MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

COMPLIANCE EXAMINATION GUIDELINES

Fiscal Year End September 30, 2021

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INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Health and Human Services (MDHHS) to assist independent audit personnel, the Prepaid Inpatient Health Plan (PIHP) personnel, and the Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by the contracts between the MDHHS and the PIHPs and/or the 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 the contracts between the MDHHS and the PIHPs to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, Flint 1115, and Substance Use Disorder Community Grant Programs (hereinafter referred to as the Medicaid Contract); the contracts between the MDHHS and the CMHSPs to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances (SED), or developmental disabilities (DD) as described in MCL 330.1208 (hereinafter referred to as the GF Contract); and, in certain circumstances, the contracts between the MDHHS and the PIHPs and/or the CMHSPs to manage the Community Mental Health Services Block Grant Program (hereinafter referred to as the CMHS Block Grant). 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 a CMHSP expends $750,000 or more in federal awards[1], the PIHP or the CMHSP must obtain a Single Audit.

The PIHPs are ultimately responsible for the Medicaid funds received from the MDHHS and are responsible for monitoring the activities of the network provider CMHSPs as necessary to ensure expenditures of the Medicaid Contract funds are for authorized purposes in compliance with laws, regulations, and the provisions of the contracts. Therefore, the PIHPs must either require their independent auditor to examine compliance issues related to the Medicaid funds awarded to the network provider CMHSPs, or require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to the contracts between the PIHPs and the CMHSPs to manage the Medicaid Contract. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 8, 9, & 10).

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2021. They replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

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 the PIHPs and the 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

The MDHHS Responsibilities:

The MDHHS must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with the current Michigan Mental Health Code (MMHC) and federal and state audit requirements; ensure the Compliance Requirements contained in these CMH Compliance Examination Guidelines are complete and accurately represent the requirements of the PIHPs and the CMHSPs; and distribute revised CMH Compliance Examination Guidelines to the PIHPs and the CMHSPs.

2. Review the examination reporting packages submitted by the PIHPs and the CMHSPs to ensure completeness and adequacy within eight months of receipt.

3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings, comments, and examination adjustments contained in the PIHP or the CMHSP examination reporting package within **eight (8) months** after the receipt of a complete and final reporting package.

4. Monitor the activities of the PIHPs and the CMHSPs, as necessary, to ensure the Medicaid Contract, the GF Contract, and the CMHS Block Grant funds are used for authorized purposes in compliance with laws, regulations, and the provisions of the contracts. The MDHHS will rely primarily on the compliance examination engagements conducted on the PIHPs and the CMHSPs by independent auditors to ensure the Medicaid Contract and the GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. The MDHHS will rely on the PIHP or the CMHSP Single Audits or the compliance examination engagements conducted on the PIHPs and the CMHSPs by independent auditors to ensure the CMHS Block Grant funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. The MDHHS may, however, 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 a MDHHS examination or review:

    a. Significant changes from one year to the next in reported line items on the Financial Status Report (FSR).

    b. A PIHP entering the MDHHS risk corridor.

    c. A large addition to an Internal Service Fund (ISF) per the cost settlement schedules.

    d. A material non-compliance issue identified by the independent auditor.

    e. The Certified Public Accountant (CPA) that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.

    f. The CPA issued an adverse opinion on compliance due to their inability to draw conclusions because of the condition of the agency's records.

The PIHPs Responsibilities

The PIHPs must:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the Medicaid Contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the Medicaid Contract.

2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the MMHC (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual (MPM), and Generally Accepted Accounting Principles (GAAP).

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, comment, and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for the corrective action, the corrective action planned, and the anticipated completion date. If the PIHP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.

7. The PIHP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by the MDHHS, and the PIHP will be notified of any required action in the management decision.

8. Monitor the activities of the network provider CMHSPs as necessary to ensure the Medicaid Contract funds are used for authorized purposes in compliance with laws, regulations, and the contract provisions. The PIHPs must either (a.) require the PIHPs independent auditor (as part of the PIHPs examination engagement) to examine the records of the network provider CMHSP for compliance with the Medicaid Contract provisions, or (b.) require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between the PIHPs and the CMHSPs to manage the Medicaid Contract. If the latter is chosen, the PIHP must incorporate the examination requirement in the PIHP and the CMHSP contract and develop Compliance Examination Guidelines specific to their PIHP and their 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.

9. If requiring an examination of the network provider CMHSPs, review the examination reporting packages submitted by the network provider CMHSPs to ensure completeness and adequacy.

10. If requiring an examination of the network provider CMHSPs, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in the network provider CMHSPs examination reporting packages.

The CMHSPs Responsibilities

(as a recipient of the Medicaid Contract funds from the PIHP and a recipient of the GF Contract funds from the MDHHS and a recipient of the CMHS Block Grant funds from the MDHHS)

The CMHSPs must:

1. Maintain internal control over the Medicaid Contract, the GF Contract, and the CMHS Block Grant that provides reasonable assurance that the CMHSP is managing the Medicaid Contract, the GF Contract, and the CMHS Block Grant in compliance with laws, regulations, and the contract provisions that could have a material effect on the Medicaid Contract, the GF Contract, and the CMHS Block Grant.

2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract, the GF Contract, and the CMHSP Block Grant. Examples of these would include, but not be limited to: the Medicaid Contract, the GF Contract, the CMHS Block Grant, the MMHC (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the MPM, and GAAPs.

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 Program 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, comment, and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for the corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.

7. The CMHSP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by the MDHHS, and the CMHSP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

The PIHPs under contract with the MDHHS to manage the Medicaid Contract and the CMHSPs under contract with the MDHHS to manage the GF Contract are required to contract annually with a CPA in the practice of public accounting (hereinafter referred to as a practitioner) to examine the PIHPs or the CMHSPs compliance with specified requirements in accordance with the American Institute of Certified Public Accountants (AICPAs) Statements on Standards for Attestation Engagements (SSAE) 18 – Attestation Standards – Clarification and Recodification – AT – C Section 205. The specified requirements and criteria are contained in these CMH Compliance Examination Guidelines under the Compliance Requirements Section.

Additionally, the CMHSPs under contract with the MDHHS to provide the CMHS Block Grant services with a total contract amount of greater than $187,500 are required to ensure the above referenced examination engagement includes an examination of compliance with specified requirements related to the CMHS Block Grant **IF** the CMHSP does not have a Single Audit or the CMHSPs Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program. The specified requirements and criteria related to the CMHS Block Grant are contained in these CMH Compliance Examination Guidelines under the Compliance Requirements Section.

Practitioner Selection

In procuring examination services, the PIHPs and the CMHSPs must engage an independent practitioner and must follow the Procurement Standards contained in 2 CFR 200.318 through 200.320. 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 (RFP), relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, the results of the MDHHS reviews, and price. Whenever possible, the PIHPs and the CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the PIHPs or the CMHSPs compliance with specified requirements is to express an opinion on the PIHPs or the CMHSPs compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that the PIHP or the 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/her examination procedures and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected. The specified requirements and criteria are contained in these CMH Compliance Examination Guidelines under the Compliance Requirements Section. In the examination of the PIHPs or the CMHSPs compliance with specified requirements, the practitioner should follow the requirements of AT-C 105 and 205.

Practitioner's Report

The practitioner's report on compliance should include the information detailed in AT-C 205.63 through 205.86, 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 PIHPs or the CMHSPs compliance with specified requirements discloses noncompliance with the applicable requirements the practitioner believes have a material effect on the entity's compliance, the practitioner should modify the report as detailed in AT-C 205.68 through AT-C 205.75.

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

1. A Schedule of Findings that includes the following:

    a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, the GF Contract, the CMHS Block Grant, and/or the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

    b. Material noncompliance with the provisions of laws, regulations, or the contract provisions related to the Medicaid Contract, the GF Contract, the CMHS Block Grant, and/or the SAPT Block Grant.

    c. Known fraud affecting the Medicaid Contract, the GF Contract, the CMHS Block Grant, and/or the SAPT Block Grant.

    Finding detail must be presented in sufficient detail for the PIHP or the CMHSP to prepare a corrective action plan and for the MDHHS to arrive at a management decision. The following specific information must be included, as applicable, in findings:

    a. The criteria or specific requirement upon which the finding is based including statutory, regulatory, contractual, or other citation. **These Compliance Examination Guidelines should NOT be used as criterion.**

    b. The condition found including facts that support the deficiency identified in the finding.

    c. Identification of applicable examination adjustments and how they were computed.

    d. Information to provide proper perspective regarding prevalence and consequences.

    e. The possible asserted effect.

    f. Recommendations to prevent future occurrences of the deficiency(ies) noted in the finding.

    g. Views of responsible officials of the PIHP and/or the CMHSP.

    h. Planned corrective actions.

i. Responsible party(ies) for the corrective action.

j. Anticipated completion date.

2. A schedule showing final **reported** FSR amounts, examination adjustments, including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section addressed below, and examined FSR amounts. **All examination adjustments must be explained.** This schedule is called the Examined FSR Schedule. NOTE: Medicaid FSRs must be provided for the PIHPs. All applicable FSRs must be included in the practitioner's report regardless of the lack of any examination adjustments.

3. A schedule showing a revised Cost Settlement for the PIHP or the CMHSP based on the examined FSR Schedule. This schedule is called the Examined Cost Settlement Schedule. This must be included in the practitioner's report regardless of the lack of any examination adjustments.

4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, the GF Contract, and/or the CMHS Block Grant only in the event the individual comment or recommendation is expected to have an impact greater than or equal to $10,000 and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency.

Examination Report Submission

The examination must be completed, and the reporting package described below must be submitted to the MDHHS within the earlier of **30 days** after receipt of the practitioner's report, or **June 30** following the contract year end. The PIHP or the CMHSP must submit the reporting package by email to the MDHHS at MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in a PDF file compatible with Adobe Acrobat reader. The subject line must state the agency name and fiscal year end. The MDHHS reserves the right to request a hard copy of the compliance examination report materials, if for any reason the electronic submission process is not successful.

Examination Reporting Package

The reporting package includes the following:

1. The practitioner's report as described above, and

2. The corrective action plan prepared by the PIHP or the CMHSP.

Penalty

If the PIHP or the CMHSP fails to submit the required examination reporting package by **June 30** following the contract year end and an extension has not been granted by the MDHHS, the MDHHS may withhold from current funding five (5) percent of the examination year's grant funding (not to exceed $200,000) until the required reporting package is received. The MDHHS may retain the withheld amount if the reporting package is delinquent more than **120 days** from the due date and the MDHHS has not granted an extension.

Incomplete or Inadequate Examinations

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

Management Decision

The MDHHS will issue a management decision on findings, comments, and examination adjustments contained in the PIHP or the CMHSP examination report within **eight (8) months** after the receipt of a complete and final reporting package. The management decision will include whether or not the examination finding and/or comment is sustained; the reasons for the decision; and the PIHP or the CMHSP expected action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, the MDHHS may request additional information or documentation from the PIHP or the CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the PIHP or the CMHSP is included in the applicable contract.

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

COMPLIANCE REQUIREMENTS

The practitioner must examine the PIHPs or the CMHSPs compliance with the A-F specified requirements based on the specified criteria stated below related to the Medicaid Contract and the GF Contract. If the PIHP or the CMHSP does not have a Single Audit or the Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major federal program, the practitioner must also examine the CMHSPs compliance with the G-I specified requirements based on the specified criteria stated below that specifically relate to the CMHS Block Grant, but only if the total contract amount for the CMHS Block Grant is greater than $187,500. If the PIHP does not have a Single Audit, or the Single Audit does not include the SAPT Block Grant (CFDA 93.959) as a major Federal program, the practitioner must also examine the PIHPs compliance with the J-K specified requirements based on the specified criteria stated below that specifically relate to the SAPT Block Grant.

COMPLIANCE REQUIREMENTS A-F
(Applicable to all the PIHP and the CMHSP Compliance Examinations)

A. FSR Reporting

The final FSRs (entire reporting package applicable to the entity) comply with contractual provisions as follows:

1. The FSRs agree with agency financial records (general ledger) as required by the reporting instructions http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html). Click on Reporting Requirements.

2. The FSRs include only allowed activities as specified in the contracts; allowable costs as specified in the Federal cost principles (located at 2 CFR 200, Subpart E)(the GF Contract, Section 6.6.1; and the Medicaid Contract, Section 7.8); and allowed activities and allowable costs as specified in the MMHC, Sections 240, 241, and 242.

3. The FSRs include revenues and expenditures in proper categories and according to reporting instructions.

Differences between the general ledger and FSRs should be adequately explained and justified. Any differences not explained and justified must be shown as an adjustment on the practitioner's Examined FSR Schedule. Any reported expenditures that do not comply with the Federal Cost Principles, the MMHC, or the contract provisions must be shown as adjustments on the auditor's Examined FSR Schedule.

The following items should be considered in determining allowable costs:

Federal Cost Principles (2 CFR 200.402) require that for costs to be allowable they must meet the following general criteria:

a. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under the principles.

b. Conform to any limitations or exclusions set forth in the principles or in the Federal award as to types or amount of cost items.

c. Be consistent with policies and procedures that apply uniformly to both federally financed and other activities of the non-Federal entity.

d. Be accorded consistent treatment.

e. Be determined in accordance with GAAPs.

f. Not be included as a cost or used to meet cost sharing or matching requirements of any other federally financed program in either the current period or a prior period.

g. Be adequately documented.

Reimbursements to **subcontractors** (including the PIHP payments to the CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). The contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive scrutiny to ensure the reasonableness criteria of 2 CFR Part 200, Subpart E – Cost Principles, 200.404 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 (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). When the PIHP pays Federally Qualified Heath Centers (FQHC) and Rural Health Centers (RHC) for specialty services included in the specialty services waiver, the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. 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 rental costs for **less-than-arms-length transactions** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (c)). 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 2 CFR Part 200.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (b)).

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 (2 CFR Part 200, Subpart E – Cost Principles, 200.436 and 200.439). All invoices for a remodeling or renovation project must be accumulated for a total project cost when determining capitalization requirements; individual invoices should not simply be expensed because they are less than $5,000.

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 in accordance with 2 CFR Part 200, Appendix VII.

Distributions of salaries and wages for employees that work on multiple activities or cost objectives must be supported in accordance with the standards listed in 2 CFR Part 200, Subpart E – Cost Principles, 200.430 (i).

B. Medical Loss Ratio (MLR) Report

The PIHPs most recently completed Medical Loss Ratio Report complied with 42 CFR § 438.8 and Medical Loss Ratio Reporting requirements contained in the PIHP contract 8.4.1.7.

C. Procurement

The PIHP or the CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326. The PIHP or the CMHSP ensured that organizations or individuals selected and offered contracts have not been debarred or suspended or otherwise excluded from or ineligible for participation in Federal assistance programs as required by 45 CFR 92.35.

D. Internal Service Fund

The PIHPs ISF complies with the ISF Technical Requirement contained in the Internal Service Fund Technical Requirement with respect to funding and maintenance.

E. Medicaid Savings and General Fund Carryforward

The PIHPs Medicaid Savings was expended in accordance with the PIHPs reinvestment strategy as required by Sections 8.6.2.2 and 8.6.2.3 of the Medicaid Contract. The CMHSPs GF carryforward earned in the previous year was used in the current year on allowable GF expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS and the CMHSP contract.

F. Match Requirement

The PIHP or the CMHSP met the local match requirement and all items considered as local match qualify as local match according to Section 7.2 of the GF Contract and Section 8.2 of the Medicaid Contract. 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 the CMHSP, (e.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSPs actual costs, and (f) donations of items that would not be an item generally provided by the PIHP or the CMHSP in providing plan services.

If the PIHP or the CMHSP does not comply with the match requirement in the MMHC, Section 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

COMPLIANCE REQUIREMENTS G-I
(Applicable to the PIHPs and/or the CMHSPs with a CMHS Block Grant of greater than $187,500 that did not have a Single Audit, or the CMHS Block Grant was not a Major Federal Program in the Single Audit)

G. CMHS Block Grant – Activities Allowed or Unallowed

The CMHSP expended the CMHS Block Grant (CFDA 93.958) funds only on allowable activities in accordance with Federal Block Grant provisions and the Grant Agreement between the MDHHS and the CMHSP.

H. CMHS Block Grant – Cash Management

The CMHSP complied with the applicable cash management compliance requirements contained in the Federal Block Grant Provisions. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by the CMHSP funds before reimbursement is requested from the MDHHS.

I. CMHS Block Grant – Sub-recipient Management and Monitoring

If the CMHSP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal CMHS Block Grant, the CMHSP complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h).

COMPLIANCE REQUIREMENTS J-K
(Applicable to the PIHPs with a SAPT Block Grant that did not have a Single Audit or the SAPT Block Grant was not a Major Federal Program in the Single Audit)

J. SAPT Block Grant – Activities Allowed or Unallowed

The PIHP or the CMHSP expended SAPT Block Grant (CFDA 93.959) funds only on allowable activities in accordance with the Federal Block Grant Provisions and the Grant Agreement.

K. SAPT Block Grant – Sub-recipient Management and Monitoring

If the PIHP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal SAPT Block Grant, the PIHP complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h).

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of **three (3) years** after the final examination review closure by the MDHHS. Also, the PIHPs are required to keep the affiliate CMHSPs reports on file for **three (3) years** from date of receipt. All examination working papers must be accessible and are subject to review by representatives of the MDHHS, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and the provider network CMHSP auditors. To the extent possible, they should share examination information and materials to avoid redundancy.

EFFECTIVE DATE AND THE MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the Fiscal Year 2020/2021 examinations. Any questions relating to these guidelines should be directed to:

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Program Development, Consultation & Contracts Division
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Larson-Elliott Building
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GLOSSARY OF ACRONYMS AND TERMS

AICPA
American Institute of Certified Public Accountants.

Children's Waiver Program
The Children's Waiver Program provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 enrolled in the program who, if not for the availability and provisions of the Waiver, would otherwise require the level of care and services provided in an Intermediate Care Facility for the Mentally Intellectual. Payment from the MDHHS is on a fee-for-service basis.

CMHS Block Grant Program
The program managed by the CMHSPs under contract with the MDHHS to provide Community Mental Health Services Block Grant program services under CFDA 93.958.

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 a CMHSPs engagement with a practitioner to examine the entity's compliance with specified requirements in accordance with the AICPAs SSAE – Attestation Standards – Clarification and Recodification – AT-C 205 (Codified Section of AICPA Professional Standards).

Flint 1115 Waiver
This demonstration waiver expands coverage to children up to age 21 and to pregnant women with incomes up to and including 400 percent of the federal poverty level who were served by the Flint water system from April 2014 through a state-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act (SSA) and is effective as of March 3, 2016, the date of the signed approval through February 28, 2021. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the State Plan. All such individuals will have access to targeted case management services under a fee-for-service contract between the MDHHS and the Genesee Health System (GHS). The fee-for-service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan, and Medicaid Policy.

GF Program
The program managed by the CMHSPs under contract with the MDHHS to provide mental health services and supports to individuals with serious mental illness, SED, or DD as described in MCL 330.1208.

MDHHS
The Michigan Department of Health and Human Services.

Medicaid Program
The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by the PIHPs under contract with the MDHHS.

PIHP
Prepaid Inpatient Health Plan. In Michigan, a PIHP is 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 438. The PIHP, also known as a Regional Entity under MHC 330.1204b or a CMHSP, also manages the Autism Program, Healthy Michigan, SATP Community Grant, and PA2 funds.

Practitioner
A CPA in the practice of public accounting under contract with the PIHP or the CMHSP to perform an examination engagement.

Serious Emotional Disturbances Waiver
The Waiver for Children with SED Program that provides services to children who would otherwise require hospitalization in the State psychiatric hospital to remain in their home and community. Payment from the MDHHS is on a fee-for-service basis.

SSAE
The AICPAs Statements on Standards for Attestation Engagements.

SAPT Block Grant Program
The program managed by the PIHPs under contract with the MDHHS to provide Substance Abuse Prevention and Treatment Block Grant program services under CFDA 93.959.

SUD Services
Substance Use Disorder Services funded by Medicaid, Healthy Michigan, and the Community Grant which consists of Federal SAPT Block Grant funds and State funds.