MHCA
Mississippi Health Care Association
Leading the way in long-term care.

July 26, 2018

Drew Snyder, Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

Via: Margaret.Wilson@medicaid.ms.gov

Dear Mr. Snyder:

The Mississippi Health Care Association ("MHCA") respectfully submits the following comments in regard to State Plan Amendment 18-0005 Long-Term Care (LTC) Updates #2 (the "SPA"), which in part implements a Minimum Data Set (MDS) Penalty and which removes MDS submissions as appealable.

As to procedure, the SPA was not filed in accordance with Mississippi Administrative Procedures Law, Miss. Code Ann Section 25-43-1, et seq. The Division of Medicaid, as set forth in Miss. Code Ann. § 43-13-137, "is an agency as defined under Section 25-43-3 and, therefore, must comply in all respects with the Administrative Procedures Law, Section 25-43-1 et seq." The Division of Medicaid has failed to comply with Mississippi Administrative Procedures Law as it has not filed the requisite notice of proposed rule adoption with the Secretary of State of the SPA as required by Miss. Code Ann. § 25-43-3.103. Division of Medicaid has also failed to comply with Mississippi Administrative Procedures Law as it has not adequately considered the economic impact of the rule or provided an economic impact statement which complies with Miss. Code Ann. § 25-43-3.105. These failures of Division of Medicaid to comply with Mississippi Administrative Procedures Law invalidate the SPA should Division of Medicaid choose to continue with the SPA.

In addition to a failure to comply with Mississippi Administrative Procedures Law, the SPA is in violation of the statutorily granted authority of Division of Medicaid. The SPA creates a new category of penalty in the State Plan, the "MDS Penalty" whereby providers are penalized a "percentage of the administrative and operating cost per day of the provider times the days paid for the quarter" when Division of Medicaid determines errors in MDS sample assessments. Division of Medicaid has not been authorized by the Mississippi legislature to implement the MDS penalty and has no authority to amend the State Plan to impose an MDS penalty. The Mississippi Supreme Court has reflected that

303 Brame Road, Ridgeland, MS 39157
Phone: 601-898-8320 Fax: 601-898-8341

> [n]o proposition of law is better established than that administrative agencies have only such powers as are expressly granted to them or necessarily implied and any power sought to be exercised must be found within the four corners of the statute under which the agency proceeds.

Mississippi Milk Commission v. Winn-Dixie Louisiana, Inc., 235 So.2d 684 (Miss. 1970) (citing *American Brass Co. v. Wisconsin State Bd. Of Health*, 245 Wis. 440, 15 N.W.2d 27 (1944)). The Mississippi Supreme Court has further stated:

> In exercising the check or review principle to restrain the agency from using unauthorized power, this Court has repeatedly stated that powers legislatively granted to and exercised by an administrative agency are limited to and must not exceed the authority prescribed by the legislative enactment. Statutory provisions control with respect to the rules and regulations promulgated by such a body. Accordingly, such a body may not make rules and regulations which conflict with, or are contrary to, the provisions of a statute, particularly the statute it is administering or which created it.

Mississippi Public Service Commission v. Mississippi Power & Light Company, 593 So.2d 997 (Miss. 1991) (internal citations omitted). Miss. Code Ann. Section 43-13-121 establishes Division of Medicaid's authority to administer the Medicaid program. The Mississippi legislature has never authorized imposition, either expressly or by implication, of a penalty by Division of Medicaid on providers such as the proffered MDS penalty set forth in the SPA and the proposed penalty exceeds the Division of Medicaid's authority under Mississippi law.

MHCA will also address specific concerns with the MDS penalty, in the event the Division of Medicaid chooses to move forward with the SPA after consideration of both the failure to follow the mandated administrative procedures and the lack of authority to implement the MDS penalty. Below are comments to the SPA.

Currently the State of Mississippi is a case mix reimbursement program with an individual Nursing Facility rate based on cost report data. Under our current format, the annual Case Mix audit will adjust the Direct Care and Care Related payment either up or down.

A facility must work to serve two masters as it relates to the MDS coding. One master is the certification requirement guided by the RAI manual and the second being the Medicaid *Supportive Documentation Requirements.* As such, each facility is left in a conundrum to decide whether to follow RAI Guidelines to be in compliance with CMS recertification process (survey) or follow case mix guidelines to be in compliance with the Division of Medicaid and avoid potential penalties to the facility as per the proposed SPA. The MDS penalty as set forth in the SPA effectively penalizes any facility which follows the RAI Guidelines.

As Division of Medicaid is aware, the MDS form and the associated guidelines, which as discussed in the paragraph above are not identical, are complex. Second to the complexity of the

documentation and guidelines, is the subjectivity and nursing judgment which must be exercised by the MDS nurses who are responsible for producing the MDS, such nursing judgments which are exercised during the applicable patient review period. The MDS penalty is then based on later review of the assigned resident classification by Division of Medicaid, wherein Division of Medicaid has authority to change the classification of the resident during its review of sample assessments. The State Plan already provides for the Division of Medicaid to make adjustments based on any classification change determined by Division of Medicaid. What the SPA will do is penalize a nursing facility with harsh penalties of up to 50% of the administrative and operating cost per day if the Division of Medicaid disagrees with the submitted MDS sample determinations. Such methodology hinders the subjectivity and nursing judgment of the MDS nurse who plays a vital role in long term care.

SPA 18-0005 will create a punitive penalty to the Administrative rate in addition to any adjustment to our Care section which is not related to the gathering of case mix data. This penalty does not create an environment to enhance patient care as it erodes the ability to operate the facility. This cost actually will go beyond a carrot and stick approach. To create a penalty of possibly half of the facility administrative and operating rate is hard to imagine.

By way of quick history, MHCA met with the Division of Medicaid in 2014 and collaborated with the Division of Medicaid to make some modifications to the rate methodology which were cost neutral in the beginning. One such item was to remove access incentives to the DC/CR rate and later to move from RUGS III to RUGS IV. By moving to RUGS IV early, the overall industry case mix index was reduced Statewide. MHCA has acted as a partner through the years to strike a balance for the viability of the Nursing Home Operations and the containment of cost to Medicaid. Please note the average cost increase to the Division of Medicaid from 2013 to 2017 has been 5% or 1% per year. We believe this speaks volumes.

Some quick suggestions would be to allow the industry to conduct additional training to those SNF's with over 25% error rate at the facility expense or for the Division to accept the RAI guidelines as the basis for Case Mix score. Addressing Division of Medicaid's apparent concerns with the MDS submissions through such alternative methods to the proffered draconian penalty system ultimately benefits Division of Medicaid as it provides a better path to lower the overall error rate, as opposed to merely penalizing any facility which exceeds the error rate. MHCA would willingly, as it has historically, work with the Division of Medicaid in this regard.

Sincerely,

Vanessa P. Henderson

Vanessa P. Henderson
Executive Director

303 Brame Road, Ridgeland, MS 39157
Phone: 601-898-8320 Fax: 601-898-8341

HORNE
CPAs & BUSINESS ADVISORS

1020 Highland Colony Parkway
Suite 400
Ridgeland, MS 39157
601.326.1000
601.898.9054 F
HORNELLP.COM

July 27, 2018

Mr. Drew Snyder, Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

Via: Margaret.Wilson@medicaid.ms.gov

Re: Proposed State Plan Amendment (SPA) 18-0005

Dear Mr. Snyder:

As the financial and reimbursement advisor to numerous long term care (LTC) providers in the State, we wish to offer our perspective on changes proposed by the Division of Medicaid in the Mississippi State Plan Amendment (SPA) 18-0005. We trust the Division will consider the following comments in a thoughtful manner.

The collaboration between long term care (LTC) providers and the Division of Medicaid has served as a model for other providers of the progress that can be made when such relationship exists. The LTC provider community greatly appreciates the quarterly meetings with the Division of Medicaid to proactively address issues related to the delivery of and reimbursement for patient care. At a recent LTC meeting, the Division discussed issues that were encountered in MDS reviews. The provider industry made inquiries in hopes to collaborate with the Division to resolve these issues.

Despite the long history of collaboration between the LTC provider community and the Division in working through such issues, the Division issued the aforementioned SPA proposing draconian penalties for MDS audit errors. While I can certainly appreciate the frustration with such errors, the penalty assessment solution is both overly punitive and counterproductive. Considering that providers are already negatively impacted financially in their direct care payments for decreases in case mix resulting from such audits, additional penalties would be duplicative and unsustainable in most cases. In addition, even case mix audits containing errors rates resulting in increases in the case mix score would trigger penalties. In other words, even facilities who under-coded their claims would be assessed these penalties.

Based upon Medicaid cost reports filed by nursing facilities for FY 2016, average net income per patient day for nursing facilities was only $4 per patient day. The minimum penalty of 10 percent of the administrative component would approximate an $8 per day penalty. Consequently, even the

minimum penalty would compromise the solvency of the average nursing facility. Furthermore, considering the other penalty tiers range from 20 percent to 50 percent of the administrative component, this would equate to $16 to more than $40 per patient day in Medicaid reimbursement. Such penalties would financially devastate affected nursing homes to the point that access to nursing home care would certainly be undermined.

While we have no reason to dispute the need to explore and rectify the audit issues encountered in the Medicaid audits, the aforementioned penalties do nothing to attain such resolutions. We encourage the Division to consider alternative initiatives to resolve these issues including but not limited to:

- Joint task force to identify root causes of audit findings
- Resolve discrepancies between the RAI manual and Medicaid MDS interpretations
- Requiring targeted facility education and certification
- Third party monitoring and review

For the aforementioned reasons, we posit that the Division should abandon the MDS penalties proposed in SPA 18-0005.

Sincerely,

HORNE LLP

W. Shane Hariel, CPA
Partner, Healthcare Services

WSH/kp

BALCH
& BINGHAM LLP

BEA TOLSDORF
t: (601) 965-8168
f: (866) 849-8955
e: btolsdorf@balch.com

July 27, 2018

VIA E-MAIL: MARGARET.WILSON@MEDICAID.MS.GOV
VIA HAND DELIVERY

Mississippi Division of Medicaid
Margaret Wilson - Office of Policy
Water Sillers Building, Suite 1000
550 High Street
Jackson, Mississippi 39201

Re: Medicaid State Plan Amendment 18-0005 Long Term Care (LTC) Updates #2

Dear Margaret:

Balch and Bingham, LLP represents the Mississippi Independent Nursing Home Association ("INHA") and we have been asked to provide written comments concerning the Medicaid State Plan ("Plan") Amendment 18-0005 Long Term Care (LTC) Updates #2 ("SPA 18-0005") which impacts, among other things, nursing facility Minimum Data Sets ("MDS") and provider appeal rights.

The INHA is a professional association that provides representation for both non-profit and for-profit long term care facilities throughout Mississippi. The INHA's mission is to promote the provision of quality health care services in long term care facilities by staying apprised of trends and changes within the long-term care and healthcare industry and then providing training to its members on the same. As part of carrying out this mission, the INHA follows proposed Medicaid State Plan Amendments ("SPA") to ensure understanding of and compliance with changes related to Medicaid reimbursement.

In that regard, the INHA has reviewed SPA 18-0005 and takes issue with several of the proposed amendments. Specifically, the INHA opposes the proposed MDS penalties. Further, the INHA contends that the Mississippi Division of Medicaid ("Medicaid" or "Division's") cannot implement SPA 18-0005 due to the lack of legislative authority and the Division's failure to comply with the Mississippi Administrative Procedures Law.

1. Medicaid has failed to comply with the Administrative Procedures Law

Medicaid is an "Agency" pursuant to Miss. Code Ann. §25-43-1.102 that is required to comply with the Mississippi Administrative Procedures Law ("Law"), 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." Miss. Code

Ann. §25-43-1.101. 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 25-43-1, et seq.". 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). Medicaid has made no such filing regarding SPA 18-0005, 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 18-0005 should Medicaid continue to move forward with the proposed amendment.

In addition to its failure to comply with the Law by refusing to file SPA 18-0005 with the Secretary of State's Office, Medicaid has also failed to conduct an adequate financial impact study. As stated above, Medicaid must comply with the Law 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 18-0005 is 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.

2. Medicaid does not have the requisite legislative authority to create and implement the MDS penalties.

The Mississippi Supreme Court has held that administrative agencies must conduct business in a manner that has been authorized by the Legislature; ". . .a statutory agency has only legislation granted authority, there is no inherent authority." *Mississippi Public Service Com'n v. Mississippi Power & Light Co.,* 593 So.2d 997, 999 (Miss. 1991).

The general administrative authority bestowed upon Medicaid by the Legislature is outlined in Miss. Code Ann. §43-13-121. Amongst these powers are to establish ". . . reasonable fees, charges and rates for medical services and drugs . . ." and to impose penalties on Medicaid only long-term care facilities that are found to be in non-compliance with division and certification standards. Additionally, pursuant to Miss. Code Ann. §43-13-145, Medicaid is authorized to levy an annual assessment upon each long-term care facility, ICF-IID facility, PRTF facility and hospital in the state.

Absent from the authority granted to Medicaid by the Legislature in Miss. Codes Ann §43-13-121 and §43-13-145, and any statute for that matter, is the Division's ability to assess MDS penalties

upon long-term care providers—the proposed fees are not for medical services or drugs, they are not in response to non-compliance with division and certification standards, and they are not the annual facility assessments outlined in §43-13-145.

Without the Legislature's explicit direction to create such a penalty, as our Supreme Court has held, Medicaid is without the requisite authority to enforce the MDS penalty proposed in SPA 18-0005. "In exercising the check or review principle to restrain the agency from using unauthorized power, this Court has repeatedly stated that powers legislatively granted to and exercised by an administrative agency are limited to and must not exceed the authority prescribed by the legislative enactment. Mississippi Pub. Serv. Comm'n v. Mississippi Power & Light Co., 593 So. 2d 997, 1000 (Miss. 1991), citing *Miss. ex rel Pittman v. MPSC,* 520 So.2d 1355 (Miss.1987); *Reserve Life Insurance Co. v. Coke,* 254 Miss. 936, 183 So.2d 490 (1966); *United Gas Pipeline Co. v. Miss. Public Service Commission,* 241 Miss. 762, 133 So.2d 521 (Miss.1961).

3. MDS Penalty

The process of evaluating residents in a long-term care facility for MDS purposes is a complex and subjective one. The MDS assessment screens all health factors—such as abilities, behaviors, conditions and needs—for each resident of a long-term care facility on a quarterly basis. While many of the factors reviewed provide for a specific and clear response (testing cognitive patters by asking what year it is and documenting the answer given), others may depend largely on the evaluator's personal and subjective impression of the resident's condition (assessing the resident's interest in "doing things[1]".) This subjective impression is a correct assessment in the evaluator's opinion; however, Medicaid could potentially determine otherwise. This difference of opinion regarding MDS assessments does not, and should not, indicate that the facility completed the MDS incorrectly or improperly, and Medicaid should not penalize facilities as if it does.

Long-term care facilities devote many employee hours to MDS evaluation and completion. Should the proposed MDS penalties be implemented, facilities will likely be required to hire an additional full-time Registered Nurse to assist with MDS completion and audit in an effort to avoid potentially catastrophic MDS penalties. This will be a difficult—if not impossible—and expensive endeavor for long-term care facilities. However, as mentioned above, this financial impact was not even considered by Medicaid in drafting SPA 18-0005.

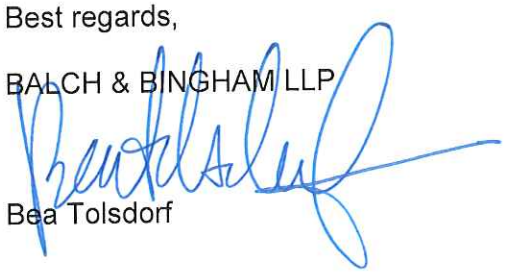
If Medicaid perceives that a high error rate in MDS assessment exists within the long-term care community, then the appropriate solution would be to increase provider trainings and in-services which would offer guidance to providers and address areas of concern. The MDS penalty is an extreme and problematic measure that will not address any confusion or misunderstanding regarding proper MDS assessment.

[1] See MDS 3.0, D0200, Page 9.

The INHA opposes the above referenced portions of SPA 18-0005 and would ask that Medicaid revisit the SPA to address the concerns outlined herein. We appreciate the opportunity to share these concerns with you. If you have any questions, please call my office, 601-965-8168 or Alice Mitchell, Executive Director of the INHA at 601-790-7033.

Best regards,

BALCH & BINGHAM LLP



Bea Tolsdorf

July 27, 2018

Drew Snyder, Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, Mississippi 39201

Via: Margaret.Wilson@medicaid.ms.gov

Dear Mr. Snyder,

I would like to take the opportunity to provide comments and my insight regarding proposed State Plan Amendment 18-0005 with regards to the Minimum Data Set (MDS) Penalty and the Case Mix Audit process.

Mr. Snyder, I've been a registered nurse in the state of Mississippi for over 23 years. Almost my entire career has been spent in Long Term Care. It's my passion. I've been a floor nurse, Staff Developer, a Director of Nursing, a Nurse Consultant, and now I'm able to be the Director of Clinical Services for our company. I've coded many MDS assessments in my tenure as a health care provider in the state of Mississippi. I've also been in management positions that assisted with the process of overseeing and guiding our MDS Nurses with teaching and training to ensure they are accurately assessing, care planning, and coding for us to be able to provide the highest quality of care to our residents.

The new plan, which came with only two days of prior notice, quite frankly scares me. The centers already are so very busy documenting the care and coding to such stringent guidelines that they are not able to spend that quality of time with the patients themselves who need us. That seems to be the fate of healthcare these days, and it's quite sad to me. More legislation / more documentation means more time away from the patients.

Please reconsider this plan and let's come up with a collaborative approach where we work with the Division of Medicaid on a training plan that helps the centers understand the guidelines. Please keep in mind that these guidelines just changed last year. The Mississippi Case Mix Supportive Documentation Requirements (SDR) are so incredibly detailed and call for so much more than the Resident Assessment Instrument (RAI) Manual. We understand that we must follow the more stringent law, but that puts us into differences in coding for our residents who are Medicare Part A and we are losing Medicare revenue due to how the resident function (ADLs) can be coded from a MS Case Mix standpoint versus the RAI standpoint.

We also have issues with being told that we are unable to submit information after the case mix audit is complete to support our assessments. Sometimes, the auditors leave without giving us the opportunity to find the information in our electronic health record to support our coding. We are able to submit additional information to Mississippi State Department of Health – Division of Licensure and Certification if we have received a deficiency on their exit to potentially refute the tag. Why would this process be any different? The auditors need to allow us the opportunity while they are in our centers to show them where in our electronic health record that the details can be found.

I also must speak to the Case Mix Auditors themselves. Can we please get additional training for them on how to conduct an audit, how to interact with our staff, and how to stay objective rather than subjective? We are seeing more and more that we are being inundated with opinions and inappropriate comments from one of the auditors in particular. Our staff members fear retaliation from auditors and therefore will not say anything to us until the audit is complete. The auditors can still find unsupported assessments, yet remain professional and respectful to our staff members during the process.

There is one particular coding requirement that I feel puts the residents in a dire situation. That would be the coding for MDS Section J - Question J1100C – 'Shortness of Breath (dyspnea) when lying flat'. We are unable to code for this unless we have a situation where we lay a resident flat and they become short of breath. In my opinion, it's horrible to put a resident in an uncomfortable, compromised position just to code this on the MDS. We must document the specific time when it happens to capture the incident. These types of residents are chronic and never lay flat due to being compromised….yet they have this issue which puts them very high risk and takes staff time to attend to their needs without being able to put them flat on their back. The RAI Manual doesn't have these specifications. If the resident has the issue, we can code it without having the specific observation of one specific time in the look-back period for the coding. In fact, the RAI says that residents can "sometime limit activities due to their shortness of breath, such as lying flat. They won't lie flat or will elevate the head of their bed due to knowing they will be short of breath, so they don't lie flat which impedes their care.

Another point that I would like to make clear is that coding the MDS is part of the resident assessment process to ensure quality resident care. Coding the MDS leads to items triggering in the Care Area Assessments (CAAs). If we are unable to code "shortness of breath" while lying flat due to a resident never lying flat because they cannot, there will be issues in the CAAs that will potentially lead to not having a thorough care plan. These Supportive Documentation Requirements could potentially cause us to not have a thorough resident assessment and thorough care plan which is problematic. The primary reason for MDS assessments is to guide the resident care process and ensure quality resident care and the best outcomes for the patient population. The financial piece of the MDS process is secondary to that.

Also, I was quite surprised to see the State Plan Amendment has that the Case Mix Audit reviews at least 10% of the total facility beds being selected for the sample. The practice for as long as I've been in long term care has been 20% of licensed beds and this can be verified by looking at the Case Mix Audit letters we receive. I believe that the practice needs to be reviewed to ensure their practice matches the plan.

So in closing, I would like for us to be able to do the following:

- Work together with the Division of Medicaid to collaborate on best practices to ensure adequate documentation is in place to support proper coding. Some of our residents truly take a lot of staff time and we need to be able to be reimbursed for this additional time accordingly.
- Review the Case Mix Audit process to ensure the current practice matches the state plan. Train the Case Mix Auditors on how to perform audits, how to speak to center staff, and how to remain objective, rather than subjective with their audits.
- Collaborate on how to better define the Supportive Documentation Requirements, so they don't interfere with patient care and accurately reflect the care we provide for various conditions. The SDRs are so specific and detailed that it's very difficult to code various conditions on the MDS despite the fact that we are caring for these types of residents. The RAI process should lead/direct good patient care, and I worry that the inability to code certain items could lead to inaccurate assessments and improper care plans.

Thank you for your time and attention. I'm happy to answer any follow up questions you may have. We all want a process that allows the Division of Medicaid to assess for reimbursement, but we want a process that will also allow us to take better care of our residents and cut through the red tape that takes us away from patient care.

Angela Cooper, RN, BSN, RAC-CT
Director of Clinical Services
Gulf Coast Health Care, LLC
Phone: 850-602-8010