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GOVERNOR

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DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF AUDIT
400 S. PINE; LANSING, MI 48933

JAMES K. HAVEMAN
DIRECTOR

April 18, 2014

Tom Watkins, Executive Director
Detroit Wayne Mental Health Authority
640 Temple, 8th Floor
Detroit, Michigan 48201-2555

Dear Mr. Watkins:

Enclosed is our final report from the Michigan Department of Community Health (MDCH) audit of the Detroit-Wayne Community Mental Health Agency for the period October 1, 2010 through September 30, 2011.

The final report contains the following: description of agency; funding methodology; purpose; objectives; scope and methodology; conclusions, findings and recommendations; Schedule of Audit Adjustments, Adjusted Financial Status Reports, Adjusted Contract Reconciliation and Cash Settlements, Original and Revised Settlement Amounts Schedule, and Corrective Action Plans. The Corrective Action Plans include the Agency's paraphrased response to the Preliminary Analysis, and the Office of Audit's response to those comments where necessary. Please pay particular attention to the additional comments provided relating to Findings 3 and 4. As you work to develop the provider network going forward, the items addressed in Findings 3 and 4 should be considered and fully addressed.

If the Agency disagrees with the MDCH audit findings, the agency must use the appeal process specified in Attachment 9.3.2.1 of the Agency's contract with MDCH. A request for the Medicaid Provider Reviews and Hearings Process must be sent within 30 days of receipt of this letter to the Administrative Tribunal & Appeals Division.

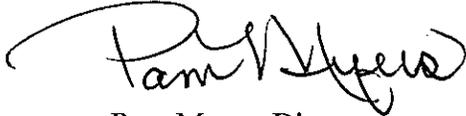
The audit resulted in a Medicaid lapse decline of \$7,458,327, Medicaid Savings decline of \$464,134, and General Fund Carryforward increase of \$3,981,229. The adjusted Financial Status Reports and Contract Reconciliation and Cash Settlement Schedules are shown on pages 17 through 26 of the enclosed final report. The adjusted numbers should be used as a starting point by the Compliance Examination practitioner in completing the revised FYE 2012 Compliance Examination.

Tom Watkins, Executive Director
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Please contact Kidada Smith at smithk67@michigan.gov or (517) 241-5572 to arrange for a return of the Medicaid lapsed funds of \$7,458,327. This amount will be reduced slightly for adjustments related to State Facilities and SED Waiver funding that were identified subsequent to MDCH's FYE 2011 settlement.

Thank you for the cooperation extended throughout this audit process.

Sincerely,



Pam Myers, Director
Office of Audit

Enclosure

cc: Stacie Durant, Chief Financial Officer, Detroit Wayne Mental Health Authority
Lynda Zeller, Senior Deputy Director, Behavioral Health and Developmental Disabilities Administration
Tim Becker, Senior Deputy Director, Operations Administration
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Audit Report

Detroit-Wayne County Community Mental Health Agency

October 1, 2010 – September 30, 2011



Office of Audit
Quality Assurance and Review Section
April 2014

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DESCRIPTION OF AGENCY

The Charter County of Wayne (the “County”) and the City of Detroit (the “City”) established the Detroit-Wayne County Community Mental Health Agency (the “Agency”) for the purpose of providing mental health services for the Wayne County mentally ill and developmentally disabled residents. The Agency also provides mental health services for the Wayne County courts, jails, seniors and juveniles.

The Agency is governed under the provisions of the Mental Health Code (the “Code”), Act 258 of the Public Acts of Michigan of 1974. Under the Code, the Agency is an official agency of the County.¹ The Agency is a division of the County Department of Health and Human Services. A Board of Directors (the “Board”) consisting of 12 members, six appointed by the Mayor of the City and six appointed by the County Executive, governs the Agency. The Board’s actions, however, are subject to the approval of the Wayne County’s Chief Executive Office (the “County Executive”) and the Wayne County Commission. Also, pursuant to the Code, the “County Executive” determines the procedures and policies that shall be applicable to the Agency. The Agency is subject to Federal government and Michigan Department of Community Health (“MDCH”) rules and regulations and the Code, and subject to oversight by MDCH.

The Agency provides administrative oversight, but does not provide direct services to consumers. The Agency contracts with numerous service providers to deliver mental health services, but the majority of the Agency’s funding is disbursed to five provider networks called Managers of Comprehensive Provider Networks (“MCPNs”). The Agency also contracts with Peter Chang Enterprises (“PCE”) to maintain a management information system called MHWIN that collects and maintains eligibility and encounter data for the populations served. PCE created and populated various modules within MHWIN that are used to meet data and financial reporting requirements of MDCH.

FUNDING METHODOLOGY

The Agency’s primary sources of revenue are Medicaid and State General Fund dollars received from MDCH through two separate contracts. The Agency also contracts for other funding from MDCH including, but not limited to, the Michigan ABW Non-Pregnant Childless Adults Waiver Section 1115 Demonstration Program (“ABW Program”). The County provides local match funding as required by the Code, and is responsible for Agency deficits.

Under the Medicaid Managed Specialty Supports and Service Concurrent 1915(b)/(c) Waiver Program Contract (the “Medicaid Contract”), MDCH provided the Agency with both the State and Federal share of Medicaid funds as capitated payments based on a Per Eligible Per Month (“PEPM”) methodology. The Medicaid Contract represents a shared risk arrangement with MDCH whereby some unexpended funds may be retained by the Agency to use in the subsequent period and the rest needs to be returned to MDCH, and some expenditures above the authorization are the responsibility of the Agency and some are the responsibility of MDCH.

¹ The Agency continued as an agency of the County through fiscal year end 2013. Effective October 1, 2013, the Agency became an Authority, a separate legal public governmental entity. Accordingly, the Agency’s structure and governance described herein changed subsequent to the audit period.

Under the Managed Mental Health Supports and Services Contract (the “GF Contract”), MDCH provided the Agency with State General Funds for mental health and developmental disability supports and services to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in Section 208 of the Mental Health Code. The funds were distributed based upon a formula. The GF Contract is not a shared risk arrangement. Up to 5% of unexpended funds may be carried forward and spent in the subsequent year, and the rest needs to be returned to MDCH. Any expenditures above the authorization are the responsibility of the Agency.

Under the Michigan ABW Non-Pregnant Childless Adults Waiver Section 1115 Demonstration Program Contract (the “ABW Contract”), MDCH provided the Agency with ABW Program funds as capitated payments based on a PEPM methodology for ABW-covered mental health and substance abuse services. The ABW Contract represents a full risk arrangement with MDCH whereby any unexpended funds may be retained by the Agency, but the Agency bears the risk that the actual PEPM payments will not cover the expenses for covered services and the risk cannot be covered with the Medicaid Contract funds.

The Agency reports their various revenues and expenditures to MDCH on a Financial Status Report (the “FSR”) and completes a Contract Reconciliation and Cash Settlement (the “CRCS”) showing the dispositions of any surpluses (unexpended funds) or any deficits (expenditures above the authorization). MDCH reviews the FSR and CRCS, and determines a cash settlement. However, MDCH reserves the right to audit the amounts reported and make necessary revisions.

PURPOSE AND OBJECTIVES

The purpose of this audit was to assess the Agency’s compliance with select components of the MDCH contracts, and the Agency’s effectiveness in reporting their financial activity to MDCH in accordance with contractual requirements. The following were the specific objectives of the audit:

1. To evaluate the Agency’s effectiveness in reporting Adult Benefit Waiver (“ABW”) expenditures to MDCH for fiscal year end 2011 in accordance with contractual and applicable statutory requirements.
2. To evaluate payments made to Matrix Human Services for compliance with the Professional Services Contract, and reasonableness of payments in comparison to payments made previously for the same services.
3. To evaluate the Agency’s use of Medicaid Savings earned in fiscal year end 2011, and maintenance of any Medicaid Savings earned in fiscal year end 2012 in compliance with contractual provisions.
4. To identify the origin (Agency or County) and types of reported administrative costs (excluding “delegated administration²”) for fiscal year end 2011; and to determine the allowability of reported administrative costs (excluding “delegated administration” and County chargebacks) for fiscal year end 2011.
5. To determine MDCH’s share of costs in accordance with applicable MDCH requirements and agreements, and to identify any balance due to or from the Agency.

² Delegated administration costs are administration costs incurred by contracted agencies that the Agency reports, but they are not incurred by the Agency.

SCOPE AND METHODOLOGY

We examined the Agency's records and activities for the fiscal period October 1, 2010 to September 30, 2011. Additionally, while performing audit steps to accomplish our objectives, we identified other findings that require corrective action. Those findings are included in the Other Findings Section of this report. Two of the findings (Findings 5 and 6) are "shared issues" requiring corrective action by both the Agency and MDCH.

Our procedures included the following:

- Reviewed the FYE 2011 Single Audit Report and FYE 2011 Compliance Examination Report for any related findings.
- Reviewed the FYE 2011 Compliance Examination workpapers to avoid duplication of efforts.
- Reconciled FSRs to supporting documentation and tested reported expenditures for accuracy and allowability.
- Compared Agency MHWIN System encounter and eligibility data to State Warehouse data to identify discrepancies.
- Reviewed the Medicaid Utilization and Net Cost Report for ABW to identify significant unresolved discrepancies between Agency data and State Warehouse data.
- Tested Matrix Human Services payments for compliance with contract terms, and adequate supporting documentation.
- Evaluated Matrix Human Services payments for reasonableness in relation to amounts previously paid for the same positions.
- Reviewed FYE 2011 Medicaid Savings for proper use in FYE 2012.
- Reviewed FYE 2012 Medicaid Savings for proper retention.

Our audit did not include a review of program content or quality of services provided.

OBJECTIVES, CONCLUSIONS, AND FINDINGS

ADULT BENEFIT WAIVER EXPENDITURE REPORTING

Objective 1: To evaluate the Agency's effectiveness in reporting Adult Benefit Waiver ("ABW") expenditures to MDCH for fiscal year end 2011 in accordance with contractual and applicable statutory requirements.

Conclusion: The Agency was not effective in reporting Adult Benefit Waiver (ABW) expenditures to MDCH for fiscal year end 2011 in accordance with contractual and applicable statutory requirements. We identified two findings (Findings 1 and 2) that resulted in the overstatement of ABW-Mental Health expenditures by 43% for FYE 2011. Due to the issues identified, the impacts on other funding sources were also determined. The reported amounts for numerous programs (Medicaid, ABW, MICHild, and General Fund) were found to be significantly misstated for FYE 2011.

Finding

1. Allocation Report Errors and Eligibility Errors

The Agency misreported costs on the FYE 2011 Financial Status Report due to reliance being placed on erroneous MHWIN-generated allocation reports, erroneous voids of clients' Medicaid eligibility within MHWIN, lack of identification of 100% funded services, and the erroneous inclusion of payments to direct service providers for specific General Fund services in the allocation to other funding categories.

Section 6.6.1 of the Agency's contracts with MDCH require that the accounting and financial systems established by the Agency shall have the capability to identify the application of funds to specific funding streams, and the Agency must assure the proper allocation of costs to the appropriate funding source.

When the Agency provides funding throughout the year to the majority of their service providers, it is generally not specified as to the type of funding (i.e. Medicaid, ABW, MI Child, or General Fund). Rather, the providers receive "blended funding" that is later allocated among the funding sources and reported to MDCH according to encounter and eligibility data contained within the Agency's MHWIN System. This process has been deemed acceptable by MDCH.

The "Encounter Data for Financial Status Report in MHWIN Report" (the "Allocation Report") is used by the Agency to report funding allocations for operational and administrative costs. The Allocation Report shows the total cost of encounters for each provider and how much of those encounters belong to each funding source based on program eligibility and other factors (i.e. Medicaid spend-down and procedure eligibility). The payments to the service providers are allocated among the funding sources based on the pro rata share of the encounters on the date the Allocation Report is generated³.

The Allocation Report and the MHWIN system contained errors that resulted in the misallocation of costs on the FYE 2011 Financial Status Report to MDCH. Seven specific errors were identified as follows:

- a. Consumer data was being duplicated;
- b. Claims for individuals on Medicaid spend-down were not being appropriately moved from Medicaid to General Fund;
- c. Claims for procedure codes that were not eligible for Medicaid were not being appropriately assigned to General Fund;
- d. Medicaid eligibility was incorrectly voided within the MHWIN system for some consumers;
- e. State facility encounters were improperly included in the total cost of encounters for applicable providers and the providers' General Fund funding source for allocation purposes, but these should have been excluded from the allocation calculation since State Facility costs are reported separately on the FSR;
- f. Payments to direct service providers for specific General Fund services were allocated to other funding sources (Medicaid, ABW, and MICHild); and
- g. Services eligible for 100% reimbursement were not properly identified as such.

³ The Allocation Report will change from one day to the next because information within MH-WIN is constantly changing due to eligibility and encounter updates. However, the later the Allocation Report is run, the more accurate it is since it would reflect updated eligibility and encounter data to report costs among funding sources.

During the audit fieldwork, the Medicaid eligibility history was rebuilt for the affected consumers, the Allocation Report was re-written, and other corrections were made. Subsequent to the issuance of the Preliminary Analysis Report, further corrections were made to address the State facility cost issue, proper allocation of payments to direct service providers for General Fund services, and proper designation of 100% reimbursed services. The Agency provided a revised Allocation Report for FYE 2011 that reflects the corrections made, and updated eligibility and encounter information that occurred subsequent to the initial Allocation Report.

The revised Allocation Report changed significantly from the original Allocation Report for numerous programs (ABW, General Fund, and Medicaid) as follows: ABW expenditures had been overstated by more than 18%; General Fund 100% expenditures had been understated by nearly 30%; General Fund 90% expenditures had been overstated by 14%; and Medicaid expenditures had been understated by \$7.9 million. We cannot quantify how much of the differences can be attributed to the corrections made, or to the eligibility and encounter updates since the original Allocation Report was generated. However, the revised Allocation Report for FYE 2011 reflects the necessary corrections and the most current eligibility and encounter data to allocate contractor payments among funding sources.

Adjusting entries are shown on the attached Schedule of Audit Adjustments.

The identified errors continued into the FYE 2012 reporting. The Agency provided a revised Allocation Report and revised FSR for FYE 2012 that reflect corrections made. The FYE 2012 Compliance Examination practitioner will examine the revised FYE 2012 FSR for compliance with reporting requirements.

Recommendation

We recommend that the Agency implement adequate internal controls over data that is processed by service organizations to ensure system-generated reports contain accurate data and the proper allocation of costs to the appropriate funding sources on Financial Status Reports. When reliance is placed on data generated by a service organization for the Agency's financial reporting, as a means of acquiring the necessary assurances about the quality and accuracy of the data, consider either requiring the service organization to engage a certified public accounting firm to report on the controls at the service organization that affect the information provided to the Agency through a Statement on Standards for Attestation Engagement (SSAE no. 16 report), "Reporting on Controls at a Service Organization," or requiring the Agency's auditor to visit the service organization to test its controls. We also recommend that a second party that is familiar with the Allocation Report and FSR reporting requirements review the Allocation Report and FSR for accuracy and to ensure the identified errors do not recur prior to submission to MDCH.

Finding

2. Encounters Coded as ABW for Individuals Not Enrolled in the ABW CMH Benefit Plan

The Agency allocated costs to the ABW Program for mental health services provided to individuals that were not enrolled in the ABW CMH Benefit Plan at the time of service, and paid substance abuse coordinating agencies ABW funds for substance abuse services provided to individuals that were not enrolled in the ABW CMH Benefit Plan at the time of service.

The ABW Contract, Section 7.4.1.2 ABW Payments, states, “MDCH will provide the Prepaid Inpatient Health Plan ABW Program managed care payments each month for the ABW covered services...HIPAA compliant 834 and 820 transactions will provide eligibility and remittance information.” Until ABW capitation payments are received from MDCH based on eligibility and remittance information provided on 834 and 820 reports, costs should not be allocated to the ABW Program and ABW payments should not be made to substance abuse coordinating agencies. Rather, other available funding sources, such as General Fund or the Substance Abuse Block Grant, should pay for these services.

For allocating mental health services costs to various programs, the Agency relies on encounter and eligibility data recorded in their MHWIN system. Additionally, for paying substance abuse ABW services costs to the two coordinating agencies, the Agency relies on encounter and eligibility data recorded in their MHWIN system. The Agency incorrectly uses the ABW Eligibility Date from the 270/271 transaction return file for determining ABW eligibility. This shows retroactive ABW eligibility dates for paying *medical* claims of providers in the physical health community on a fee for service basis. The capitation payments for mental health and substance abuse services, however, are paid prospectively based on the ABW CMH Benefit Plan Date (the date enrolled with the CMH and capitation payments begin). The ABW Eligibility Date does not always correspond with the ABW CMH Benefit Plan Date. In fact, the ABW CMH Benefit Plan Date is often a month or more behind the ABW Eligibility Date. Until the ABW CMH Benefit Plan Date begins according to the 834 and 820 reports and the Agency begins receiving ABW capitation payments, costs should not be allocated to the ABW Program, and payments should not be made from ABW funds to the substance abuse coordinating agencies.

Because of the incorrect use of the ABW Eligibility Date rather than the ABW CMH Benefit Plan Date for determining ABW eligibility, mental health service costs are being allocated to the ABW Program before the respective ABW capitation payments are received, and substance abuse coordinating agencies are being paid for ABW services for individuals served before the Agency receives the respective ABW capitation payments.

Of the total amount of ABW encounters used in the mental health allocation calculation (revised allocation per Finding 1), 17% should not have been included as ABW encounters. Using the correct ABW encounter information by excluding encounters that do not belong as ABW because the client was not yet in the ABW CMH Benefit Plan, the reported ABW expenditure amount declines \$1,386,283. The expenditures should have instead been reported as General Fund. Adjusting entries are shown on the attached Schedule of Audit Adjustments.

Additionally, it appears the Agency overpaid the substance abuse coordinating agencies \$267,409 plus the applicable administration amount for claims showing as ABW, but the Agency is not yet getting the capitation payments for the individuals. The coordinating agencies should likely have paid for the services with Block Grant funds or some other source.

Recommendations

We recommend that the Agency revise the MHWIN system, allocation processes, and coordinating agency payment processes to ensure ABW eligibility is based on ABW CMH Benefit Plan Dates and payment remittance information contained on the 834 and 820 reports, respectively. We also recommend the Agency perform a monthly reconciliation between the 820 and 834 Reports, and revise MHWIN system eligibility information as needed to ensure eligibility agrees with payments according to the benefit plan shown on the 820 report.

MATRIX HUMAN SERVICES CONTRACT PAYMENTS

Objective 2: To evaluate payments made to Matrix Human Services for compliance with the Professional Services Contract, and reasonableness of payments in comparison to payments made previously for the same services.

Conclusion: The Agency's payments to Matrix Human Services complied with the Professional Services Contract, and were found to be reasonable in comparison to payments made previously for the same services.

MEDICAID SAVINGS

Objective 3: To evaluate the Agency's use of Medicaid Savings earned in fiscal year end 2011, and maintenance of any Medicaid Savings earned in fiscal year end 2012 in compliance with contractual provisions.

Conclusion: The Agency's reported fiscal year end 2011 Medicaid Savings was appropriately reported as being used on fiscal year end 2012 expenditures, and reported fiscal year end 2012 Medicaid Savings was appropriately shown as deferred revenue (funding that was unearned at September 30, 2012 and will be carried over to be expended in the subsequent fiscal year) on the Agency's audited financial statements. No exceptions were noted relating to this objective.

ADMINISTRATIVE COSTS

Objective 4: To identify the origin (Agency or County) and types of reported administrative costs (excluding "delegated administration") for fiscal year end 2011; and to determine the allowability of reported administrative costs (excluding "delegated administration" and County chargebacks) for fiscal year end 2011.

Conclusion: MDCH reviewed Agency administrative costs and found no exceptions.

MDCH'S SHARE OF COSTS AND BALANCE DUE

Objective 5: To determine MDCH's share of costs in accordance with applicable MDCH requirements and agreements, and to identify any balance due to or from the Agency.

Conclusion: The Agency's allowable expenditures and allocations among funding sources changed as a result of Findings 1 and 2. The audit adjustments are shown on the Schedule of Audit Adjustments and Adjusted FSRs. The impacts on funding are shown on the Adjusted Contract Reconciliation and Cash Settlement Schedules. As a result of the audit adjustments, the Medicaid lapse declined \$7,458,327, Medicaid Savings declined \$464,134, and the General Fund Carryforward increased \$3,981,229. The original and revised settlement amounts are summarized on tables after the Adjusted CRCSs.

OTHER FINDINGS

Finding

3. MCPN Contracts Do Not Adhere to MDCH Contract and Mental Health Code Provisions, and Do Not Agree with Actual Practices

The Agency's contracts with their MCPNs do not adhere to MDCH Contract terms regarding Medicaid Savings retention; do not adhere to Mental Health Code provisions regarding General Fund carryforward; and do not agree with actual practices regarding excess payments, lapse funds, and deficits.

The Agency's contracts with MDCH (Section 6.4) require that "*All subcontracts must be in compliance with State of Michigan statutes and will be subject to the provisions thereof. All subcontracts must fulfill the requirements of this contract that are appropriate to the services or activities delegated under the subcontract.*" The Agency's contracts with MDCH (Section 6.4) also require that the Agency provide MDCH with a copy of each contract that contains incentives, bonuses, withholds, sanction provisions, and sub-capitations with subcontractors, and MDCH reserves the right to disallow such contracts. While the Agency may have provided the MCPN contracts to MDCH, the contracts contain a provision that does not adhere to MDCH Contract terms and Mental Health Code provisions, and the contracts are not followed. The Agency is not following the contracts with respect to excess payments to MCPNs, lapses due back from MCPNs, and deficit funding. Not only has the actual method of operation not been approved by MDCH, it has not been agreed upon in a legally binding agreement between the Agency and the MCPNs. Without a legally binding agreement with respect to payment practices, the Agency is subject to undue risk.

The following list includes the MCPN contract provision that does not adhere to MDCH Contract terms and Mental Health Code provisions, and examples of components of the MCPN contracts that are not followed:

- a. The MCPN contracts allow savings retention by MCPNs. While not practiced by the Agency, this would be a violation of the Medicaid contract with MDCH which states at Section 7.7.2, *“It should be noted that only a PIHP may earn and retain Medicaid savings.”* This would also be a violation of Section 226(2)(c) of the Mental Health Code as only Community Mental Health Service Providers have the power to carry forward General Funds, and MCPNs are not Community Mental Health Service Providers as defined in the Mental Health Code.
- b. The MCPN contracts require the return of excess funding to the Agency, but this is not practiced. Instead, the Agency reports the excess funding to MCPNs as a “prepayment” on their books. The financial statements of the MCPNs, however, show no recognition of the deferred revenue. Rather, it appears that the MCPNs are treating all revenue received from the Agency as earned in the period received. Without a clear understanding and a legally binding agreement regarding these “prepayments,” treating the payments as future period revenue or attempting recovery of the overpayments could be problematic for the Agency. This issue is further addressed in Finding 4.
- c. MCPN deficits do not appear to be handled the way the contract requires with the Agency covering 50% of MCPN losses in excess of 5% of the annual funding to the MCPN subject to the MCPN’s pro rata availability of the Agency’s Reserve Fund. In 2009, Gateway had a significant deficit. It is uncertain if the Agency had reserves available to fund a portion of the loss at that time. However, it appears none was funded by reserves. Rather, subsequent year capitation payments (2010 and 2011) covered the prior year deficit and the payments used to cover the prior period deficit were reported to MDCH as expenditures.

The Agency’s responses to the FYE 2009 and FYE 2010 Compliance Examinations indicated that the Agency would work with Corporation Counsel to ensure that contracts with MCPNs are consistent, include proper reference to monitoring and cost settlement, and adhere to the MDCH contracts with an estimated completion date of October 1, 2011. To date, this has not been completed. According to the Interim Finance Director, new contract language does not exist, and they *“will bid out the system per the AFP; at that time language will be developed.”*

Recommendations

We recommend that the Agency immediately develop contract language with MCPNs that comply with MDCH contract terms and the Mental Health Code with respect to Medicaid savings and General Fund carryforward, address monitoring and cost settlement, address prepayments and deferred revenue, and allow for the recovery of excess funds if needed by the Agency; and obtain MDCH approval of the contracts prior to execution. Once approved by MDCH, execute the revised MCPN contracts.

Finding

4. Surplus Funds (Multiple Years) Retained by MCPNs Reported as Prepayments by the Agency but Unrestricted Fund Balances by MCPNs

The Agency has allowed the MCPNs to retain surplus funding every year since 2003 rather than requiring the MCPNs to return the funds to the Agency as required by contract, and has reported the excess funding as “Prepayments and Deposits” on the financial statements with a corresponding fund balance amount, but the MCPNs are treating the “prepayments” as unrestricted fund balance rather than deferred revenue making the Agency’s ability to recoup the funds or expect the use of the funds for future expenses questionable. At 9/30/2012, nearly 84% of the Agency’s reported fund balance that was not reserved for risk funding, or \$23,036,108, was held at the MCPNs, and this continues to grow each year the MCPNs’ fund balances grow. Also, the Notes to the Agency’s Financial Statements mislead the readers into believing the “Prepayments” are reported as risk reserves to the State, which they are not.

The Agency reports the payments to the MCPNs as expenditures to MDCH. The MCPN payment amounts are generally reduced by gains in the MCPNs’ fund balances for the year based on the audited financial statements of the MCPNs at the end of each year, and that is the expenditure amount reported to MDCH. Rather than requiring the MCPNs to return any excess funds (gains in fund balance as a result of capitation payments exceeding expenses), however, as required by their contracts with the Agency, the MCPNs are allowed to keep the excess funds and build their fund balances. The excess funds are not MDCH funds and this issue has no impact on MDCH funding. Rather, the excess funds provided to the MCPNs are Agency funds. The total amount grew from \$17,123,411 at FYE 2011 to \$23,036,108 at FYE 2012, representing nearly 84% of the Agency’s fund balance (that is not reserved for risk funding). This significant amount of the Agency’s fund balance could be at risk of loss as explained below.

The Agency reports each MCPN’s ending fund balance in a “Prepayments and Deposits” account that is reported on the Agency’s financial statements with a corresponding fund balance that is designated as “nonspendable.” Each year, the “prepayment” amount is reversed out, and a new entry is made to record each MCPN’s ending fund balance as a “Prepayments and Deposits” with a corresponding fund balance that is designated as “nonspendable.” The Agency makes no adjustments to the MCPNs’ future capitation payments to recognize any “prepayments” made. Rather, the full actuary-determined capitation payments are made each year to the MCPNs. Each year, any surpluses are retained at the MCPNs and are allowed to continue to grow the MCPNs’ fund balances.

If ever an MCPN’s expenses exceed the current year capitation payments, the MCPN dips into their available fund balance. Then, the Agency’s year end adjustment to the “Prepayments and Deposits” account reflects the use of the “Prepayment.”

The MCPNs, however, do not treat the excess payments as advances against future expenses, and none of the MCPNs have restricted their fund balances. None of the MCPNs have reported the excess payments on their audited financial statements as deferred revenue, which is defined as advance payments or unearned revenue recorded on the recipient's balance sheet as a liability until the services have been rendered. Rather, the MCPNs treat the entire amount of the capitation payments as current year revenue, and are using any excess payments to build their fund balances. Additionally, none of the MCPNs show any restrictions on their fund balances. Accordingly, all funds are considered to be available for unrestricted use by the MCPNs.

The Agency's contracts with the MCPNs state that gains shall be returned to the Agency, with no specific mention of retaining the excess funds and treating them as "prepayments." Accordingly, it appears that while the Agency is reporting the excess payments as "prepayments," the MCPNs are not. The lack of an agreement on this process, and the fact that the MCPNs are not recognizing the "prepayments" as deferred revenue or restricted fund balance, bring into question the Agency's proper classification of the excess payments to the MCPNs as "prepayments" and fund balance on their financial statements, and the Agency's ability to recover the funds or expect the use of the funds for future expenses.

While the contracts with the MCPNs contain a closeout clause stating that the portion of all reserve accounts accumulated by the MCPN that were funded with the Agency funds are owed to the Agency upon cancelation or non-renewal of the contract, the MCPNs' financial statements do not recognize this contract provision as neither a liability nor restricted net assets is showing on the financial statements.

Furthermore, the contract provision to return reserves to the Agency upon closeout conflicts with the MCPNs' Articles of Incorporation. None of the Articles of Incorporation for the MCPNs show the Agency as being the recipient of resources upon dissolution.

The Agency and MCPN contracts, Appendix I, Section 11.2, state that any gains in excess of 5% of the annual funding shall be returned to the Agency. In 2012, MDCH acknowledged that the contract provision was not followed and that rather than the MCPNs returning the gains, the MCPNs' reserve balances on hand are recorded as a prepaid expense. MDCH deemed this process acceptable since it was thought that expenditure reporting to MDCH was limited to actual audited expenditures of the MCPNs, and with the understanding that the "prepaid expense" was properly classified as a "current asset" meaning that the prepaid was reasonably expected to be realized within one year according to Generally Accepted Accounting Principles. MDCH, however, did not approve multiple year surpluses ("prepayments") to be retained at the MCPNs as fund balances with no written agreement regarding the prepayments, since this situation puts the Agency's fund balance in jeopardy.

Follow-up with a CPA firm that completed the financial statement audits for two of the five MCPNs for FYE 2011 confirmed that they believe all funds received by the MCPNs from the Agency (including all unexpended funds retained) were earned in the year received and consequently recognized as net revenue. Thus, there has been no recognition of deferred revenue, nor restrictions put on the fund balances at the MCPNs. This belief was likely due to reliance being placed on the Agency/MCPN contracts that are not followed with respect to the return of unexpended risk-corridor-related funds to the Agency. The unexpended funds that were not returned (as they should have been according to the Agency/MCPN contract) were likely believed to be the portions that *could be* retained according to the contract. Furthermore, while the contracts with the MCPNs contain a closeout clause stating that the portion of all reserve accounts accumulated by the MCPN that were funded with Agency funds are owed to the Agency upon cancelation or non-renewal of the contract, the CPA firm stated that only the unexpended funds *in a given year* would be deferred and recorded as refundable to the Agency. Accordingly, there is no recognition on the MCPN financial statements that reserves accumulated from *prior year funding* surpluses from the Agency are due to the Agency upon cancelation or non-renewal.

Clearly, the Agency's treatment of the surplus funds provided to the MCPNs as "Prepayments and Deposits" and "Fund Balance" is at odds with the MCPNs' treatment of the funds on the respective financial statements. Without recognition by the MCPNs of the "prepayment" funds being deferred revenue or restricted and due back to the Agency, the Agency should not be considering the funds as prepayments or fund balance.

Finally, the Notes (Note 2) to the Agency's FYE 2011 and 2012 Financial Statements state the following with respect to the Prepayments and Deposits: "*Deposits are comprised of reserves held by Managed Care Provider Networks (MCPNs) who contract with the Agency. They are allowed to be maintained by the MCPNs in order to maintain cash for operations. These amounts are included in the Agency's records in order to capture them in the Agency's risk reserve balance to the State.*" The "Prepayments and Deposits" amount is not in fact included in any reserve balances reported to the State, so the last sentence is not accurate.

Recommendations

We recommend that the Agency:

- a. Attempt to obtain MCPNs' agreements to recognize past excess payments as deferred revenues rather than fund balances;
- b. Immediately develop contract language with MCPNs that address prepaids and deferred revenue (if not requiring the lapse of surplus funds), and allow for the recovery of excess funds if needed by the Agency;
- c. Obtain MDCH approval of the MCPN contracts prior to execution;
- d. Once the revised MCPN contracts are approved by MDCH, implement the contracts; and
- e. Correct the Notes to the Financial Statements to eliminate reference to the reserves held by the MCPNs as being included in the Agency's risk reserve balance reported to MDCH.

Finding

5. Erroneous Data Submitted to State Warehouse

The Agency or their contractor, PCE, submitted erroneous and duplicate data to the State Warehouse, and neither the Agency's MHWIN System nor the State System had sufficient controls in place to prevent the erroneous submissions.

Section 6.5.2 of the MDCH ABW Contract states that the Agency shall submit encounter data containing detail for each recipient encounter reflecting all services provided by the Agency in order to assess quality of care, determine utilization patterns and access to care for various health care services, and affirm capitation rate calculations and estimates. Data in the State Warehouse is relied upon by the Legislature, program management, budget staff, and actuaries during planning, budget and rate setting processes. Accordingly, the submission of accurate data is crucial for the completion of many program functions.

In comparing State Warehouse data to the Agency's MHWIN data, the following problems were identified:

- a. The Agency or their contractor, PCE, erroneously resubmitted three partially-rejected 837 files to the State, and the State Warehouse ended up with both the resubmitted encounters and previously-accepted encounters. This issue resulted in 37,124 claims in the State Warehouse that should not have been. Safeguards were not in place within the MHWIN System, or the State System to prevent the resubmission of previously-accepted encounters.
- b. PCE's testing staff generated an encounter batch out of a system integration testing environment and erroneously submitted the batch to the State. This caused a "non-production" encounter batch consisting of 167 claims to appear in the State Warehouse that should not have been. Safeguards were not in place within the MHWIN System to prevent the inadvertent submission.
- c. The Agency's MHWIN system and the State Warehouse each contain duplicate claims. We found 57 units of substance abuse services that were reported as being provided twice on the same day. These units were for procedure codes 80100, H0001, H0002, H0015, H0019, and H0049 and more than one of these procedures should not be reported for a day. While the number found is not significant, there are no controls within the MHWIN System or the State System to prevent this from occurring.

In many situations, it is not possible to determine with certainty that an encounter is a duplicate, so the State system accepts it. The State system, however, has an edit that reports the *possibility* of a duplicate submission of an encounter and this is reported on the Encounter Transaction Results Report that the Agency receives with each Encounter batch submission. It is the Agency's responsibility to correct these, as MDCH cannot change the data that is submitted.

Recommendation

We recommend that the Agency implement controls to ensure previously-accepted encounters are not resubmitted, non-production encounter batches are not submitted, and duplicate claims cannot be submitted. We also recommend that MDCH research the possibility of strengthening system edits to limit the acceptance of duplicate encounters and service claims into the State Warehouse.

Finding

6. MUNC Report Differences Not Researched Nor Resolved

The Agency reported units of ABW services on their Medicaid Utilization and Aggregate Net Cost (MUNC) Report for FYE 2011 that varied significantly from units of service MDCH queried from the State's Data Warehouse, but did not take action to identify the causes of the differences or to resolve the differences.

Section 6.5.1 of the MDCH ABW Contract states that the Agency must provide the MDCH with uniform data and information as specified by MDCH to measure the PIHP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates. Attachment 6.5.1.2 of the MDCH ABW Contract requires a Medicaid Utilization and Aggregate Net Cost Report (MUNC) to report the aggregate Medicaid and ABW service data necessary for MDCH management of contracts and rate-setting by the actuary. The "Instructions for Adult Benefit Waiver Consumers, Units and Costs" states, *"It is expected that the information in this report be consistent with the Financial Status Report and with the units and cases reported via the encounter data system to the MDCH data warehouse."*

The Agency reported service cases, units, and costs under 94 different codes on the MUNC Report. MDCH then inserted State Warehouse cases and units based on a query of State Warehouse data, and calculated the cost per unit for each service code. The MUNC Report was then posted to the Internet for the Agency to review, research differences, and make any needed corrections. For the 94 codes reported, 10 varied by more than 10% and more than 100 units from the amounts reported in the State Warehouse as shown on the following table. These differences ranged all the way from 187 units of service all the way up to 31,067 units of service.

HCPCS Code or Modifier	MUNC Reported Units	State Warehouse Units	Number Difference	Percent Difference
H0002	1,510	1,291	219	16.96%
H0004	2,164	2,660	(496)	(18.65%)
H0010	1,597	4,364	(2,767)	(63.41%)
H0015	1,423	1,688	(265)	(15.70%)
H0018	2,151	5,340	(3,189)	(59.72%)
H0019	15,337	46,404	(31,067)	(66.95%)
H0023	22,022	2,881	19,141	664.39%
H2016	3,861	0	3,861	NA
PT73	836	649	187	28.81%
90801	3,901	3,278	623	19.01%

The differences indicate errors in either the data submitted to the State Warehouse or errors within the Agency's MHWIN system, or possibly differences in the way data was queried. However, the differences were not researched and resolved with the assistance of MDCH as made available. When asked about the differences during the audit, staff at the Agency simply stated they did not know what caused the differences. Further review and inquiry that occurred during the audit fieldwork revealed issues that likely caused some of the differences (see Findings 1, 2 and 5).

Recommendation

We recommend that the Agency implement policies and procedures to ensure differences between the Agency's reported numbers on the MUNC Report and State Warehouse numbers are researched, resolved, and corrected within timeframes established by MDCH for final MUNC reporting. We also recommend that MDCH continue their policy of providing requested assistance to community mental health providers in researching and resolving MUNC Report differences such as providing query details, and other information useful in identifying reasons for differences. We also recommend MDCH consider incorporating consequences for lack of adequate resolution of MUNC Report differences within the contract such as penalty provisions.

**Detroit-Wayne County Community Mental Health Agency
Schedule of Audit Adjustments
September 30, 2011**

Adjusting Entries	Medicaid Line A 202	ABW Line AC 203	GF 100% Line B 201	GF 90% Line B 203 (Column A)	MI Child Line D 290
To adjust to the corrected Allocation Report (Finding 1)	\$7,922,461	(\$1,521,230)	\$5,309,177	(\$11,723,474)	\$13,066
To adjust the allocation of ABW expenditures based on the use of the ABW CMH Benefit Plan date rather than the ABW Benefit Plan Date (Finding 2)		(1,386,283)		1,386,283	
Total Audit Adjustment (To Adjusted FSR)	\$7,922,461	(\$2,907,513)	\$5,309,177	(\$10,337,191)	\$13,066

**Detroit-Wayne County Community Mental Health Agency
ADJUSTED FINANCIAL STATUS REPORT - ADULT BENEFIT WAIVER (ABW)
FOR THE YEAR ENDED SEPTEMBER 30, 2011**

		YEAR TO DATE REPORTING					
		A	B	C	I	J	K
		Reporting Board	CMHSP or CA		Settlement Total	Adjustments	Adjusted Totals
# 1	# 2						
1	PIHP or CMHSP or CA	DWCCMHA	Detroit CA	SEMCA			
AC	ADULT BENEFIT WAIVER SERVICES - PIHP USE ONLY						
AC 100	REVENUE						
AC 101	Revenue - Mental Health						
AC 102	ABW - Mental Health	\$ 13,856,200			\$ 13,856,200		\$ 13,856,200
AC 103	ABW - Affiliate Contracts - MH	-			-		-
AC 120	Subtotal Revenue - Mental Health	13,856,200			13,856,200		13,856,200
AC 130	Revenue - Substance Abuse						
AC 131	ABW - Substance Abuse	8,576,234			8,576,234		8,576,234
AC 132	ABW - Affiliate Contracts - SA	(2,978,233)	2,831,007	147,226	-		-
AC 140	Subtotal Revenue - Substance Abuse	5,598,001	2,831,007	147,226	8,576,234		8,576,234
AC 190	TOTAL REVENUE	19,454,201	2,831,007	147,226	22,432,434		22,432,434
AC 200	EXPENDITURE						
AC 201	Expenditure - Mental Health						
AC 202	PIHP Use Tax Liability - MH	791,253			791,253		791,253
AC 203	ABW Services - MH	9,630,558			9,630,558	(2,907,513)	6,723,045
AC 220	Subtotal Expenditure - Mental Health	10,421,811			10,421,811	(2,907,513)	7,514,298
AC 230	Expenditure - Substance Abuse						
AC 231	PIHP Use Tax Liability - SA	489,460			489,460		489,460
AC 232	ABW Services - SA		2,831,007	147,226	2,978,233		2,978,233
AC 240	Subtotal Expenditure - Substance Abuse	489,460	2,831,007	147,226	3,467,693		3,467,693
AC 290	TOTAL EXPENDITURE	10,911,271	2,831,007	147,226	13,889,504	(2,907,513)	10,981,991
AC 291	Subtotal Net ABW Services Surplus (Deficit) - MH	3,434,389			3,434,389	2,907,513	6,341,902
AC 292	Subtotal Net ABW Services Surplus (Deficit) - SA	5,108,541			5,108,541		5,108,541
AC 295	SUBTOTAL NET ABW SERVICES SURPLUS (DEFICIT)	8,542,930			8,542,930	2,907,513	11,450,443
AC 300	Redirected Funds (To) From						
AC 301	Affiliate Total Redirected Funds - IA390						
AC 302	FROM General Fund - Redirected to Unfunded MH ABW Costs - B301.3						
AC 303	FROM Substance Abuse MDCH Contract - L300.3						
AC 304	FROM Local Funds - M301.3						
AC 390	Total Redirected Funds						
AC 400	BALANCE ABW SERVICES	\$ 8,542,930	\$ -	\$ -	\$ 8,542,930	\$ 2,907,513	\$ 11,450,443

AD	REMARKS
AD	Remarks may be added about any entry or activity on the report for which additional information may be useful. Please note risk management arrangement between PIHP and Affiliates.
AD	

**Detroit-Wayne County Community Mental Health Agency
ADJUSTED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2011**

		Settlement Total	Adjustments	Adjusted Totals
A	MEDICAID SERVICES - Summary From FSR - Medicaid Worksheet			
A 190	TOTAL REVENUE	\$ 497,284,993	\$ -	\$ 497,284,993
A 290	TOTAL EXPENDITURE	442,315,921	7,922,461	450,238,382
A 295	NET MEDICAID SERVICES SURPLUS (DEFICIT)	54,969,072	(7,922,461)	47,046,611
A 390	Total Redirected Funds	-	-	-
A 400	BALANCE MEDICAID SERVICES	\$ 54,969,072	\$ (7,922,461)	\$ 47,046,611

AC	ADULT BENEFIT WAIVER SERVICES - Summary From FSR - ABW Worksheet			
AC 190	TOTAL REVENUE	\$ 22,432,434	\$ -	\$ 22,432,434
AC 290	TOTAL EXPENDITURE	13,889,504	(2,907,513)	10,981,991
AC 295	NET ABW SERVICES SURPLUS (DEFICIT)	8,542,930	2,907,513	11,450,443
AC 390	Total Redirected Funds	-	-	-
AC 400	BALANCE ABW SERVICES	\$ 8,542,930	\$ 2,907,513	\$ 11,450,443

B	GENERAL FUND			
B 100	REVENUE			
B 101	CMH Operations	\$ 94,040,544		\$ 94,040,544
B 102	Categorical	2,922,466		2,922,466
B 103	State Services	26,838,524		26,838,524
B 120	Subtotal - Current Period General Fund Revenue	123,801,524		123,801,524
B 121	1st & 3rd Party Collections (Not in Section 226a Funds) 100% Services			
B 122	1st & 3rd Party Collections (Not in Section 226a Funds) 90% Services			
B 123	Prior Year GF Carry Forward			
B 124	ISF Abatement			
B 140	Subtotal - Other General Fund Revenue			
B 190	TOTAL REVENUE	123,801,524		123,801,524
B 200	EXPENDITURE			
B 201	100% MDCH Matchable Services / Costs	12,438,974	5,309,177	17,748,151
B 202	100% MDCH Matchable Services Based on CMHSP Local Match Cap			
B 203	90% MDCH Matchable Services / Costs - SETTLEMENT	\$ 95,353,147		
	90% MDCH Matchable Services / Costs - ADJUSTMENTS	(10,337,191)		
	90% MDCH Matchable Services / Costs - ADJUSTED	\$ 85,015,956		
B 204	State Services - Payments to MDCH for State Services	24,546,872	(9,303,472)	15,243,400
B 205	Payment into GF ISF			
B 290	TOTAL EXPENDITURE	122,803,678	(3,994,295)	118,809,383
B 295	NET GENERAL FUND SURPLUS (DEFICIT)	997,846	3,994,295	4,992,141
B 300	Redirected Funds (To) From			
B 301	(TO) Medicaid - Redirected for Unfunded Medicaid Costs - A331 (PIHP use only)			
B 301.3	(TO) ABW - Redirected for Unfunded MH ABW Costs - AC302 (PIHP use only)			
B 302	(TO) SED-GF Benefit - C301	(4,811)		(4,811)
B 303	(TO) GF Cost of MICHild - Required Match - D302	(73,994)		(73,994)
B 304	(TO) GF Cost of MICHild - Above Required Match - D303	(151,298)	(13,066)	(164,364)
B 305	(TO) GF Cost of SED - Required Match - E301			
B 306	(TO) GF Cost of SED - Above Required Match Screen - E303			
B 307	(TO) GF Cost of SED - Not SED Waiver eligible - E305			
B 308	(TO) GF Cost of Children's Wavier - F301	(89,777)		(89,777)
B 309	(TO) Allowable GF Cost of Injectable Medications - G301			
B 309.5	(TO) PIHP to Affiliate ABW Services Contracts - IA302			
B 310	(TO) CMHSP to CMHSP Earned Contracts - J305 (explain - section Q)			
B 311	(TO) Substance Abuse - L301			
B 312	Intentionally left blank			
B 313	FROM CMHSP to CMHSP Earned Contracts - J302			
B 314	FROM Non-MDCH Earned Contracts - K302			
B 330	Subtotal Redirected Funds rows 301 - 314	(319,880)	(13,066)	(332,946)
B 331	FROM Local Funds - M302			
B 332	FROM Risk Corridor - N303			
B 390	Total Redirected Funds	(319,880)	(13,066)	(332,946)
B 400	BALANCE GENERAL FUND (cannot be < 0)	\$ 677,966	\$ 3,981,229	\$ 4,659,195

OTHER GF CONTRACTUAL OBLIGATIONS

C	SED-GF BENEFIT			
C 190	Revenue	\$ 4,987		\$ 4,987
C 290	Expenditure	9,798		9,798
C 295	NET SED-GF BENEFIT SURPLUS (DEFICIT)	(4,811)		(4,811)
C 300	Redirected Funds (To) From			
C 301	FROM General Fund - B302	4,811		4,811
C 302	FROM Local Funds - M303			
C 390	Total Redirected Funds	4,811		4,811
C 400	BALANCE SED-GF BENEFIT (must = 0)	\$ -	\$ -	\$ -

**Detroit-Wayne County Community Mental Health Agency
ADJUSTED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2011**

		Settlement Total	Adjustments	Adjusted Totals
D	MICHILD - MENTAL HEALTH			
D	1	Enter Current MICHild FFP 0.7605		
D	190	Revenue	\$ 234,957	\$ 234,957
D	290	Expenditure	460,249	473,315
D	295	NET MICHILD SURPLUS (DEFICIT)	(225,292)	(238,358)
D	300	Redirected Funds (To) From		
D	301	Federal share applied - REPORTED	\$ 234,957	
		Federal share applied - EXAMINATION ADJUSTMENT	-	
		Federal share applied - EXAMINED	\$ 234,957	
D	302	FROM General Fund - Required Match - B303	73,994	73,994
D	303	FROM General Fund - Above Required Match - B304	151,298	164,384
D	304	FROM Local Funds - M304		
D	390	Total Redirected Funds	225,292	238,358
D	400	BALANCE MICHILD (cannot be < 0)	\$ -	\$ -

FEE FOR SERVICE MEDICAID

E	SED WAIVER			
E	100	REVENUE		
E	101a	FFS Medicaid - Federal portion recvd at current year Qtr 1 FFP rate - SED-Trad.	0.7557	\$ -
E	101b	FFS Medicaid - Federal portion recvd at current year Qtr 2 FFP rate - SED-Trad.	0.7274	-
E	101c	FFS Medicaid - Federal portion recvd at current year Qtr 3 FFP rate - SED-Trad.	0.7086	-
E	101d	FFS Medicaid - Federal portion recvd at current year Qtr 4 FFP rate - SED-Trad.	0.6579	-
E	102	FFS Medicaid - Federal portion recvd at subsequent year FFP rate - SED-Trad.	0.6614	-
E	103	FFS Medicaid - SED-DHS	272,794	272,794
E	190	TOTAL REVENUE	272,794	272,794
E	200	EXPENDITURE		
E	201	Expenditure - Traditional - Federal Reimbursable	272,794	272,794
E	202	Expenditure - Traditional - Not SED waiver eligible		-
E	203	Expenditure - SED-DHS - Federal Reimbursable		-
E	204	Expenditure - SED-DHS - Not SED waiver eligible		-
E	290	TOTAL EXPENDITURE	272,794	272,794
E	295	NET SED WAIVER (DEFICIT)		
E	300	Redirected Funds (To) From		
E	301	FROM General Fund - Required Match - B305	-	-
E	302	FROM Local Funds - Required Match - M305		
E	303	FROM General Fund - Above Required Match Screen - B306		
E	304	FROM Local Funds - Above Required Match Screen - M306		
E	305	FROM General Fund - Not SED Waiver eligible - B307		
E	306	FROM Local Funds - Not SED Waiver eligible - M307		
E	390	Total Redirected Funds		
E	400	BALANCE SED WAIVER (must = 0)	\$ -	\$ -

F	CHILDREN'S WAIVER			
F	190	Revenue	\$ 821,271	\$ 821,271
F	290	Expenditure	911,048	911,048
F	295	NET CHILDREN'S WAIVER (cannot be > 0)	(89,777)	(89,777)
F	300	Redirected Funds (To) From		
F	301	FROM General Fund - B308	89,777	89,777
F	302	FROM Local Funds - M308		
F	303	FROM Activity not otherwise reported - O301		
F	390	Total Redirected Funds	89,777	89,777
F	400	BALANCE CHILDREN'S WAIVER (must = 0)	\$ -	\$ -

G	INJECTABLE MEDICATIONS			
G	190	Revenue		\$ -
G	290	Expenditure		-
G	295	NET INJECTABLE MEDICATIONS (cannot be > 0)		
G	300	Redirected Funds (To) From		
G	301	FROM General Fund - B309		
G	302	FROM Local Funds - M309		
G	390	Total Redirected Funds		
G	400	BALANCE INJECTABLE MEDICATIONS (must = 0)	\$ -	\$ -

**Detroit-Wayne County Community Mental Health Agency
ADJUSTED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2011**

		Settlement Total	Adjustments	Adjusted Totals
OTHER FUNDING				
H	MDCH EARNED CONTRACTS			
H 100	REVENUE			
H 101	PASARR	\$ 2,102,816		\$ 2,102,816
H 102	DCH Block Grants for CMH services	5,641,472		5,641,472
H 103	DD Council Grants			-
H 104	PATH/Homeless	1,008,374		1,008,374
H 105	Prevention			-
H 106	Aging			-
H 107	HUD Shelter Plus Care	767,339		767,339
H 150	Other MDCH Earned Contracts (describe): HUD Supportive Housing	1,013,918		1,013,918
H 151	Other MDCH Earned Contracts (describe): ARRA - Byrne Justice (Mental Health Court)	202,954		202,954
H 152	Other MDCH Earned Contracts (describe):			-
H 190	TOTAL REVENUE	10,736,873		10,736,873
H 200	EXPENDITURE			
H 201	PASARR	2,102,816		2,102,816
H 202	DCH Block Grants for CMH services	5,641,472		5,641,472
H 203	DD Council Grants			-
H 204	PATH/Homeless	1,008,374		1,008,374
H 205	Prevention			-
H 206	Aging			-
H 207	HUD Shelter Plus Care	767,339		767,339
H 250	Other MDCH Earned Contracts (describe): HUD Supportive Housing	1,013,918		1,013,918
H 251	Other MDCH Earned Contracts (describe): ARRA - Byrne Justice (Mental Health Court)	202,954		202,954
H 252	Other MDCH Earned Contracts (describe):			-
H 290	TOTAL EXPENDITURE	10,736,873		10,736,873
H 400	BALANCE MDCH EARNED CONTRACTS (must = 0)	\$ -	\$ -	\$ -
I	PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS - CMHSP USE ONLY			
I 100	REVENUE			
I 101	Revenue - from PIHP			\$ -
I 102	1st & 3rd Party Collections - Medicare/Medicaid Consumers - Affiliate			-
I 190	TOTAL REVENUE			
I 290	Expenditure			-
I 295	NET PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS SURPLUS (DEFICIT)			
I 300	Redirected Funds (To) From			
I 301	(TO) CMHSP to CMHSP Earned Contracts - J306	-	-	-
I 302	FROM CMHSP to CMHSP Earned Contracts - J303			-
I 303	FROM Non-MDCH Earned Contracts - K303			-
I 390	Total Redirected Funds			-
I 400	BALANCE PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS (must = 0)	\$ -	\$ -	\$ -
IA	PIHP to AFFILIATE ABW SERVICES CONTRACTS - CMHSP USE ONLY			
IA 100	REVENUE			
IA 101	Revenue - MH - from PIHP			\$ -
IA 102	Revenue - SA - from PIHP			-
IA 190	TOTAL REVENUE			
IA 200	EXPENDITURE			
IA 201	Expenditure - MH			-
IA 202	Expenditure - SA			-
IA 290	TOTAL EXPENDITURE			
IA 295	NET PIHP to AFFILIATE ABW SERVICES CONTRACTS SURPLUS (DEFICIT)			
IA 300	Redirected Funds (To) From			
IA 301	(TO) CMHSP to CMHSP Earned Contracts - J306.5	-	-	-
IA 302	FROM General Fund - B309.5			-
IA 303	FROM CMHSP to CMHSP Earned Contracts - J303.5			-
IA 304	FROM Non-MDCH Earned Contracts - K303.5			-
IA 305	FROM Substance Abuse MDCH Contract - L300.5			-
IA 306	FROM Local Funds - M309.5			-
IA 390	Total Redirected Funds			-
IA 400	BALANCE PIHP to AFFILIATE ABW SERVICES CONTRACTS (cannot be < 0)	\$ -	\$ -	\$ -

**Detroit-Wayne County Community Mental Health Agency
ADJUSTED FINANCIAL STATUS REPORT - ALL NON MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2011**

		Settlement Total	Adjustments	Adjusted Totals
J	CMHSP to CMHSP EARNED CONTRACTS			
J	190 Revenue			\$ -
J	290 Expenditure			-
J	295 NET CMHSP to CMHSP EARNED CONTRACTS SURPLUS (DEFICIT)			-
J	300 Redirected Funds (To) From			
J	301 (TO) Medicaid Services - A302 (PIHP use only)	-	-	-
J	302 (TO) General Fund - B313	-	-	-
J	303 (TO) PIHP to Affiliate Medicaid Services Contracts - I302	-	-	-
J	303.5 (TO) PIHP to Affiliate ABW Services Contracts - IA303	-	-	-
J	304 FROM Medicaid Services - A301 (PIHP use only)			-
J	305 FROM General Fund - B310			-
J	306 FROM PIHP to Affiliate Medicaid Services Contracts - I301			-
J	306.5 FROM PIHP to Affiliate ABW Services Contracts - IA301			-
J	307 FROM Local Funds - M310			-
J	390 Total Redirected Funds	-	-	-
J	400 BALANCE CMHSP to CMHSP EARNED CONTRACTS (must = 0)	\$ -	\$ -	\$ -

K	NON-MDCH EARNED CONTRACTS			
K	190 Revenue			\$ -
K	290 Expenditure			-
K	295 NET NON-MDCH EARNED CONTRACTS SURPLUS (DEFICIT)			-
K	300 Redirected Funds (To) From			
K	301 (TO) Medicaid Services - A303 (PIHP use only)	-	-	-
K	302 (TO) General Fund - B314	-	-	-
K	303 (TO) PIHP to Affiliate Medicaid Services Contracts - I303	-	-	-
K	303.5 (TO) PIHP to Affiliate ABW Services Contracts - IA304	-	-	-
K	304 (TO) Local Funds - M315	-	-	-
K	305 FROM Local Funds - M311			-
K	390 Total Redirected Funds	-	-	-
K	400 BALANCE NON-MDCH EARNED CONTRACTS (must = 0)	\$ -	\$ -	\$ -

L	SUBSTANCE ABUSE MDCH CONTRACT			
L	100 REVENUE			
L	101 State Agreement			\$ -
L	102 MICHild - SA			-
L	190 TOTAL REVENUE			-
L	200 EXPENDITURE			
L	201 State Agreement			-
L	202 MICHild - SA			-
L	290 TOTAL EXPENDITURE			-
L	295 NET SUBSTANCE ABUSE CONTRACT SURPLUS (DEFICIT)			-
L	300 Redirected Funds (To) From			
L	300.3 (TO) ABW - Redirected for Unfunded SA ABW Costs - AC303 (PIHP use only)	-	-	-
L	300.5 (TO) PIHP to Affiliate ABW Services Contracts - IA305	-	-	-
L	301 FROM General Funds - B311			-
L	302 FROM Local Funds - M312			-
L	390 Total Redirected Funds	-	-	-
L	400 BALANCE SUBSTANCE ABUSE CONTRACT	\$ -	\$ -	\$ -

Detroit-Wayne County Community Mental Health Agency
ADJUSTED FINANCIAL STATUS REPORT - ALL NON-MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2011

		Settlement Total	Adjustments	Adjusted Totals
M	LOCAL FUNDS			
M 100	REVENUE			
M 101	County Appropriation for Mental Health	\$ 16,507,165		\$ 16,507,165
M 102	County Appropriation for Substance Abuse - Non Public Act 2 Funds			-
M 103	Section 226 (a) Funds			-
M 104	Affiliate Local Contribution to State Medicaid Match Provided from CMHSP (PIHP only)			-
M 105	Children's Waiver (CWP) Adjuster Payments			-
M 106	Local Grants			-
M 107	Interest	392,449		392,449
M 108	Public Act 2 - SA			-
M 109	SED Partner			-
M 110	All Other Local Funding			-
M 190	TOTAL REVENUE	16,899,614		16,899,614
M 200	EXPENDITURE			
M 201	GF 10% Local Match	9,535,315	(1,033,719)	8,501,596
M 202	Local match cap amount			
	Examination adjustment local match cap amount			
	Adjusted total local match cap amount	\$		
M 203	GF Local Match Capped per MHC 330.1308			-
M 204	Local Cost for State Provided Services	4,598,157		4,598,157
M 205	Local Contribution to State Medicaid Match (CMHSP Contribution Only)	5,050,188		5,050,188
M 206	Local Contribution to State Medicaid Match on Behalf of Affiliate (PIHP Only)			-
M 207	Local Match to Grants and MDCH Earned Contracts			-
M 208	Public Act 2 - SA			-
M 209	Local Only Expenditures			-
M 290	TOTAL EXPENDITURE	19,183,660	(1,033,719)	18,149,941
M 295	NET LOCAL FUNDS SURPLUS (DEFICIT)	(2,284,046)	1,033,719	(1,250,327)
M 300	Redirected Funds (To) From			
M 301	(TO) Medicaid Services - A332 (PIHP use only)	-	-	-
M 301.3	(TO) ABW Services - AC304 (PIHP use only)	-	-	-
M 302	(TO) General Fund - B331	-	-	-
M 303	(TO) SED-GF Benefit - C302	-	-	-
M 304	(TO) MiChild - D304	-	-	-
M 305	(TO) SED Waiver - Required Match - E302	-	-	-
M 306	(TO) SED Waiver - Above Required Match Screen - E304	-	-	-
M 307	(TO) Not SED Waiver eligible - E306	-	-	-
M 308	(TO) Children's Waiver - F302	-	-	-
M 309	(TO) Injectable Medications - G302	-	-	-
M 309.5	(TO) PIHP to Affiliate ABW Services Contracts - IA306	-	-	-
M 310	(TO) CMHSP to CMHSP Earned Contracts - J307	-	-	-
M 311	(TO) Non-MDCH Earned Contracts - K305	-	-	-
M 312	(TO) Substance Abuse - L302	-	-	-
M 313	(TO) Activity Not Otherwise Reported - O302	-	-	-
M 314	Intentionally left blank			
M 315	FROM Non-MDCH Earned Contracts - K304			
M 390	Total Redirected Funds			
M 400	BALANCE LOCAL FUNDS	\$ (2,284,046)	\$ 1,033,719	\$ (1,250,327)
M 401	Balance Local funds - PA 2 Restricted			
N	RISK CORRIDOR			
N 100	REVENUE			
N 101	Stop/Loss Insurance			\$ -
N 102	Medicaid ISF for PIHP Share Risk Corridor			-
N 103	MDCH for MDCH Share of Medicaid Risk Corridor			-
N 104	GF ISF for State Facility Cost Over Runs			-
N 190	TOTAL REVENUE			
N 300	Redirected Funds (To) From			
N 301	(TO) Medicaid Services - PIHP Share - A333 (PIHP use only)	-	-	-
N 302	(TO) Medicaid Services - MDCH Share - A334 (PIHP use only)	-	-	-
N 303	(TO) General Fund - B332	-	-	-
N 390	Total Redirected Funds			
N 400	BALANCE RISK CORRIDOR (must = 0)	\$ -	\$ -	\$ -

**Detroit-Wayne County Community Mental Health Agency
 ADJUSTED FINANCIAL STATUS REPORT - ALL NON-MEDICAID
 FOR THE YEAR ENDED SEPTEMBER 30, 2011**

		Settlement Total	Adjustments	Adjusted Totals
O	ACTIVITY NOT OTHERWISE REPORTED			
O 100	REVENUE			
O 101	Other Revenue (describe): Audit Findings	\$ 350,559		\$ 350,559
O 102	Other Revenue (describe):			-
O 103	Other Revenue (describe):			-
O 190	TOTAL REVENUE	350,559		350,559
O 200	EXPENDITURE			
O 201	Other Expenditure (describe):			-
O 202	Other Expenditure (describe):			-
O 203	Other Expenditure (describe):			-
O 290	TOTAL EXPENDITURE			
O 295	NET ACTIVITY NOT OTHERWISE REPORTED SURPLUS (DEFICIT)	350,559		350,559
O 300	Redirected Funds (To) From			
O 301	(TO) Children's Waiver - F303	-	-	-
O 302	FROM Local Funds - M313			
O 390	Total Redirected Funds			
O 400	BALANCE ACTIVITY NOT OTHERWISE REPORTED	\$ 350,559	\$ -	\$ 350,559

P	GRAND TOTALS			
P 190	GRAND TOTAL REVENUE	\$ 672,840,006	\$ -	\$ 672,840,006
P 290	GRAND TOTAL EXPENDITURE	610,583,525	-	610,583,525
P 390	GRAND TOTAL REDIRECTED FUNDS (must = 0)			
P 400	NET INCREASE (DECREASE)	\$ 62,256,481	\$ -	\$ 62,256,481

Q	REMARKS
Q	This section has been provided for the CMHSP to provide narrative descriptions as requested in the FSR Instructions or where additional narrative would be meaningful to the CMHSP / MDCH.
Q	

**Detroit-Wayne County Community Mental Health Agency
ADJUSTED CONTRACT RECONCILIATION AND CASH SETTLEMENT - GENERAL FUND
FOR THE YEAR ENDED SEPTEMBER 30, 2011**

1. General Fund Services - Available Resources	Funding Resources
a. CMH Operations (FSR B 101)	\$ 94,040,544
b. Categorical (FSR B 102)	2,922,456
c. State Services (FSR B 103)	26,838,524
d. Sub-Total General Fund Contract Authorization	123,801,524
e. 1st & 3rd Party Collections (FSR B 121 + B 122)	-
f. Prior Year GF Carry-Forward (FSR B 123)	-
g. Intentionally left blank	-
h. Redirected CMHSP to CMHSP Contracts (FSR B 313)	-
i. Redirected Non-MDCH Earned Contracts (FSR B 314)	-
j. Sub-Total Other General Fund Resources:	-
k. Local 10% Associated to 90/10 Services (FSR M 201)	8,501,596
l. Local 10% Match Cap Adjustment (FSR M 203)	-
m. Sub-Total Local 10% Associated to 90/10 Services:	8,501,596
n. Total General Fund Services - Resources:	\$ 132,303,120

3. Summary of Resources / Expenditures	Amount
a. Total General Fund Services - Resources	\$ 132,303,120
b. Total General Fund Services - Expenditures	127,643,925
c. Sub-Total General Fund Services Surplus (Deficit)	4,659,195
d. Less: Forced Lapse to MDCH (GF work sheet 4 F column F)	-
e. Net General Fund Services Surplus (Deficit)	\$ 4,659,195

4. Disposition: Surplus	Amount
a. Surplus	
b. Transfer to Fund Balance - GF Carry-Forward Earned	\$ (4,659,195)
c. Lapse to MDCH - Contract Settlement	-
d. Total Disposition - Surplus:	\$ (4,659,195)

Deficit	Amount
f. Redirected from Local (FSR B 331)	\$ -
g. Redirected from risk corridor (FSR B 332)	-
h. Total Disposition - Deficit:	\$ -

5. Cash Settlement: (Due MDCH) / Due CMHSP	Amount
a. Forced Lapse to MDCH	\$ -
b. Lapse to MDCH - Contract Settlement	-
c. Return of Prior Year General Fund Carry-Forward	-
d. State Facility	-
e. Contract Authorization - Late Amendment	-
f. Misc. (please explain)	-
g. Total Cash Settlement: (Due MDCH) / Due CMHSP:	\$ -

2. General Fund Services - Expenditures	90/10 - Local Cap	Expenditures
a. 100% MDCH Matchable Services (FSR B 201)		\$ 17,748,151
b. 100% MDCH Matchable Services - CMHSP Local Match Cap (FSR B 202)		-
c. 90/10% MDCH Matchable Services (FSR B 203 Column A)	85,015,956	-
d. Local 10% Match Cap Adjustment (FSR M 203)	-	65,015,956
e. State Services (FSR B 204)		24,546,872
f. Intentionally left blank		-
g. Sub-Total General Fund Services - Expenditures:		127,310,979
h. GF Supplement for Unfunded Medicaid (FSR B 301)		-
i. GF Supplement for SED-GF Benefit (FSR B 302)		4,811
j. GF Supplement / Match for MICHad (FSR B 303 & B 304)		238,358
k. GF Supplement / Match for SED (FSR B 305 + B 306 + B 307)		-
l. GF Supplement for Children's Waiver (FSR B 308)		89,777
m. GF Supplement for Injectable Medications (FSR B 309)		-
n. GF Supplement for CMHSP to CMHSP Contracts (FSR B 310)		-
o. GF Supplement for Substance Abuse (FSR B 311)		-
p. GF Supplement for Unfunded MH ABW (FSR B 301.3)		-
q. GF Supplement for PIHP to Affiliate ABW Services Contracts (FSR B 309.5)		-
r. Intentionally left blank		-
s. Sub-Total General Fund Services Supplement - Expenditures:		332,046
t. Total General Fund Services - Expenditures:		\$ 127,643,925

6. General Fund MDCH Commitment	Amount
MDCH / CMHSP Contract Funded Expenditures	\$ 119,142,329
Earned General Fund Carry-Forward	4,659,195
Total MDCH General Fund Commitment:	\$ 123,801,524

**Detroit-Wayne County Community Mental Health Agency
ADJUSTED CONTRACT RECONCILIATION AND CASH SETTLEMENT - MEDICAID
FOR THE YEAR ENDED SEPTEMBER 30, 2011**

		PIHP Contract Cost Settled
1. Medicaid Services - Available Resources		
a. State Plan (b) (FSR A 101)		\$ 237,189,882
b. State Plan (b3) (FSR A 102)		168,624,153
c. Habilitation Support Waiver (c) (FSR A 103)		73,934,758
d. Total Managed Care Capitation		479,748,773

e. 1st & 3rd Party Collections (FSR A 121)		-
f. Prior Year Medicaid Savings (FSR A 123)		17,536,220
g. ISF Abatement - Medicaid (FSR A 124)		-
h. Redirected CMHSP to CMHSP Contracts (FSR A 302)		-
i. Redirected Non-MDCH Earned Contracts (FSR A 303)		-
j. Sub-Total Other Medicaid Services - Resources		17,536,220
k. Total Medicaid Services - Available Resources		\$ 497,284,993

2. Medicaid Services - Expenditures		
a. PIHP QAAP/Use Tax Liability (FSR A 201)		\$ 28,647,831
b. Medicaid Services (FSR A 202-A122-A325)		389,974,581
c. Deposits Into Medicaid ISF (FSR A 203)		21,100,223
d. Psych Hospital HRA (FSR A 204)		10,515,747
e. Sub-Total Medicaid Services - Expenditures		450,238,382
f. Redirected CMHSP to CMHSP Contracts (FSR A 301)		-
g. Total Medicaid Services - Expenditures		\$ 450,238,382

3. Net Medicaid Services Surplus / (Deficit)		
a. Medicaid Funding Surplus / (Deficit)		\$ 47,046,611
b. Less: Forced Lapse to MDCH (Medicaid worksheet 2.a)		-
c. Net Medicaid Services Surplus / (Deficit)		\$ 47,046,611

4. Disposition		Amount
a. Surplus		
1. Transfer to Fund Balance - Medicaid Savings Earned		\$ (35,517,025)
2. Lapse to MDCH - Contract Settlement		(11,529,586)
3. Total Disposition - Surplus		\$ (47,046,611)

b. Deficit		
1. Redirected from General Fund (FSR A 331)		\$ -
2. Redirected from Local (FSR A 332)		-
3. Redirected Risk Corridor - PIHP Share (FSR A 333)		-
4. Redirected Risk Corridor - MDCH Share (FSR A 334)		-
5. Total Disposition - Deficit		\$ -

5. Cash Settlement: (Due MDCH) / Due PIHP		Amount
a. Forced Lapse to MDCH		\$ -
b. Lapse to MDCH - Contract Settlement		(11,529,586)
c. Risk Corridor - MDCH Share		-
d. Return of Prior Year Medicaid Savings		-
e. Misc (please explain) - Settlement Amount Paid To Date		18,987,913
f. Misc (please explain)		-
g. Total Cash Settlement: (Due MDCH) / Due PIHP		\$ 7,458,327

6. Medicaid MDCH Commitment		
MDCH / PIHP Medicaid Funded Expenditures		\$ 432,702,162
Earned Medicaid Savings		35,517,025
Sub-Total MDCH Commitment		\$ 468,219,187
Risk Corridor - MDCH Share		-
Total MDCH Medicaid Commitment		\$ 468,219,187
Intentionally left blank		
General Fund Supplement for Unfunded Medicaid		\$ -

Original and Revised Settlement Amounts

September 30, 2011

Medicaid

	Original	Revised	Change
Surplus	\$54,969,072	\$47,046,611	(\$7,922,461)
Medicaid Savings Earned	(35,981,159)	(35,517,025)	\$464,134
Lapse	\$18,987,913	\$11,529,586	(\$7,458,327)

General Fund

	Original	Revised	Change
Surplus/(Deficit)	\$677,966	\$4,659,195	\$3,981,229
GF Carryforward Earned	(677,966)	(\$4,659,195)	(\$3,981,229)
Lapse/(Redirect from Local)	\$0	\$0	\$0

Corrective Action Plan

Finding Number: 1

Page Reference: 4

Finding: Allocation Report Errors and Eligibility Errors

The Agency misreported costs on the FYE 2011 Financial Status Report due to reliance being placed on erroneous MHWIN-generated allocation reports, erroneous voids of clients' Medicaid eligibility within MHWIN, lack of identification of 100% funded services, and the erroneous inclusion of payments to direct service providers for specific General Fund services in the allocation to other funding categories.

Recommendation: Implement adequate internal controls over data that is processed by service organizations to ensure system-generated reports contain accurate data and the proper allocation of costs to the appropriate funding sources on Financial Status Reports. When reliance is placed on data generated by a service organization for the Agency's financial reporting, as a means of acquiring the necessary assurances about the quality and accuracy of the data, consider either requiring the service organization to engage a certified public accounting firm to report on the controls at the service organization that affect the information provided to the Agency through a Statement on Standards for Attestation Engagement (SSAE no. 16 report), "Reporting on Controls at a Service Organization," or requiring the Agency's auditor to visit the service organization to test its controls. Also, require a second party that is familiar with the Allocation Report and FSR reporting requirements review the Allocation Report and FSR for accuracy and to ensure the identified errors do not recur prior to submission to MDCH.

Agency Comments: Management concurs with the finding and acknowledges there were errors, omissions and duplications in the MHWIN system and in the Financial Status Report that was submitted to MDCH.

Corrective Action: The programming errors and other issues identified were corrected and the reports were re-generated. The Agency will request that the auditors obtain and review the SSAE No. 16 report or perform fieldwork at the service organization. In addition, effective October 1, 2013, the Agency become an Authority and is no longer a part of the County government and subject to hiring freezes and staff reductions. The Authority hired additional staff which enables the Authority to review and monitor the data and identify discrepancies and be proactive opposed to reactive to issues.

**Anticipated
Completion Date:** February 2014

MDCH Response: None.

Corrective Action Plan

Finding Number: 2

Page Reference: 6

Finding: Encounters Coded as ABW for Individuals Not Enrolled in the ABW CMH Benefit Plan

The Agency allocated costs to the ABW Program for mental health services provided to individuals that were not enrolled in the ABW CMH Benefit Plan at the time of service, and paid substance abuse coordinating agencies ABW funds for substance abuse services provided to individuals that were not enrolled in the ABW CMH Benefit Plan at the time of service.

Recommendations: Revise the MHWIN system, allocation processes, and coordinating agency payment processes to ensure ABW eligibility is based on ABW CMH Benefit Plan Dates and payment remittance information contained on the 834 and 820 reports, respectively. Perform a monthly reconciliation between the 820 and 834 Reports, and revise MHWIN system eligibility information as needed to ensure eligibility agrees with payments according to the benefit plan shown on the 820 report.

Agency Comments: Management does not concur with the finding. The State provides the CHAMPS 270/271 transaction to the PIHPs and Providers to validate eligibility. CHAMPS is the ultimate source of eligibility information for the State. CHAMPS is also the source for the 834 and 820 transactions. CHAMPS is providing a different date in the 270/271 transaction than the date in the 834/820 transactions. The Agency depended on the 270/271 to be accurate and equivalent to the 834/820 transactions.

Corrective Action: The system has been changed to reflect information from the 834/820 transaction file. The Agency reconciles the ABW 834 and 820 files and bases ABW eligibility solely on the reconciled 834/820 information.

**Anticipated
Completion Date:** June 1, 2013

MDCH Response: The MDCH contract states that MDCH will provide eligibility and remittance information on 834 and 820 reports with no reference to the 270/271 transaction return file. The 270/271 transaction return file and the 834/820 reports serve different purposes, and MDCH acknowledges that differences exist with dates. As explained within the finding, the 270/271 transaction return file shows *retroactive* ABW eligibility dates for paying medical claims of providers in the physical health community on a fee for service basis. The 834/820 reports, however, show the ABW CMH Benefit Plan Date, which is the date enrolled with the CMH and prospective capitation payments begin. The 270/271 transaction return file recognizes retroactive eligibility, but the 834 and 820 reports do not; thus, differences in dates exist.

Corrective Action Plan

Finding Number: 3

Page Reference: 8

Finding: MCPN Contracts Do Not Adhere to MDCH Contract and Mental Health Code Provisions, and Do Not Agree with Actual Practices

The Agency's contracts with their MCPNs do not adhere to MDCH Contract terms regarding Medicaid Savings retention; do not adhere to Mental Health Code provisions regarding General Fund carryforward; and do not agree with actual practices regarding excess payments, lapse funds, and deficits.

Recommendations: Immediately develop contract language with MCPNs that comply with MDCH contract terms and the Mental Health Code with respect to Medicaid savings and General Fund carryforward, address monitoring and cost settlement, address prepayments and deferred revenue, and allow for the recovery of excess funds if needed by the Agency; and obtain MDCH approval of the contracts prior to execution. Once approved by MDCH, execute the revised MCPN contracts.

**Agency
Comments:**

Management partially agrees with the finding. In 2002, the CMS Waiver required the Agency to bid out the system to Managers of Comprehensive Provider Networks and the contracts were risk based. This system was the first in the nation and served as a pilot. Unfortunately, over time as problems with the system arose, the Agency sought guidance from the State and received approval in certain situations that deviated from the contractual terms to ensure the sustainability of the system as a whole.

Additionally, at the direction of MDCH, in 2008, the Agency began reporting the MCPN's net assets/fund balance on the books of the Agency as a prepaid asset. The intent of the Department was to ensure that excess funds held by the MCPN's were included in the Agency's calculation of Medicaid Savings, ISF and General Fund carry forward. All excess funds held by the MCPN's at year end are carried over to the following year and

are used to support future consumer services. The MCPN contracts clearly state that at closeout of the contract, the funds belong to the Agency.

Finally, at no time do we believe any of our practices are in violation of the Mental Health Code.

Corrective Action: The Agency requested the MCPNs to include language in their audited financial statements that funds belong to the Agency at closeout. Develop a workgroup consisting of MDCH finance, contract and audit staff; Agency finance staff; and an independent audit firm to address the intent of the MCPN structure prior to re-bidding the system in 2014. The Agency will be re-bidding the system in 2014 and will resolve the contract language issues.

**Anticipated
Completion Date:** June 30, 2014

MDCH Response: The Agency's actual methods of operation with the MCPNs with respect to excess payments, lapse funds, and deficits have not been agreed upon in a legally binding agreement with the MCPNs, which subjects the Agency to undue risk. Agency management recognizes that they have deviated from contractual terms but has not taken action to update the contracts. This issue has been cited for several years via compliance examinations and again in this audit, but the Agency has continued to fail to address it.

Agency management stated that at the direction of MDCH in 2008, the Agency began reporting the MCPNs' net assets/fund balances on the books of the Agency as a prepaid asset, with the intent of the Department being to ensure that excess funds held by the MCPNs were included in the Agency's calculation of Medicaid Savings, ISF and General Fund carry forward. No evidence was provided that MDCH directed the Agency in 2008 to account for the MCPNs' net assets on the Agency's books as a prepaid asset. Regardless, the intent was surely not to include these

amounts in the Agency's calculation of Medicaid Savings, ISF and General Fund carry forward. By contract and Mental Health Code provision, these amounts are to be retained at the Agency. Additionally, the amounts retained at the MCPNs are NOT included in the Agency's calculation of Medicaid Savings, ISF and General Fund carry forward as evidenced on the Agency's audited financial statements.

Corrective Action Plan

Finding Number: 4

Page Reference: 10

Finding: Surplus Funds (Multiple Years) Retained by MCPNs Reported as Prepayments by the Agency but Unrestricted Fund Balances by MCPNs

The Agency has allowed the MCPNs to retain surplus funding every year since 2003 rather than requiring the MCPNs to return the funds to the Agency as required by contract, and has reported the excess funding as “Prepayments and Deposits” on the financial statements with a corresponding fund balance amount, but the MCPNs are treating the “prepayments” as unrestricted fund balance rather than deferred revenue making the Agency’s ability to recoup the funds or expect the use of the funds for future expenses questionable. At 9/30/2012, nearly 84% of the Agency’s reported fund balance that was not reserved for risk funding, or \$23,036,108, was held at the MCPNs, and this continues to grow each year the MCPNs’ fund balances grow. Also, the Notes to the Agency’s Financial Statements mislead the readers into believing the “Prepayments” are reported as risk reserves to the State, which they are not.

Recommendations:

- a. Attempt to obtain MCPNs’ agreements to recognize past excess payments as deferred revenues rather than fund balances;
- b. Immediately develop contract language with MCPNs that address prepaids and deferred revenue (if not requiring the lapse of surplus funds), and allow for the recovery of excess funds if needed by the Agency;
- c. Obtain MDCH approval of the MCPN contracts prior to execution;
- d. Once the revised MCPN contracts are approved by MDCH, implement the contracts; and
- e. Correct the Notes to the Financial Statements to eliminate reference to the reserves held by the MCPNs as being included in the Agency’s risk reserve balance reported to MDCH.

**Agency
Comments:**

Management partially concurs with the finding. The MCPNs contract with service providers to serve over 70,000 consumers in the largest CMH in the nation. To date, we have disbursed over \$4.4 billion in funding to the MCPNs and over the 10 year period the MCPNs have accumulated \$23 million or .5% (five tenths of a percent) of \$4.4 billion. The \$23 million equates to an annual accumulation of \$450,000 per year.

It is essential that the MCPNs have adequate cash flows to pay providers in a timely fashion. The following table depicts the five year history of the MCPNs year-end reserves:

	9/30/2008	9/30/2009	9/30/2010	9/30/2011	9/30/2012
CLS	\$531,815	\$2,489,648	\$3,953,916	\$5,544,575	\$5,645,392
ConsumerLink	2,553,852	2,557,674	1,506,190	2,814,806	2,840,223
CareLink	1,968,610	1,325,644	3,232,856	6,854,359	6,868,481
Gateway	5,755,124	Deficit	Deficit	1,799,671	7,582,012
Synergy	231,367	0	110,069	110,000	100,000
Total	\$11,040,768	\$6,372,966	\$8,803,031	\$17,123,411	\$23,036,108

The reserve amounts have remained relatively consistent year to year with the exception of Gateway. The growth reported is primarily attributable to the fact that Gateway was previously in a negative position and had to build its reserves to handle the cash flow needs of the providers as they are the largest MCPN. The modest increase in reserves also has a direct correlation to the increase in the funding and consumers served over the past five years.

To suggest that the Agency retain all funds in our coffers although the MCPNs administer our entire system, would be catastrophic to the provider network in the event the MCPNs do not have adequate cash flow to address timing issues between the receipt of funds and disbursing payments to the providers. Currently, the MCPNs maintain a modest 30 days of cash on hand. The Agency serves as an administrator; we provide no direct services thus to retain all system reserves held is not necessary.

Up to this point, the Agency's financial position and cash flows have been strong and stable.

The report states that the Agency does not adjust future capitation payments for the prepayments from the prior year. At our request, the MDCH auditors were requested however unable to support this statement with contract provisions or generally accepted accounting principles that require such practices; no such provisions or rules exist. Additionally, the report states that we should report the surplus as prepaid expenses. The surplus is reported as a prepayment (same as prepaid expenses) and in accordance with GASB 54, *Fund Balance Reporting and Governmental Fund Type Definitions*, requires the Agency to report the fund balance as "Non-Spendable." To deviate would violate Generally Accepted Accounting Principles.

The audit report suggests that the MCPNs' financial statements are materially misstated although they are audited annually by independent auditors. The audit report suggests that four different national firms incorrectly reported the net assets/fund balance of all five MCPNs. In an effort to specifically address this finding, the Agency requested and obtained an opinion letter from the independent auditors of two of the five MCPNs. The opinion letter provides direct support for the treatment of the reserves and provided the applicable accounting standards that support their audit opinion.

The Agency is confident that the MCPN's audited financial statements are materially accurate as determined by the audit firms. However, the Agency has directed the MCPNs to disclose the reserves as restricted on the face of the financial statements as they are restricted for mental health services. It should be noted that the restriction of the fund balance as recommended in the audit report verses reporting it as unrestricted does not change any amounts reported in the financial statements rather is merely a classification change.

Finally, we do concur with the finding as it relates to the language in footnote 2 and we will remove the last sentence.

Corrective Action: The MCPNs' FYE 2013 audited financial statements have restricted the fund balance and disclosed in the footnote that the excess funds belong to the Agency. Further, the Agency has included language in the FYE 2014 MCPN contracts that require them to classify the net assets as restricted. In addition, the Agency will change footnote 2. Finally, in conjunction with the re-bid, the Agency will consider closing out the MCPN contracts and obtain all excess funds thus eliminating the prepayment. This would resolve the past practices and issues going forward into a new system; to make such changes now would deplete the MCPNs' cash on hand.

Anticipated

Completion Date: September 30, 2014

MDCH Response: MDCH maintains that the "prepayments" to the MCPNs, if truly prepayments or advances, should be recognized as such on the MCPNs' financial statements as deferred revenue rather than fund balance. The fund balance restriction simply restricts the MCPNs' spending for a specific purpose, but provides no obligation to return the funds to the Agency. Furthermore, there appears to be no clear contractual obligation to return the "prepayments" from multiple years to the Agency. The closeout language previously referenced would only be applicable to the current contract unspent funds, not prepayments from multiple years that have accumulated in the MCPNs' fund balances. The Agency continues to fail to adopt contract language with the MCPNs that clearly address the prepayments and deferred revenue practices.

The Agency recognized over \$23 million in "prepayments" to the MCPNs as of FYE September 30, 2012 and recorded them on the Agency's records as fund balance, but the MCPNs did not recognize the funds as deferred revenue or advances. Rather, the MCPNs recognized the funds

as already earned (rather than as advances or deferred revenue). Consequently, these funds (that made up 84% of the Agency's fund balance exclusive of required risk reserves) are at risk of loss. Additionally, contrary to the statement by the Agency in their reply, reserve amounts have NOT remained relatively consistent year to year. The amounts continue to grow with no definitive plans to limit the "prepayments" or "advances" to the MCPNs, or contractual agreement that assures the funds will be returned to the Agency.

The Agency obtained a letter from a CPA firm to support the MCPNs' financial statement presentation regarding these funds. The letter from the CPA firm does nothing more than support MDCH's concern about this issue. It is clear that there is great confusion and a lack of understanding as to the workings of this Agency/MCPN "arrangement" since it is not clearly documented in an agreement. It appears the CPA firm may have been provided a combination of old and newly *drafted* contract language, since there are references to sections that did not exist in the executed contract at the time. There are inconsistencies noted throughout the CPA letter regarding contract references, so it is not real clear what contract language they used in developing their letter. Regardless, the CPA firm appears to have reviewed contract language that is not followed with respect to the return of unexpended risk-corridor-related funds, and appears to assume that it is followed. The CPA firm opinion is clearly driven by contract language that is not followed. The CPA firm references the return of unexpended risk-corridor-related funds between 0% and 95%. This does not happen and that is the whole point of this finding. The lack of understanding and the CPA firm reliance on contract language that is not even followed further supports our concern. The CPA firm states that unexpended risk-corridor-related funds should be recognized as net revenue in the year it relates to. However, again, they are relying on the contract language that is not followed. The Agency is allowing the MCPNs to retain the funds that should be returned according to the contractual arrangement. By allowing the MCPNs to retain the funds, the

CPA firm likely believes the money is earned in the year received. Finally, the CPA firm states that terms (reserves, carry-forward funds, and savings) referenced in the close-out section are not defined and it is not clear what would occur at close out, but then they state if the contract were to be canceled in a given year any unexpended funds at that time would be deferred and recorded as refundable to the Agency. The FYE 2012 MCPNs' financial statements and the CPA letter show that there is clearly no plan to return reserves earned in prior years. There was no recognition (by the MCPNs on their financial statements) that these funds are due back to the Agency. Furthermore, the CPA firm has relied on contract language that is not even followed. If the CPA firm had a true understanding of the Agency's expectations regarding these funds, their opinion would likely be different. The Agency cannot provide the CPA firm with contract language that is not followed and expect an accurate opinion.

Finally, MDCH agrees that the MCPNs need adequate cash flow to pay providers, but if the Agency wants to continue to provide Agency funds as cash advances for MCPN cash flow needs, this must be specifically addressed in contract language with the MCPNs. The contract language must clearly state that the funds are **advances**, provide for the return of funds to the Agency, provide information on how amounts are determined, and provide limitations. Furthermore, the MCPNs must be required to recognize the advance/prepayment funds as deferred revenue. Reporting advances any other way (e.g. fund balance) is not accurate. Any advances not recognized as deferred revenue by the MCPNs cannot be recognized as prepayments by the Agency and the Agency's financial statements must be revised accordingly.

Corrective Action Plan

Finding Number: 5

Page Reference: 13

Finding: Erroneous Data Submitted to State Warehouse

The Agency or their contractor, PCE, submitted erroneous and duplicate data to the State Warehouse, and neither the Agency's MHWIN System nor the State System had sufficient controls in place to prevent the erroneous submissions.

Agency

Recommendation: Implement controls to ensure previously-accepted encounters are not resubmitted, non-production encounter batches are not submitted, and duplicate claims cannot be submitted.

Agency Comments: The Agency concurs with this finding however it should be noted that the erroneous claims represent less than 1% of the total claims.

Agency

Corrective Action: The CIO (Chief Information Officer) Forum is currently working with MDCH to create improved reporting from MDCH to the PIHPs regarding the information and timeliness needed to reconcile the encounters in the State Data Warehouse with the encounters in the PIHP systems. This work should provide the tools necessary to rectify this problem. In addition, each claim is marked as submitted when it is sent and will not be contained in another batch unless there is some change in the encounter. In that case, the original claim will be voided and the replacement sent in its place. Also, MHWIN has been programmatically modified to prevent sending any data from a non-production environment. Lastly, the Agency will implement edits in MHWIN to reject duplicate encounters.

Agency Anticipated

Completion Date: April 1, 2014

MDCH Response: None

MDCH

Recommendation: Research the possibility of strengthening system edits to limit the acceptance of duplicate encounters and service claims into the State Warehouse.

MDCH Comments: MDCH's Behavioral Health and Developmental Disabilities Administration (BHDDA) agrees that system edits should be strengthened to limit the acceptance of duplicate encounters and service claims into the State Warehouse.

MDCH

Corrective Action: MDCH's BHDDA will work with staff in MDCH's Medical Services Administration to review current edits and identify additional edits and procedures needed to ensure duplicate encounters and service claims are not accepted and/or retained in the State Warehouse.

MDCH Anticipated

Completion Date: October 1, 2014.

Corrective Action Plan

Finding Number: 6

Page Reference: 14

Finding: MUNC Report Differences Not Researched Nor Resolved

The Agency reported units of ABW services on their Medicaid Utilization and Aggregate Net Cost (MUNC) Report for FYE 2011 that varied significantly from units of service MDCH queried from the State's Data Warehouse, but did not take action to identify the causes of the differences or to resolve the differences.

Agency

Recommendation: Implement policies and procedures to ensure differences between the Agency's reported numbers on the MUNC Report and State Warehouse numbers are researched, resolved, and corrected within timeframes established by MDCH for final MUNC reporting.

Agency Comments: The Agency concurs with this finding.

Agency

Corrective Action: The CIO (Chief Information Officer) Forum is currently working with MDCH to create improved reporting from MDCH to the PIHPs regarding the information and timeliness needed to reconcile the encounters in the State Data Warehouse with the encounters in the PIHP systems. This work should provide the tools necessary to rectify this problem. In addition, the Agency will implement policies and procedures to reconcile MUNC and MDCH Data Warehouse numbers.

Agency Anticipated

Completion Date: June 1, 2014

MDCH Response: None

MDCH

Recommendation: Continue the policy of providing requested assistance to community mental health providers in researching and resolving MUNC Report differences such as providing query details, and other information useful in identifying reasons for differences. Also, consider incorporating consequences for lack of adequate resolution of MUNC Report differences within the contract such as penalty provisions.

MDCH Comments: MDCH's Behavioral Health and Developmental Disabilities Administration (BHDDA) agrees that it should continue the policy of providing requested assistance to community mental health providers in researching and resolving MUNC Report differences with the State Warehouse.

MDCH

Corrective Action: BHDDA will provide query details and other information to assist in identifying differences and their underlying reasons. BHDDA added timeliness requirements for MUNC report submissions to the FY 2014 PIHP contract. The timeliness requirement has related financial sanctions in the contract terms. The sanction is a withhold of a percentage of the capitated payments that will be released only upon timely filings of the applicable reports including the MUNC Reports. In addition, BHDDA is researching the establishment of appropriate measures of accuracy for inclusion in the contracts.

MDCH Anticipated

Completion Date: Timeliness requirement included in the contract effective January 1, 2014. Measurements of accuracy to be included in the contract beginning October 1, 2014.