Office of the Auditor General
Follow-Up Report on Prior Audit Recommendations

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

Michigan Department of Health and Human Services

July 2026

391-0570-18F

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

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

Article IV, Section 53 of the Michigan Constitution

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Report Summary

Follow-Up Report
Administration of Medicaid Payments to Nursing Facilities for Long-Term Care
Michigan Department of Health and Human Services (MDHHS)

Report Number:
391-0570-18F

Released:
July 2026

We conducted this follow-up to determine whether MDHHS had taken appropriate corrective measures in response to the material condition noted in our November 2019 audit report.

Prior Audit Information	Follow-Up Results		
	Conclusion	**Finding**	**Agency Preliminary Response**
Finding 1 - Material condition Consideration of alternative reimbursement methodologies. Agency agreed.	Partially complied	Material condition still exists. See Finding 1.	Agrees

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July 29, 2026

Amy Epkey, Acting Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Acting Director Epkey:

This is our follow-up report on the material condition (Finding 1) and corresponding recommendation reported in the performance audit of the Administration of Medicaid Payments to Nursing Facilities for Long-Term Care, Michigan Department of Health and Human Services. That audit report was issued and distributed in November 2019.

Your agency provided the preliminary response to the follow-up recommendation included in this report. The *Michigan Compiled Laws* require an audited agency to develop a plan to comply with the recommendations and submit it to the State Budget Office (SBO) upon audit completion. State administrative procedures require the audited agency to develop the plan as early as practicable and within 60 days after report issuance and submit the plan to the Office of Internal Audit Services (OIAS), SBO. Within 30 days of receipt, OIAS will 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 our follow-up. If you have any questions, please call me or Laura J. Hirst, CPA, Deputy Auditor General.

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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ADMINISTRATION OF MEDICAID PAYMENTS TO NURSING FACILITIES FOR LONG-TERM CARE

INTRODUCTION, PURPOSE OF FOLLOW-UP, AND PROGRAM DESCRIPTION

INTRODUCTION

This report contains the results of our follow-up of the material condition* (Finding 1) and corresponding recommendation reported in our performance audit* of the Administration of Medicaid Payments to Nursing Facilities* for Long-Term Care (LTC), Michigan Department of Health and Human Services (MDHHS), issued in November 2019.

PURPOSE OF FOLLOW-UP

To determine whether MDHHS had taken appropriate corrective measures to address our corresponding recommendation.

PROGRAM DESCRIPTION

MDHHS reimburses Michigan nursing facilities for Medicaid-eligible patients at per diem rates calculated based on facility-specific annual Medicaid cost report data. Through its LTC Reimbursement Division (LTCRD) and LTC Audit Division, MDHHS administers the Medicaid reimbursement rate setting, audit, and cost settlement processes for services provided by LTC facilities (see Exhibits 1 and 2). MDHHS's:

- Rate setting process establishes the Medicaid LTC per diem reimbursement rates for LTC facility providers*.
- Audit process coordinates the review of LTC facility providers' annual cost reports*.
- Cost settlement process ensures providers are paid based on the expenditures incurred.

For fiscal year 2026, MDHHS established the following per diem rates for LTC services provided to Medicaid-eligible patients for reimbursement to Michigan providers, which included 378 nursing facilities, 35 county medical care facilities, 18 inpatient hospitals with LTC units, and 11 nursing facilities with ventilator dependent units:

Type	Minimum	Maximum	Average
Nursing facility	$106.86	$354.93	$271.50
County medical care facility or inpatient hospital LTC unit	$274.14	$471.50	$399.15
Nursing facility ventilator dependent unit	$593.61	$850.15	$726.57

MDHHS reimbursed providers $3.8 billion for LTC services for the period from October 1, 2024 through April 23, 2026. As of February 5, 2026, the Divisions had 37 total employees.

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

PRIOR AUDIT FINDING AND RECOMMENDATION; AGENCY PLAN TO COMPLY; AND FOLLOW-UP CONCLUSION, RECOMMENDATION, AND AGENCY PRELIMINARY RESPONSE

FINDING 1

Audit Finding Classification: Material condition.

Summary of the November 2019 Finding:
MDHHS should consider alternative methodologies for reimbursing LTC nursing facility providers for Medicaid-eligible beneficiaries, because the existing methodology is complicated, labor intensive, ineffective, and inefficient.

Our research and review of MDHHS's reimbursement process noted:

- Michigan is one of only two states who utilize an annually adjusted, facility-specific Medicaid cost reimbursement methodology based on actual allowable costs*. Effective October 1, 2019, the Centers for Medicare and Medicaid Services implemented a new case-mix reimbursement methodology called the Patient-Driven Payment Model (PDPM). PDPM focuses more on the patients' conditions and resulting care needs than on the amount of care provided and reduces the administrative burden on providers.

- MDHHS's cost report acceptance process, audit process, and cost settlement process needed improvement. Our analyses indicated the overall LTC cost report, audit, and settlement processes, from the provider's period end date through final cost settlement, was extensive.

Recommendation Reported in November 2019:
We recommended MDHHS reevaluate its Medicaid LTC cost reimbursement methodology.

AGENCY PLAN TO COMPLY*

On June 17, 2020, MDHHS indicated it had done some preliminary work in assessing alternative reimbursement methodologies and would continue to research and develop a recommendation on how to best identify and implement reforms to the current methodology.

FOLLOW-UP CONCLUSION

Partially complied. A material condition still exists.

Throughout fiscal years 2022 and 2023, MDHHS assessed alternative reimbursement methodologies and met with stakeholders to discuss various proposed methodologies. Differences of opinion regarding reform parameters existed

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

between MDHHS and its stakeholders and a revised methodology was not agreed upon at the time.

Based on its discussions with stakeholders, MDHHS informed us it believed an alternative methodology could be implemented and would benefit service delivery if transition funding was provided. MDHHS stated the funding was necessary to ensure sufficient time was available for providers to adjust financial operations while maintaining patient care services. Therefore, as part of its fiscal year 2024 budget, MDHHS requested additional funding to continue its reform efforts. While the funding was included in the executive branch and House of Representatives proposed budgets, it was not included in the Senate proposed budget and was removed during conference discussions. Without this funding, MDHHS informed us the rate reform implementation and associated stakeholder discussions did not continue. MDHHS also informed us it asked for inclusion of the additional funding within its proposed fiscal year 2025 budget; however, the funding was not included. MDHHS did not request any additional funding in fiscal year 2026 because of competing funding priorities.

FOLLOW-UP RECOMMENDATION

We recommend MDHHS continue to pursue an alternative LTC cost reimbursement methodology.

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees with the finding. While the department continues to assess alternative reimbursement methodologies, MDHHS' current focus is on reducing administrative complexity and enhancing financial operations associated with the current cost-based reimbursement methodology.

MDHHS will continue to evaluate other potential reimbursement reforms to further reduce administrative complexity and strengthen financial operations associated with the existing Medicaid skilled nursing facility reimbursement methodology. In addition, MDHHS is currently reviewing its cost reimbursement process to identify additional efficiencies within the process.

SUPPLEMENTAL INFORMATION

UNAUDITED
Exhibit 1

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

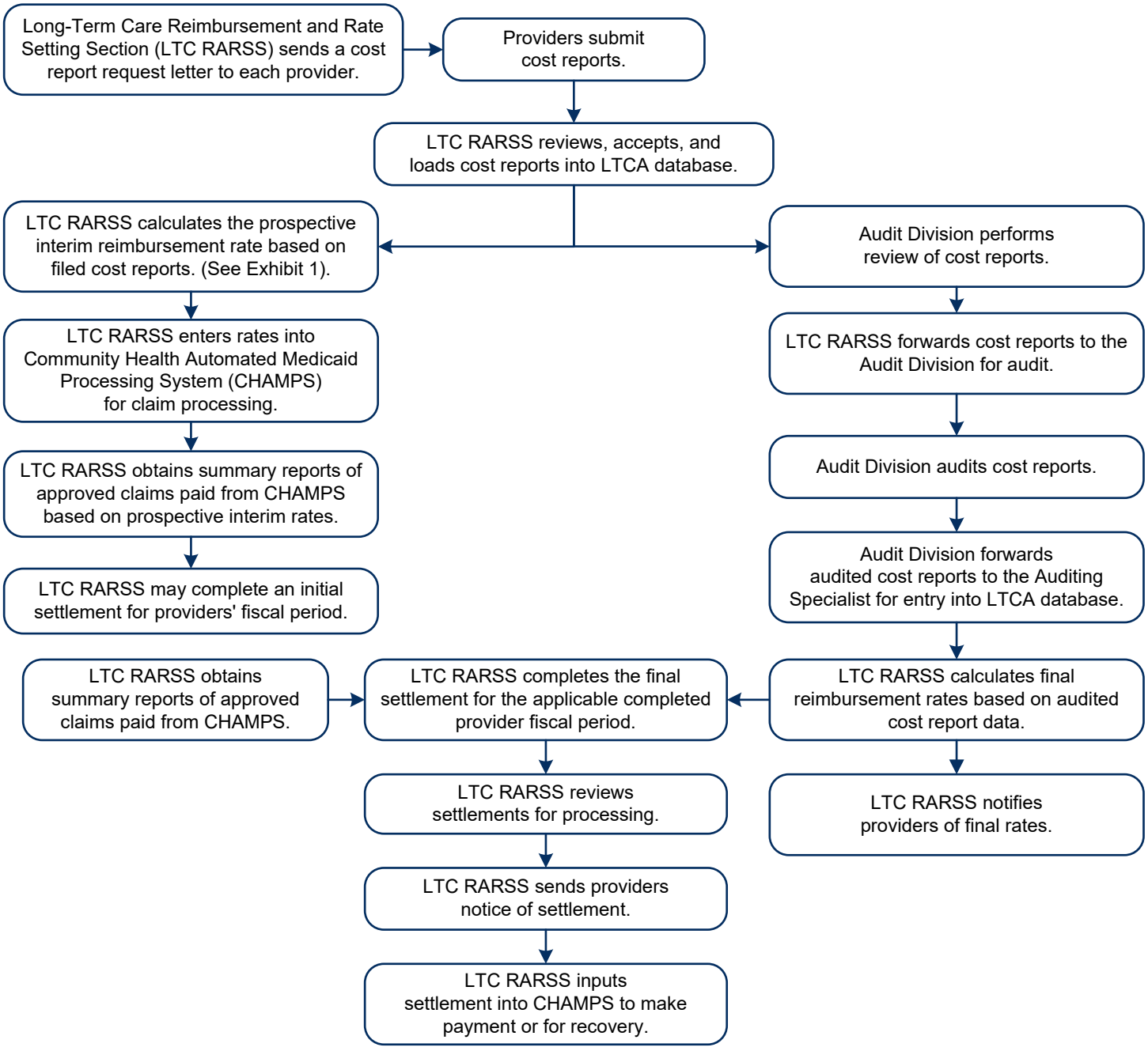
Step 1	LTC nursing facilities submit annual cost reports to MDHHS LTCRD.
Step 2	LTCRD reviews the cost reports and: a. For initial rate setting - Determines if the cost report was filed appropriately and accepts the cost report for interim rate setting by loading the filed cost report into the Long-Term Care Application (LTCA). b. For final rate setting - Uses the audited cost report to create a final rate. *The following steps are followed for both initial and final rate setting.*
Step 3	LTCA separates the costs into variable*, plant*, and add-on* categories.
Step 4	The LTCA rate-setting application 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	LTCRD indexes base costs* per day to the beginning of the State's fiscal year and calculates a support-to-base ratio* to establish a facility-specific variable cost.
Step 6	LTCRD adjusts the variable and plant-per-day costs by upper limits, ceilings, or floors grouped by facility type and bed size.
Step 7	LTCRD determines the Medicaid reimbursement rate for routine patient days by adding the adjusted variable and plant-per-day costs.
Step 8	LTCRD calculates the add-ons for nurse aide testing, training, and quality assurance supplement for eligible facilities.

Source: The OAG prepared this exhibit based on the Michigan Medicaid Provider Manual.

** 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

Business Process for Long-Term Care Cost Report Rate Setting, Audits, and Settlements



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

FOLLOW-UP METHODOLOGY, PERIOD, AND AGENCY RESPONSES

METHODOLOGY

We reviewed MDHHS's corrective action plan and applicable MDHHS policies and procedures, and interviewed applicable MDHHS management and staff. Specifically, we:

- Gained an understanding of MDHHS's current processes related to its LTC Medicaid reimbursement rate setting, audit, and cost settlement process for services provided by LTC facilities to determine if any reimbursement methodology changes were implemented.
- Reviewed various meeting materials between MDHHS and its stakeholders regarding alternative reimbursement methodologies.
- Interviewed MDHHS management to obtain an understanding of MDHHS's rate reform funding requests.
- Reviewed MDHHS's LTC services appropriation line item for fiscal years 2025 and 2026 to determine if additional rate reform funding was received.
- Researched other states' reimbursement methodologies.

PERIOD

Our follow-up generally covered October 1, 2024 through March 31, 2026.

AGENCY RESPONSES

Our follow-up report contains 1 recommendation. MDHHS agrees with the recommendation.

The agency preliminary response to the follow-up 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* requires an audited agency to develop a plan to comply with the recommendations and submit it to State Budget Office (SBO) upon audit completion. The State of Michigan Financial Management Guide (Part VII, Chapter 3, Section 100) requires the audited agency to develop the plan as early as practicable and within 60 days after report issuance and submit the plan to Office of Internal Audit Services (OIAS), SBO. Within 30 days of receipt, OIAS will either accept the plan as final or contact the agency to take additional steps to finalize the plan.

GLOSSARY OF ABBREVIATIONS AND TERMS

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.

agency plan to comply — The response required by Section 18.1462 of the *Michigan Compiled Laws* for an audited agency to develop a plan to comply with Office of the Auditor General audit recommendations and submit the plan to SBO upon audit completion. The State of Michigan Financial Management Guide (Part VII, Chapter 3, Section 100) requires the audited agency to develop the plan as early as practicable and within 60 days after report issuance and submit the plan to the OIAS, SBO. Within 30 days of receipt, OIAS will either accept the plan as final or contact the agency to take additional steps to finalize the plan.

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 Centers for Medicare and Medicaid Services, 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.

CHAMPS — Community Health Automated Medicaid Processing System.

cost report — A formal compilation of the nursing facility ownership, financial, and statistical data in MDHHS-prescribed format. This data 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.

LTC	Long-Term Care.
LTCA	Long-Term Care Application.
LTC RARSS	Long-Term Care Reimbursement and Rate Setting Section.
LTCRD	Long-Term Care Reimbursement Division.
material condition	A matter, in the auditor's judgment, which 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.
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.
OIAS	Office of Internal Audit Services.
PDPM	Patient-Driven Payment Model.
performance audit	An audit which 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.
SBO	State Budget Office.
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 the 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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