Office of the Auditor General

Performance Audit Report

Administration of Medicaid Payments to Nursing Facilities for Long-Term Care

Michigan Department of Health and Human Services

November 2019

391-0570-18

State of Michigan Auditor General
Doug A. Ringler, CPA, CIA

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.

The auditor general may make investigations pertinent to the conduct of audits.

Article IV, Section 53 of the Michigan Constitution

Office of the Auditor General

Report Summary

Performance Audit

Administration of Medicaid Payments to Nursing Facilities for Long-Term Care (LTC)

Michigan Department of Health and Human Services (MDHHS)

Report Number:
391-0570-18

Released:
November 2019

Through its LTC Reimbursement Division and LTC Audit Division, MDHHS administers the Medicaid reimbursement rate setting, audit, and cost settlement processes for services provided by LTC facilities. MDHHS sets the Medicaid LTC per diem reimbursement rates for facility providers and coordinates the review of annual cost reports. As of October 1, 2018, MDHHS set rates for 374 nursing facilities, 34 county medical care facilities, 21 inpatient hospitals with LTC units, and 11 nursing facilities with ventilator dependent units. In fiscal year 2018, MDHHS reimbursed providers $1.9 billion for LTC services.

Audit Objective	Conclusion
Objective #1: To assess the effectiveness of MDHHS's efforts to administer its LTC rate setting process.	Moderately effective

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS's Medicaid LTC cost reimbursement methodology is complicated, labor intensive, ineffective, and inefficient (Finding #1).	X		Agrees
MDHHS returned 708 (60%) of the cost reports received with period end dates from October 2015 through July 2018 for correction and took 33 calendar days, on average, to accept the remaining 479 cost reports (Finding #2).		X	Agrees

Audit Objective	Conclusion
Objective #2: To assess the effectiveness of MDHHS's efforts to administer its LTC audit process.	Moderately effective

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
See Finding #1.	X		Agrees

Findings Related to This Audit Objective *(Continued)*	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS did not always identify obvious unallowable costs or disallow identified unallowable costs, potentially resulting in inflated future reimbursement rates and LTC provider payments (Finding #3).		X	Agrees
MDHHS took more than a year to complete 94% of the audits and did not physically visit the nursing facility provider for 67% of the 43 audits reviewed (Finding #4).		X	Agrees

Audit Objective	Conclusion
Objective #3: To assess the effectiveness of MDHHS's efforts to administer its LTC cost settlement process.	Moderately effective

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
See Finding #1.	X		Agrees
MDHHS took longer than 6 months to complete 68% of the cost settlements and miscalculated 18% of the 17 final cost settlements reviewed (Finding #5).		X	Agrees

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November 15, 2019

Mr. Robert Gordon, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Dear Mr. Gordon:

This is our performance audit report on the Administration of Medicaid Payments to Nursing Facilities for Long-Term Care, Michigan Department of Health and Human Services.

We organize our findings and observations by audit objective. Your agency provided preliminary responses to the recommendations at the end of our fieldwork. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, 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,

Doug Ringler
Auditor General

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AUDIT OBJECTIVES, CONCLUSIONS, FINDINGS, AND OBSERVATIONS

ADMINISTERING THE RATE SETTING PROCESS

BACKGROUND

The Michigan Department of Health and Human Services (MDHHS) reimburses Michigan nursing facilities* for Medicaid eligible patients at per diem rates calculated based on facility-specific annual Medicaid cost report* data (see Exhibits #1 and #2).

The Medicaid Provider Manual (MPM) requires nursing facilities to submit their cost reports to MDHHS within five months of the nursing facility provider's* cost reporting period end date. MDHHS accepts a submitted cost report only after it has verified that the cost report is:

- A complete package using required formatting.
- Mathematically accurate, reasonable, and consistently calculated.
- In accordance with prior year(s) audit adjustments, Medicaid policy, and cost reporting instructions.
- Successfully run against a set of validation checks.

If necessary, MDHHS allows a provider 15 calendar days to submit a corrected cost report. If not received, MDHHS will issue a delinquency notice and withhold payments to the nursing facility provider until an acceptable cost report* is received.

MDHHS uses the provider's accepted cost report to calculate the prospective, per resident, per diem reimbursement rate, which may later be adjusted based on audited cost report data.

During fiscal year 2018, MDHHS reimbursed Michigan nursing facilities for long-term care (LTC) provided to Medicaid eligible patients at the following per diem rates:

Type	Minimum	Maximum	Average
Nursing facility	$112.00	$ 252.94	$195.07
County medical care facility or inpatient hospital - LTC unit	$205.87	$ 311.22	$274.92
Nursing facility - ventilator dependent unit	$385.80	$1,059.60	$672.97

AUDIT OBJECTIVE

To assess the effectiveness* of MDHHS's efforts to administer its LTC rate setting process.

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

CONCLUSION

Moderately effective.

FACTORS IMPACTING CONCLUSION

- MDHHS appropriately stopped payments to providers, as necessary, for the 14 delinquent initial or corrected cost reports that we reviewed.
- MDHHS ensured that all applicable providers submitted cost reports, as required.
- MDHHS appropriately returned incomplete and/or inaccurate cost reports to the providers.
- MDHHS maintained appropriate user access to its Long-Term Care Application (LTCA) database*.
- MDHHS accurately developed the LTCA rate formulas that we reviewed.
- MDHHS appropriately approved all of the providers' alternative cost allocation statistical basis requests that we reviewed.
- Material condition* related to the need to consider alternative reimbursement methodologies (Finding #1).
- Reportable condition* related to the need to improve the cost report acceptance process (Finding #2).

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

FINDING #1

Consideration of alternative reimbursement methodologies.

MDHHS's Medicaid LTC reimbursement methodology is complicated, labor intensive, ineffective, and inefficient.

MDHHS should consider alternative methodologies for reimbursing LTC nursing facility providers for Medicaid eligible beneficiaries. Its existing methodology is complicated, labor intensive, ineffective, and inefficient.

Section 18.1485 of the *Michigan Compiled Laws* (Section 485, Public Act 431 of 1984) requires that MDHHS establish and maintain an internal accounting and administrative control system, including effective and efficient control techniques.

We researched LTC reimbursement methodologies at the federal level, at another State agency with similar operations, and in other states; reviewed and analyzed MDHHS's LTC cost report acceptance, audit (including cost report audit results and supporting documentation), and settlement processes; and surveyed LTC providers:

a. Our research noted:

   (1) The federal Medicaid and CHIP Payment and Access Commission's summary of state Medicaid nursing facility payment policies between October 2018 and July 2019 indicated that Michigan is 1 of only 2 states that utilize an annually adjusted, facility-specific Medicaid cost reimbursement methodology that is based on actual allowable costs*. This methodology does not consider the difference between the level of care provided and the level of nursing care needed for each patient.

   (2) The Centers for Medicare and Medicaid Services (CMS) used the Resource Utilization Group (RUG) system to reimburse skilled nursing facilities for covered services provided to Medicare beneficiaries from 1998 to 2019. Effective October 1, 2019, CMS implemented a new case-mix reimbursement methodology called the Patient-Driven Payment model (PDPM). The PDPM focuses more on the patients' conditions and resulting care needs rather than on the amount of care provided and reduces the administrative burden on providers. Both systems utilize standardized federal per diem rates based on historical nationally aggregated data, changes in patient level of care (case-mix), geographic wage variations, and inflation.

   (3) A June 2015 MDHHS position paper identified the following benefits of a case-mix reimbursement methodology:

      (a) Alleviates many of the systematic challenges, such as eliminating complex cost reporting calculations and delays caused by the audit and appeals

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

process, that would allow departmental resources to provide more immediate and effective assistance to, and oversight of, nursing facility providers.

(b) Minimizes the need for cost reports as they would not be the central mechanism to determine a facility's reimbursement rate.

(c) Is consistent with the Medicare reimbursement process.

(d) Is compatible with managed care.

(4) MDHHS approved a case-mix reimbursement methodology, effective June 1, 2018, for Medicaid-certified State veterans' homes based on the Medicare RUG rates.

b. Our review of MDHHS's LTC cost report acceptance process noted that MDHHS needs to improve the accuracy and timeliness of accepting LTC cost reports (Finding #2).

c. Our review of MDHHS's LTC cost report audit process noted:

(1) MDHHS did not always identify obvious unallowable costs or disallow the unallowable costs identified, potentially inflating future reimbursement rates (Finding #3).

(2) MDHHS did not complete audits in a timely manner and had a significant backlog (Finding #4).

(3) Audits often resulted in provider appeals, further delaying the cost settlements. From October 1, 2015 through July 3, 2018, MDHHS finalized 268 provider appeals. Our review of 27 appeals noted that 23 (85%) appeals did not result in any change to the audit adjustment amounts.

(4) Most audit adjustments do not result in an overpayment/underpayment as most adjustments are between cost centers or may not be large enough to impact the various cost report calculations. For 35 of the 1,504 cost report audits that MDHHS finalized from October 1, 2015 through June 30, 2018, MDHHS identified an absolute value of $44.1 million in audit adjustments that resulted in overpayments of only $1.6 million, 1% of the $123.4 million paid to the 35 LTC providers for their respective cost reporting periods.

(5) Although the nursing facility providers assert to the accuracy of each cost report upon submission, 5 of the

9 providers who responded to our survey indicated that they rely on their external preparers to ensure the accuracy of cost reports. However, our discussions with one external cost report preparer and review of that contract indicated that the preparer is only responsible for compiling the data from the provider's accounting system.

d. Our review of MDHHS's LTC cost settlement process noted that MDHHS did not complete timely and accurate cost settlements (Finding #5).

e. Our analyses indicated that the overall LTC cost report, audit, and settlement process from the provider's period end date through final cost settlement was extensive (Exhibits #3 and #4).

f. Eight of the 9 LTC providers that responded to our survey indicated that they pay an external expert to prepare their cost reports because the process is complicated and time consuming.

Although we identified deficiencies in MDHHS's audit process, we contend that, as long as the cost reports are utilized to determine future reimbursement rates, the audit process is necessary to deter flagrant and fraudulent cost reporting.

We consider this finding to be a material condition based on the combined significance of the weaknesses noted with the LTC reimbursement processes (Findings #1 through #5).

RECOMMENDATION

We recommend that MDHHS reevaluate its Medicaid LTC cost reimbursement methodology.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees. Medicare and most state Medicaid agencies have moved away from cost-based reimbursement in favor of case-mix reimbursement. Case-mix reimbursement is based on the residents' service needs and their estimated resource utilization while cost-based reimbursement is based on individual facility allowable cost experience. The current cost-based methodology is inherently inflationary and does not reimburse based on the services needed by or delivered to the residents.

The complicated cost report acceptance, audit and settlement processes are necessary under the current reimbursement system to ensure the accuracy of rates paid to Medicaid participating nursing facilities. These processes help prevent nursing facilities from being reimbursed for unallowable costs and help protect Michigan taxpayer dollars. We estimate that over $32 million was recovered from nursing facilities through

our audit and settlement processes from fiscal years 2016 through 2019.

As referenced in the finding, MDHHS has done some preliminary work in assessing alternative reimbursement methodologies. We continue that research and plan to develop a recommendation on how to best identify and implement reforms to the current methodology.

FINDING #2

Improvements needed to the cost report acceptance process.

MDHHS needs to enhance its cost report submission and initial review processes to help improve the accuracy and timeliness of accepting LTC cost reports. MDHHS returned 708 (60%) of the cost reports received with period end dates from October 1, 2015 through July 9, 2018 for correction and took 33 calendar days, on average, to accept the remaining 479 cost reports.

The MPM requires that providers submit a complete and accurate Medicaid cost report to MDHHS by the last day of the fifth month following the cost reporting period end date and allows MDHHS to withhold subsequent payments until an acceptable cost report is submitted.

MDHHS reviews an initially filed cost report to ensure completeness, consistency, and uniform presentation of certain data elements before it is accepted. Also, for cost reporting periods ended on or after March 31, 2016, MDHHS implemented a cost reporting software application that alerted cost report preparers of identified errors and other potential issues. Our analysis of MDHHS's cost report submission and initial review processes noted:

a. MDHHS's cost reporting software application was:

   (1) Not designed to reject cost reports containing identified errors.

   (2) Designed only to alert cost report preparers of certain issues that should have been identified as errors, such as inconsistencies and incorrect cost center allocation data.

b. For the 1,187 cost reports received with period end dates from October 1, 2015 through July 9, 2018:

   (1) MDHHS returned 708 (60%) cost reports to the providers for correction. Our review of 43 of these reports noted that MDHHS returned 30 reports because of inaccurate provider identification information, inaccurate quality assurance supplement payments, and the utilization of alternative cost allocation methodologies that were not preapproved.

   (2) MDHHS processed the 708 returned cost reports in 74 calendar days, on average.

   (3) MDHHS processed the remaining 479 cost reports in 33 calendar days, on average.

   MDHHS informed us that its manual review process, staffing limitations prior to and during our audit period, the cyclical nature of some staff tasks, and higher priority tasks caused the cited delays in the cost report acceptance process.

RECOMMENDATION

We recommend that MDHHS enhance its cost report submission and initial review processes.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that its cost report submission and initial review processes can be enhanced.

Public Act 612 of 2018 amended the Michigan Social Welfare Act effective June 26, 2019 and established timelines for the cost report acceptance process. To ensure compliance with the statute, MDHHS updated its cost report acceptance, audit and settlement policy through bulletin MSA 19-28. All LTC staff were trained on these policy changes at staff meetings and providers were trained on these policy changes at the first annual "Audit Seminar" in the fall of 2019 (in 4 different locations). The policy changes in bulletin MSA 19-28 are effective November 1, 2019.

MDHHS is also working to implement an automated cost report acceptance process which will reduce the number of cost reports submitted with errors significantly.

Finally, LTC Audit Division staff educated both providers and cost report preparers on several statewide "cost report submission error" trends during the "Audit Seminar". The intent of providing this information during the seminar was to help reduce the number of cost reports returned to providers for correction in future years.

ADMINISTERING THE AUDIT PROCESS

BACKGROUND

The cost report audit process helps to ensure that the cost report information is accurate for the determination of Medicaid reimbursement rates and confirms that:

- Only reasonable and allowable costs are included.
- The methods used to calculate the required statistical information are adequate and the statistical data is recorded accurately.
- Audit adjustments are accurately and fairly computed.
- The costs allocated to Medicaid are accurate.
- The nursing facility provider is in compliance with and has consistently and uniformly applied federal and State laws, rules, regulations, and policies for reimbursable costs.

MDHHS may assess a refundable financial penalty on providers that do not submit requested audit information within 15 business days. At the conclusion of audit fieldwork, MDHHS issues a preliminary summary of audit adjustments and advises the provider of the appeal rights, including the right to an Area Office Conference. MDHHS issues a final summary of audit adjustments upon the provider's agreement with the audit adjustments or if the provider does not respond to the preliminary summary of audit adjustments within 15 business days of notice. MDHHS then processes the final audit adjustments into the filed cost report creating a finalized, audited cost report that can move into the cost settlement phase.

In lieu of conducting an audit of a cost report and to reduce the audit backlog, MDHHS began piloting a process in December 2017 to calculate a separate average base and support cost adjustments using the last seven years of audit cost adjustments.

MDHHS may forward to the Health Care Fraud Division, Department of Attorney General, instances of potential fraud or abuse involving personal expenses, inflated charges, concealed activities, falsified records, inappropriate billings, or knowingly failing to disclose required information.

AUDIT OBJECTIVE

To assess the effectiveness of MDHHS's efforts to administer its LTC audit process.

CONCLUSION

Moderately effective.

FACTORS IMPACTING CONCLUSION

- MDHHS appropriately considered prior period audit adjustments when determining the scope of a current audit.
- Only 15% of provider appeals that we reviewed resulted in modifications to the appealed audit adjustments, the majority of which were based on additional information submitted by the provider.
- MDHHS accurately calculated the audit adjustments that we reviewed that were part of its pilot process.
- MDHHS has a process for handling instances of potential fraud and abuse identified in the provider cost reports.
- Material condition related to the need to consider alternative reimbursement methodologies (Finding #1).
- Reportable conditions related to the need to:
    - Improve the cost report audit process (Finding #3).
    - Improve the timeliness of the audit process (Finding #4).

FINDING #3

Cost report audit process needs improvement.

Absent a change in its methodology for reimbursing LTC nursing facility providers for Medicaid eligible beneficiaries as recommended in Finding #1, MDHHS should improve its cost report audit process. MDHHS did not always identify obvious unallowable costs or disallow all of the unallowable costs it identified, which may result in inflated future reimbursement rates and LTC provider payments.

The MPM requires MDHHS to audit the records of each participating nursing facility provider to ensure that the expenses are allowable, accurately reported, and properly supported.

Our review of MDHHS's LTC cost report audit process related to the 1,504 cost report audits that MDHHS finalized from October 1, 2015 through June 30, 2018 noted:

a. The cost reports of the 4 providers that we visited and reviewed supporting documentation for included unallowable costs, some of which were obvious and not identified by MDHHS. Specifically:

   (1) Our sample of 248 transactions noted unallowable costs of 10%. The 248 transactions totaled $485,492 and the unallowable costs identified in 48 (19%) transactions totaled $46,866.

   (2) Our cursory review of the providers' cost reports identified $181,712 of other unallowable costs, some of which MDHHS had identified and disallowed:

Description of Unallowable Costs	Total Identified by OAG	Portion of OAG Total That MDHHS Reviewed During Its Audit Process	Portion of OAG Total That MDHHS Inappropriately Allowed
Promotional activities, advertising, vacation costs, personal cell phone bills, entertainment costs, late fees, and alcohol	$ 88,409	$46,958	$19,312
Unsupported or insufficiently documented costs	93,303	12,057	12,057*
Total	$181,712	$59,015	$31,369

* MDHHS issued a warning to the provider.

b. For 43 cost report audits (related to 43 unique providers), MDHHS identified unallowable costs totaling $66,067 that it did not consistently disallow, as follows:

   (1) $48,474 of vehicle costs for 5 providers for which mileage logs were either insufficient or nonexistent. MDHHS:

      (a) Did not disallow any of the $35,803 of vehicle costs reported by 3 providers.

      (b) Did not disallow $717 (40%) of the $1,793 of vehicle costs reported by 1 provider.

      (c) Appropriately disallowed all $10,878 of the vehicle costs reported by 1 provider.

   (2) $11,646 of personal cell phone costs for 4 providers. MDHHS:

      (a) Did not disallow $5,431 (50%) of the $10,862 of personal cell phone costs reported by 3 providers.

      (b) Appropriately disallowed all $784 of personal cell phone costs for 1 provider.

   (3) $5,947 of unsupported meal and entertainment costs for 1 provider. MDHHS did not disallow $1,487 (25%) of these costs.

MDHHS indicated that it may have allowed flexibility for providers that expressed confusion regarding the MPM requirements (including the extent of supporting documentation that should be maintained) and because of pressure from external organizations for MDHHS to educate providers and apply policy on a prospective basis.

RECOMMENDATION

We recommend that MDHHS improve its audit procedures to help identify unallowable costs and more consistently disallow unallowable costs.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that audit procedures can be improved to help identify additional unallowable costs and to consistently disallow unallowable costs identified during an audit.

During the audit process, MDHHS auditors perform an analysis of the cost report to determine which expenditures to select for audit during that cost report period. This analysis is done every year and the expenditures selected for review each year may change. However, in the event that an MDHHS auditor disallows expenditures that haven't previously been reviewed or questioned

during an audit, the industry has interpreted this as MDHHS is changing or reinterpreting policy. As a result of this, MDHHS has received significant pressure from external parties, and as noted in the finding, and modified some disallowances.

Regardless of this, the LTC audit teams have still been identifying significant audit adjustment and recovery amounts across the State. For fiscal year (FY) 2016 through FY 2019, the initial and final settlements processed through Gross Adjustments totaled:

- *FY 2016 – Net savings of $1,785,924*
- *FY 2017 – Net savings of $4,293,669*
- *FY 2018 – Net savings of $11,146,324*
- *FY 2019 – Net savings of $14,820,485*

To further improve audit procedures, the LTC audit teams have begun using a new audit management software (TeamMate) in 2019 that is designed to help with all aspects of the audit process. This audit software is also currently utilized by 6 other State departments/offices (including the Office of the Auditor General) and helps with the consistency of our audit steps and findings.

In addition, the LTC Audit Division is holding monthly manager meetings and quarterly staff meetings to specifically discuss policy and emerging audit trends to ensure that there is consistency of our interpretation and audit procedures across all regional offices.

Finally, the LTC Audit Division conducted its first annual "Audit Seminar" in the fall of 2019 (in 4 different locations) to educate our providers on the statewide audit trends. The compilation of data for the "Audit Seminar" involved multiple meetings with all three regional offices and helped to ensure that we are identifying and consistently addressing issues across all LTC audits.

FINDING #4

Timeliness of audit process needs improvement.

MDHHS needs to improve the timeliness of its audit process and perform on-site audits at least once every four years. Untimely audits resulted in delays in identifying and resolving audit adjustments, negatively affecting the timeliness of final cost settlements and prospective rate determinations. Also, providers may continue to report unallowable expenses without timely notification of the errors.

The Medicaid State Plan requires MDHHS to verify each cost report submitted for completeness, accuracy, reasonableness, and consistency through a desk audit and/or a computer check and to conduct an on-site audit at least once every four years.

Our review of MDHHS's cost report audit process from October 1, 2015 through May 17, 2018 noted:

a. MDHHS completed 1,182 audits in an average of 956 days, taking more than 1 year to complete 94% of the audits and more than 2 years to complete 67% of the audits:

	Completed Cost Report Audits	
180 days or less	18	2%
More than 180 days and less than or equal to 1 year	49	4%
More than 1 year and less than or equal to 2 years	318	27%
More than 2 years and less than or equal to 3 years	333	28%
More than 3 years and less than or equal to 4 years	297	25%
More than 4 years	167	14%
	1,182	100%

These 1,182 audits were awaiting assignment to the audit planning and audit work phases an average of 552 (58%) of the 956 days:

Cost Report Audit Phase	Average Number of Days
Awaiting audit planning	**396**
Audit planning	204
Awaiting audit work	**156**
Audit work	200
Total days	956

b. MDHHS had 996 audits in progress that, as of May 17, 2018, were outstanding for an average of 601 days, including awaiting assignment to the audit planning and audit work phases an average of 349 (58%) of the 601 days.

c. MDHHS had 218 audits, with period end dates ranging back to March 31, 2009, for which the audit fieldwork was completed prior to October 1, 2015 and for which the audit was finalized from October 1, 2015 through May 17, 2018. The delay in finalizing these audits further postponed MDHHS's cost settlement process for the associated cost reports.

d. MDHHS did not physically visit 29 (67%) nursing facilities during the 43 "on-site" audits that it completed. For 27 of the facilities, MDHHS conducted the audits at the location where the audit records were maintained, including the provider's home office* location, a different facility within the chain organization*, or the nursing facility's contracted accounting firm. For the other 2 facilities, MDHHS completed the audits through exchange of electronic information.

   MDHHS did not have a mechanism to track when it last physically visited the facilities and informed us that it interpreted "on-site" to mean the location at which the financial records are maintained.

MDHHS indicated that the cited delays were attributable to staffing limitations prior to and during the audit period, accommodation of provider scheduling requests, and completion of multiple cost report year audits for the same providers simultaneously.

RECOMMENDATION

We recommend that MDHHS improve the timeliness of its audit process and perform on-site audits at least once every four years.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that timeliness of its audit processes needs improvement.

Public Act 612 of 2018 amended the Michigan Social Welfare Act effective June 26, 2019 to establish audit timelines for newly accepted cost reports and prior year unaudited cost reports.

To ensure compliance with this statute's new timelines, MDHHS updated its cost report acceptance, audit and settlement policy through bulletin MSA 19-28. All LTC staff were trained on these policy changes at our quarterly staff meetings and providers were trained on these policy changes at the first annual "Audit Seminar" in the fall of 2019 (in 4 different locations). The policy changes in bulletin MSA 19-28 are effective November 1, 2019.

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

The MDHHS LTC Audit Division has also implemented various tools to monitor the audit process throughout its lifecycle to track various timelines and to ensure PA 612 requirements will be met. These tools are used during the biweekly regional office managers meetings to review the status of all ongoing and pending audits with adjustments to timelines made as necessary.

MDHHS is working to amend the Medicaid State Plan to eliminate the requirement of on-site audits at least once every four years. LTC Audit Division staff will continue to perform a significant number of audits on-site but have recognized that advancements in technology have created efficiencies in audit work and allow us to receive the same documentation in an electronic format. As a result, this is reducing the need to go on-site to every provider and instead determine the need to perform on-site audit activity based on audit risk.

ADMINISTERING THE COST SETTLEMENT PROCESS

BACKGROUND

MDHHS calculates the Michigan Medicaid LTC reimbursement rates at the beginning of the rate year and may update them based on subsequent information, including a more recently filed or audited cost report, a plant cost* certification, or a special reimbursement policy action. Revised reimbursement rates may affect prior or future reimbursements for related dates of service. MDHHS calculates a final cost settlement for each audited cost report to determine if any adjustments are necessary.

AUDIT OBJECTIVE

To assess the effectiveness of MDHHS's efforts to administer its LTC cost settlement process.

CONCLUSION

Moderately effective.

FACTORS IMPACTING CONCLUSION

- MDHHS ensured that the number of patient census days included on the provider's cost report agreed with the claims submitted through the Community Health Automated Medicaid Processing System (CHAMPS).
- MDHHS's controls ensured that LTC claim payments were not duplicated and were not made for beneficiaries who were deceased or incarcerated.
- Cost settlement calculation delays did not result in significant receivable write-offs.
- Material condition related to the need to consider alternative reimbursement methodologies (Finding #1).
- Reportable condition related to the need to improve the timeliness and accuracy of settlement calculations (Finding #5).

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

FINDING #5

Improvements needed to the cost settlement process.

MDHHS needs to improve the timeliness and accuracy of its cost settlement process. MDHHS took longer than 6 months to complete 68% of the cost settlements and miscalculated 18% of the 17 final cost settlements that we reviewed. Timely and accurate cost settlements could improve cash flow for the State and LTC providers and decrease the risk that overpayments may not be collected.

The MPM requires that after a cost report is audited, MDHHS will calculate a final cost settlement to determine if a retroactive payment adjustment is needed for the rate period covered by the cost report. To analyze the timeliness of MDHHS's cost settlement process, we used a 6-month period as a reasonable benchmark.

Our review of MDHHS's cost settlement process noted:

a. MDHHS took more than 180 days to complete 825 (68%) of the 1,209 cost settlements completed from October 1, 2015 through May 17, 2018 and, as of May 17, 2018, 367 (65%) of the 563 outstanding cost settlements had been outstanding for more than 180 days:

Length of Time From Audit Completion Date to Cost Settlement Completion Date[1]	Completed Cost Settlements				Outstanding Cost Settlements			
	Without Appeals[2]	With Appeals	Total		Without Appeals[2]	With Appeals	Total	
90 days or less	150	13	163	13%	124		124	22%
91 to 180 days	203	18	221	18%	66	6	72	13%
181 days through 1 year	271	79	350	29%	71	43	114	20%
More than 1 year through 2 years	217	27	244	20%	75	27	102	18%
More than 2 years through 3 years	163	10	173	14%	117	21	138	25%
More than 3 years through 4 years	43	3	46	4%	4	3	7	1%
More than 4 years	9	3	12	1%	5	1	6	1%
Total	1,056	153	1,209	99%	462	101	563	100%

[1]Does not include time to process in CHAMPS.

[2]May have been delayed in connection with a prior year appeal.

MDHHS informed us that it devoted resources to reducing the audit backlog before focusing on cost settlements.

b. MDHHS miscalculated 3 (18%) of the 17 final cost settlements that we reviewed that were processed from October 1, 2015 through June 30, 2018, understating the amount owed to one provider by $10,926 and understating the amount owed to the State by $12,560. We determined that manual data entry errors and staff not following procedures contributed to these miscalculations.

c. MDHHS identified the need for an automated settlement process in 2009 that would reduce manual data entries. However, it did not identify it as a priority until September

2017, and as of November 5, 2018, MDHHS still did not have an automated settlement process.

RECOMMENDATION

We recommend that MDHHS improve the timeliness and accuracy of its cost settlement process.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that timeliness and accuracy of its cost settlement process needs to improve.

Public Act 612 of 2018 amended the Michigan Social Welfare Act effective June 26, 2019 to establish timelines for new cost report settlements and prior year unprocessed cost report settlements.

To ensure compliance with this statute's new timelines, MDHHS updated its cost report acceptance, audit and settlement policy through bulletin MSA 19-28. All LTC staff were trained on these policy changes at staff meetings and providers were trained on these policy changes at the first annual "Audit Seminar" in the fall of 2019 (in 4 different locations). The policy changes noted in bulletin MSA 19-28 are effective November 1, 2019.

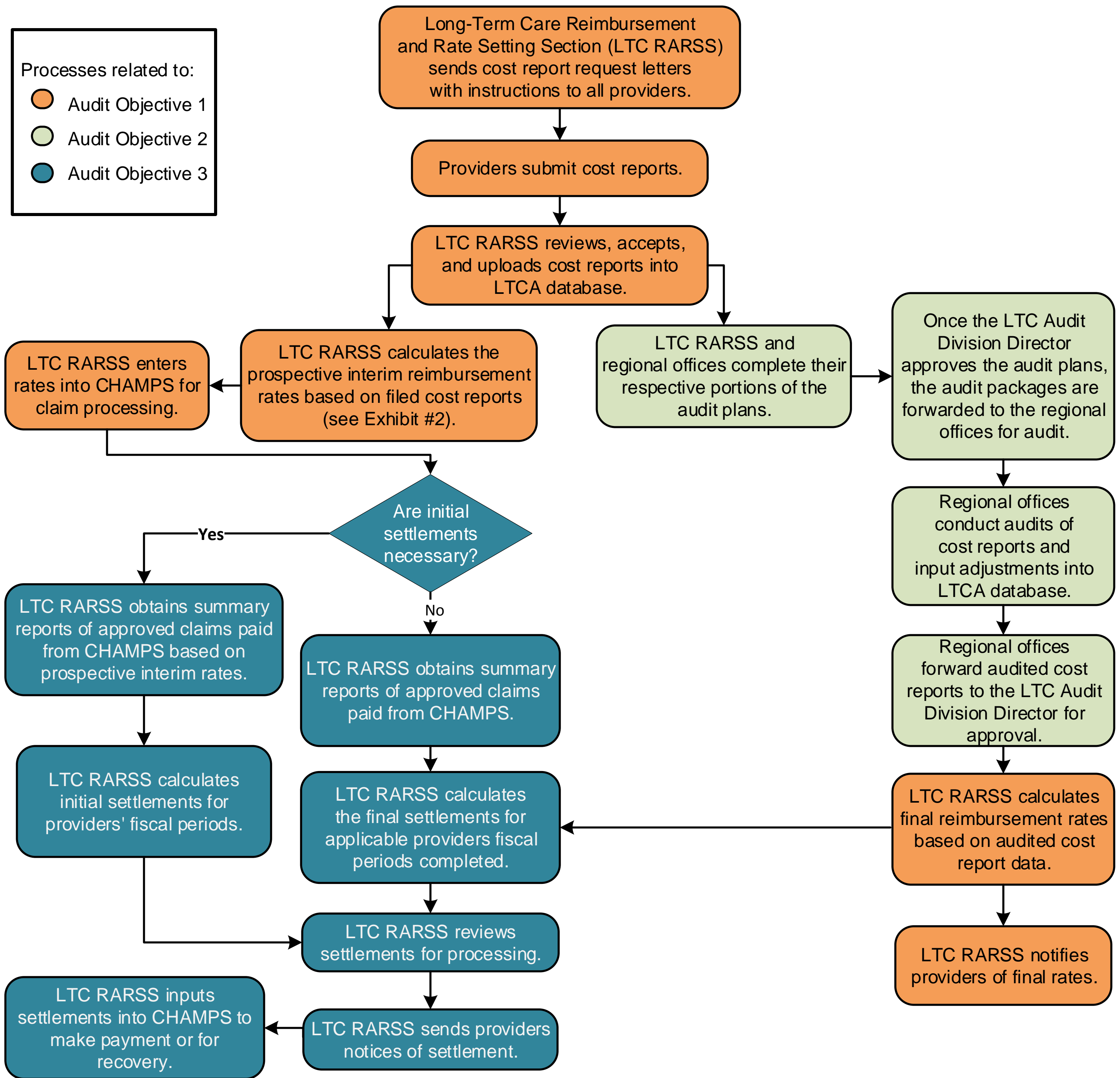
The MDHHS LTC Reimbursement Division has begun utilizing new reports to monitor the settlement process. These reports are being utilized during the weekly staff meetings to track the status of all settlements and prioritize the work accordingly to ensure PA 612 requirements will be met.

In addition, MDHHS is currently developing an automated settlement application that will help eliminate manual data entry errors.

UNAUDITED
Exhibit #1

ADMINISTRATION OF MEDICAID PAYMENTS TO NURSING FACILITIES FOR LONG-TERM CARE
Michigan Department of Health and Human Services

Business Process for LTC Cost Report Rate Setting, Audits, and Settlements



Source: The OAG prepared this exhibit based on information obtained from the LTC Reimbursement Division and LTC Audit Division.

UNAUDITED
Exhibit #2

ADMINISTRATION OF MEDICAID PAYMENTS TO NURSING FACILITIES FOR LONG-TERM CARE
Michigan Department of Health and Human Services

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

Step 1	LTC nursing facilities submit annual cost reports to the LTC Reimbursement Division.
Step 2	The LTC Reimbursement Division and the LTC Audit Division review each cost report and: a. For initial rate setting – The LTC Reimbursement Division determines that the cost report was filed appropriately and accepts the cost report for interim rate setting by uploading the filed cost report into the LTCA database. b. For final rate setting – The LTC Audit Division completes an audit of the accepted cost report and makes adjustments so that only Medicaid allowable costs are included. *The following steps are followed for both initial and final rate setting.*
Step 3	The LTCA database arrays the costs into variable*, plant, and add-on* categories.
Step 4	LTC RARSS divides the costs by total inpatient resident days, adjusted by an 85% minimum occupancy rate factor, when applicable, to determine a per resident day cost*.
Step 5	LTC RARSS indexes base costs* per day to the beginning of the State fiscal year* and calculates a support-to-base ratio* to establish a facility-specific variable cost.
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 for eligible facilities.

Source: The OAG prepared this exhibit based on the MPM.

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

ADMINISTRATION OF MEDICAID PAYMENTS TO NURSING FACILITIES FOR LONG-TERM CARE
Michigan Department of Health and Human Services

Processing Times to Issue Cost Settlements
From October 1, 2015 Through June 21, 2018

Length of Time From Provider's Period End Date to Cost Settlement Process Date	Number of Cost Settlements Processed by Provider Type: Nursing Facility	County Medical Care Facility	Inpatient Hospital - LTC Unit	Nursing Facility - Ventilator Dependent Unit	Total	
1 year or less	1				1	0.1%
More than 1 year through 2 years	10	4	1		15	1.6%
More than 2 years through 3 years	107	34	10		151	15.7%
Subtotal	118	38	11	0	167 [1]	17.4%
More than 3 years through 4 years	160	31	14	3	208	21.6%
More than 4 years through 5 years	181	18	7	2	208	21.6%
More than 5 years through 6 years	148	5	3	2	158	16.4%
Subtotal	489	54	24	7	574 [2]	59.6%
More than 6 years through 7 years	87	2	2	1	92	9.6%
More than 7 years through 8 years	84	1		1	86	8.9%
More than 8 years	37	5		1	43	4.5%
Subtotal	208	8	2	3	221 [3]	23.0%
Total	815	100	37	10	962	100.0%

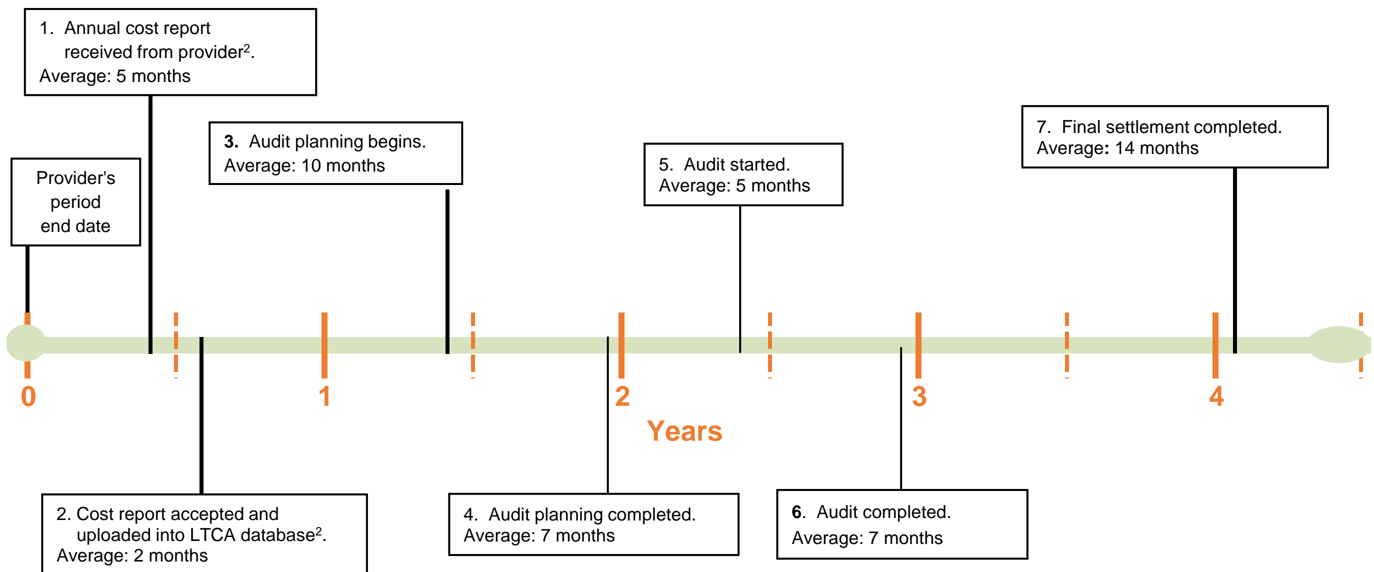
[1] These 167 cost settlements related to 132 unique providers, 2 (2%) of which had some level of appeal activity.
[2] These 574 cost settlements related to 226 unique providers, 36 (16%) of which had some level of appeal activity.
[3] These 221 cost settlements related to 129 unique providers, 55 (43%) of which had some level of appeal activity.

Source: The OAG prepared this exhibit based on cost settlement gross adjustments processed in CHAMPS and provider appeal reports obtained from the LTC Reimbursement Division.

UNAUDITED
Exhibit #4

ADMINISTRATION OF MEDICAID PAYMENTS TO NURSING FACILITIES FOR LONG-TERM CARE
Michigan Department of Health and Human Services

Average Number of Months to Complete the Major Steps in the LTC Cost Report, Audit, and Settlement Processes[1]
October 1, 2015 Through May 17, 2018[2]



Notes:
[1] Average number of months is calculated from the previous step.
[2] Data for Steps 1 and 2 covered October 1, 2015 through July 9, 2018.

Source: The OAG prepared this exhibit based on the following reports obtained from the LTC Reimbursement Division and LTC Audit Division: Cost Report Status Detail Reports, Audit Status Reports, Audits in Appeal Status Reports, and Audited Cost Report Status Reports.

PROGRAM DESCRIPTION

Through its LTC Reimbursement Division and LTC Audit Division, MDHHS administers the Medicaid reimbursement rate setting, audit, and cost settlement processes for services provided by LTC nursing facilities (see Exhibits #1 through #4):

- MDHHS's rate setting process establishes the Medicaid LTC per diem reimbursement rates for LTC facility providers.
- MDHHS's audit process coordinates the review of LTC facility providers' annual cost reports.
- MDHHS's cost settlement process ensures that providers are paid based on the expenditures incurred.

As of October 1, 2018, LTC facility providers receiving Medicaid reimbursement included 374 nursing facilities, 34 county medical care facilities, 21 inpatient hospitals with LTC units, and 11 nursing facilities with ventilator dependent units.

In fiscal year 2018, MDHHS reimbursed providers $1.9 billion for LTC services. As of October 22, 2018, the Divisions had 37 total employees.

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine and evaluate MDHHS's records and processes related to LTC rate setting, auditing, and cost settlement. 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.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered October 1, 2015 through June 30, 2018.

METHODOLOGY

We conducted a preliminary survey to gain an understanding of MDHHS's processes related to LTC rate setting, auditing, and cost settlement in order to establish our audit objectives, scope, and methodology. During our preliminary survey, we:

- Interviewed MDHHS's management and staff regarding their functions and responsibilities.
- Reviewed applicable laws, regulations, MPM requirements, and the Medicaid State Plan.
- Analyzed Michigan's Medicaid LTC expenditure data.
- Reviewed Michigan LTC nursing facility providers' Medicaid reimbursement per diem rates and compared them to those of neighboring states.
- Analyzed MDHHS's status tracking reports applicable to cost report acceptance, audit, and cost settlement.
- Conducted an LTC provider site visit to observe MDHHS's audit process.

OBJECTIVE #1

To assess the effectiveness of MDHHS's efforts to administer its LTC rate setting process.

To accomplish this objective, we:

- Reviewed 3 of the 20 potentially delinquent initial cost reports and 11 of the 71 potentially delinquent corrected cost reports received with period end dates from

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

October 1, 2015 through January 31, 2018 to determine if MDHHS appropriately stopped payment until an acceptable cost report was on file. We randomly selected our samples to eliminate bias and enable us to project the results to these populations.

- Compared LTC nursing facility provider claim payments with cost report submissions to determine if all applicable providers submitted cost reports.

- Reviewed 9 of the 89 cost reports that were uploaded into the LTCA database, after the 30-day grace period, for cost reports received with period end dates from October 1, 2015 through July 9, 2018 to determine reasonableness. We randomly selected our sample to eliminate bias and enable us to project the results to this population.

- Analyzed the population of cost reports that MDHHS received as of July 9, 2018 for cost report period end dates from October 1, 2015 through July 9, 2018 to determine the timeliness of cost report submissions, corrections, and acceptance.

- Reviewed 43 of the 708 cost reports that MDHHS returned to nursing facility providers for correction relating to the 1,187 cost reports received as of July 9, 2018 with period end dates from October 1, 2015 through July 9, 2018 to determine that MDHHS appropriately returned the cost reports. We randomly selected our sample to eliminate bias and enable us to project the results to this population.

- Reviewed the appropriateness of user access for 13 of the 78 LTCA users. We judgmentally selected the 5 high-risk users and randomly selected an additional 8 users; therefore, we could not project the results to the overall population.

- Reviewed rate calculations for 1 class I* facility provider and 1 class III* facility provider to ensure proper LTCA inputs and calculations. We judgmentally selected our sample to ensure our review included coverage of both rate calculations. Therefore, we could not project the results to the overall population.

- Reviewed 43 of the 1,504 cost report audits that MDHHS finalized from October 1, 2015 through June 30, 2018 to verify that preapproval was obtained for any alternative cost allocation statistics. We randomly selected our sample to eliminate bias and enable us to project the results to this population.

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

- Reviewed Medicaid LTC reimbursement methodologies used throughout the United States and a study on Michigan's use of an alternative Medicaid reimbursement method.

OBJECTIVE #2

To assess the effectiveness of MDHHS's efforts to administer its LTC audit process.

To accomplish this objective, we:

- Reviewed MDHHS's processes for ensuring that its auditors followed the policies that were effective as of the providers' period end dates and that its audit planning process considered prior period audit adjustments when determining the scope of a current audit.

- Reviewed 43 of the 1,504 cost report audits that MDHHS finalized from October 1, 2015 through June 30, 2018. Our sample included provider period end dates from December 31, 2010 through September 30, 2016 and was randomly selected to eliminate bias and enable us to project the results to this population. We reviewed these cost report audits to:

  - Determine if on-site audits were completed at least once every four years.

  - Ensure that policies were applied consistently and that documentation was reasonable.

  - Assess the cost benefit of the audit process.

- Visited and reviewed cost report supporting documentation to verify allowable costs for 4 of the 43 nursing facility providers discussed in the previous bullet. We judgmentally selected these facilities to ensure audit efficiency across different types of facilities. We selected the facilities based on the facility or home office location, changes in ownership or facility operation status, cost limits, type of facility, individual or group ownership, overall costs, and the level of MDHHS review. We also judgmentally selected 248 transactions from the 4 facilities based on dollar size, frequency of occurrence, and cost pools to ensure audit efficiency across different types of payments. In addition, we completed an arbitrary review of the 4 providers' cost report supporting documentation to identify any additional unallowable costs. Therefore, we could not project the results to the overall population.

- Analyzed the length of time from the cost report period end date to the date that the audit was finalized for the 1,182 audits that MDHHS completed from October 1,

2015 through May 17, 2018. The 1,182 audits did not include the 104 audits that were finalized from May 18, 2018 through June 30, 2018 or the 218 audits for which the audit fieldwork was completed prior to October 1, 2015 but finalized from October 1, 2015 through May 17, 2018.

- Analyzed the time to complete each major step in the audit process for the 996 audits that were in progress as of May 17, 2018.

- Reviewed 27 of the 267 appeals that MDHHS finalized from October 1, 2015 through July 3, 2018 to determine if appeal decisions were upheld or overturned and if similar appeal decisions were handled consistently. Our sample was randomly selected to eliminate bias and enable us to project the results to this population.

- Reviewed MDHHS's methodology for determining which providers were offered an average adjustment agreement and reviewed 8 of the 63 average adjustment agreements that MDHHS completed during the audit period to determine if the adjustments were appropriate and properly calculated. Our sample was randomly selected to eliminate bias and enable us to project the results to this population.

- Obtained a listing of potential fraud cases that were forwarded to the MDHHS Office of Inspector General during our audit period and obtained an understanding of related policies and procedures that MDHHS auditors are required to follow.

OBJECTIVE #3

To assess the effectiveness of MDHHS's efforts to administer its LTC cost settlement process.

To accomplish this objective, we:

- Reviewed 43 of the 1,504 cost report audits that MDHHS finalized from October 1, 2015 through June 30, 2018. Our sample was randomly selected to eliminate bias and enable us to project the results to this population. We reviewed the 19 cost report audits for which a cost settlement was completed to:

    - Verify the accuracy of initial and final settlement amounts processed in CHAMPS.

    - Analyze claim payments to determine if the count of claims materially reconciled to MDHHS reports and to the reported patient census days from the providers' cost reports to ensure accuracy in reporting.

- Conducted phone surveys with 9 of the 43 nursing facility providers selected for survey from the 1,504 cost report audits that MDHHS finalized from October 1, 2015 through June 30, 2018 regarding the LTC Medicaid reimbursement process.

- Analyzed gross adjustment settlement activity processed from October 1, 2015 through June 27, 2018 to:

  - Compare processing times of payment and recovery gross adjustments.

  - Identify if trends existed by nursing facility provider, regional office, or individual auditor.

- Analyzed claims paid from October 1, 2015 through June 27, 2018 to identify duplicate LTC claim payments.

- Analyzed claims paid from October 1, 2015 through June 27, 2018 to identify incarcerated beneficiaries.

- Analyzed claims paid from October 1, 2015 through June 30, 2018 to identify deceased beneficiaries.

- Analyzed cost settlements completed from October 1, 2015 through May 17, 2018 to determine the length of time to complete the cost settlements after the audits were finalized.

- Analyzed a population of terminated providers to determine if cost settlement calculation delays resulted in significant receivable write-offs.

CONCLUSIONS

We base our conclusions on our audit efforts and any resulting material conditions or reportable conditions.

When selecting activities or programs for audit, we direct our efforts based on risk and opportunities to improve State government operations. Consequently, we prepare our performance audit reports on an exception basis.

AGENCY RESPONSES

Our audit report contains 5 findings and 5 corresponding recommendations. MDHHS's preliminary response indicates that it agrees with all of the recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion at the end of our fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Office upon completion of an audit. Within 30

days of receipt, the Office of Internal Audit Services, State Budget Office, 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.

PRIOR AUDIT FOLLOW-UP

Following is the status of the reported findings from our April 2012 performance audit of the Long-Term Care Nursing Facility Medicaid Reimbursement and Rate Setting Process, Department of Community Health (391-0570-11):

Prior Audit Finding Number	Topic Area	Current Status	Current Finding Number
1	Improvements needed to support alternative allocation of general service costs.	Complied	Not applicable
2	Improvements needed to ensure timeliness of LTC facility audits.	Rewritten*	4
3	Timeliness of cost settlements needs improvement.	Rewritten	5

SUPPLEMENTAL INFORMATION

Our audit report includes supplemental information presented as Exhibits #1 through #4. Our audit was not directed toward expressing a conclusion on this information.

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

GLOSSARY OF ABBREVIATIONS AND TERMS

acceptable cost report	A complete and accurate accounting of the financial and statistical activities of a nursing facility provider prepared in accordance with Medicaid policy and cost reporting instructions using the electronic format required by MDHHS. The cost report must include the certification statement signed by an authorized representative of the nursing facility certifying the cost report as a true, correct, and complete statement of facility financial and statistical activities prepared from the nursing facility provider's books and records.
add-on costs	Reimbursable costs that are not included in the provider's variable cost component or plant cost component, such as the nurse aide training and testing add-on.
allowable costs	Costs incurred in the provision of nursing facility services subject to guidelines and limitations set forth in the Medicare Principles of Reasonable Cost Reimbursement, as they appear in federal regulations and in manuals published by the federal CMS, unless stated to the contrary in policies and procedures issued by MDHHS.
base costs	Costs that cover activities associated with direct patient care. Major items under these categories are payroll and payroll-related costs for departments of nursing, nursing administration, dietary, laundry, diversional therapy, and social services; food; linen (does not include mattress and mattress support unit); workers' compensation; utility costs; consultant costs from related party organizations for services related 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 as previously defined, are separated into base costs and support costs using the industry-wide average base-to-variable cost ratio.
chain organization	A group of two or more nursing care facilities, or at least one nursing care facility and another business or entity, that is owned, leased, or through any other device controlled or operated by one organization. Chain nursing facility organizations include, but are not limited to, proprietary organizations and various religious, charitable, and governmental organizations, any of which may be engaged in other activities not directly related to health care.
CHAMPS	Community Health Automated Medicaid Processing System.
CHIP	Children's Health Insurance Program.

class I	Proprietary and nonprofit nursing facilities that are not for the mentally ill or developmentally disabled, county-operated medical care facilities, state-owned and operated institutions (including intermediate care facilities) with intellectual disabilities, or the distinct portion of a special nursing facility for the care of ventilator-dependent residents.
class III	Proprietary nursing facilities, hospital LTC units, and nonprofit nursing facilities that are county-operated medical care facilities.
CMS	Centers for Medicare and Medicaid Services.
cost report	A formal compilation of the nursing facility ownership, financial, and statistical data in MDHHS-prescribed format that is required on an annual basis for the reporting period, generally extending 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.
effectiveness	Success in achieving mission and goals.
home office	The central office of a chain organization (see chain organization).
Long-Term Care Application (LTCA) database	The database used to track LTC cost report intake and audits of cost reports.
LTC	long-term care.
LTC RARSS	Long-Term Care Reimbursement and Rate Setting Section.
material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program. Our assessment of materiality is in relation to the respective audit objective.
MDHHS	Michigan Department of Health and Human Services.
MPM	Medicaid Provider Manual.

nursing facility — A facility (or distinct part of a facility) that 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.

performance audit — An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision-making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.

per resident day cost — The total cost for a cost component divided by the total number of resident days. The number of resident days used is the greater of the number of resident days listed in the facility's cost report or 85% of the total number of available bed days for the cost reporting period.

plant costs — Depreciation, interest expense (incurred for either working capital or capital indebtedness, such as 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 related to the capital asset acquisition, and specific lease expenses.

provider — A legal entity (person, partnership, corporation, or organization) that has been approved to participate in the Michigan Medicaid Program.

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 audit objectives; 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.

rewritten — The recurrence of similar conditions reported in a prior audit in combination with current conditions that warrant the prior audit recommendation to be revised for the circumstances.

RUG — Resource Utilization Group.

State fiscal year October 1 through September 30.

support-to-base ratio A facility's allowable support costs divided by allowable base costs. A facility's support-to-base ratio is limited to the 80th percentile support-to-base ratio for the facility's bed size group. The bed-size groups are defined as 0 - 50, 51 - 100, 101 - 150, and 151+ nursing care beds in the facility. Group bed size is based on the number of licensed beds in a facility regardless of bed type or whether the bed is available. This includes all types of licensed nursing beds, Home for the Aged beds, or any other type of licensed bed where nursing care is provided. A facility's support-to-base ratio is rebased annually from the most recent audited based period, regardless of ownership.

variable costs A facility's total allowable base and support costs for providing routine nursing services to residents.

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