Table of Contents

State/Territory Name: Mississippi

State Plan Amendment (SPA) #: 20-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

August 31, 2020

Drew L. Snyder
Executive Director
Office of the Governor, Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201

Re: Mississippi State Plan Amendment 20-0004

Dear Mr. Snyder:

We have completed our review of State Plan Amendment (SPA) 20-0004. This SPA modifies Attachment 4.19-D of Mississippi's Title XIX State Plan. Specifically, the amendment proposes to revise language in the plan for providers to submit cost reports and any supporting data from hard copy to electronic upload. In addition, the SPA also specifies the handling of capitalized assets valued at less than $5,000 each and related depreciation schedule documentation if the provider chooses to capitalize the item for financial purposes, but expenses the item for cost report purposes.

We conducted our review of this SPA according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving Mississippi State plan amendment 20-0004 with an effective date of April 1, 2020. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, or require additional information, please call Anna Dubois at (850) 878-0916.

Sincerely,

[redacted]

For
Rory Howe
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **20-0004**

2. STATE: **MS**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: **REGIONAL ADMINISTRATOR**
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 C.F.R. § 447.201

7. FEDERAL BUDGET IMPACT:
FFY 2020: $0.00
FFY 2021: $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 – D, Page 19, 30 and 56

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19 – D, Page 19, 30 an d 56

10. SUBJECT OF AMENDMENT:
State Plan Amendment (SPA) 20-0004 is being submitted to revise the method for submitting cost reports and any supporting data from hard copy to electronic upload, and specifies the handling of capitalized assets valued at less than $5,000 each and related depreciation schedule documentation if the provider chooses to capitalize the item for financial purposes, but expenses the item for cost report purposes.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: **Drew L. Snyder**
Drew Snyder

14. TITLE: **Executive Director**

15. DATE SUBMITTED: JUN 10 2020

16. RETURN TO:
Drew L. Snyder
Miss. Division of Medicaid
Attn: Margaret Wilson
550 High Street, Suite 1000
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 8/31/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 4/1/20

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Rory Howe

22. TITLE: Acting Director, FMG

23. REMARKS:

the additional information. For cost reports which are submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information will be made. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. Information that is requested that is not submitted following either the first or the second request may not be submitted for reimbursement purposes. Providers will not be allowed to submit the information at a later date, at the time of audit, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including revenue cost findings, is omitted.

F. Where to File

The cost report and related information must be uploaded electronically to the cost report data base as designated by the Division of Medicaid.

G. Cost Report Forms

All cost reports must be filed using forms and instructions that

the cost report. In addition, the Division of Medicaid would prepare an "Annual" case mix report to determine the case mix score for the cost report period. A "Quarter Final" case mix report would be prepared to determine the case mix score for each quarter beginning with the quarter July 1, 2000 through September 30, 2000. The facility's rates for the period August 15, 2000 through December 31, 2001 would be calculated using actual cost and census data from the August 15 through October 31 cost report, after desk review. The case mix reports would also be used in calculating the rates. The initial Quarter Final case mix score would be used for the rate periods beginning August 15, 2000; October 1, 2000; and January 1, 2000. The following quarters' rates would be set on the normal schedule using the quarter Final roster score from the second preceding quarter.

P. Out-of-State Providers

For services not available in Mississippi, Nursing Facilities, PRTFs ICF/IIDs and swing beds from states other than Mississippi may file claims for services provided to Mississippi Medicaid beneficiaries that are

new beds, replaced beds, renovated beds, or for depreciation expense.

d. Assets less than $5,000.

Assets purchased for an amount less than $5,000 should be included in allowable costs as a current period expense.

Additionally, the portion of assets allocated to the certified unit for less than $5,000 should be expensed in the current period. The expense should be included in the Miscellaneous Administrative and Operating Costs on the cost report.

e. Facility depreciation.

A facility may choose to depreciate an asset that cost less than $5,000 or was allocated at less than $5,000. In these cases, the Division of Medicaid will not adjust the depreciation expense nor enter an adjustment to allow the asset as an expense in the cost report period. Similarly, the provider should not adjust depreciation expense and expense these assets, for cost report purposes only, either. However, if the provider chooses to do so, a separate depreciation schedule, for Medicaid purposes only, must be prepared and submitted with these expensed assets removed. Additionally, the capitalized asset will not be used for comparison to the new bed value to determine depreciation type. Only assets greater than or equal to $5,000 are used for the comparison.

8. Dues.

Providers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary provider operating costs. Some of those organizations promote objectives in the provider's field of health care activity. Others have purposes or functions which bear little or no relationship to this activity. In order to determine for Medicaid purposes the allowable costs incurred as a result of membership in various organizations, memberships have been categorized into three basic groups: (A) professional, technical or business related; (B) civic; and (C) social, fraternal, and other. The Division of Medicaid will look to comparable providers, as well as to the justification by the individual provider, in determining the reasonableness of the number of organizations in which the provider maintains memberships and the claimed costs of such memberships.