MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 19-28

Distribution: Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, State Veterans' Homes, Ventilator-Dependent Care Units

Issued: October 1, 2019

Subject: Omnibus Nursing Facility Cost Reporting Audit & Reimbursement Revisions

Effective: November 1, 2019

Programs Affected: Medicaid

NOTE: Implementation of this policy is contingent upon approval of a State Plan Amendment (SPA) by the Centers for Medicare & Medicaid Services (CMS).

This bulletin describes changes to the Nursing Facility Cost Reporting & Reimbursement Appendix of the Medicaid Provider Manual. The Michigan Department of Health and Human Services (MDHHS) is revising various nursing facility cost reporting, audit and reimbursement policies to comply with the requirements of Michigan Public Act (PA) 612 of 2018, to make processes more efficient and effective to meet the new requirements, and to update certain outdated policies.

The major requirements of Michigan PA 612 of 2018 include:

- A nursing facility cost report must be accepted within 60 calendar days of the filing of the cost report;
- An audit of an accepted cost report must be completed within 21 months;
- An on-site audit cannot last longer than 30 calendar days per cost report year for an individual nursing facility and no longer than 180 calendar days for more than six commonly owned or -controlled nursing facilities (if the provider and MDHHS agree, then the on-site days limit may be waived); and
- A final settlement of an audited cost report must be delivered to the provider within 60 calendar days of the issuance of the Final Summary of Audit Adjustments Notice.

This bulletin is effective November 1, 2019, except as otherwise indicated.

I. Definitions

The following definitions are added to the Definitions section:

Audit	Review of the financial records used to complete a Medicaid cost report for compliance with allowable cost principles and other policy contained in the Medicaid Provider Manual. An audit includes, but is not limited to, a limited-scope audit or an on-site audit.
Audit Adjustment	An adjustment to the cost report after an audit to correct items that are noncompliant with allowable cost principles or other policy contained in the Medicaid Provider Manual. Adjustments can be a direct adjustment (i.e., an adjustment only for the noncompliant item[s]), an extrapolation adjustment, or a combination of the two adjustment methods.
Audit Disallowance	See Audit Adjustment definition.
Completed Audit	Issuance of the Preliminary Summary of Adjustment Notice. Completed audit includes the Exit Meeting with the nursing facility provider, unless the Exit Meeting is waived.
Extrapolation	An audit adjustment methodology that projects an error rate (using valid statistical procedures) for expenses reported on the cost report through the audit of statistically sampled items. The error rate will solely or partially determine the provider's audit adjustments.
Filed Cost Report	A cost report package is only considered filed when all the following conditions are met: ▪ the package is complete; ▪ the cost report calculations are mathematically accurate, reasonable, and consistent; ▪ the completed electronic cost report (ECR) data uses the required software and specified format; ▪ MDHHS audit staff can generate a full cost report applicable to the cost year from the ECR file; ▪ an electronic copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file; ▪ the data meets a set of validation checks contained within the ECR plus the appropriate bed size and certification reporting requirements; ▪ the submitted ECR file includes proper reporting of costs and related cost report allocations in accordance with prior year(s) audit adjustment determinations for like costs or cost reporting issues; and

	▪ the cost report preparation complies with Medicaid policy and cost reporting instructions.
Non-statistical Sampling	An audit sampling method that does not meet the definition of statistical sampling. Under an audit using solely non-statistical sampling methods, extrapolation methods may not be used to determine audit adjustments.
Settlement	The process of reconciling a nursing facility's interim rates based on filed cost report data to audited cost report data. A final settlement is computed after the cost report has been audited, a final rate based on audited data issued, and all appeals have been adjudicated.
Statistical Sampling	An audit sampling method that has the following characteristics: ▪ random selection of the sampled items; ▪ the use of probability theory to evaluate sample results; and ▪ the use of valid statistical procedures. Under an audit that solely or partially uses the statistical sampling method, extrapolation methods may be used to determine audit adjustments.

The following definitions replace the current definitions in the Definitions section:

Cost Report	Reports submitted annually by a nursing facility that is participating in the Medicaid program at a utilization rate on average of at least six Medicaid residents, on MDHHS cost reporting forms. A nursing facility provider with fewer than six Medicaid residents per day must file a "less than complete cost report" and is not subject to audit or rate setting purposes.
Fiscal Year – Facility	For purposes of cost reporting, a nursing facility provider's financial reporting year for tax purposes, normally a 12-month period unless approved for an exception. Exceptions include, but are not limited to, a change in provider ownership, fiscal period end date change, or facility relocation to a replacement facility.
New Facility (for rate-setting purposes)	A nursing facility provider that does not have a current Medicaid historical cost, including a newly-constructed facility, an existing facility that has never before participated in the Medicaid program, a facility that has participated in Medicaid in a different provider class, or an existing facility that qualified as a "No Medicaid" or "Low Medicaid" activity cost reporting provider for two consecutive fiscal years. The consecutive fiscal years must cover a period of at least 24 months in total and may only cover dates in which the facility was enrolled in Medicaid and averaged six or more

	Medicaid residents per day. A nursing facility that has made physical plant additions or renovations, including a total replacement, or a facility that has been sold or resold is not considered a new facility.

II. Cost Reporting

Changes described in this section are effective for cost reporting periods ending on or after November 1, 2019.

A. Cost Report Requirements

The following revisions are made to the Cost Report Requirements subsection.

The completed cost report package submitted to RARSS must include:

- The standardized electronic cost report (ECR) data in accordance with specified formatting and software.
- An electronic copy of the Certification Statement (Worksheet A), which has been prepared and printed from the completed ECR file, and physically signed by an authorized representative of the nursing facility certifying to the accuracy of the prepared cost report.
- A copy of the nursing facility's detailed general ledger and complete (no grouping or summary) trial balance of revenues and expenses. Both documents must be submitted as electronic Excel files.
- A completed cost report submission checklist.
- Copies of supporting workpapers for all Worksheet 1 – A and Worksheet 1 – B adjustments as electronic Word or Excel files (invoices may be submitted as PDF files).

B. Cost Report Acceptance

The following sentence is added to the Cost Report Acceptance subsection:

MDHHS shall accept a non-delinquent cost report no more than 60 calendar days after the cost report is filed.

C. No Medicaid Utilization (Less Than Complete Cost Report)

The following revisions are made to the No Medicaid Utilization (Less Than Complete Cost Report) subsection:

A nursing facility with no Medicaid utilization during a cost reporting period is required to submit a less than complete cost report. Providers with no Medicaid utilization can no longer submit a standard Medicaid cost report.

D. Low Medicaid Utilization (Less Than Complete Cost Report)

The following revisions are made to the Low Medicaid Utilization (Less Than Complete Cost Report) subsection:

A nursing facility with low Medicaid utilization during a cost reporting period is required to submit a less than complete cost report. Providers with low Medicaid utilization can no longer submit a standard Medicaid cost report. "Low utilization" is defined as an average of less than six Medicaid residents per day in the facility for the cost year (i.e., fewer than 1,825 Medicaid nursing days).

E. Corrected Cost Report Due Date

The following revisions are made to the Corrected Cost Report Due Date subsection:

If a cost report is returned to the provider as unaccepted by the LTC Reimbursement and Rate Setting Section (RARSS), the provider is given five business days from the date of the RARSS cost report return letter to resubmit a corrected cost report via File Transfer. Providers will no longer have 15 calendar days to resubmit a corrected cost report.

F. Cost Report Delinquency

The following revisions are made to the Cost Report Delinquency subsection:

A cost report is considered delinquent if it is not received by RARSS within five business days of the date the delinquency and Medicaid payment termination notice is issued. Providers will no longer have 10 business days from the issuance of the notice.

G. Amended Cost Report

The following revisions are made to the Amended Cost Report subsection:

Providers cannot amend an audited cost report, or a filed cost report after the reimbursement rate period using the filed cost report has ended (i.e., a 2017 year-end cost report cannot be amended after it is audited or after September 30, 2019, whichever comes first). Providers will no longer be allowed to amend an unaudited filed cost report after the rate period ends.

III. Plant Cost Certification

Changes described in this section are effective for Plant Cost Certifications submitted on or after November 1, 2019.

A. Plant Cost Certification Eligibility Criteria

The following revisions are made to the Plant Cost Certification Eligibility Criteria subsection:

In addition to the other qualifying criteria, a Plant Cost Certification is available for a provider with capital expenditures that are on average $5,000 or more per licensed bed for a Class I facility and $3,000 or more per licensed bed for a Class III facility in a single cost reporting period. This reflects an update to the $1,500 capital expenditure per licensed bed amount set in 1978. Medicaid will update the capital expenditure per licensed bed amount effective October 1, 2020 and biennially thereafter based on a construction cost index for steel frame buildings and rounded to the nearest $500 (i.e., $5,150 would round to $5,000, and $5,250 would round to $5,500, etc.).

B. Plant Cost Certification Submission

The following revisions are made to the Plant Cost Certification Submission subsection:

- In addition to other submission criteria, a provider must complete the Plant Cost Certification and RARSS must receive the Plant Cost Certification prior to the cost reporting period filing deadline and meet the qualifications to receive an interim reimbursement rate.

- A Certificate of Need (CON) approval letter is no longer required supporting documentation for a Plant Cost Certification submission, even if CON approval is required.

C. Plant Cost Certification Effective Period

The following revisions are made to the Plant Cost Certification Effective Period subsection:

If a Plant Cost Certification is filed after the provider's cost report year end filing deadline but prior to the rate year beginning immediately after the filing deadline, the plant cost reimbursement rate change is only effective on a prospective basis in accordance with the period established by the Plant Cost Certification request receipt date. Plant Cost Certifications filed on or after the rate year beginning after the applicable cost report filing deadline will not be accepted (i.e., if a provider has a December 31, 2018, cost report year end and made a qualifying capital change in 2018, then the provider would need to submit a Plant Cost Certification prior to October 1, 2019, for it to be accepted).

IV. Audit

Changes described in this section are effective for audits beginning on or after November 1, 2019.

A. Audit Timeline (New Subsection)

MDHHS shall ensure that an audit of a cost report is completed no later than 21 months after the final acceptance of a cost report, and that the 21-month period does not include any time associated with any appeal or a charge of fraud filed against the provider. A cost report not audited within the 21 months will be accepted as filed and move to settlement.

B. On-Site Audit (New Subsection)

MDHHS shall complete an on-site audit on an as-needed basis. This replaces the requirement for an on-site audit at least once every four years. The on-site audit shall not last more than 30 calendar days per cost report year for an individual nursing facility and not more than 30 calendar days per cost report year per nursing facility for two or more commonly owned or controlled facilities up to a maximum of 180 calendar days per cost report year (i.e., the on-site audit could last 60 days per cost report year for two facilities, 90 days for three facilities, etc. up to a maximum of 180 days for six or more facilities), unless MDHHS and the nursing facility agree in writing to extend the timeline. An on-site audit will occur where the nursing facility's records are located, regardless of whether those records are located on the nursing facility's premises or elsewhere. A limited-scope audit shall be performed for cost reports in which an on-site audit is not performed.

C. Audit Sampling (New Subsection)

MDHHS shall use statistical sampling, non-statistical sampling, or a combination of sampling methods for selecting items to audit. If a combination of sampling methods is used, then the items that could be selected under the statistical sample cannot be included in the non-statistical sample and vice versa (i.e., if 29 items are selected through a statistical sample out of a possible 500 items, then the other 471 items cannot be included in a non-statistical sample).

D. Scheduling an Audit (New Subsection)

MDHHS will submit an Intent to Audit – Scheduling Notice at least 30 calendar days prior to the intended audit start date. The audit start date may take place no more than 10 business days after the intended audit start date or on a date prior to the intended audit start date. The provider must provide a response to the notice within five business days, otherwise the audit will begin on the intended audit start date. If the intended audit start date does not work for the provider, then they must notify MDHHS within five business days and provide alternative dates for the audit. If a mutually agreed upon audit start date cannot be selected, then the audit will commence on the intended audit start date.

E. Availability of Information

The Availability of Information subsection is revised to read as follows:

The nursing facility must have an accounting and records maintenance system to provide accurate cost, revenue and statistical data, and other information that can be verified by MDHHS Bureau of Audit staff or their designees. Documentation must be provided to support the actual expenditure of costs; non-actuarial estimates are not allowable supporting documentation.

Prior to the audit start date, MDHHS staff will submit an Audit Engagement Notice to the provider via File Transfer. This notice will include a list of the required documentation and the consequences for unavailable documentation. The documentation required by the Audit Engagement Notice must be available to MDHHS within 15 business days. If none of the documentation requested in the notice is available within 15 business days, then MDHHS will move to schedule an Exit Meeting. If some of the documentation is available, then the provider will have two or five business days to submit the unavailable documentation; two business days for an individual facility and five business days for two or more commonly owned or controlled facilities. If documentation is not released within the timeframes described in this paragraph, then the costs in question will be preliminarily disallowed and the provider may not submit the unavailable documentation until the Exit Meeting.

While reviewing available documentation, MDHHS may determine that additional documentation is necessary to support an expense. MDHHS will submit a written request to the provider, and the provider will have two or five business days to submit the additional documentation; two business days for an individual facility and five business days for two or more commonly owned or controlled facilities. If the documentation is not released within the timeframes described in this paragraph, then the costs associated with the item in question will be preliminarily disallowed and the provider may not submit the unavailable documentation until the Exit Meeting.

MDHHS will no longer assess a financial penalty for documentation that is unavailable after 15 business days of a written request. MDHHS will move to schedule an Exit Meeting or audit other expenses after the timeframes described in this subsection have passed, even if requested documentation is not made available.

F. Extrapolation (New Subsection)

MDHHS may use extrapolation methods to determine audit adjustments for expenses included in the sampling universe (i.e., all items that have a chance to be sampled in a random sampling process) in a statistical sample. The provider will be notified if extrapolation methods were used in the Exit Meeting Summary of Audit Adjustments Notice, the Preliminary Summary of Audit Adjustments Notice, and the Final Summary of Audit Adjustments Notice. The notice will include the sampling selection methodology, the sample size, the disallowed expenses, and the extrapolation formulas and calculations. The Preliminary Summary of Audit Adjustments Notice will also

include the provider's appeal rights, which include the ability to appeal the extrapolation methods used to determine the audit adjustment.

G. Exit Meeting (New Subsection)

An Exit Meeting is a meeting offered to the provider to be held within five business days after the completion of the audit work to communicate the audit results to the provider and to obtain the provider's comments on the proposed findings of the audit prior to the issuance of the Preliminary Summary of Audit Adjustments Notice. The offer to schedule an Exit Meeting will be sent to the provider in the Exit Meeting Summary of Audit Adjustments Notice. To schedule an Exit Meeting, a provider must specify dates and times for the meeting to take place that are within five business days of the written offer to schedule a meeting. An Exit Meeting may be scheduled prior to the issuance of the Exit Meeting Summary of Audit Adjustment Notice, but if the scheduled Exit Meeting does not occur within five business days of the issuance of the Exit Meeting Summary of Audit Adjustments Notice, then the meeting date must change to occur within five business days of the notice. An Exit Meeting may be held in person, via telephone, or via electronic correspondence (i.e., email, video chat, etc.). If a provider does not attend a scheduled Exit Meeting, then the provider forfeits their right to an Exit Meeting. The provider may designate an authorized representative to attend the Exit Meeting (e.g., their cost report preparer, etc.).

In addition to the offer to schedule an Exit Meeting, the Exit Meeting Summary of Audit Adjustments Notice will contain a summary of MDHHS' proposed audit adjustments. The provider may submit additional information related to a proposed audit adjustment at the Exit Meeting and for up to two business days after the Exit Meeting (or within five business days of the Exit Meeting Summary of Audit Adjustments Notice if an Exit Meeting is not held). MDHHS will not consider any additional information related to a proposed audit adjustment after two business days have passed from the date of the Exit Meeting (or five business days from the issuance of the Exit Meeting Summary of Audit Adjustments Notice if an Exit Meeting is not held).

H. Completed Audit (New Subsection)

A completed audit is represented by the issuance of the Preliminary Summary of Audit Adjustments Notice. The Preliminary Summary of Audit Adjustments Notice will be issued after the Exit Meeting is held or waived.

I. Reopening Audit Determinations

The following revisions are made to the Reopening Audit Determinations subsection:

MDHHS will not reopen an audit determination for any reason other than fraud beyond the 21-month period described in the Audit Timeline subsection. This replaces the policy allowing an audit to be reopened for non-fraud reasons for up to three years following the final settlement.

V. Cost Report Reimbursement Settlements

A. Final Settlement Timeline (New Subsection)

MDHHS shall issue a Notice of Program Reimbursement for a final settlement not more than 60 calendar days after the issuance of the Final Summary of Audit Adjustments Notice or no more than 60 calendar days after the Preliminary Summary of Audit Adjustments becomes the Final Summary of Audit Adjustments Notice.

VI. Allowable Costs and Non-Allowable Costs

A. Interest

The following bullet is added to the Interest subsection:

- For loans issued on or after November 1, 2019, interest on loans, to be allowable, must reflect a principal balance payment on at least an annual basis if the loan is greater than 4 years old. For loans issued prior to November 1, 2019, interest on loans, to be allowable, must reflect a principal balance payment on at least an annual basis starting on November 1, 2023. Refinancing of a loan or refinancing of multiple loans is not considered a principal balance payment, nor is a refinanced loan considered a new loan for purposes of this section.

VII. Cost Classifications and Cost Finding

A. Related or Chain Organization Cost Allocation

The following revisions are made to the Related or Chain Organization Cost Allocation subsection:

For cost reports where the home office and the individual nursing facility's fiscal year ends are different, a provider must elect to forego the inclusion of an allocation of the current year's home office costs in the current year's individual provider cost report. A written request must be submitted annually to RARSS, with the individual provider's cost report signed by the appropriate corporate official acknowledging that the cost report is being submitted with the prior fiscal year's home office costs. The written request must also indicate that the corporation is waiving the right to inclusion of any allocation of the current year's home office costs in the current year's individual provider cost report. Providers will no longer amend the provider cost report to include complete cost data when the home office has a different fiscal year.

For example, a home office fiscal year end (FYE) is December 31 and the individual facility's FYEs are May 31, August 31, September 30 and December 31. For individual facility cost reporting for fiscal year 2018 ending in May, August, September and October, the individual facility must elect to report only the home office costs from the FYE December 31, 2017, home office cost report. The home office allocation of costs from FYE December 31, 2017, to the individual facility would be reported and audited.

During the audit of the individual facility cost report, adjustments to allocate actual FYE December 31, 2018 home office costs would not be made. For individual facilities with FYE December 31, 2018, the home office costs from FYE December 31, 2018 cost report would be reported.

This change is effective for cost reporting periods ending on or after November 1, 2019.

VIII. Rate Determination

A. Rate Determination

The following revisions are made to the Rate Determination section:

If the cost reporting period of the Medicaid routine unit is less than seven months, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months. The cost reporting period may only cover dates the facility was enrolled in Medicaid and averaged six or more Medicaid residents per day.

B. Retroactive Rate Changes

The following revisions are made to the Retroactive Rate Changes subsection:

A retroactive change may be made for facilities that have interim prospective rates based on filed cost reports. Retroactive changes may be made for, but are not limited to, the following:

- audit adjustments to a filed cost report that was used for setting an interim rate;
- facilities that filed timely and were approved for Plant Cost Certification due to capital cost changes, an approved non-available bed plan, a plant rate affected by a DEFRA rate limitation for the cost report period, or when an interim rate was incorrectly calculated;
- audit adjustments that are required because of an appeal;
- audit adjustments that are required because of fraud or facility failure to disclose required financial information; and
- Class I nursing facilities approved for Rate Relief for the rate year period.

C. Tenure Factor

The following revisions are made to the Tenure Factor subsection:

The tenure factor is dependent on a provider's number of full years of continuous Medicaid certification as of the beginning of the Medicaid rate year (i.e., months of continuous Medicaid certification divided by 12 and disregarding fractions). The continuous Medicaid certification is based on the current ownership of the nursing facility. The tenure factor will no longer be tied to continuous years of licensure.

Continued Medicaid certification is based on the number of full years that have elapsed from the effective date of a provider's initial Medicaid certification to the beginning of the Medicaid rate year. For example, a provider that has been Medicaid certified for 42 continuous months has, for purposes of the tenure factor, been certified for three full years.

D. Facility Plant Cost Limit Per Resident Day

The following revisions are made to the Facility Plant Cost Limit Per Resident Day subsection:

The nursing facility must meet the filing requirements and complete the Plant Cost Certification process to qualify for consideration of the update to the individual facility Plant Cost Limit. A plant cost certification filed after the applicable period's cost report will not be accepted for calculation of an updated facility plant cost limit. The provider must meet the qualifying provisions for Plant Cost Certification eligibility, other than non-available bed designation or returning non-available beds to service, to be eligible for a revised plant cost limit.

E. Class V – Ventilator Dependent Care (VDC) Units

The following revisions are made to the Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units subsection:

A new VDC nursing unit that has not previously participated in Medicaid for VDC services will have a reimbursement rate in the initial two years (24 months) of Medicaid operations (from the date of admitting the first Medicaid beneficiary) based upon the statewide average VDC unit reimbursement rate for the current year.

F. Variable Cost Component (VCC) – Class I and Class III Facilities

The following revisions are made to the VCC – Class I and Class III Facilities subsection:

The Variable Rate Base for the new facility and provider will be determined using special methods. During the first two cost reporting periods, new facilities and facilities with a change of class will have a Variable Rate Base equal to the Class Average of Variable Costs. The first two cost reporting periods must cover a period of at least 19 months (the first cost reporting period must cover a period of at least seven months and the second cost reporting period must cover a period of 12 months) and the facility must have averaged six or more Medicaid residents per day. This rate base will be used in the calculation of the nursing facility Variable Cost Component as outlined in the policy for the respective nursing class. In subsequent periods, the nursing facility's Variable Rate Base will be determined using the methods described in the Rate Determination section of the Nursing Facility Cost Reporting & Reimbursement Appendix.

G. Facility Innovative Design Supplemental (FIDS) Program Change of Ownership

The following revisions are made to the FIDS Program Change of Ownership subsection:

The new owner must notify RARSS via File Transfer within 45 calendar days of the change of ownership if the facility is going to continue participation in the FIDS program, or RARSS will assume participation has been discontinued and end FIDS reimbursement supplemental payments.

H. Rate Relief Eligibility Criteria

The sixth criterion for rate relief qualification under the Rate Relief for Class I Nursing Facilities, Eligibility Criteria subsection (last bullet point) is revised to read as follows:

A nursing facility may qualify for rate relief (if all other applicable criteria is met) if their current actual variable costs are less than or equal to 60 percent of the corresponding rate year's Variable Cost Limit. A facility is not eligible under this criterion if an owner's or administrator's compensation is above the current compensation limit. A provider with non-allowable related party transaction costs or non-allowable related party lease costs is not eligible under this criterion. This criterion replaces the criterion allowing a provider to qualify for rate relief if their Variable Rate Base is less than or equal to 60 percent of the Variable Cost Limit.

I. Rate Relief Petition Process

The following revisions are made to the Rate Relief Petition Process subsection:

A petition is not considered filed or complete unless all required supporting documentation is filed with the petition request.

J. Rate Relief Agreement

The following revisions are made to the Rate Relief Agreement subsection:

If RARSS issues a written notice of approval for rate relief, an authorized representative from the nursing facility must sign and submit the rate relief approval agreement included in the letter to RARSS via File Transfer within 30 calendar days of the issuance of the notice. If the signed rate relief approval agreement is not submitted to RARSS within this time frame, then the rate relief approval is rescinded.

K. Rate Relief Period

The following revisions are made to the Rate Relief Period subsection:

Rate relief is effective on a prospective basis beginning in the month after receipt of the request and all required supporting documentation by RARSS.

IX. Appeal Process

A. Audit Appeals

The Audit Appeals subsection is revised to read:

Each nursing facility cost report is audited to ensure that expenses were reported in adherence with Medicaid policy. Once the Exit Meeting is completed or waived, the provider is given a Preliminary Summary of Audit Adjustments Notice via File Transfer. This notice outlines audit results, serves as the adverse action notice, and advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 calendar days from the date of the Preliminary Summary of Audit Adjustments Notice to request a formal hearing in accordance with MDHHS rules for hearings.

If the provider or the provider's designee does not respond to the Preliminary Summary of Audit Adjustments Notice within 30 calendar days of the date of the notice, then the Preliminary Summary of Audit Adjustments Notice will serve as the Final Summary of Audit Adjustments Notice. If the appeal process is exhausted, the provider will receive a Final Summary of Audit Adjustments Notice. The Final Summary of Audit Adjustments Notice outlines the final audit results and may not be appealed. A Preliminary Summary of Audit Adjustments Notice that serves as a Final Summary of Audit Adjustments Notice is also not appealable. Providers will no longer be able to request an Area Office Conference to contest the results of an audit.

To ensure faster processing of final settlements, a provider should notify MDHHS via File Transfer if they are not appealing any of the audit adjustments in the Preliminary Summary of Audit Adjustments Notice.

If a provider does not appeal or does not respond to the Preliminary Summary of Audit Adjustments Notice or other notices or processes related to a conference or hearing within the allotted timeframe, the provider has waived the right to any further administrative review.

These changes are effective for audits beginning on or after November 1, 2019.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Kate Massey, Director
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