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.

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

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.

D. 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.

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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 ~~and submissions~~ in accordance with Medicaid policy. Final Roster Reports upon the close of the quarter are not subject to an informal reconsideration or an appeal.

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.

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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. ~~but will be reflected in subsequent quarterly calculations and in the annual report.~~ 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. ~~Refer to Roster Reports below for an exception to the close of the quarter.~~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. ~~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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