDS will be verified by Registered Nurses. At least ten percent (10%) of the total facility beds will be selected for the sample. The sample should include at least one resident from each major classification group. Residents may be added to the minimum sample as deemed appropriate by the review nurse(s) and/or other case mix staff. The sample will not be limited to Title XIX beneficiaries since the total case mix of the facility will be used in computing the per diem rate. If twenty-five percent (25%) or greater of the sample assessments are found to have errors which change the classification of the resident, the sample will be expanded.

D. MDS Penalty. If twenty-five percent (25%) or greater of the sample assessments are found to have errors which change the classification of the resident, a penalty will be applied. The MDS penalty will be calculated as follows: The penalty will be applied to the Medicaid days paid for the quarter in which the case mix assessment review determination was made. (e.g. The case mix review was performed during May 2018 for a previous period and an error rate of 25% was determined. The penalty calculation would be applied to the Medicaid days for the quarter April 1, 2018 through June 30, 2018.) The penalty will be calculated as a percentage of the administrative and operating cost per

day of the provider times the days paid for the quarter. The penalty will be applied based on the percentage of unsupported resident assessments during the case mix review depending on if the percentage of unsupported resident assessments is:

- 25%-34%, the administrative component MDS penalty percent is 10%,
- 35%-44%, the administrative component MDS penalty percent is 20%,
- 45%-54%, the administrative component MDS penalty percent is 30%, and
- 55% or greater, the administrative component MDS penalty percent is 50%.

In the event an MDS penalty is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office to the provider's allowable administrative costs. Reimbursement lost as a result of any corrective remedies will not be allowable on the cost report.

Policies adopted by the Division of Medicaid will be used as a basis for changes in reviews of the MDS, the sample selection process, and the acceptable error rate. If MDS data is not available, the Division may temporarily cease performing reviews.

E. Roster Reports. Roster reports are used for reporting each beneficiary's MDS RUG classification with assigned case mix index (CMI) for all days within the report period. Bed hold days are reflected on the roster reports. The facility's weighted average index, or score, is also reported. Roster reports are run for each calendar quarter (quarterlies) and for each cost report period (annuals). The annual rosters are used to set base per diem rates each January 1. The quarterlies are used in setting the direct care per diem rate each quarter. Roster reports are made available to all facilities electronically. Interim roster reports should be checked by the facilities to confirm assessments completed by the facility have been submitted to the QIES ASAP System used by the Division of Medicaid case mix database and to confirm discharge assessments are reflected on the report. Facilities should also use the interim roster reports and bed hold reports to confirm all hospital and home/therapeutic leave has been properly reported. Missing assessments, discharge assessments, and bed hold day information should be submitted electronically prior to the close of the quarter. If the quarter close date is on a weekend, a state of Mississippi holiday, or a Federal holiday, the data should be submitted on or before the first business day following such weekend or holiday. Final Roster Reports upon the close of the quarter are not subject to an informal reconsideration or an appeal.

F. Failure to Submit MDS Forms. Nursing facilities that do not submit the MDS for residents for which an assessment was due and completed, transmitted electronically and accepted, the period beginning day 93 is considered an inactive assessment or expired assessment period. The days following an expired assessment (starting the 93rd day) will be assigned the delinquent RUG classification of BC1, Inactive Category, with a CMI of 0.450, equivalent to the lowest case mix category until the next assessment is received. Delinquent assessments will result in the calculation of delinquent days at the Inactive classification of BC1. Delinquent assessments are defined as those assessments not completed according to the schedule required by CMS and the Division of Medicaid.

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Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset whether by acquisition or merger for which any payment has previously been made shall not be considered reasonable in the provision of health care services and, therefore, shall not be included in allowable costs. These costs include, but are not limited to, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies.

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The submission schedule may be extended as deemed necessary by the Division of Medicaid for extenuating circumstances. ~~This will include the dates of submission following the end of a calendar quarter and the use of assessments received after the cut-off date.~~

B. Assessments Used to Compute a Facility's Average Case Mix Score.

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day of the provider times the days paid for the quarter. The penalty will be applied based on the percentage of unsupported resident assessments during the case mix review depending on if the percentage of unsupported resident assessments is:

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