# Community Mental Health Service Programs

# COMPLIANCE EXAMINATION GUIDELINES

## Michigan Department of Health and Human Services

Fiscal Year End September 30, 2025

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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 and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDHHS and 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 MDHHS to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, Flint 1115 and Substance Use Disorder Community Grant Programs (hereinafter referred to as "Medicaid Contract"); the contracts between CMHSPs and MDHHS 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 Contract"). 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 CMHSP expends $750,000 or more in federal awards[1], the CMHSP must obtain a Single Audit.

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2025, and 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 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

## MDHHS Responsibilities

MDHHS must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code, and federal and state 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 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 CMHSP examination reporting package within eight 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 Contract, GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Contract, and GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely on PIHP or CMHSP Single Audits or the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure the funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. 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 an MDHHS examination or review:
    a. Significant changes from one year to the next in reported line items on the FSR.
    b. A PIHP entering the MDHHS 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.
    e. The 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.

## CMHSP Responsibilities

**(As a recipient of Medicaid Contract funds from PIHP and a recipient of GF funds from MDHHS)**

CMHSPs must:

1. Maintain internal control over the Medicaid Contract, and GF Contract that provides reasonable assurance that the CMHSP is managing the Medicaid Contract, and GF Contract in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid Contract, and GF Contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract, and GF Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Managed Mental Health Supports and Services Contract (General Fund Contract), the Mental Health Code (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, and Generally Accepted Accounting Principles (GAAP).
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, and comment and recommendation 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 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 MDHHS, and the CMHSP will be notified of any required action in the management decision.

## EXAMINATION REQUIREMENTS

Unless the PIHP managing the Medicaid Contract requires their independent auditor to perform a compliance examination at the CMHSP, the CMHSPs under contract with MDHHS to manage the GF Contract 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 CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 18 –Attestation Standards – Clarification and Recodification AT-C Section 205. 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, CMHSPs must engage an independent practitioner, and must follow the Procurement Standards contained in 2 CFR 200.317 through 200.327. 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, the results of MDHHS reviews, and price. When possible, CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

## Examination Objective

The objective of the practitioner's examination procedures applied to the CMHSP's compliance with specified requirements is to express an opinion on the CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that 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 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 CMHSP's compliance with specified requirements, the practitioner should follow the requirements of AT-C 105 and 205.

## Practitioner's Report

The practitioner's examination 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 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-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, and/or GF Contract.
    b. Material noncompliance with the provisions of laws, regulations, or contract provisions related to the Medicaid Contract, and/or GF Contract.
    c. Known fraud affecting the Medicaid Contract, and/or GF Contract.

Finding detail must be presented in sufficient detail for the CMHSP to prepare a corrective action plan and for 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. **The 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 CMHSP.
h. Planned corrective actions.
i. Responsible party(ies) for the corrective action.
j. Anticipated completion date.

2. A schedule showing final **reported** Financial Status Report (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." 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 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, and/or GF Contract, only in the event the individual comment or recommendation is expected to have an impact greater than or equal to $25,000; 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 MDHHS within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The CMHSP must submit the reporting package by e-mail to MDHHS at MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat

(read only). The subject line must state the agency name and fiscal year end. 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. Practitioner's report as described above.
2. Corrective action plan prepared by the CMHSP.

## Penalty

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

## Incomplete or Inadequate Examinations

If MDHHS determines the examination reporting package is incomplete or inadequate, the 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 provided to the CMHSP.

## Management Decision

MDHHS will issue a management decision on findings, comments, and examination adjustments contained in the CMHSP examination report within eight months after the receipt of a complete and final reporting package. The management decision will include whether the examination finding and/or comment is sustained; the reasons for the decision and the expected CMHSP action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, MDHHS may request additional information or documentation from the CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the CMHSP is included in the applicable contract.

If there are no findings, comments, and/or questioned costs, MDHHS will notify 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 CMHSP's compliance with the A-E specified requirements based on the specified criteria stated below related to the Medicaid Contract and GF Contract.

# COMPLIANCE REQUIREMENTS A-E
**(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)**

## A. FSR Reporting

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

a. FSRs agree with agency financial records (general ledger) as required by the reporting instructions. (Reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).
b. 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)(GF Contract, Section 6.6.1; and Medicaid Contract, Section1.S.9); and allowed activities and allowable costs as specified in the Mental Health Code, Sections 240, 241, and 242.
c. 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 Code, or 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 200.403) 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 generally accepted accounting principles.
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 or a prior period.
g. Be adequately documented.

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 (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). 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 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. Procurement

The CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326.

The CMHSP completed the required Federal database checks in accordance with 42 CFR 455.436. The Lists of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) have been completed by the CMHSP no less frequently than monthly.

Subcontracts entered into by the CMHSP have addressed A through M in Part II section 6.4.1 (Provider Contracts) of the GF contract. Furthermore, subcontracts that contain

provisions for a financial incentive, bonus, withhold, or sanctions must have provisions that protect recipients from practices that result in the inappropriate limitation or withholding of required (MCL 330.1206-1) services that would otherwise be provided to eligible individuals (MCL 330.1208).
Note: A *provider* means one who furnishes medical or pharmaceutical services or supplies (42 CFR 50.502). This provider check is not required administrative contracts.

## C. Cost of Service and Ability to Pay

Note: This compliance exam section is impacted by the memo issued by Jeff Wieferich on April 18. 2023. CMHSPs should be following their documented methodology until updated administrative guidance is provided and implemented by October 1, 2023. Until this time, MDHHS does not consider this a contract violation or non-compliance with audit and compliance exam criteria.

The CMHSP determined the cost of services for the purposes of compliance with MCL 330.1804. Cost of services means the total operating and capital costs incurred (MCL 330.1800). In the comparison of cost to ability to pay the practitioner may consider a cost-based rate sheet or other documentation that is supported by cost records as evidence of costs of services.

The CMHSP determined responsible parties' insurance coverage and ability to pay before, or as soon as practical after, the start of services as required by MCL 330.1817. Also, the CMHSP annually determined the insurance coverage and ability to pay of individuals who continue to receive services and of any additional responsible party as required by MCL 330.1828.

The CMHSP's charges for services represent the lesser of ability to pay determinations or cost of services according to MCL 330.1804. Until the CMHSP has determined the ability to pay in accordance with the department promulgated rules (MCL 330.1818(2), the responsible party's ability to pay is considered to be $0. If the responsible party willfully refuses to apply for insurance benefits or provide information in accordance with MCL 330.1814, the CMHSP may charge for the full cost of services. Once ability to pay is determined in accordance with MCL 330.1818(2), the CMHSP may, but is not required to, bill for services up to 2 years in the past (MCL 330.1824).

Medicaid eligible consumers are deemed to have zero ability to pay so there is no need to determine their ability to pay. The one exception is during the period when a Medicaid eligible consumer has a deductible. In that case, an ability to pay determination does apply.

## D. General Fund Carryforward

The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

## E. Match Requirement

The CMHSP met the local match requirement, and all items considered as local match actually qualify as local match according to Section 7.2 of the General Fund 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.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (c.) donations of funds from subcontractors of the CMHSP, (d.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSP's actual costs, and (e) donations of items that would not be an item generally provided by the CMHSP in providing plan services.

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

# 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 MDHHS. All examination working papers must be accessible and are subject to review by representatives of the Michigan Department of Health and Human Services, the Federal Government, and their representatives. There should be close coordination of examination work between the PIHP and provider network CMHSP auditors. To the extent possible, they should share examination information and materials to avoid redundancy.

# EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2024/2025 examinations. Any questions relating to these guidelines should be directed to:

Jackie Sproat, Director
Division of Contracts & Quality Management
Bureau of Specialty Behavioral Health Services

Michigan Department of Health and Human Services
Capitol Commons Center 400 South Pine St., Lansing, Michigan 48913
SproatJ@michigan.gov
Phone: (517) 230-8847 Fax: (517) 335-5376

# GLOSSARY OF ACRONYMS AND TERMS

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| 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 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) 18 –Attestation Standards – Clarification and Recodification – AT-C 205 (Codified Section of AICPA Professional Standards). |
| Flint 1115 Waiver | The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) 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 and is effective as of March 3, 2016 the date of the signed approval through September 30, 2026. 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 persons will have access to Targeted Case Management services under a fee for service contract between MDHHS and Genesee Health Systems (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 CMHSPs under contract with MDHHS 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.

MDHHS .....Michigan Department of Health and Human Services

Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by PIHPs under contract with 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 Community Mental Health Services Program.

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.