MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF THE

LONG-TERM CARE NURSING FACILITY
MEDICAID REIMBURSEMENT AND RATE SETTING PROCESS

DEPARTMENT OF COMMUNITY HEALTH

April 2012

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

391-0570-11

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit
Long-Term Care Nursing Facility Medicaid Reimbursement and Rate Setting Process
Department of Community Health

Report Number:
391-0570-11

Released:
April 2012

The Department of Community Health (DCH) administers the Medicaid cost reporting, rate setting, and reimbursement settlement for long-term care for nursing facility providers. DCH coordinates the annual review of cost reports and sets the Medicaid reimbursement per diem rates for the approximately 440 nursing facilities. DCH expended $1.58 billion and $1.68 billion in fiscal years 2008-09 and 2009-10, respectively, related to long-term care for nursing facility providers.

Audit Objective:
To assess the effectiveness of DCH's efforts to ensure a timely and accurate rate setting process for long-term care at nursing facilities.

Audit Conclusion:
We concluded that DCH's efforts were moderately effective in ensuring a timely and accurate rate setting process. We noted one reportable condition (Finding 1).

Reportable Condition:
DCH did not always maintain documentation of the justification for and preapproval of the providers' use of an alternative statisical basis for allocation of general service costs (Finding 1).

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Audit Objective:
To assess the effectiveness of DCH's efforts to ensure a timely and accurate cost settlement process for long-term care at nursing facilities.

Audit Conclusion:
We concluded that DCH's efforts were moderately effective in ensuring a timely and accurate cost settlement process for long-term care at nursing facilities. We noted two reportable conditions (Findings 2 and 3).

Reportable Conditions:
DCH did not ensure completion of audits of cost reports for Medicaid long-term care facilities in a timely manner and did not perform on-site audits at least once every four years (Finding 2).

DCH did not cost settle cost reports for Medicaid long-term care facilities in a timely manner (Finding 3).

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Audit Objective:
To assess the effectiveness of DCH's efforts to evaluate alternative reimbursement methodologies for long-term care at nursing facilities.

Audit Conclusion:
We concluded that DCH's efforts were effective in evaluating alternative reimbursement methodologies for long-term care at nursing facilities. Our audit report does not include any reportable conditions related to this audit objective.

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Agency Response:
Our audit report includes 3 findings and 3 corresponding recommendations. DCH's preliminary response indicates that it agrees with all 3 recommendations.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: http://audgen.michigan.gov

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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

April 17, 2012

Ms. Olga Dazzo, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Dazzo:

This is our report on the performance audit of the Long-Term Care Nursing Facility Medicaid Reimbursement and Rate Setting Process, Department of Community Health.

This report contains our report summary; description of process; audit objectives, scope, and methodology and agency responses and prior audit follow-up; comments, findings, recommendations, and agency preliminary responses; various exhibits, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's response subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Thomas H. McTavish, C.P.A.
Auditor General

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TABLE OF CONTENTS

LONG-TERM CARE NURSING FACILITY
MEDICAID REIMBURSEMENT AND RATE SETTING PROCESS
DEPARTMENT OF COMMUNITY HEALTH

SUPPLEMENTAL INFORMATION

GLOSSARY

Description of Process

The Long-Term Care Reimbursement and Rate Setting Section (LTC RARSS) administers the Medicaid cost reporting, rate setting, and reimbursement settlement for long-term care for facilities* (see Exhibit 1). Facilities include nursing homes, county medical care facilities, hospital long-term care units, and State regional centers. LTC RARSS coordinates the annual review of cost reports* and sets the Medicaid reimbursement per diem rates for the approximately 440 nursing facilities (see Exhibit 2).

The nursing facility reimbursement methodology is a prospective payment system that utilizes cost data, primarily from cost reports, to establish reimbursement rates for routine nursing care services* and various rate add-ons* that are for allowable costs* not already included in the rate (see Exhibit 3). Each nursing facility provider is required to submit an annual cost report within five calendar months after the close of its cost report year. LTC RARSS may determine the facility per diem rate based on filed cost report data, audited cost report data, cost data submissions and projections for specific reimbursement activities, or interim reimbursement provisions in accordance with Medicaid policies. The facility rate is a per diem amount in effect for one year and coincides with the State's fiscal year as of September 30.

LTC RARSS receives cost reports and performs reporting acceptance reviews of the cost reports and calculates an interim reimbursement rate based on the filed cost report. The provider is reimbursed an interim per diem rate based on the cost information submitted. The Office of Audit performs a full scope audit, a limited scope audit, or a desk review of the cost reports. After a cost report is audited, LTC RARSS will perform a final settlement and determine if a final settlement adjustment is necessary. If a final settlement is necessary, LTC RARSS will make a retroactive payment adjustment for the rate period covered by the cost report. The interim reimbursement is then adjusted to actual allowable costs through the annual cost settlement.

Cost settlements involve payment of money to or recovery of money from the nursing facility providers. Facility providers receive notification of the cost settlement and have an opportunity for an informal and/or a formal appeal of the reimbursement action. LTC RARSS handles informal appeal actions. If the appeal cannot be resolved, the provider is given a formal appeal through the Bureau of Legal and Policy Affairs.

** See glossary at end of report for definition.*

Audit Objectives, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up

Audit Objectives

Our performance audit* of the Long-Term Care Nursing Facility Medicaid Reimbursement and Rate Setting Process, Department of Community Health (DCH), had the following objectives:

1. To assess the effectiveness* of DCH's efforts to ensure a timely and accurate rate setting process for long-term care at nursing facilities.

2. To assess the effectiveness of DCH's efforts to ensure a timely and accurate cost settlement process for long-term care at nursing facilities.

3. To assess the effectiveness of DCH's efforts to evaluate alternative reimbursement methodologies for long-term care at nursing facilities.

Audit Scope

Our audit scope was to examine the program and other records of the long-term care nursing facility Medicaid reimbursement and rate setting process. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our audit procedures, conducted from April through August 2011, generally covered the period October 1, 2008 through April 30, 2011.

As part of our audit, we prepared supplemental information (Exhibits 1 through 6) that relates to our audit objectives. Our audit was not directed toward expressing a conclusion on this supplemental information and, accordingly, we express no conclusion on it.

** See glossary at end of report for definition.*

Audit Methodology

We conducted a preliminary review of the DCH Long-Term Care Reimbursement and Rate Setting Section's (LTC RARSS's) operations to formulate a basis for defining the audit objectives and scope. Our review included interviewing the management and selected personnel of LTC RARSS, the Office of Audit, the Office of Long-Term Care Policy, and the Actuarial Division; reviewing applicable laws, regulations, policies, and procedures, including appropriations acts and legislative boilerplate, the Medicaid State Plan*, the Medicaid Provider Manual*, and the LTC RARSS Operational Procedures Manual; and reviewing providers' cost reports, rate calculations, audits of cost reports, and cost settlements to obtain an understanding of the long-term care nursing facility reimbursement and rate setting process.

To assess the effectiveness of DCH's efforts to ensure a timely and accurate rate setting process for long-term care of nursing facilities, we selected a sample of 41 cost reports from a population of 952 cost reports. Our sample of 41 cost reports consisted of 20 providers from nursing homes and hospital long-term care units.

We verified the completeness, accuracy, and reasonableness of the financial and statistical data from the providers' cost reports that was used to calculate the interim Medicaid reimbursement per diem rate. We reviewed the Medicaid Provider Manual for the guidelines and the instructions to the providers for preparing the cost reports. We verified the completeness, accuracy, and reasonableness of the providers' cost report data related to Medicaid days, allowable costs, allocation of costs, valuation of plant assets, other statistical data, and DCH's calculation of the interim Medicaid reimbursement per diem rate.

To assess the effectiveness of DCH's efforts to ensure a timely and accurate cost settlement process for long-term care at nursing facilities, we analyzed cost report status logs that detailed the dates when cost reports were due and accepted and examined audits of cost reports and cost settlements paid during the audit period. We selected samples of cost reports to perform detailed testing to determine whether DCH performed in a timely manner the initial acceptance review for 38 cost reports, the cost report audits for 32 cost reports, and the cost settlements for 17 cost reports. We evaluated the Office of Audit's audit planning documents to determine if DCH conducted on-site audits at least every four years. We also analyzed cost reports that were not settled to determine the reasonableness of the time lag for cost settlement.

** See glossary at end of report for definition.*

In addition, we reviewed a sample of 20 audits of cost reports to determine if the audits were sufficient to conclude on the reasonableness of the information provided in the cost reports. We reviewed DCH's variance and risk analyses, audit plan assessments, audit plan scopes, audit working papers, and audit adjustments for cost reports to assess the reasonableness of the audits of cost reports. We also reviewed cost settlement calculations for cost reports.

To assess the effectiveness of DCH's efforts to evaluate alternative reimbursement methodologies for long-term care at nursing facilities, we met with personnel from the Office of Long-Term Care Policy, the Actuarial Division, the Medical Services Administration, and the workgroup established to examine long-term care reimbursement methodologies. We inquired about the workgroup's efforts to examine Medicaid reimbursement methodologies to nursing facilities. We reviewed the workgroup's meeting minutes, proposed case mix reimbursement system model, participant letters, and reports to the Legislature.

Our audit procedures included the use of nonstatistical sampling techniques. We utilized random sampling methodologies for selecting samples of cost reports, audits of cost reports, and cost settlements. Our samples were taken from cost reports and cost report audits within the audit period to ensure that the items tested provided a true representation of the entire population. We did not project errors into the population.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit effort on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis.

Agency Responses and Prior Audit Follow-Up

Our audit report includes 3 findings and 3 corresponding recommendations. DCH's preliminary response indicates that it agrees with all 3 recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DCH to develop a plan to comply with the audit recommendations and submit it within 60 days after the release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

Within the scope of this audit, we followed up one prior audit recommendation from our June 2010 financial audit, including the provisions of the Single Audit Act, of the Department of Community Health (391-0100-10). This prior audit recommendation was rewritten for inclusion in Finding 2 in this audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFORTS TO ENSURE A TIMELY AND ACCURATE RATE SETTING PROCESS

COMMENT

Audit Objective: To assess the effectiveness of the Department of Community Health's (DCH's) efforts to ensure a timely and accurate rate setting process for long-term care at nursing facilities.

Audit Conclusion: DCH's efforts were moderately effective in ensuring a timely and accurate rate setting process. Our assessment disclosed one reportable condition* related to allocation of general service costs (Finding 1).

FINDING

1. Allocation of General Service Costs

   DCH did not always maintain documentation of the justification for and preapproval of the providers' use of an alternative statistical basis for allocation of general service costs. DCH accepted providers' prepared cost reports that used allocation bases that were not preapproved and could affect the calculation of the Medicaid reimbursement rate. DCH spent a total of $4.12 billion on Medicaid long-term care for nursing facilities during the audit period.

   Title XIX instructions from DCH's Michigan Nursing Facility and Special Care Unit, Medical Services Administration, for preparing the cost reports recommend that providers use the standard statistical basis listed in the cost reports for each cost center*. The instructions also state that the provider must have prior approval to use an alternative statistical basis. The Medicaid Provider Manual and the federal Centers for Medicare and Medicaid Services Manual (Publication 15, Chapter 23, Section 2313) require providers that change from using one statistical basis to another to submit a request in writing to DCH and to include reasonable justification and supporting documentation that the new basis is more accurate and appropriate to allocate costs. In addition, the provider must maintain data on both the prior and proposed statistical bases until the change is approved.

** See glossary at end of report for definition.*

Annually, DCH requires Medicaid providers to submit an electronic cost report as a basis for LTC RARSS to set an interim Medicaid reimbursement rate. Providers input general cost information in the cost reports and allocate the costs to other cost centers using a statistical basis.

We reviewed 41 cost reports for 20 providers received from October 1, 2007 through May 31, 2011 with total costs of $420.9 million and general service costs of $195.2 million (see Exhibit 4). We noted that 5 of the 41 cost reports included statistical allocation bases that were different from the standard. Of those 5 cost reports, we noted:

a. For 4 (80%) of the cost reports, DCH did not maintain documentation of the providers' requests or justification to use an alternative statistical basis to allocate costs for general service cost centers for medical records and library, social services, diversional therapy activities, nursing administration, central supplies, laundry, and dietary.

b. For 4 (80%) of the cost reports, DCH did not maintain documentation of its preapproval for providers to use an alternative statistical basis. In each of the 4 cost reports that we reviewed, at least one statistical basis to allocate costs was different from the standard statistical basis.

DCH did not have any documentation to support the reason for the change in the statistical allocation basis. DCH followed up these cost report exceptions and determined that, in each instance, the long-term care nursing facility only had a Medicaid nursing service cost center so, regardless of the statistical basis used, all of the general service costs would have been allocated to the Medicaid nursing service cost center. However, because some nursing facilities may have more than one nursing service cost center, DCH should ensure that it approves any change in statistical basis to ensure that providers use a fair and equitable method to allocate costs.

RECOMMENDATION

We recommend that DCH maintain documentation of the justification for and preapproval of the providers' use of an alternative statistical basis for allocation of general service costs.

AGENCY PRELIMINARY RESPONSES

DCH agrees that historical copies approving a provider's request to use an alternative statistical basis may not always have been maintained as required by record retention guidelines.

DCH informed us that it will ensure that documentation for all future "provider-initiated" requests to change the statistical basis for allocation of general costs will be maintained.

EFFORTS TO ENSURE A TIMELY AND ACCURATE COST SETTLEMENT PROCESS

COMMENT

Background: DCH issues prospective payments to nursing facility providers for long-term care of Medicaid patients for routine nursing care services. DCH determines most providers' annual Medicaid reimbursement rate based on filed cost reports; however, rates may also be based on audited cost report data, cost data submissions and projections for a specific reimbursement activity, or interim reimbursement. DCH calculates an interim per diem rate or interim payment for each facility from the cost information submitted by that facility. DCH adjusts the interim reimbursement to actual allowable costs through cost settlements.

After the acceptance of the cost report, LTC RARSS determines if an initial settlement adjustment is necessary. If a settlement adjustment is necessary, LTC RARSS will make a retroactive payment adjustment to the nursing facility rate and payments. The retroactive adjustment may be necessary because of a previous interim rate revision or to implement a rate based on actual cost report data. The initial settlement uses the most recent accepted cost report data and paid Medicaid claims and other payment data, such as other insurance and patient payment amounts, to calculate the retroactive reimbursement.

After the close of each nursing facility's one-year reimbursement period, DCH determines the final cost settlement. Medicaid reimbursement per diem rates are in effect for one year and coincide with the State's fiscal year. Because a facility's fiscal

year may not be the same as the State's fiscal year, up to three cost report years may be used in determining the final cost settlement. At final settlement, DCH reconciles payments made based on filed cost reports to payments that should have been made based on audited cost reports. Final settlements determine if additional payment is due to the nursing facility or the State.

Audit Objective: To assess the effectiveness of DCH's efforts to ensure a timely and accurate cost settlement process for long-term care at nursing facilities.

Audit Conclusion: We concluded that DCH's efforts were moderately effective in ensuring a timely and accurate cost settlement process for long-term care at nursing facilities. Our assessment disclosed two reportable conditions related to the timeliness of long-term care facility audits and the timeliness of cost settlements (Findings 2 and 3).

FINDING

2. Timeliness of Long-Term Care Facility Audits

   DCH did not ensure completion of audits of cost reports for Medicaid long-term care facilities in a timely manner and did not perform on-site audits at least once every four years. Delays in cost report audits could cause delays in identification and resolution of items that could affect both final cost settlements and prospective rate determination.

   Because audits verify the cost reporting data used for calculating prospective rates and final cost settlements, DCH should establish criteria to help ensure timely completion of audits of cost reports (see Exhibit 5). In addition, the Medicaid State Plan specifies that on-site audits are to be conducted no less than once every four years.

   The Medicaid State Plan states that the annual audit process may include a desk review or that an audit of either limited or full scope should be performed on the records of each participating long-term care nursing facility provider to ensure that the expenses attributable to allowable cost items are accurately reported in accordance with established principles and guidelines. Upon completion of the audit, DCH must prepare a preliminary summary of audit adjustments notice and issue it to the long-term care nursing facility.

We sampled 32 cost reports to review for the timeliness of the audits. Our examination of the timeliness of these cost report audits disclosed that DCH did not complete an audit for 14 (44%) of 32 cost reports within one year of the receipt of the final cost reports. Of these 14 cost reports, DCH had not started the audits of 8 cost reports as of the end of our audit period. DCH had receipt of the final cost report for 1 provider for approximately one year and for 7 providers for approximately two years but had not started the audits as of the end of our audit period.

We also reviewed 38 cost reports to determine if an on-site audit had been conducted within four years. We noted that 10 (26%) of the 38 long-term care nursing facilities did not have a field audit completed within the last four years. In addition, we reported in our June 2010 financial audit, including the provisions of the Single Audit Act, of the Department of Community Health (391-0100-10) that the same 10 facilities had not been audited during the last four years. In response to that finding, DCH indicated that it had initiated an additional step in the audit planning process to ensure that an on-site review is completed at least once every four years. However, the Office of Audit stated that these audits were not completed in a timely manner because of limitations in staff availability.

RECOMMENDATION

We recommend that DCH ensure completion of audits of cost reports for Medicaid long-term care facilities in a timely manner and perform on-site audits at least once every four years.

AGENCY PRELIMINARY RESPONSE

DCH agrees that audits are not always completed on a timely basis and that on-site audits were still pending for 10 of the facilities cited in DCH's single audit for the period ended September 30, 2009.

DCH informed us that staffing reductions within the Office of Audit have caused delays in completion of all required audits on a timely basis. DCH indicated that the Office is working on streamlining various processes as well as analyzing the distribution of the audit universe across all regional offices; once completed, this will help ensure that audits are completed on a timelier basis. DCH also indicated that it helps to ensure compliance with the Medicaid State Plan during completion

of the audit planning document for each audit. However, the Office of Audit informed us that it has limited resources; therefore, audits need to be prioritized during the audit planning process based on level of risk. In addition, DCH informed us that the 10 facilities cited in the finding were all considered to be at a very low risk of having any impact on Medicaid reimbursement and, thus, audit staff resources were directed to more appropriate reviews. DCH indicated that as of March 2012, all 10 facilities have undergone on-site field audits.

FINDING

3. Timeliness of Cost Settlements

DCH did not cost settle cost reports for Medicaid long-term care facilities in a timely manner. This could result in lost interest earnings for the State and federal governments and long-term care facilities and increase the risk that DCH will be unable to collect amounts that may have been overpaid to long-term care facilities. DCH processed gross cost settlements of $12.0 million and $17.0 million during fiscal years 2008-09 and 2009-10, respectively, and $0.8 million through April of fiscal year 2010-11.

Section 1610 of the fiscal year 2008-09, 2009-10, and 2010-11 appropriations acts states that settlements of properly submitted cost reports shall be paid not later than 9 months from receipt of the final report.

DCH informed us that the boilerplate in the appropriations act was unclear in its definition of a final report. The LTC RARSS Operational Procedures Manual, Section 100.5.3, states that, after a cost report has been accepted, an initial settlement will be completed and processed within 9 months of the cost report acceptance. In addition, Section 800 states that initial settlements are to be calculated within 9 months of a cost report being filed and cites the annual legislative appropriations act as the requirement for cost settlements to be completed within 9 months of receiving the filed cost report.

During our review of cost settlements, we noted that DCH was unable to perform initial or final settlements on cost reports that included August and September 2009 in the facility fiscal year in a timely manner. Because of the conversion of the Medicaid Management Information System (MMIS) in September 2009, DCH was

unable to verify the accuracy of third-party liability and patient pay amounts that are necessary to calculate cost settlements because these amounts were not always captured in MMIS's data warehouse. We noted that 416 long-term care facilities filed cost reports that included August or September 2009 during the facility fiscal year. DCH was unable to provide an estimate of when the programming would be corrected by the Department of Technology, Management, and Budget or when these cost settlements would be completed after the programming was corrected.

In addition, we reviewed DCH's final cost settlement process. DCH performs final cost settlements of the Medicaid reimbursements paid to providers during a reimbursement period. Because Medicaid reimbursement rates are established prospectively based on the most recent cost report data available, the rate for a provider's particular reimbursement period may be determined using several cost reports. Therefore, we determined that final cost settlements could reasonably take up to 23 months after the end of the provider's reimbursement period to complete because initial settlements and audits of each cost report used to calculate the interim rate and the retroactive pay adjustment rate must be performed prior to the final cost settlement.

We sampled 17 cost reports for 11 long-term care nursing facilities that were due for an initial or a final cost settlement during our audit period. Our review of the timeliness of these cost settlements disclosed that DCH did not process 1 initial cost settlement and 12 final cost settlements for a total of 13 (25%) of 52 cost settlements within 23 months from the reimbursement period end date. We noted that these cost settlements were as much as 1 year and 4 months outstanding and averaged 8 months outstanding. For 7 of the 13 cost settlements, DCH could not complete the final cost settlement within 23 months because it had not yet conducted the audits of the cost reports. Exhibit 6 presents our analysis of the amount of time it took DCH to cost settle all final settlements processed during the audit period.

We noted that these 11 long-term care nursing facilities received 21 initial cost settlements and 31 final cost settlements. These settlements disclosed that long-term care nursing facility providers owed DCH a total of $362,026 and DCH owed long-term care nursing facility providers a total of $698,315.

RECOMMENDATION

We recommend that DCH cost settle cost reports for Medicaid long-term care facilities in a timely manner.

AGENCY PRELIMINARY RESPONSE

DCH agrees that cost settlements should be completed on a timely basis; however, DCH disagrees with the auditor's assumption that 23 months is a reasonable period to expect completion of all final settlements. DCH indicated that there is no LTC RARSS/Medicaid policy or State Plan requirement that dictates final settlements must be completed within 23 months.

DCH informed us that the process of finalizing a cost settlement includes a requirement that the cost report must be audited by the Office of Audit. Final settlements will not occur until the cost report audit is complete. Therefore, timeliness of final settlements is largely contingent upon the ability of the facilities to make their books and records available to audit staff and the completion of the cost report audits. LTC RARSS believes that the Office of the Auditor General's expectation that cost report audits be completed within 6 months is not reasonable. LTC RARSS also contends that it has been timely in completing the final settlements after the cost report audits have been completed. In addition, DCH indicated that Section 1610 of the appropriations acts states that settlements of properly submitted cost reports shall be paid not later than 9 months from receipt of the final report. DCH informed us that, assuming that the appropriations acts are referring to a final submitted cost report by the provider, LTC RARSS meets the 9-month time line as generally all initial settlements are completed and paid within 9 months of receipt of the provider's final submitted report.

OFFICE OF THE AUDITOR GENERAL EPILOGUE

DCH indicated that it "disagrees with the auditor's assumption that 23 months is a reasonable period to expect completion of all final settlements" and "that there is no LTC RARSS/Medicaid policy or State Plan requirement that dictates final settlements must be completed within 23 months."

We concur that there is no policy or State Plan requirement that dictates final settlement must be completed within 23 months. Also, as stated in the finding, DCH had informed us that the appropriations act requiring settlements be paid not later than 9 months from receipt of the final report was unclear in its definition of a final report; therefore, it designed its procedures to ensure that an initial settlement be paid within 9 months of receiving the final report. Because there was no requirement for timeliness of the final cost settlement and the existing guidance was unclear, it was difficult to evaluate DCH's timeliness in processing cost settlements. Therefore, we evaluated the various due dates within DCH's process to final cost settle and calculated what we believed to be a reasonable time line to final cost settle.

To establish the estimate, we started with the provider's reimbursement period end date and then estimated a time frame as follows:

1. Added 5 months to the reimbursement period end date because the cost report is due from the provider 5 months after the reimbursement period end date.

2. Added 3 more months to account for unforeseen issues or delays in providing and accepting the reports and because this date would be the latest date necessary for the cost report to be used to establish the provider's rate for the next year.

3. Added 6 months to allow for the audit process, which is required to complete the final cost settlement.

4. Added 9 months to consider the boilerplate requirement that settlement must be completed within 9 months of the final report.

Based on this analysis, it is reasonable to expect the final cost settlements to be completed within 23 months of the provider reimbursement period end date.

EFFORTS TO EVALUATE ALTERNATIVE REIMBURSEMENT METHODOLOGIES

COMMENT

Audit Objective: To assess the effectiveness of DCH's efforts to evaluate alternative reimbursement methodologies for long-term care at nursing facilities.

Audit Conclusion: We concluded that DCH's efforts were effective in evaluating alternative reimbursement methodologies for long-term care at nursing facilities. Our audit report does not include any reportable conditions related to this audit objective.

DCH developed a proposed case mix reimbursement system model for long-term care nursing facility providers during fiscal year 2008-09. However, DCH did not implement the case mix reimbursement system because of uncertainty in the economic climate of Michigan and the nursing industry, because of changes to federal assessment requirements, and because long-term care providers did not support the initiative. In April 2011, the Centers for Medicare and Medicaid Services awarded Michigan an innovation contract to develop ways to improve care and services for individuals dually eligible for Medicare and Medicaid. DCH proposed to integrate Medicare and Medicaid funds to deliver all covered services for dually eligible beneficiaries, including services to nursing facility residents. Under this proposal, dually eligible Medicare and Medicaid recipients would be enrolled into an integrated care plan but may elect to opt out. DCH also proposed to contract with one or more entities to administer the program under an acuity-based capitation arrangement.

SUPPLEMENTAL INFORMATION

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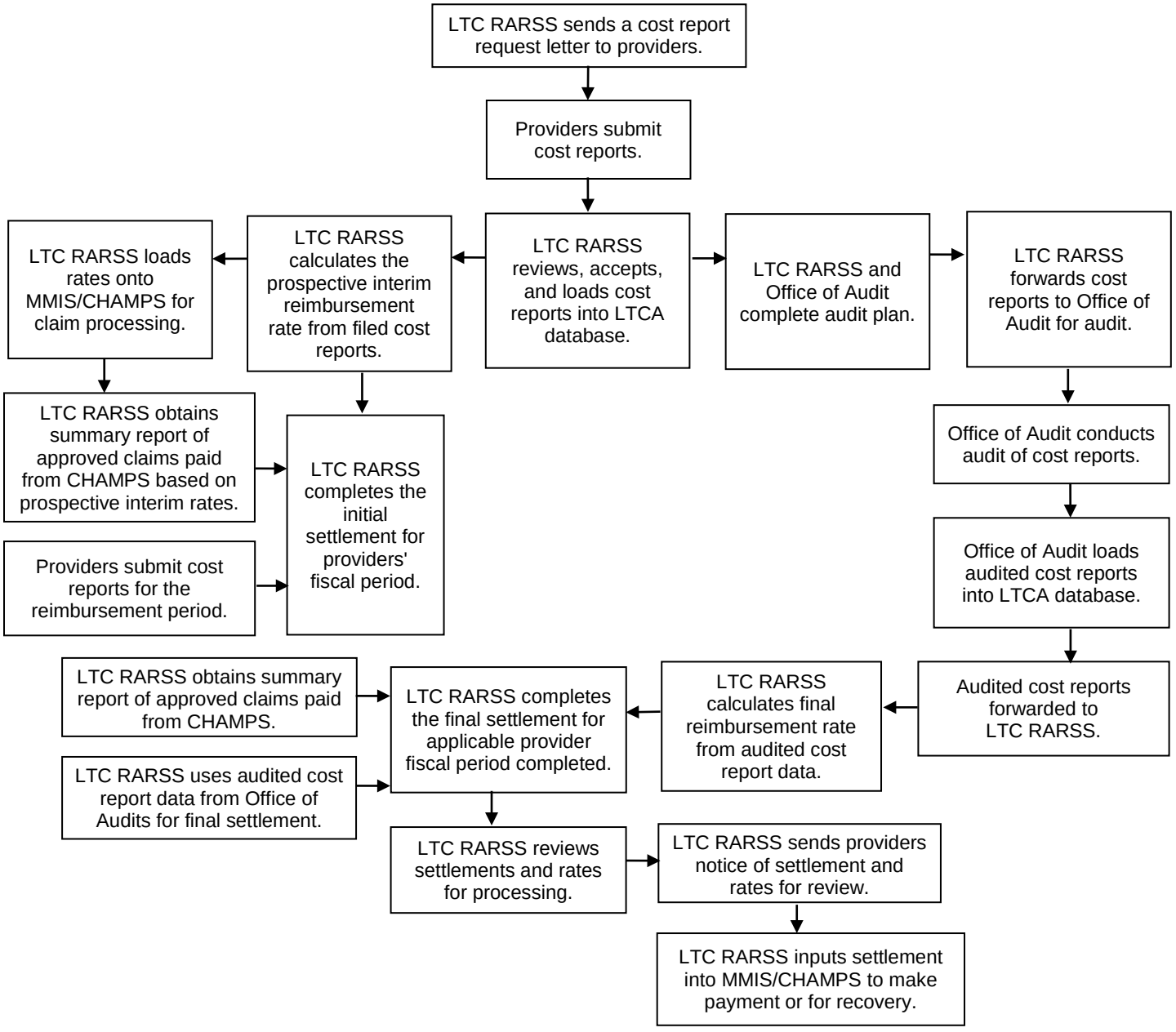
LONG-TERM CARE NURSING FACILITY MEDICAID REIMBURSEMENT AND RATE SETTING PROCESS
Department of Community Health

Business Process for Cost Reports, Rate Setting, Audits, and Settlements



Purpose: The purpose of this exhibit is to show the flow of the business process for establishing the long-term care Medicaid reimbursement rates.

Source: Auditor prepared using information obtained from the Long-Term Care Reimbursement and Rate Setting Section (LTC RARSS).

LONG-TERM CARE NURSING FACILITY MEDICAID REIMBURSEMENT AND RATE SETTING PROCESS
Department of Community Health

Medicaid Long-Term Care Nursing Facility Statistics
October 1, 2008 Through August 16, 2011

	Fiscal Year			
	2008-09	2009-10	2010-11	
Expenditures	$ 1,581,062,430	$ 1,679,494,217	$ 1,496,461,791	
Long-term care nursing facilities	443	435	430	
Long-term care days	9,208,503	9,216,943	7,619,160	
Total beds available	45,466	45,032	27,048	
Total occupancy rate	87.90%	87.31%	86.98%	
Medicaid activity rate	65.06%	65.56%	68.03%	
Total Medicaid-funded beds	29,580	29,523	18,401	
Average Medicaid reimbursement rate	$ 161	$ 170	$ 173	*

* Average Medicaid reimbursement rate for fiscal year 2010-11 was calculated as of September 30, 2011.

Source: Auditor prepared from information obtained from various sources, e.g., expenditures were from Michigan Administrative Information Network (MAIN) data and statistics were from the Long-Term Care Application (LTCA) database.

LONG-TERM CARE NURSING FACILITY MEDICAID REIMBURSEMENT AND RATE SETTING PROCESS
Department of Community Health

General Steps to Establishing the Medicaid Reimbursement Per Diem Rate for Nursing Facilities

Step 1: Long-term care nursing facilities submit annual cost reports to the Long-Term Care Reimbursement and Rate Setting Section (LTC RARSS).

Step 2: LTC RARSS reviews the cost reports and makes adjustments so that only Medicaid allowable costs* are included.

Step 3: LTC RARSS arrays the costs into variable*, plant*, and add-on* categories.

Step 4: LTC RARSS divides the costs by Medicaid resident days, which may be adjusted by an occupancy rate factor to determine the cost per day.

Step 5: LTC RARSS indexes variable costs per day to the beginning of the State's fiscal year.

Step 6: LTC RARSS adjusts the variable and plant-per-day costs by upper limits, ceilings, or floors grouped by facility type and bed size.

Step 7: LTC RARSS determines the Medicaid reimbursement rate for routine patient days by adding the adjusted variable and plant-per-day costs.

Step 8: LTC RARSS calculates the add-ons for nurse aide testing and training and quality assurance supplement for eligible facilities.

Source: Auditor prepared from information obtained during the audit.

** See glossary at end of report for definition.*

LONG-TERM CARE NURSING FACILITY MEDICAID REIMBURSEMENT AND RATE SETTING PROCESS
Department of Community Health

Summary of Sampled Providers That Used the Recommended Basis
Rather Than an Alternative Basis to Allocate General Service Costs

	Number of Providers in Sample of 20 Using the Recommended Statistical Basis						
Cost Center	Square Feet	Time Spent	Hours of Service	Cost Requisition	Salaries	Pounds of Laundry	Meals Served
Plants 1 and 3	20						
Plant 2	20						
Plant operation and maintenance	20						
Utilities	20						
Medical records and library		6					
Social services		8					
Diversional therapy activities		8					
Housekeeping			6				
Nursing administration			13				
Central supplies				12			
Medical supplies				12			
Employee health and welfare					20		
Laundry						9	
Dietary							7

Observation:

We noted that 5 of the 20 providers changed the statistical allocation basis during the period October 1, 2007 through May 31, 2011. As discussed in Finding 1, DCH did not maintain documentation of its preapproval for providers to use an alternative statistical basis to allocate their general service costs in the cost reports.

Source: Auditor prepared from testing results.

Exhibit 4

Number of Providers in Sample of 20 That Used an Alternative Basis	Percent of Use of Recommended Basis	Percent of Use of Alternative Basis
0	100%	0%
0	100%	0%
0	100%	0%
0	100%	0%
14	30%	70%
12	40%	60%
12	40%	60%
14	30%	70%
7	65%	35%
8	60%	40%
8	60%	40%
0	100%	0%
11	45%	55%
13	35%	65%

UNAUDITED
Exhibit 5

LONG-TERM CARE NURSING FACILITY MEDICAID REIMBURSEMENT AND RATE SETTING PROCESS
Department of Community Health

Days to Complete Cost Report Audits as of April 30, 2011 for Nursing Facilities
For the Period October 5, 2008 Through March 31, 2010

Facility Type	Cost Reports Received	Days to Complete Audit		Audit Started But Not Completed	Audit Not Started
		Up to 365	More Than 365		
Nursing homes	691	61	91	69	470
County medical care facilities	72	17	6	2	47
Hospital long-term care units	48	4	5	7	32
Total	811	82	102	78	549

Source: Auditor prepared using data from the Long-Term Care Reimbursement and Rate Setting Section (LTC RARSS) cost report status logs and the Office of Audit audit plans.

LONG-TERM CARE NURSING FACILITY MEDICAID REIMBURSEMENT AND RATE SETTING PROCESS
Department of Community Health

Time Frame for Final Cost Settlements Processed
October 1, 2008 Through April 30, 2011

Facility Type	Cost Settlements Processed	Time to Settle: 1 Year or Less	1 to 2 Years	2 to 3 Years	3 to 4 Years	4 to 5 Years	5 to 8 Years
Nursing homes	630	6	198	295	85	33	13
County medical care facilities	68	0	55	10	1	2	0
Hospital long-term care units	40	0	23	13	3	1	0
Total	738	6	276	318	89	36	13

Observations:

Of the 738 cost settlements processed during the audit period, 6 (1%) were related to facility reimbursement periods ended in calendar year 2009. As discussed in Finding 3, DCH was unable to cost settle reimbursement periods that included August and September 2009 in the facility fiscal year because of the conversion of the Medicaid Management Information System (MMIS).

Of the 738 cost settlements processed during the audit period, 637 (86%) were related to facility reimbursement period end dates ranging from calendar years 2006 through 2008.

Of the 738 cost settlements processed during the audit period, 95 (13%) were related to facility reimbursement period end dates ranging from calendar years 2002 through 2005.

Source: Auditor prepared using final cost settlement data from MMIS.

GLOSSARY

add-on costs	Costs that are not previously included in the provider's variable cost component.
allowable costs	Costs incurred in the provision of nursing facility services subject to guidelines and limitations set forth in the Medicare Principles of Reimbursement, as they appear in federal regulations and in manuals published by the federal Centers for Medicare and Medicaid Services, unless stated to the contrary in policies and procedures issued by DCH.
base costs	Costs that cover activities associated with direct patient care. Major items under these categories are payroll and payroll-related costs (salaries, wages, related payroll taxes, and fringe benefits) for departments of nursing, nursing administration, dietary, laundry, diversional therapy, and social services; food; linen; workers' compensation; utility costs; and consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments. With the exception of nursing pool services, purchased services and contract labor from unrelated parties or from related organizations, incurred in lieu of base costs, are separated into base costs and support costs using the industry-wide average base-to-variable cost ratio.
CHAMPS	Community Health Automated Medicaid Processing System.
cost center	A division, department, or subdivision thereof; a group of services; or any other unit or type of activity into which functions of an organization or nursing facility are divided for purposes of cost assignment and allocation.

cost report	A formal compilation of the nursing facility ownership, financial data, and statistical data in DCH-prescribed format that is required on an annual basis for the reporting period, which generally extends over a 12-month period based on the nursing facility's fiscal year. Each nursing facility provider's cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility.
DCH	Department of Community Health.
effectiveness	Success in achieving mission and goals.
facility	An entire nursing facility or a distinct part thereof being considered for rate setting. The entire building may be considered a distinct part unit for rate setting purposes. A unit smaller than the entire building may also be considered a distinct part unit for rate setting purposes if the identified facility space area meets required certification requirements. The facility is licensed by the State of Michigan to provide nursing care and related medical services for residents who require such care above the level of room and board.
Long-Term Care Application (LTCA) database	The database used to track long-term care cost report intake and audits of cost reports.
LTC RARSS	Long-Term Care Reimbursement and Rate Setting Section.
Medicaid Provider Manual	The manual that contains coverage, billing, and reimbursement policies for the Medicaid Program administered by DCH.

Medicaid State Plan	A document that defines how Michigan will operate its Medicaid Program. The Medicaid State Plan addresses the areas of State program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement and is approved by the federal Centers for Medicare and Medicaid Services.
MMIS	Medicaid Management Information System.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve program operations, to facilitate decision making by parties responsible for overseeing or initiating corrective action, and to improve public accountability.
plant costs	Depreciation, interest expense (incurred for either working capital or capital indebtedness, mortgage discount points), property taxes, amortization costs associated with loan financing costs (e.g., letters of credit), letter of credit application or commitment fees, amortization of legal fees pertaining to acquisition, recording fees or other fees relating to the capital asset acquisition, and specific lease expenses.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the objectives of the audit; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.

routine nursing care services	Organized nursing care and activities for the resident, under the observation and assessment of licensed nurses, which enable the resident to attain or to maintain the highest practicable physical, mental, and psychosocial well-being in accordance with a written plan of care.
support costs	Costs that are payroll and benefit-related (salaries, wages, related payroll taxes, and fringe benefits) for the departments of housekeeping, plant operation and maintenance, medical records and library, medical director, and nursing administration; administrative costs; all consultant costs not specifically identified as base costs; all equipment maintenance and repair costs; purchased services; and contract labor not specified as base costs.
variable costs	A facility's total allowable base costs and support costs (see definitions) for providing routine nursing care services to residents.

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