

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION**

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM

Section 450 Report

March 31, 2006

Background

The Michigan Department of Community Health (MDCH) began an internal analysis of the reporting requirements of, and MDCH site visits to, the 46 Community Mental Health Services Programs (CMHSPs) following a spring 2003 meeting between MDCH Director Janet Olszewski and the Michigan Association of Community Mental Health Boards (MACMHB). During that meeting, MACMHB members expressed concerns about duplicative and unnecessary administrative requirements. Following the meeting on May 14, 2003, MDCH received a list of their issues (Attachment #1). In June 2003, the Legislature passed the MDCH 2004 Appropriations Act (Act 159 of the Public Acts of 2003), with a new Section 450 requiring a report on administrative simplification activities.

The MACMHB list addressed issues in five categories: a) Deemed Status/Accreditation, b) Audits, c) Reporting Requirements, d) Medicaid, and e) Other. The MACHMB subsequently indicated that its priorities were Deemed Status/Accreditation and Audits.

Process for Improvement

In May 2003, MDCH established an internal Administrative Simplification Process Improvement Team (PIT) to analyze the issues addressed in the MACMHB document. MDCH team members represented the Audit Division, Budget and Finance, Office of Recipient Rights, Division of Mental Health Contracts, Office of Mental Health Services to Children and Families, and Division of Quality Management and Planning. The internal group analyzed all of the MACMHB issues to determine what it considered to be negotiable, non-negotiable (because it was a federal or state requirement), worthy of further study, or required clarification to MACMHB. The result of the analysis is in Attachment #2.

The MACMHB named eight representatives to join the PIT in June 2003. The PIT met monthly between June 2003 and March 2004, and quarterly thereafter. In addition, three ad hoc committees were established to address specific issues on the list: Audit (items under B), Documentation (items C 12 and 13), and Quick Fix (all other items under C and D). These committees met multiple times, and reported at the PIT meetings. Two additional work groups had already been meeting and were able to incorporate two of MACMHB's issues into their work: 1) identify better measures of person-centered planning implementation (E.6); and

2) identify gaps in the availability of Medicaid-funded transportation service (C. 26).

Report on Progress

Reports on the progress made in the years one and two were submitted to the Appropriations Committee on March 31, 2004 and 2005. The major and most significant accomplishment for year three was the development of a streamlined audit process for CMHSPs. Leadership of the CMHSPs voiced approval of this process on March 7, 2006. At the meeting on March 21, 2006, the MACMHB PIT members expressed the opinion that their issues had all been addressed or resolved and that the team's work is complete. The PIT audit work and highlights of three years of accomplishments are summarized below.

I. Audit Streamline Project

Issue: "The department shall continue a workgroup comprised of CMHSPs or specialty prepaid health plans and departmental staff to recommend strategies to streamline audit and reporting requirements for CMHSPs or specialty prepaid health plans. The charge to this workgroup shall include a requirement to develop a set of standards and criteria that satisfy all of the department's audit requirements that are to be used by any contractor performing services for the CMHSPs or specialty prepaid health plans. The department shall by March 31, 2006 provide those proposed standards and criteria to the house of representatives and senate appropriations subcommittees on community health, the house fiscal agency, the senate fiscal agency, and the state budget director."

Report on Progress

A representative work group, made up of MDCH program and internal audit staff, local CMHSPs, Prepaid Inpatient Health Plans (PIHPS) and the MACMHB, continued meeting to find ways to streamline the requisite auditing processes. In the course of these meetings, the work group examined and discussed the existing internal audit system, alternative audit methods, and the numerous accounting standards that result from multiple state and federal mental health and substance abuse services funding streams.

Early on, the following three facts became evident:

1. To serve their primary purpose, audits should be structured to help identify and correct accounting problems. Also, to avoid being punitive, audits need to be conducted frequently enough so that CMHSPs and PIHPS can use the audit finding to make timely accounting practice changes before they become ingrained multi-year accounting problems. Audit findings that result in multiple-year paybacks to the state and federal government

- often result in a loss of funding for current year programs, expensive litigation for all parties, and local public embarrassment when large sums that could have been spent on local services must instead be returned to the state or federal government.
2. MDCH does not have the internal audit staffing capacity or resources to conduct annual audits around the state due to early retirements and budget constraints. To work within the resources available, MDCH internal audits of local public mental health agencies are now conducted every three to five years.
 3. While the required accounting and audit standards for each funding stream and program are published in a number of federal laws, federal regulations, state laws, and various professional accounting standards manuals, there had not been a single overarching resource document created that described all the standards that public mental health agencies are required to follow.

To address each of these identified concerns and to simplify the overall audit process, MDCH and the members of the MACMHB have agreed to the following:

1. Effective for the FY 2006-07 audit period, all CMHSPs and PIHPs will contract with independent accounting firms of their choice to conduct an annual independent audit of their operations. In marked contrast to our current internal office audit cycle, the new process will identify audit issues from the immediate past year and resolve them in the current year. All parties believe this approach will significantly reduce audit exceptions, funds lost to audit recoveries, and the legal costs of disputing such financial matters.
2. The CMHSPs, PIHPs, and their independent auditors will rely upon the MDCH internal audit division's newly developed compilation of all the applicable accounting and audit standards. This document, Attachment #3, titled Compliance Examination Guidelines, should go far in helping to create a common understanding of what is expected in dealing with multiple funding source requirements; simplify the audit process itself; and make the process more transparent to all.
3. These changes to streamline the audit process are scheduled to become effective October 1, 2006, via amendments to the state's master contracts with the individual CMHSPs and PIHPs.

MDCH and the members of the MACMHB believe that the charge to streamline the audit process and develop a set of standards and criteria has been completed.

II. Highlights of the Remaining Work of the PIT:

Issue: Model payments have separate tracking and payment mechanisms than other foster care programs.

MDCH implemented an electronic model payments reimbursement system that went into effect April 1, 2005. CMHSPs and providers were trained during January and February. The electronic system enables CMHSPs to electronically authorize model payments, and the providers to electronically submit to MDCH claims for payment. The system not only eliminates paper authorizations and paper claims, but also decreases the amount of time between claims submission and payment.

Issue: Evaluate state expectations requiring CMHSPs to complete redundant review. Requiring independent proof that site visits occurred and that staff have been trained adds unnecessary expense.

- a. **MACMHB surveyed its membership about the preference for a single comprehensive site review each year, or several shorter reviews. The membership responded with a preference for a single comprehensive review. During 2004, MDCH consolidated the site reviews for Mental Health/Developmental Disabilities Medicaid, Substance Abuse Medicaid, and the Children's Waiver into a single site visit at each PIHP. In addition, MDCH eliminated from the Medicaid site reviews all of the Balanced Budget Act standards that are being reviewed on-site as part of the federally-mandated External Quality Review that commenced January 2005. One result of the consolidation was removal of 27 pages from the Medicaid site review protocol. Further simplification occurred with the approval of a revised Quality Strategy contained in the renewal of Michigan's 1915(b) and (c) Medicaid waivers. The Quality Strategy approved by the PIT called for reduction of the annual site reviews of PIHPs to one every other year.**
- b. **A Practice Guideline on Coordination of Rights Protection Services among CMHSPs was developed by MDCH. The coordination guideline would allow CMHSPs to recognize each other's training, policy reviews and site assessments of providers they have in common, thus eliminating the need for redundant reviews by CMHSPs. MDCH intends that the guideline will be discussed as part of the FY'07 MDCH/CMHSP contract negotiations.**

Issue: Find more efficient ways to extract data and eliminate redundant data.

- a. **The Encounter Data Integrity Team (EDIT), made up of representatives from the MACMHB, Provider Alliance, and MDCH, meets monthly to advise MDCH on data collection through the encounter data system and the cost reports. EDIT produced guidance for the mental health system on how to determine and report costs of Medicaid managed care administrative functions. EDIT also developed and disseminated guidance on how to assign direct and indirect costs to units of services. Finally EDIT developed recommendations to MDCH for the most efficient and least-burdensome way of reporting costs for units of service beginning FY'06.**
- b. **The Quality Improvement Council evaluated the 49 performance indicators the data for which was collected from the CMHSPs quarterly. The evaluation resulted in elimination of 31 indicators. The remaining indicators draw data primarily from the encounter and demographic data already reported to the MDCH data warehouse and the cost data submitted annually by CMHSPs and PIHPs. Some of the indicators that require separate data collection and reporting became annual indicators rather than quarterly. This action dramatically reduced the need for additional data collection and reporting by the CMHSPs.**
- c. **During the spring of 2005, the PIT work group on documentation completed the work of identifying the minimum expectations for documentation of person-centered planning, plan of service, and service delivery. These documentation expectations will be incorporated into the MDCH site review interpretive guidelines to be issued prior to October 1, 2006.**

Issue: Provider Alliance reports that there is a high degree of variability in data collection requirements and methods among the CMHSPs. Some do not use HIPAA-compliant methods.

- a. **This issue was referred to EDIT with a request that progress reports be made to the PIT. Provider Alliance representatives sit on EDIT. This is also a contract issue since CMHSPs and PIHPs have the capacity to receive claims electronically and be HIPAA-compliant.**
- b. **This issue is also being addressed by the MACMHB Policy Committee with the intent that the requirements for HIPAA compliance for transfer of consumer-level data be broadcast**

throughout the system. The MACMHB is developing model provider contracts that will be used by all CMHSPs with their providers.

Issue: Mental Health and Substance Abuse agencies have different reporting requirements and different performance indicators. In addition, delegation of managed care functions to CAs seems to be from MDCH rather than PIHPs.

- a. **MDCH issued a Technical Advisory on September 30, 2004, to PIHPs on purchasing substance abuse services when the CA encompasses more than one PIHP.**
- b. **MDCH issued a Technical Advisory on November 17, 2004, to PIHPs clarifying the funding and reporting related to people with co-occurring disorders and the provision of substance abuse and mental health services.**
- c. **The federal Centers for Medicare and Medicaid Services (CMS) views Michigan's PIHPs as the managers of all Medicaid specialty services – for Medicaid beneficiaries with mental illness, developmental disabilities, or substance use disorders. Therefore, CMS expects MDCH to require the PIHPs to manage their provider networks that include CMHSP affiliates and CAs by purchasing services and, if applicable, delegating managed care functions like customer services, utilization management or information technology. The External Quality Review that commenced in FY'05 looks at the delegation of managed care functions by the PIHPs to their provider networks, including CAs. Findings from the review are already driving change in local practice, as well as MDCH standards development.**

Attachment #1

May 14, 2003

ADMINISTRATIVE SIMPLIFICATION:

In response to requests from the administration and from the Legislature and recognizing the long-standing interest of CMHSPs in administrative simplification, I have appointed a workgroup to make recommendations on reducing unnecessary administrative requirements. Asked to participate were CMH directors serving as MACMHB officers and standing committee co-chairpersons. I intend to serve as a member of the workgroup as well.

CMHSPs were asked to submit their specific ideas on which duplicative and unnecessary administrative requirements should be modified, reviewed or eliminated. Approximately 23 CMHSPs responded. Comments gathered were grouped into 5 categories:

- A. Deemed Status/Accreditation Issues
- B. Audits
- C. Reporting Requirements
- D. Medicaid
- E. Other Issues

Following are some of the themes which have emerged in each area and a more detailed summary of issues raised in the first four area. Issues falling into the category will be addressed in the future as work on individual suggestions commences. The Association has asked DCH director Janet Olszewski to meet and discuss the themes which have been identified. We have further requested that a DCH/CMH work group be convened to begin to discuss specific suggestions for change. We look forward to moving ahead and addressing these and other issues which may be brought forward.

Thank you!

Mary Balberde
President

A. DEEMED STATUS/ACCREDITATION ISSUES

Overview: *The current processes of national accreditation and DCH certification reviews overlap one another and are duplicative. For those CMHSPs who have achieved accreditation by one of the national organizations approved by the department, further DCH review is not required. Deemed status means elimination of requirements for departmental certification review for those CMHSPs who are nationally accredited.*

1. Eliminate the requirement for an annual DCH review for CMHSPs who have achieved national accreditation.
2. DCH surveying should be limited to areas specific to Michigan and not covered by national accreditation surveys.
3. Reduce frequency and improve coordination of DCH reviews. Multiple DCH reviews should be collapsed into a single review. Some of the current reviews are: DCH site reviews, specialty residential reviews, coordinating agency reviews, recipient rights reviews, AFP reviews, children's model waiver reviews, Medicaid 5% records review.
4. Any DCH certification reviews should be conducted on a 2-year basis, consistent with the waiver period, not annually.

B. AUDITS

Overview: *Every CMHSP is required to have an annual independent fiscal audit. DCH also conducts fiscal audits, which routinely take 3-6 months and are labor intensive and time consuming. DCH, in collaboration with MACMHB, should develop audit specifications for independent auditors which address departmental audit objectives and which may be applied by the independent auditors.*

1. Reduce the scope of DCH financial audits. DCH audits routinely take 3-6 months. DCH, in collaboration with MACMHB, should develop audit specifications for independent auditors which address the audit objectives of the department. Independent audits performed by CPAs are already required of each CMHSP.
2. It is often difficult to obtain clarifications from DCH around issues which may have future audit implications.

C. REPORTING REQUIREMENTS

Overview: *Complicated and costly reporting requirements do often not add to the quality of care provided by CMHSPs or improved outcomes for consumers. Data definitions are often vague resulting in information which is not reliable, reporting requirements are often too frequent, and realistic time frames for making information system changes at the local level are often not provided. The*

state has, on occasion, made changes or additions to federal requirements which make compliance more time consuming and costly. When in doubt simplify, simplify, simplify.

1. State changes to federal 837 transaction requirements have added cost.
2. Eliminate/simplify DCH grant report requirements.
3. Eliminate quarterly reports as there is not an accurate fiscal picture until year end.
4. DCH Microsoft Access report format to submit Hab Waiver data has added costs.
5. Billing model children's waiver on fee for service basis adds cost.
6. Separate OBRA billings add cost.
7. Model payments has separate tracking and payment mechanisms than other foster care programs.
8. Evaluate continued provision of PPG reports.
9. Inconsistency and/or confusion over data definitions are ongoing problem.
10. Sufficient lead time is not always provided to make changes in reporting requirements.
11. Reduce unfunded mandates for payer/provider systems such as standards of care which contribute little value to consumer outcomes.
12. Reduce time direct care staff spend on paperwork including multiple signatures, start and stop times, and others.
13. Develop single form format statewide used for required documentation.
14. Improve timeliness/reliability/accuracy of statewide data.
15. Evaluate state expectations requiring CMHSPs to complete redundant reviews. Requiring independent proof that site visits (CCI/LPU's) have occurred and that staff have been trained adds unnecessary expense.
16. The defined frequency of many reports required by DCH is duplicative.
17. Find more efficient ways to extract data and eliminate redundant data.
18. Consider elimination of outcome measures when statewide performance is consistently good.
19. Other specific recommendations:
 - Continue with plan to eliminate need for shadow claims reporting and COB model.
 - QI Data Item #17 - Disability Designation: MDCH can figure this from the diagnoses submitted in the encounter data.
 - QI Data Item #18 - Service Designation: MDCH can figure this from the diagnosis and service information submitted in the encounter data.
 - QI Data Item #26.1 - Persons on Hab Supports Waiver is reported monthly to MDCH on the Hab Waiver Report.
 - QI Data Item #'s 26.3, 26.4, 26.8, 26.9, 26.10, and 26.11 - Specific insurance information is reported in the encounter data.
 - QI Data could be sent as a quarterly roll up rather than a monthly roll up.
 - MIMBPIS Table 1 - Unduplicated Counts: MDCH can figure this information from the QI and encounter data submitted.

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- MIMBPIS Table 2 - Penetration rates: MDCH can figure this information from the QI and encounter data submitted.
 - MIMBPIS Table 10 - Quality of Life - Living Situation: MDCH can figure this information from the QI and encounter data submitted.
 - Eliminate the need for trial balance and claims aging reports. The purpose and intended use is unclear.
 - OBRA measure benefits are unclear.
 - Percentage of people in day programs receiving supported employment is both unclear and inconsistent with DCH policy direction.
20. Make reasonable accommodations for CMHSPs in rural areas on performance indicators reporting. Small ends make compliance with performance indicator standards more challenging
 21. DCH performance indicator system should be reviewed and reduced. Indicators that remain or are added should have an outcome that is reliable, meaningful and that adds value.
 22. Any changes in reporting requirements should meet all compliance criteria, result in improved in improved outcomes for consumers, reduce administrative costs, or improve management efficiency without negatively affecting outcomes for consumers, and be developed with consumer input. Is the new requirement mandatory or optional? If optional, on what basis is it being recommended?
 23. Require department to calculate the cost to the system before any new reporting requirements are added.
 24. Encounter and demographic data should be reported on a quarterly not monthly basis.
 25. Current requirements that copy-righted outcome measures be implemented are costly and often too stringent.
 26. Look at better coordination between FIA and CMHSPs on transportation and home health services, especially the portion of these services funded by FIA.
 27. When in doubt, simplify, simplify, simplify.

D. MEDICAID

Overview: *The majority of comments regarding the Medicaid program had to do with the burdensome requirements of the spend down program. The monthly spend down process is onerous for consumers and providers. It results in uncertain coverage for consumers and high administrative costs and fewer dollars for CMHSPs.*

28. Monthly spend down process is very burdensome, provides uncertainty about coverage for consumers and results in higher administrative costs and fewer available Medicaid dollars for CMHSPs.
29. Spend down reporting requirements add costs for CMHSPs and FIA.
30. CMHSPs must report information to DCH about some aspects of Medicaid enrollment (such as when re-determinations are effective) that the state already has.
31. Look at longer period of eligibility (than 1 month) for those on spend down.
32. DCH manuals (children's waiver and HAB waiver) should be updated.
33. DCH has added another duplicative layer of reporting by requiring PHPs to monitor and report monthly on utilization of HAB waivers. The department and PHPs should not expensively duplicate their efforts around HAB waiver reporting.
34. Review and streamline various consumer appeal processes.
35. FIA must process Medicaid eligibility determination and redetermination in a timely manner.
36. Specific requirements for nursing services for consumers in crisis residential programs regardless of their medical and/or mental health needs is unrealistic and costly.

E. OTHER ISSUES

1. Video-conferencing and tele-conferencing technology could save travel expenses.
2. FIA home help duplicates community living supports services and should be coordinated.
3. Level of care standards for persons in home care, AFC placement, nursing home would be helpful and efficient.
4. CMH has to bill out Michigan rehab funding on a fee for service basis which is costly.
5. Review ability to pay requirements.
6. Review documentation requirements for PCP.
7. Recent requirements for specialized residential homes have resulted in fewer of these programs.
8. Require integrated services for persons served by multiple systems (FIA, CMH, QHP, SA, MRS, Public Health, Corrections).
9. Provide for licensure of community-based alternatives to reduce state facility costs.
10. Seek additional ways to integrate mental health and substance abuse services including articulation of a specific integration policy by DCH, establishing a single ability to pay schedule for the substance abuse and CMH systems, developing a single set of access standards for substance abuse and CMH systems, fully integrating points of access to the substance abuse and CMH systems, making SA/CA requirements more similar and removing barriers to PHPs serving as CAs where there is local agreements to do so.

11. OBRA/PASSAR screenings. Individuals having state determination of nursing home/or mental health services be exempt from annual behavioral review requirements.
12. Annual assessments for those in ACT programs required as needed.
13. Eliminate OBRA screenings for everyone entering a nursing home regardless of whether a person is in need of a mental health service. As a minimum, OBRA screenings should be able to be performed by a single qualified practitioner. Similar to the evaluation provided to anyone else seeking a CMH service. Current requirements for separate and specific multiple assessments were described by one board to be, in some cases, so pointless as to be absurd.
14. Seek ways of reducing the scope and impact of federal procurement requirements.
15. Allow local united of government to tap into state purchasing to take advantage of economies of scale.
16. Privacy regulations and requirements of HIPAA and Michigan Mental Health Code should be coordinated.
17. County of Financial Responsibility requirements are confusing, time consuming and expensive to implement.
18. Streamline annual assessment process for consumers who are served over the long term.
19. Combine application for service information or provide mechanism for sharing basic demographic information among local service providers.
20. Eliminate any regulation not directly mandated by state or federal law.

This is not an exhaustive list. We expect that as we begin to review these ideas that other areas will be identified as well.

Thank you!

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM
RESPONSE TO MACMHB ISSUES
Quality Management Site Reviews & Reporting Requirements Sub-Committee
 Revised 2/13/04

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
<p>A.1. Certification (including Children’s Diagnostic) Process <i>DCH is working internally to coordinate the schedule of the recipient rights reviews and certification reviews so that they coincide with the expiration of the CMHSP’s certification. DCH anticipates that the coordinated schedule will be complete by 2006.</i></p>	<p>A4. Certification reviews consistent with waiver period. <i>Certification reviews are conducted every three years per Section 330.123a of the MHC. Annual Medicaid site reviews have been modified to allow an administrative review of the PIHP once during the 2-year waiver period while maintaining the annual review of a sample of clinical records (10% for HSW), interviews of a sample of consumers, and follow-up on implementation of any previous plans of correction. The admin review, once per waiver</i></p>		<p>A.1. Difference between certification review and annual site review <i>Clarification provided that annual DCH site reviews are conducted at PIHP level per the CMS-approved Quality Strategy (Sect C.1. of the waiver application) and the BBA. National accreditation is a partial substitute for triennial certification of CMHSP per MHC 330.123a</i></p>	

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
	<p><i>period, of CMHSPs will be limited to any functions that the PIHP delegated, and to the triennial certification process if the CMHSP is not accredited.</i></p>			
<p>A3. Scope, frequency, consolidation of site reviews <i>During FY'03 the two-stage DCH M'caid reviews were consolidated into a single annual review that also integrates the SA, Children's Waiver, HSW 10% sample, and the AFP follow-up on plans of correction. The admin portion of the single annual review is limited to those areas that were not covered in the one-time-only AFP site review or were subject to plans of</i></p>	<p>B. 1.Reduce scope of DCH financial audits. <i>An ad hoc group has been meeting with Dr. Michael Ezzo, Patrick Barrie, and audit staff to resolve this.</i></p>	<p>B. 2. Difficult to obtain clarifications from DCH around issues, which may have future audit implications. <i>An ad hoc group has been meeting with Dr. Michael Ezzo, Patrick Barrie, and audit staff to resolve this</i></p>	<p>A2. DCH cert surveys. <i>The site visit associated with the certification process is waived if the CMHSP is accredited</i></p>	

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
<i>correction.</i>				
Provide incentives for meeting or exceeding standards	Impose sanctions for poor performance			

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
<p>C.12 &13. Documentation needed to verify that direct care was provided; statewide format</p> <p><i>An ad hoc group is reviewing all requirements (e.g., Chapter III, admin rules, MHC) to determine that minimum amount of documentation that is needed for evidence of compliance</i></p>	<p>C.19.b. Diagnosis code is insufficient for determination of developmental disability, and for eligibility for specialty services and supports. Need to know who is DD and who is MI</p>	<p>C.9. Confusion over data definitions & C.14. Improve timeliness, reliability, and accuracy of statewide data. Would like to discuss strategies for doing this.</p> <p><i>EDIT has been an important player in encouraging PIHPs to submit good data. It also conducted a training on 9/11/03, appeared at various conferences, and will put on an additional session 2/26/04. The group will remain a part of the solution to this problem.</i></p>	<p>C1. Changes to 837 have added costs.</p> <p><i>DCH did not change federal 837 transaction requirements. Because DCH determined that it should collect financial information with the encounter data for use in calculating actuarially sound capitation rates, it required that the PIHP use COB loops to report financial info. DCH compromised with MACMHB to allow PIHPs to report average allowed</i></p>	<p>C.8. Evaluate the need for PPGs: Budget office and CMHSP contracts</p> <p><i>This is a MHC requirement that is a valuable source of information.</i></p>

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
		<p>C.10. Sufficient lead-time for implementing changes to reporting requirements.</p> <p><i>The contracting process makes changes to reporting requirements difficult.</i></p>	<p><i>amount to substitute for reporting 4 financial fields.</i></p> <p>C.4. & D.6: MACMHB members may need additional training to understand the HSW registration process</p> <p><i>Enrollment and re-certification of HSW consumers has been brought back to Central Office. The database will be replaced by the use of the 834 and 837 transaction standards</i></p>	
<p>C.18. What outcome measures should be retained, what measures dropped when the system demonstrates good</p>	<p>C.19.f. and 24: <i>QI data needs to be reported monthly so that it can match up with 837.</i></p>	<p>C.16. Frequency of reports is duplicative. <i>ORR data reporting could be consolidated to annual; and</i></p>	<p>C.15. <i>Reviews of CCI/LPUs can be coordinated among CMHSPs thus eliminating</i></p>	<p>C.25. CAFAS requirements: check out utility with Wotring <i>CAFAS is used for functional assessment</i></p>

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
<p>performance</p> <p><i>The use of outcome measures will be considered by the newly re-established Quality Improvement Council along with the rest of the performance indicator system.</i></p>		<p><i>categories of reporting consolidated as well. This will require a change in the MHC. DCH has analyzed the other reports that are required: frequency, format, etc.</i></p>	<p><i>duplicative reviews</i></p>	<p><i>for service need and for outcomes measurement. It is likely that we will need to do something similar with all populations.</i></p>
<p>C.19.a. Need for COB is being discussed in workgroup that Fitton and MACMHB are coordinating</p> <p><i>Agreement was reached between MDCH and MACMHB to report a calculated "allowed amount" for each encounter.</i></p>	<p>C.19.h. Medicaid penetration rate required by CMS</p> <p><i>Once encounter data is submitted in a timely fashion, it will not be necessary to collect this via the performance indicator data.</i></p>	<p>C.19.c. Service designation: has proved to be of no use</p> <p><i>This QI element will be removed from the contract via amendment #2 of the PIHP contract, and amendment #1 of the CMHSP contract</i></p>	<p>C.19.g Unduplicated counts: <i>cannot get count of people served in the previous quarter due to lag time of encounter data reporting to accommodate adjudication of claims</i></p>	<p>E. 11. OBRA screening for NH/no MH services exemption: check with Verseput</p>
<p>C.19.e. Program eligibility is not present on 837, and collecting it is required by Sec. 404. Ask Approps to reconsider 404</p>	<p>E. 3. DCH does not want to impose level of care for home care, AFC, or NH...why would MACMHB want this?</p>	<p>C.19.d. Hab supports waiver designation is redundant now that monthly registry is in place</p> <p><i>This QI element will be removed from the</i></p>	<p>C.20. Small "n": <i>DCH's reporting of Performance indicators accommodates this in the narratives</i></p>	

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
<p>requirements? <i>Program eligibility is an important sorting key in data base management</i></p>		<p><i>contract via amendment #2 of the PIHP contract, and amendment #1 of the CMHSP contract</i></p>		
<p>C.19.h. Information from QI and encounter will not be available for quarterly penetration rates. Consider annual penetration rates, and/or dropping some that are not useful <i>Review of all performance indicators, including penetration rates, has been referred to the QI Council for possible refinement.</i></p>	<p>E.13. OBRA screening is a federal requirement in exchange for OBRA funds to serve NH residents who need mental health care.</p>	<p>C.21. Performance indicator system requires periodic review. Suggest a QI committee of CMHSPs, advocates, providers and consumers to help <i>A QI Council was re-established and had its first meeting 1/21/04.</i></p>	<p>D.7. There are various interpretations of these requirements. DCH will provide a training on the new tech requirement <i>The technical requirement is being revised per input from the PIHP hearing officers</i></p>	
<p>C.19.i. Quality of living situation</p>		<p>C.22. & 23. Reporting</p>	<p>D.9. Individuals in crisis residential</p>	

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
<p>required by Sec. 404. Consider annual rather than quarterly reporting</p> <p><i>Review of all performance indicators, including quality of living, has been referred to the QI Council for possible refinement</i></p>		<p>requirements changes: Suggest the QI committee to help do that</p> <p><i>This was referred to the QI Council</i></p>	<p>require intensive MH care overseen by an RN. If consumers do not need this level of care a regular AFC would suffice.</p>	
<p>C.19.k. OBRA: mental health services for persons in nursing homes needing less than specialized: consider dropping</p> <p><i>This indicator will be dropped via the amendment #1 of the CMHSP contract</i></p>		<p>C.27. Simplify, yes: Suggest the QI committee to help do that</p> <p><i>This has been referred to the QI Council</i></p>	<p>E. 12. ACT consumers need ongoing assessment of their needs for treatment. Annual is minimum for good practice.</p>	
<p>C.19.l. Percentage of persons with DD in day programs receiving SE: consider dropping or revising</p> <p><i>Review of all performance</i></p>		<p>D.5. DCH manuals should be updated</p> <p><i>Work on the Children's Waiver manual has begun. DCH agrees that the HSW manual needs to be updated.</i></p>	<p>E. 14. Interpretation by PHPs of the procurement requirements may have created more complexity than is needed. MDCH</p>	

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
<i>indicators, including employment, has been referred to the QI Council for possible refinement. MARO will be invited to participate</i>			(P. Barrie) will provide clarification.	
C. 3. Eliminate quarterly FSR reports <i>Per the contracts, the first quarter FSR report has been eliminated. DCH needs the other three reports to manage the funds.</i>		E. 1. Tele- and video-conferencing	E. 16. HIPAA privacy and MHC coordination: This work has been done by the AG's office	
C. 5. Billing model children's waiver on fee for service basis. <u>Non-negotiable</u>	C. 6. Separate OBRA billings. Federal government regulations require reporting actual costs.	E.5. Ability to pay requirements	E. 18. Annual assessments are not required. Annual review of plan of service is.	
		E.6. Review documentation requirements for PCP: A workgroup to do that was established 2 months ago. Suggest that other CMHSPs		

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
		<p>attend.</p> <p><i>An ad hoc committee on documentation is preparing recommendations for minimum requirements for PCP documentation.</i></p>		
		E.8. How would this be done		
		E. 10. Integration of MH and SA		
		E. 20. Agree that we can consider non-mandated (fed, state law) requirements, but some may be needed for contract management		

Items that need further clarification from MACMHB

- 9. Inconsistency and/or confusion over data definitions. Which ones?
- C. 2. Eliminate/simplify DCH grant Report Requirements. We need more clarification from MACMHB. What specific grant reports are they asking us about?
- C. 7. The model payments system is currently being reviewed by the Office of Audit. Could MACMHB coordinate obtaining CMHSP input relative to this program, and what changes would they recommend?
- 11. Un-funded mandates for payer/provider systems such as standards of care. Which standards of care?
- 17. Efficient ways of extracting data. Please clarify.
- E. 2. FIA home help duplicates community living supports. Please clarify.
- E. 4. CMH had to bill out Michigan rehab funding on a fee-for-service basis. Please clarify.
- E. 7. Recent requirements for specialized residential homes have resulted in fewer programs. Please clarify the problem.
- E. 9. Provide licensure of community-based alternatives. Please clarify.
- E. 15. Units of government tap into state purchasing. Please clarify.
- E. 17. County of financial responsibility requirements are confusing, etc. It is our understanding that the MACMHB has a workgroup that is studying this. What recommendations does the group have for MDCH?

Attachment #3

**Proposed
Community Mental Health
COMPLIANCE EXAMINATION GUIDELINES
Michigan Department of Community Health**



March 2006

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INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are being issued by the Michigan Department of Community Health (MDCH) to assist independent audit personnel, Prepaid Inpatient Health Plan (PIHP) personnel, and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDCH and PIHPs or CMHSPs, and to assure examinations are completed in a consistent and equitable manner.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDCH to manage the Concurrent 1915(b)/(c) Medicaid Programs (hereinafter referred to as “Medicaid Program”), and contracts between CMHSPs and MDCH to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208 (hereinafter referred to as “GF Program”). These CMH Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a PIHP or CMHSP expends \$500,000 or more in federal awards¹, the PIHP or CMHSP must still obtain a Single Audit.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related specifically to MDCH contracts with PIHPs for the Medicaid Program, and MDCH contracts with CMHSPs for the GF Program. These CMH Compliance Examination Guidelines, however, do not address compliance examinations for CMHSPs for the Medicaid funds received under contract with PIHPs. PIHPs are ultimately responsible for the Medicaid funds received from MDCH, and are responsible for monitoring the activities of affiliated CMHSPs as necessary to ensure subawarded Medicaid Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. Therefore, PIHPs must either require their independent auditor to examine compliance issues related to the Medicaid funds awarded to the affiliated CMHSPs, or require the affiliated CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 7, 8, & 9).

These CMH Compliance Examination Guidelines will be effective for fiscal years ending on or after September 30, 2007.

Failure to meet the requirements contained in these CMH Compliance Examination Guidelines may result in the withholding of current funds or the denial of future awards.

¹ Medicaid payments to PIHPs and CMHSPs for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended for the purposes of determining Single Audit requirements.

RESPONSIBILITIES

MDCH Responsibilities

MDCH must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code and federal audit requirements, and to ensure the **COMPLIANCE REQUIREMENTS** contained in the CMH Compliance Examination Guidelines are complete and accurately represent requirements of PIHPs and CMHSPs; and distribute revised CMH Compliance Examination Guidelines to PIHPs and CMHSPs.
2. Review the examination reporting packages submitted by PIHPs and CMHSPs to ensure completeness and adequacy within four months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in the PIHP or CMHSP examination reporting package within six months after the receipt of a complete and final reporting package.
4. Monitor the activities of PIHPs and CMHSPs as necessary to ensure the Medicaid Program and GF Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDCH will rely primarily on the examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. However, MDCH may determine it is necessary to also perform a limited scope compliance examination or review of selected areas. Any additional reviews or examinations shall be planned and performed in such a way as to build upon work performed by other auditors. The following are some examples of situations that may trigger an MDCH examination or review:
 - a. Significant changes from one year to the next in reported line items on the FSR.
 - b. A PIHP or CMHSP entering the MDCH risk corridor.
 - c. A large addition to an ISF per the cost settlement schedules.
 - d. A material non-compliance issue identified by the independent auditor.

PIHP Responsibilities

PIHPs must:

1. **Maintain internal control over the Medicaid Program that provides reasonable assurance that the PIHP is managing the Medicaid Program in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid Program.**
2. **Comply with laws, regulations, and the provisions of contracts related to the Medicaid Program.**
3. **Prepare appropriate financial statements.**

4. **Ensure that the examination required by these CMH Compliance Examination Guidelines is properly performed and submitted when due.**
5. **Follow up and take corrective action on examination findings.**
6. **Prepare a corrective action plan to address each examination finding included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the PIHP does not agree with the examination findings or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.**
7. **Monitor the activities of affiliated CMHSPs as necessary to ensure subawarded Medicaid Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. PIHPs must either (a.) require the PIHP's independent auditor (as part of the PIHP's examination engagement) to examine the records of the affiliated CMHSP for compliance with the subawarded Medicaid Program provisions, or (b.) require the affiliated CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program. If the latter is chosen, the PIHP must incorporate the examination requirement in the PIHP/CMHSP contract and develop Compliance Examination Guidelines specific to their PIHP/CMHSP contract. Additionally, if the latter is chosen, the CMHSP examination must be completed in sufficient time so that the PIHP auditor may rely on the CMHSP examination when completing their examination of the PIHP if they choose to.**
8. **If requiring an examination of the affiliated CMHSP, review the examination reporting packages submitted by affiliated CMHSPs to ensure completeness and adequacy.**
9. **If requiring an examination of the affiliated CMHSP, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in affiliated CMHSP's examination reporting packages.**

CMHSP Responsibilities

CMHSPs must:

1. **Maintain internal control over the Medicaid and GF Programs that provides reasonable assurance that the CMHSP is managing the Medicaid and GF Programs in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid and GF Programs.**

- 2. Comply with laws, regulations, and the provisions of contracts related to the Medicaid and GF Programs.**
- 3. Prepare appropriate financial statements.**
- 4. Ensure that the examination required by these CMH Compliance Examination Guidelines, and any examination required by the PIHP from which the CMHSP receives Medicaid funds are properly performed and submitted when due.**
- 5. Follow up and take corrective action on examination findings.**
- 6. Prepare a corrective action plan to address each examination finding included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with the examination findings or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.**

EXAMINATION REQUIREMENTS

PIHPs under contract with MDCH to manage the Medicaid Program, and CMHSPs under contract with MDCH to manage the GF Program are required to contract annually with a certified public accountant in the practice of public accounting (hereinafter referred to as a practitioner) to examine the PIHP's or CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 10 – Compliance Attestation – AT 601 (Codified Section of AICPA Professional Standards) (hereinafter referred to as an examination engagement). The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled “Compliance Requirements.”

Practitioner Selection

In procuring examination services, PIHPs and CMHSPs must engage an independent practitioner, and must follow the procurement standards prescribed by the Grants Management Common Rule (A-102 Common Rule). The codified common rule for PIHPs and CMHSPs is located at 45 CFR 92, Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments. Procurement standards are addressed in Section 92.36. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, and price. When possible, PIHPs and CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the PIHP's or CMHSP's compliance with specified requirements is to express an opinion on the PIHP's or CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that the PIHP or CMHSP complied, in all material respects, based on the specified criteria.

Practitioner Requirements

The practitioner should exercise due care in planning, performing, and evaluating the results of his or her examination procedures; and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected.

The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled “Compliance Requirements.” In the examination of the PIHP’s or CMHSP’s compliance with specified requirements, the practitioner should:

1. Obtain an understanding of the specified compliance requirements (See AT 601.40).
2. Plan the engagement (See AT 601.41 through 601.44).
3. Consider the relevant portions of the PIHP’s or CMHSP’s internal control over compliance (See AT 601.45 through 601.47).
4. Obtain sufficient evidence including testing compliance with specified requirements (See AT 601.48 through 601.49).
5. Consider subsequent events (See AT 601.50 through 601.52).
6. Form an opinion about whether the entity complied, in all material respects with specified requirements based on the specified criteria (See AT 601.53).

Practitioner’s Report

The practitioner’s examination report on compliance should include the information detailed in AT 601.55 and 601.56, which includes the practitioner’s opinion on whether the entity complied, in all material respects, with specified requirements based on the specified criteria. When an examination of the PIHP’s or CMHSP’s compliance with specified requirements discloses noncompliance with the applicable requirements that the practitioner believes have a material effect on the entity’s compliance, the practitioner should modify the report as detailed in AT 601.64. An example of the form of the report for material noncompliance is shown in AT 601.65.

In addition to the above examination report standards, the practitioner must prepare:

1. A schedule(s) of findings for the Medicaid and/or GF Program(s) that includes the following:
 - a. Reportable conditions that are individually or cumulatively material weaknesses in internal control over the Medicaid and/or GF Program(s).
 - b. Material noncompliance with the provisions of laws, regulations, or contracts related to the Medicaid and/or GF Program(s).
 - c. Known fraud affecting the Medicaid and/or GF Program(s).
2. A schedule(s) showing reported Financial Status Report (FSR) amounts, examination adjustments, and examined FSR amounts for the Medicaid and/or GF Program(s). The examination adjustments must be explained. This schedule is called the “Examined FSR Schedule.”
3. A schedule(s) showing a revised cost settlement(s) for the PIHP or CMHSP based on the Examined FSR Schedule(s). Any amount due back to MDCH from the PIHP or CMHSP represents a “questioned cost” amount. This schedule is called

the “Examined Cost Settlement Schedule.”

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDCH within the earlier of 30 days after receipt of the practitioner’s report(s), or nine months after the end of the PIHP’s or CMHSP’s fiscal year end. The PIHP or CMHSP must submit the reporting package to MDCH at the following address:

Michigan Department of Community Health
Office of Audit
Quality Assurance and Review Section
P.O Box 30479
Lansing, Michigan 48909-7979
Or
400 S. Pine Street
Capital Commons Center
Lansing, Michigan 48933

Examination Reporting Package

The reporting package includes the following:

1. Practitioner’s report as described above;
2. Corrective action plan prepared by the PIHP or CMHSP.

Penalty

If the PIHP or CMHSP fails to submit the required examination reporting package within nine months after the end of the agency’s fiscal year, MDCH may withhold from current funding five percent of the examination year’s grant funding (not to exceed \$100,000) until the required reporting package is received. MDCH may retain the withheld amount if the reporting package is delinquent more than 120 days.

Incomplete or Inadequate Examinations

If MDCH determines the examination reporting package is incomplete or inadequate, the PIHP or CMHSP, and possibly its independent auditor will be informed of the reason of inadequacy and its impact in writing. The recommendations and expected time frame for resubmitting the corrected reporting package will be indicated.

Management Decision

MDCH will issue a management decision on findings and questioned costs contained in the PIHP or CMHSP examination report within six months after the receipt of a complete and final reporting package. The management decision will include whether or not the examination finding is sustained; the reasons for the decision; the expected PIHP or CMHSP action to repay disallowed costs, make financial adjustments, or take other action; and a description of the appeal process available to the PIHP or CMHSP. Prior to issuing the management decision, MDCH may request additional information or documentation from the PIHP or CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the PIHP or CMHSP is included in the applicable contract.

If there are no findings and/or questioned costs, MDCH will notify the PIHP or CMHSP that the review of the examination reporting package is complete and the results of the review.

COMPLIANCE REQUIREMENTS

The practitioner must examine the PIHP's or CMHSP's compliance with the following specified requirements.

FSR Reconciliation

The auditor must reconcile the Financial Status Report (FSR) to the general ledger, and determine if amounts reported on the FSR are supported by the PIHP's or CMHSP's general ledger. Any differences between the general ledger and FSR should be adequately explained and justified, and all FSR reporting must comply with the contractual FSR reporting instructions. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule."

Expenditure Reporting

The auditor must determine if the PIHP's or CMHSP's expenditures reported on the FSR comply with the Office of Management and Budget (OMB) Circular A-87 cost principles, the Mental Health Code (Code), and contract provisions. Any reported expenditures that do not comply with the OMB Circular A-87 cost principles, the Code, or contract provisions must be shown on the auditor's "Examined FSR Schedule."

Generally, OMB Circular A-87 cost principles require that for costs to be allowable they must meet the following general criteria:

- a. Be necessary and reasonable for proper and efficient performance and administration of the grant.**
- b. Be allocable to the grant under the provisions of the applicable OMB Circular.
- c. Be authorized or not prohibited under State or local laws or regulations.
- d. Conform to any limitations or exclusions set forth in the applicable OMB Circular, other applicable laws and regulations, or terms and conditions of the grant and agreement.
- e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
- f. Be accorded consistent treatment.
- g. Be determined in accordance with generally accepted accounting principles.
- h. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period.
- i. Be the net of all applicable credits.

j. Be adequately documented.

All reported expenditures must be traceable to the agency's general ledger, and adequately supported.

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services. Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness criteria of OMB Circular A-87 was met. If subcontractors are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation. If the subcontract is for inpatient services, the rates need to be reviewed to ensure the rates paid do not exceed the rates generally paid for Medicaid patients. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported costs for **less-than-arms-length transactions** must be limited to underlying cost. For example, the agency may rent their office building from the agency's board member/members, but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in OMB Circular A-87.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost.

Capital asset purchases that cost greater than \$5,000 must be capitalized and depreciated over the useful life of the asset rather than expensing it in the year of purchase.

Costs must be allocated to programs in accordance with relative benefits received. Accordingly, **Medicaid costs must be charged to the Medicaid Program, and GF costs must be charged to the GF Program**. Additionally, **administrative/indirect costs** must be distributed to programs on bases that will produce an equitable result in consideration of relative benefits derived.

Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported by personnel activity reports that meet the standards listed in OMB Circular A-87.

Expenditures relating to providing the **20 outpatient visit services** for Qualified Health Plans (QHPs) must be recorded as earned contract expenditures, NOT matchable expenditures.

Revenue Reporting

The auditor must determine if the PIHP or CMHSP has properly reported all revenue on the FSR.

SSI revenue and other reimbursements that support matchable Medicaid and GF expenditures must be properly recorded to offset matchable expenditures.

SSA Revenue received and then sent to residential providers cannot be recorded as a matchable expenditure.

Revenue received from QHPs for providing 20 outpatient visits must be recorded as earned contract revenue.

Procurement

The auditor must determine if the acquisition of assets or services complied with contractual and regulatory requirements.

Rate Setting and Ability to Pay

The auditor must determine if service rates are updated at least annually. The auditor must determine if consumers are completing ability to pay forms.

Internal Service Fund (ISF)

The auditor must determine if the establishment, funding, and maintenance of any Internal Service Fund complies with the contractual provisions. The auditor must verify that:

- a. The establishment and funding of the ISF is based on a sound actuarial study or historical cost information,
- b. assumptions used in the actuarial or historical study used to justify the ISF are supported,
- c. any interest earned on the ISF is reinvested back into the ISF,
- d. any use of the ISF is for risk corridor financing for allowable costs, and
- e. any overfunding of the ISF is reduced through an abatement of current charges.

Medicaid Savings and General Fund Carryforward

The auditor must determine that Medicaid Savings and General Fund Carryforward earned in the previous year was used in the current year on allowable expenditures

and it was properly recorded on the FSR (matchable expenditures must be properly reduced).

Match Requirement

The auditor must determine if the PIHP or CMHSP met the local match requirement. As part of this determination, the auditor must determine if items considered as local match actually qualify as local match. Some examples of funds that do NOT qualify as local match are: (a.) revenues (such as workers' compensation refunds) that should be offset against related expenditures, (b.) interest earned from ISF accounts, (c.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (d.) donations of funds from subcontractors of the PIHP or CMHSP, and (e.) donations of items that would not be an item generally provided by the PIHP or CMHSP in providing plan services.

If the PIHP or CMHSP does not comply with the match requirement, or cannot provide reasonable evidence of compliance¹, ...

Service Documentation

The auditor must determine if services are adequately documented according to contractual and Code provisions.

Consumer Fund Review

The auditor must determine that consumer funds are maintained separate from other CMH funds, amounts are accurate, SSI revenue is properly recorded, and that rent payments made on behalf of consumers are accurate.

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDCH. Also, PIHPs are required to keep affiliate CMHSP's reports on file for three years from date of receipt. All examination working papers must be accessible and are subject to review by representatives of the Michigan Department of Community Health, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and affiliate CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDCH CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2006/2007 examinations. Any questions relating to these guidelines should be directed to:

James B. Hennessey, Director
Office of Audit
Michigan Department of Community Health
Capital Commons Center
400 S. Pine Street
Lansing, Michigan 48933
hennesseyj@michigan.gov
Phone: (517) 335-5323 Fax: (517)335-5443

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400 S. Pine Street
Lansing, Michigan 48933
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GLOSSARY OF ACRONYMS AND TERMS

- AICPA.....American Institute of Certified Public Accountants.
- CMHSP.....Community Mental Health Services Program (CMHSP). A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended.
- Examination Engagement.....A PIHP or CMHSP’s engagement with a practitioner to examine the entity’s compliance with specified requirements in accordance with the AICPA’s Statements on Standards for Attestation Engagements (SSAE) 10 – Compliance Attestation – AT 601 (Codified Section of AICPA Professional Standards).
- GF Program.....The program managed by CMHSPs under contract with MDCH to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.
- MDCH.....Michigan Department of Community Health
- Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program managed by PIHPs under contract with MDCH.
- PIHP.....Prepaid Inpatient Health Plan. An organization that manages Medicaid specialty services under the state’s approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care.
- Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.
- SSAE AICPA’s Statements on Standards for Attestation Engagements.