

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519



July 15, 2009

Mr. Stephen Fitton, Acting Director
Medical Services Administration
Michigan Department of Community Health
400 South Pine Street
Lansing, Michigan 48933

Dear Mr. Fitton:

Enclosed for your information is a Centers for Medicare & Medicaid Services (CMS) Final financial management review report entitled "Review of Medicaid Claims Related to Michigan Local Health Departments". The report control number is 05-FS-2006-MI-004-F.

The State commented to the draft report in a response dated January 4, 2008 and disagreed with all the findings. The State's positions have been summarized in the body of the report with the entire response being incorporated as Attachment B.

The CMS considered the State's response and has decided to eliminate the two findings related to indirect costs and the one finding concerning oversight. The final report was revised to reflect these changes. The CMS maintains the financial finding related to full cost reimbursement of Qualified Health Plan (QHP) encounters and expects the State to refund the financial amount identified in the report. The CMS is also preserving the finding related to revising the reimbursement language included in the State Plan by submitting a State Plan amendment.

We would like to thank Michigan Department of Community Health for their time, assistance and cooperation in the performance of this review. If you have any questions, please contact Thomas Caughey, Funding Specialist for Michigan, in Lansing at (517) 487-8598.

Sincerely,

A handwritten signature in black ink, appearing to read "Vernon Johnson". The signature is written in a cursive style with some loops and flourishes.

Vernon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures



**REVIEW OF MEDICAID CLAIMS RELATED TO MICHIGAN LOCAL
HEALTH DEPARTMENTS**

State of Michigan Fiscal Year 2004
October 1, 2003 through September 30, 2004

Control Number: 05-FS-2006-MI-004-F

Date Issued:

Prepared by:
Michigan, Minnesota, Wisconsin
Financial Management Branch
Division of Medicaid and Children's Health Operations
Chicago Regional Office

EXECUTIVE SUMMARY

The Michigan Department of Community Health (MDCH) utilizes Medicaid as a funding source for several services provided by the State through public entities, including services provided by local health departments (LHD). The Centers for Medicare and Medicaid Services (CMS) staff reviewed this area to gain a better understanding of the State and LHD Medicaid claims and to determine if the State is meeting current Federal requirements. CMS interviewed State staff and reviewed cost reports that the State used to develop the Federal Medicaid claim.

We reviewed 43 cost reports, including State procedures and policies related to the development of those reports, and identified two areas of concern. These areas are 1) the impermissible claims for services provided to Qualified Health Plan (QHP) beneficiaries and 2) a State Plan reimbursement methodology which is not sufficiently detailed to fully document the methodology.

Consequently, we recommend the following:

- The State returns \$5,771,386 FFP for impermissible claims by LHDs for unreimbursed costs of services provided to QHP beneficiaries, as these services were paid for by the QHP. The State also adjusts all similar claims submitted subsequent to the claims identified in this report to eliminate claims for services provided to QHP beneficiaries.
- The State submit a State Plan amendment to revise Attachment 4.19B reimbursement language for LHDs to come into compliance with Federal requirements.

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A. INTRODUCTION

The Medicaid program is a joint Federal-State program established in 1965 in which the Federal government provides Federal financial participation (FFP) to States to reimburse certain costs of providing medical treatment to needy individuals. It is authorized under title XIX of the Social Security Act (the Act) and is administered according to each State's approved State plan. States have flexibility in designing Medicaid Programs, but must comply with Federal requirements specified in Medicaid statute, regulations, and program guidance.

Each State's Federal medical assistance percentage (FMAP) varies, determined by a statutory formula described in section 1905(b) of the Act and implemented through Federal regulations at 42 CFR 433.10.

The Centers for Medicare and Medicaid Services (CMS) ensure that statutory requirements within the Medicaid Program are met. Sections 1902(a)(2), 1903(a) and 1905(b) of the Act require States to share in the cost of medical assistance and the administration of the State plan. Federal regulations based on these sections of the Act establish guidelines with which States must comply to receive FFP.

In Michigan, the Medicaid Program is administered by the Michigan Department of Community Health (MDCH). MDCH is organized into various organizational units including the Medical Services Administration, which is the State Medicaid Agency.

Michigan has 45 local health departments (LHD) that provide services throughout Michigan's 83 counties. LHDs are in a unique position to coordinate and eliminate duplication of services in the community. As providers, LHDs can use various funds to provide a wide array of health services and related activities, including, but not limited to, family planning services, maternal and child health services, services to children with special health care needs, and dental services.

When LHDs provide services to Medicaid beneficiaries, these services can be billed to the State as fee-for-service (FFS) claims or billed to Medicaid qualified health plans (QHPs). The vast majority of Medicaid beneficiaries are mandatory enrollees in QHPs under Michigan's 1915(b) managed care waiver.

State Plan Requirements

Federal policy requires that a State Plan include language in a sufficient amount of detail to fully explain the reimbursement process that will be followed for each provider. The cost report and related instructions used to develop the Medicaid claim must also be submitted and approved by CMS. Michigan's approved State Plan permits LHDs to finance the non-Federal share of Medicaid services provided by them. To simplify the

funding flows, LHDs in Michigan provide the non-Federal share by completing an annual cost report and certifying that the total computable amounts have been expended.

Michigan's current State Plan relating to public clinic reimbursement was approved in 1998 and contains broad language that states, in part:

“The methodology for achieving full cost reimbursement is fee-for-service billings which are subsequently cost settled. To participate in this methodology, qualified providers must supply the Program with a Medicaid cost report which lists medical costs, revenue, and encounters for services covered by this section. Based on the Medicaid cost report, a provider specific encounter rate is determined and used to make initial full-cost payments which are made on a quarterly basis, as applicable”

Fee-For-Service Claims

The State processes direct fee-for-service billings from the LHDs through the Medicaid Management Information System (MMIS) which checks provider eligibility, beneficiary eligibility, and pays a specified fee screen amount for each eligible service.

Michigan Qualified Health Plan Claims

Michigan's QHPs are entities that assume full financial risk on a prospective basis for the provision of health care services according to the State contracts. This relationship and corresponding requirements are specified in 42 CFR 438. In Michigan, QHPs are entities organized under Michigan law as health maintenance organizations (HMOs).

As HMOs, QHPs assume risk and make arrangements with health care providers and institutions, such as LHDs, to assume all or part of the financial risk of providing the covered services. It would be a duplication of payment for the State to pay LHDs for services that are included in the base capitation rates for the QHP population. Therefore, claims for QHP enrollee services are not processed through the MMIS. Instead, LHDs must bill the QHP carrier directly. The State's contract language with QHPs, and LHD policy pages, determines whether the QHPs pay for certain LHD services through a contract with the LHDs or, if no contract exists, as out-of-plan services. Regardless of the situation, the QHPs must pay the LHDs for immunizations, sexually transmitted disease treatment, tuberculosis diagnosis and treatment, family planning services, blood lead testing for children up to 6 years old, and hearing and vision screening. Language must exist in the contract that states reimbursement for the out-of-plan and contracted services are to be paid at fair market rate or Medicaid rate for similarly situated enrollees served by a non-LHD provider. This language meets 42 CFR 438.210 demonstrating that MDCH has made QHP contract requirements that address coverage and authorization of special services.

We reviewed documentation relating to the development of the QHP capitation rate and the services documented as being included in that rate and determined that the services provided by the LHDs are included in the capitation rates for the QHPs. We contacted

the State to confirm our understanding of the rates and subsequently have not been provided documentation that would show otherwise. Provisions at Section 1903(m)(1)(A) (of the Act) and 42 CFR 438.60 specifies that the state must ensure no payment is made to a provider other than the managed care organization (MCO) for services available under the contract between the State and MCO.

After careful review of all material obtained during this review, it is clear that LHDs can only recover costs of providing services to QHP enrollees through arrangements with the QHP. The full cost reimbursement methodology is only applicable to fee-for-service billings as specified in the Michigan State Plan. In addition, the majority of LHD/QHP contracts specifically states that payment from the QHP will be considered payment in full and no other entity may be billed for the services.

Local Health Department Cost Report

The payment cycle is completed annually when a cost report is filed. The LHD cost reports are filed annually with the State five months after the end of the normal fiscal period. A procedure exists for 30-day extension of the due date granted for good cause. The cost report from the public provider is filed certifying, to the State, the actual costs of providing services.

An initial settlement is generally completed within three months of a complete and acceptable cost report. MDCH provides interim payments to the LHD that supplement the difference between payments from fee-for-service and QHP services and its actual costs. Settlements to the LHDs follow a written procedure published in the State's Medicaid Provider Manual, Local Health Department chapter. Final settlements for LHDs are generally completed within one year of the end of the fiscal year using updated Medicaid data for the period covered by the LHD cost report.

The Federal government reimburses the State at the permissible Federal matching rate. Local health departments in turn receive and retain 100 percent of the FFP related to Medicaid services.

B. PURPOSE AND SCOPE

The objectives of the review were 1) to gain an understanding of the services and activities provided by LHDs, and 2) to determine if allowable, allocable, and reasonable expenditures were properly documented by LHDs.

The review focused on the claims submitted for reimbursement by LHDs during the State fiscal year (SFY) 2004 that runs from October 1st through September 30th. Aggregate LHD claims totaled \$25,086,047 (\$15,002,395 FFP) on SFY 2004 cost reports.

The review was performed on a selective basis and tests of appropriate records, controls, and operations were made to the extent deemed necessary. CMS staff reviewed the

State's Medicaid provider manual, the approved Medicaid State Plan, as well as the State's accounting records for the specified year to identify and document the amounts certified. Interviews were held with various State personnel to obtain an understanding of the reporting practices and procedures used by MDCH as well as to obtain the documentation deemed necessary to meet the objectives of the review.

C. FINDINGS AND RECOMMENDATIONS

CMS reviewed 43 cost reports and State procedures and policies related to the development of those reports. Two areas of concern are reported with specific findings and recommendations. The areas of concern include impermissible claims for services provided to Qualified Health Plan beneficiaries and a State Plan reimbursement methodology which does not meet requirements to fully describe the methodology. Attachment A details the financial amounts identified for each LHD.

Michigan's State Plan has very broad language describing the methodology used to determine reimbursement. It simply says that the methodology for achieving full cost reimbursement is fee-for-service billings reported on the Medicaid cost report, which are subsequently cost settled. Based on the Medicaid cost report, a provider specific encounter rate is determined and used to make initial full-cost payments that supplement the difference between a LHD's actual cost of services and the fee-for-service payments from the State and payments from the QHPs.

Although briefly mentioned in the State Plan, an all inclusive rate per encounter is crucial to understanding the final method of payment to LHDs. MDCH identifies, counts, and totals face-to-face contact between a patient and the provider called an encounter. A total encounter count is used to determine a per encounter rate by dividing the fully loaded cost of covered services by the total encounters. Finally, the encounter rate is in turn multiplied by the total Medicaid fee-for-service and QHP encounters to calculate a total Medicaid cost.

In the paragraph above, the encounter rate is calculated from a numerator that includes a fully loaded cost of covered services. The State Plan does not identify allowable costs or their allocation method; thus not fully describing the reimbursement methodology. CMS found countywide costs may be allocated to the LHDs and included in indirect costs.

All 43 cost reports allocated administrative costs to covered services and other facility costs based on the percentage of costs related to each area. The total cost of covered services is the sum of the identified reimbursable service costs plus the applicable portion of the administrative overhead costs.

Finding #1 – Non-allowable Settlements for Qualified Health Plan Costs

Both the Social Security Act and Federal regulations restrict payment for services available under MCO arrangements. Section 1903(m)(1)(A) (of the Act) and 42 CFR

438.60 directs that the State must ensure no payment is made to a provider other than the managed care organization (MCO) for services available under the contract between the State and MCO. In addition, the Michigan State Plan references fee-for-service billings and makes no mention of the inclusion of QHP services in the reimbursement methodology.

As discussed previously in this report, LHDs submit bills to QHPs for allowed out-of-plan services and/or services under contract. The QHPs reimburse the LHD for a contracted amount, which may or may not be equal to the Medicaid fee screen. The managed care providers are paid an actuarially sound capitation payment per enrollee to cover the cost of providing services otherwise covered under the Medicaid FFS program, including family planning services. Federal dollars pay the appropriate share of the Medicaid capitation payments.

Financial implications resulting from decisions made by LHDs to provide services to QHP clients are outside the scope of the Medicaid program. Medicaid has already covered the cost of services through the capitation payments to the QHPs. Any subsequent gains or losses that accrue to LHDs as a result of individual business decisions to provide services to QHP clients have no impact on Medicaid funding.

Moreover, the contracts between the QHPs (identified as The Plan) and the LHDs (identified as the Primary Care Provider) contain a section under Payment for Services that specifies:

“The Primary Care Provider accepts the compensation as full compensation for all covered services rendered to Enrollees. Primary Care Provider agrees that it and staff shall not have any claim against or bill, charge, or seek compensation, remuneration, or reimbursement, from the Plan, MDCH, or any other local, State or Federal agency, for costs incurred in providing covered services to enrollees under this agreement”.

However, our review disclosed that Medicaid funds were being claimed through the LHD cost settlements to cover shortfalls from QHP payments. The Medicaid eligible encounters being counted include both fee-for-service individuals and individuals enrolled in QHPs. This inclusion violates the contracts between the LHDs and the QHPs, is omitted from the approved State Plan, and effectively results in duplicate payments since Medicaid has already paid for these services in the capitation payments to the QHPs. We identified the impermissible amount claimed on FY 2004 LHD cost reports related to QHP beneficiaries to be \$5,771,387 FFP. The results of our calculations are included in Attachment A to this report.

Recommendations

We recommend:

1. The State makes a decreasing adjustment of \$5,771,387 FFP on the next CMS-64 quarterly expenditure report for the impermissible amount claimed on FY 2004 LHD cost reports related to QHP beneficiaries.
2. The State adjusts all claims submitted subsequent to the claims identified in this report, to eliminate claims for services provided to QHP beneficiaries.

State Response

The State disagreed with the above finding. The State makes reference to a 1998 letter from Walter Kummer, the Chicago Regional Office Associate Regional Administrator at the time, which they assert allows reimbursement for services furnished to Medicaid beneficiaries as long as the supplemental payments are excluded from the capitated payments made to the MCO's. The State confirms the supplemental payments are not included in the MCO rates.

CMS Comments to State Response

42 CFR, Section 438.60, which was issued on June 14, 2002, states, "The State must ensure that no payment is made to a provider other than the MCO...for services available under the contract between the State and the MCO..." This regulation supersedes the 1998 Walter Kummer letter. CMS stands by this finding for the reasons stated above and requests the State return the FFP on the next CMS-64 expenditure reporting the amount of \$5,771,386 FFP. In addition, the State should adjust the claims for all subsequent periods to eliminate the duplicate claims for services provided to QHP beneficiaries.

Finding #2 — Cost Finding Methodology Not Federally Approved

States must provide adequate documentation to CMS that identifies the costs that are being included in Medicaid claims certified by providers and used as the non-Federal share of Medicaid expenditures. FFP is provided only when there is a corresponding and documented expenditure for a covered Medicaid service to a Medicaid recipient. OMB Circular A-87 identifies the types of expenses that may be claimed and acceptable allocation methodologies. It is unclear exactly what costs are being included, or allocated, to the Medicaid program through the LHD cost reports. The State was unable to produce written instructions that specify what costs the LHDs are to include on the cost report. In summary, the State has not demonstrated that it has an adequate cost reporting mechanism to support the use of CPEs to fund the non-Federal share of payment.

In addition, States must submit periodic updates describing the nature and scope of its Medicaid Program and give assurances that it is administrated in conformity with specific requirements of title XIX according to 42 CFR 430.10 to 430.20. Attachment 4.19-B, section 15 of Michigan's State Plan was approved in 1998 and identifies in general terms the reimbursement methodology used for public clinic services. The State Plan specifies, in part:

“The methodology for achieving full cost reimbursement is fee-for-service billings which are subsequently cost settled.” and “Based on the Medicaid cost report, a provider specific encounter rate is determined and used to make initial full-cost payments...” In addition, it is stated that, “Annual cost settlements are performed to ensure that the initial payments were made at reasonable and allowable full cost.”

The LHD cost reports and State Plan reimbursement language do not fully support the cost finding methodology employed for Michigan LHDs and does not reflect the State’s current procedures. Further, the limited narrative included in Section 15 of Attachment 4.19B of the Michigan Medicaid State Plan is insufficient in detail to fully document this methodology. The Centers for Medicare and Medicaid Services is willing to provide technical assistance to the State of Michigan in order to address the requirements of Certified Public Expenditures.

Recommendations

1. The State must submit a 4.19B State Plan amendment to revise the reimbursement language for LHDs to come into compliance with Federal policy that the State Plan language includes a sufficient amount of detail to fully explain the reimbursement process that will be followed. The State Plan must specifically define allowable costs and the allocation methodology. Alternatively, the cost report and related instructions used to develop the Medicaid claim must also be submitted and approved.

State Response:

The State disagreed with this finding and does not believe they are out of compliance with Federal requirements. Their state plan was approved in 1998 without an expiration date and the State is asking what authority, regulatory change or promulgated rule CMS is basing its determination that the State is no longer in compliance with Federal requirements.

CMS Comment to State Response

CMS agrees that the state plan was approved in 1998. However, CMS disagrees with the State’s assertion that they are in compliance with Federal requirements. The Michigan Medicaid state plan is insufficient in detail and does not adequately reflect the current reimbursement methodology being employed. In addition, the costs being included on the LHD cost reports may be subject to deferral until the State can demonstrate that its cost reporting process complies with OMB Circular A-87 and is adequate enough to assure proper funding of the non-Federal share of payment for those services.

The regulation at 42 CFR 430.12(c)(1) states, “The plan must provide that it will be amended whenever necessary to reflect (i) changes in Federal law, regulations, policy

interpretations, or court decisions; or (ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program.”

In addition, the regulation at 42 CFR 447.525(b) requires that the state plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the state plan must be comprehensive enough to determine the required level of FFP and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for Federal financial participation, it is important that the plan's language be clear and unambiguous.

Attachment A
Control Number: 05-FS-2006-MI-004 F

Facility Number	Facility Name	FFP to Eliminate QHP claims			
23-L058	Allegan County Health Department	\$108,641			
23-L016	Barry-Eaton District Health Department	\$95,047			
23-L015	Bay County Health Department	\$47,512			
23-L045	Benzie-Leelanau District Health Department	\$2,059			
23-L004	Berrien County Health Department	\$131,583			
23-L057	Branch-Hillsdale-St. Joseph Community Health	\$27,330			
23-L006	Calhoun County Health Department	\$68,515			
23-L053	Central Michigan District Health Department	\$54,432			
23-L046	Chippewa County Health Department	\$70,901			
23-L009	City of Detroit Health Department	\$1,187,652			
23-L062	Delta-Menominee District Health Dept. – Escanaba	\$54,566			
23-L060	Dickinson-Iron District Health Department	\$84,552			
23-L007	District Health Department #10	\$176,482			
23-L005	District Health Department #2, West Branch	\$85,616			
23-L002	District Health Department #4, Alpena	\$66,632			
23-L017	Genesee County Health Department	\$386,183			
23-L018	Grand Traverse County Health Department	\$1			
23-L055	Huron County Local Health Department	\$44,806			
23-L021	Ionia County Health Department	\$21,195			
23-L008	Jackson County Health Department	\$99,120			
23-L023	Kalamazoo County Health Department/Human Services	\$72,026			
23-L024	Kent County Health Department	\$849,556			
23-L013	Lapeer County Health Department	\$8,690			
23-L026	Lenawee County Health Department	\$65,949			
23-L027	Livingston County Department of Public Health	\$5,348			
23-L010	Luce-Mackinac-Alger-Schoolcraft Health Department	\$108,563			
23-L028	Macomb County Health Department	\$98,870			
23-L054	Marquette County Local Health Department	\$38,008			

23-L031	Midland County Health Department	\$9,396
23-L032	Mid-Michigan District Health Department	\$71,548
23-L056	Monroe County Health Department	\$52,101
23-L003	Northwest Michigan Community Health Agency	\$51,993
23-L051	Oakland County Health Department	\$0
23-L063	Ottawa County Health Division	\$123,145
23-L036	Saginaw County Department of Public Health	\$223,481
23-L059	Sanilac County Health Department	\$45,362
23-L039	Shiawassee County Health Department	\$101,859
23-L038	St. Clair County Health Department	\$465,892
23-L052	Tuscola County Health Department	\$64,200
23-L011	Van Buren County Health Department	\$99,593
23-L042	Washtenaw County Department of Human Services, PH	\$311,943
23-L043	Wayne County Health Department	\$13,616
23-L044	Western U.P. District Health Department	\$77,423
Totals		\$5,771,386

Attachment B



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

January 4, 2008

Verlon Johnson, Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Dear Ms. Johnson:

The Michigan Department of Community Health (MDCH), Medical Services Administration (MSA) is in receipt of the report entitled "Review of Medicaid Claims Related to Michigan Local Health Departments". The report findings recommended a return of \$9,020,652 Federal financial participation for FY 04 and the corresponding amounts for subsequent years.

We have reviewed the report and non-concur with the findings. Each of the findings and the basis for our disagreements are as follows:

Finding #1 – Non-allowable Settlements for Qualified Health Plan Costs

The Centers for Medicare and Medicaid Services (CMS) is recommending the State return \$5,771,386 FFP for impermissible claims for services provided to QHP beneficiaries and reimbursed by the QHP's and the State adjusts all related claims submitted subsequent to the claims identified in this report to eliminate claims for services provided to QHP beneficiaries.

MSA disagrees with the above finding. Attached is a letter received in January of 1998 from Walter V. Kummer, Associate Regional Administrator of the Chicago Regional Office, which states federal financial participation will continue to be available to supplement LHD reimbursement as allowable cost reimbursement for services furnished to Medicaid beneficiaries as long as the supplemental payments are excluded from the capitated payments made by the state to the managed care organizations (MCOs) and implemented in accordance with section 1902(a)(11) and (22)(C) of the Social Security Act and 42 CFR 431.615(c)(4). We have confirmed and assure CMS that these supplemental payments are not included in the MCO rates.

Finding #2 – Overhead Costs Inappropriately Claimed at 90 Percent Enhanced FFP

CMS recommends the State return \$65,241 FFP for overhead costs claimed at the enhanced 90% Federal rate and the State adjust future LHD family claims to only include direct services costs for 90 percent reimbursement.

We disagree with this finding. The cost of providing services includes both direct and indirect services. We consider this organization to be in compliance with CFR 431.615(c)(4), as the Medicaid agency agrees to reimburse the provider for the cost of services. In addition, we follow Medicare cost principles for cost allocations and consider these determinations appropriate.

Finding #3 – Inclusion of Overhead Costs Based on an Unapproved Methodology

Under this finding, CMS is recommending the State return \$3,183,935 FFP for overhead costs calculated using an unapproved cost methodology and that the State submit documentation to the cognizant agency (HHS) for approval of an indirect cost methodology.

Verlon Johnson
January 4, 2008
Page 2

We also disagree with this finding. The indirect cost methodology of OMB circular, A-87, does not limit overhead costs to ten percent (10%). The circular states under G, Interagency Services, that a "standard indirect cost allowance equal to ten percent may be used in lieu of determining the actual indirect cost of the service". Since we determine actual costs we are not required to limit the indirect costs to the ten percent allowance.

Finding #4 – Inadequate State Oversight of Reported Costs

CMS recommends the State implement procedures for the adequate review and audit of cost reports and settlements.

The State disagrees that State oversight is inadequate. There are a number of procedures in place we consider appropriate for an adequate review and audit of cost reports and settlements. While no specific audit of the Medicaid cost report is done, many costs in the report are audited. Each county is subjected to a certified audit, which includes the health department. Each county also has a certified cost allocation plan which audits, reviews and tests statistics and costs. The plan allocates common costs to the various entities within the county, including the health department. Also, some costs and programs within the health department are audited (such as the WIC program costs) by the State of Michigan. When the cost report is received by MDCH's or MSA's Contract Management Section, staff reviews the information based on their knowledge of the specific health department and their review of the Financial Status Reports. Comparisons to prior year costs and verification of calculations are also conducted.

Finding #5 – Cost Finding Methodology Not Federally Approved

Finally, CMS is recommending the State submit a 4.19B State Plan amendment to revise the reimbursement language for LHD's to come into compliance with Federal requirements.

We disagree with this finding as we do not believe we are out of compliance with Federal requirements. Our state plan was approved in 1998 without an expiration date. The previously approved process of reimbursing costs to local health departments has not changed so it has not been necessary for us to amend the State Plan. Please advise under what authority, regulatory change or promulgated rule CMS is basing its determination that we are no longer in compliance with Federal requirements.

We also disagree with the findings that disallow funds for FY 04 and subsequent years and that we have to adjust our claims for LHD services. If CMS requires MSA to amend the State Plan to include a detailed description of a new reimbursement methodology, the State should not be required to adhere to such a change retrospectively. We have been operating under an approved state plan for over ten years. Should CMS require us to change our current reimbursement methodology, this can only be done with a future effective date. It is unreasonable for CMS to recoup funds previously paid under an approved State Plan.

Sincerely,



Paul Reinhart, Director
Medical Services Administration

CC: Cynthia Garraway
Julie Greenway

Refer to: MI 8

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15th Floor
Chicago, Illinois 60603-6201Robert Smedes, Chief Executive Officer
Medical Services Administration
Michigan Department of Community Health
Capitol Commons Center
400 Pine Street
P.O. Box 30479
Lansing, Michigan 48909-7979

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JAN 13 1993

MGA DIRECTOR'S
OFFICE

Dear Mr. Smedes:

I am responding to your inquiry concerning the extent to which full federal financial participation is available when the state is cost settling local health department (LHD)-capitated provider contracted service reimbursements. You indicate that the Department would like to receive federal match for the difference between the LHD's cost of covered services and the Medicaid revenue received from the capitated provider (health maintenance organization, qualified health plan, or clinic plan) as authorized under sections 1902(a)(11) and (22)(C) of the Social Security Act, implementing regulation 42 CFR 431.615(c)(4) and your Medicaid State plan.

To the extent that adjustments have been made under your 1915(b) waiver program to exclude these LHD supplemental payment amounts from the capitated payments made by the state to the managed care organizations, as well as from the base fee-for-service rates for the HMO population for the purposes of calculating the managed care upper payment limits, federal financial participation will continue to be available to supplement LHD reimbursement for the purpose of achieving 100 percent reasonable and allowable cost reimbursement for services furnished to Medicaid beneficiaries. However, it is important to keep in mind that the above referenced provisions do not provide justification for making duplicate or excessive payments to LHDs.

I hope this provides clarification sufficient to permit you to proceed with your LHD cost settlements. If you have any questions, please contact Jim Sims on (517) 323-9660.

Sincerely,


Walter V. Kummer
Associate Regional Administrator
Division of Medicaid and State Operations