**Federal Awards Compliance Audit Guidance and Testing**

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| **NAME OF CLIENT:** |  |
| **YEAR ENDED:** | 2018 |

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| **FEDERAL AWARD NAME:** | Medical Assistance Program (Medicaid; Title XIX)*[Note: #93.775 (State Medicaid Fraud Control Units) and #93.777 (State Survey and Certification of Health Care Providers and Suppliers Medicare – Title XVIII) are also clustered with #93.778. However, these programs should only apply at the State level. If auditors encounter these programs at the local level, please contact CFAE for guidance.]* |
| **CFDA#:** | #93.778 |

**This File has been broken into following sections:**

* Discussion on Agency Adoption of the UG and example citations
* Introduction- Materiality Sheet – See the table of contents
* Part I- General OMB Compliance Supplement Information,
* Part II- Pass Through Agency Program Specific Introductory Information,
* Part III- Applicable Compliance Requirement Guidance
	+ OMB compliance requirements
	+ Pass through agency/grant agreement compliance requirements
	+ Audit Objectives and Control Testing Procedures
	+ Suggested Audit Procedures- Compliance/Substantive Tests
	+ Audit Implications Summary
* Program Testing Conclusion

# Important Information (please read)

**This FACCR has been tailored for local governments and Not-For–Profits. It does not include all required references and testing for Institutes of Higher Learning or State organizations.**

**The 2018 OMB Compliance Supplement was issued as a skinny version, only significant updates and changes were included in the 2018 version. For areas where there were no updates or changes in the 2018 OMB Compliance Supplement, the 2017 OMB Compliance Supplement should be used. The AICPA has published a tool that shows the specific changes made by section and program. When using this boilerplate to write a FACCR you may be required to use both the 2017 OMB Compliance Supplement and the 2018 OMB Compliance Supplement. Refer to the** [**AICPA tool**](AICPA%202018%20OMB%20Compliance%20Supplement%20Changes%20Tool.pdf) **to aid in determining what parts have been updated.**

NOTE:

* Please review the ODODD Medicaid payment confirmation on the AOS Confirmations page.
* Most MAC monies relate strictly to salaries charged via indirect cost rates, however, if you have a material amount of MAC expenditures that do not relate to salaries, or were charged direct, contact CFAE via the FACCR Inbox.
* In accordance with 2 CFR section 200.519, when the auditor is using the risk-based approach for determining major programs, the auditor should consider that the Department of Health and Human Services (HHS) has identified the Medical Assistance Program (Medicaid) as a program of higher risk. While not precluding an auditor from determining that the Medicaid cluster qualifies as a low- risk program (e.g., because prior audits have shown strong internal controls and compliance with Medicaid requirements), the above should be considered as part of the risk assessment process and audit documentation should support the consideration. *(Source: 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX))*
* In many cases, if Medicaid is a major program, you will need to test both the JFS and non-JFS Medicaid FACCRs. As stated in step 5 of the RSAR, quantitative federal program materiality is typically 5% of total program expenditures. Since most Counties receive Medicaid for JFS, and from ODODD, both the JFS and non-JFS FACCR’s would need tested if expenditures from both funding streams exceeded 5% of total Medicaid expenditures.
	+ Note: Since non-JFS transactions are a separate population from JFS transactions, separate samples must be selected and tested. These transactions have different processes, controls, etc. so they are treated as separate populations under the Federal sampling guidance.
* Since the JFS and non-JFS portions of the Medicaid program are both part of the CFDA #93.778 major program, only one opinion on compliance will be issued using the results of testing in both FACCRs.

**NAVIGATION PANE**

**This file has been arranged to be navigable. Click on the view tab above and check the box that says “Navigation Pane” to bring up the headings. Click on the various sections within the navigation pane to go directly to that section.**

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**UG vs Non- UG**

This FACCR was written using UG requirements, however:

* + You must document, in your w/p’s, your determination that this major program fell under Uniform Guidance requirements.
	+ This FACCR was written as a UG FACCR. If there are material non-UG transactions to test, auditors should contact CFAE via the FACCR Inbox.
	+ Per the 2018 AICPA Government Auditing Standards & Single Audit Guide, paragraph 11.49 through 11.50 states that a separate sample for non-UG award transactions and post-UG award transactions within a major program would not typically be needed. However, if testing both UG and non-UG populations, auditors will need to determine if control testing is sufficient for both UG and non-UG transactions and if additional control testing is necessary for UG specific requirements.

# AGENCY ADOPTION OF THE UG AND EXAMPLE CITATIONS

Federal awarding agencies adopted or implemented the Uniform Guidance in 2 CFR part 200. The OMB guidance is directed to Federal agencies and, by itself, does not establish regulatory requirements binding on non-federal entities. The Federal awarding agency implementation gives regulatory effect to 2 CFR part 200 for that agency’s Federal awards and, thereby, establishes requirements with which the non-Federal entity must comply when incorporated in the terms and conditions of the federal award. The following code sections are where ED, HHS, USDA, DOT, EPA, DOL and HUD have adopted the Uniform Guidance in 2 CFR part 200. For the complete list of agencies adopting 2 CFR 200, as of the date of the OMB Compliance Supplement, see [**Appendix II**](OMB_Compliance_Supplement_APP_II.pdf)**.**

In implementing the UG, agencies were able to make certain changes to the part 200 by requesting needed exceptions. A few adopted the UG with no changes; however most agencies did make changes to the UG by either adding specific requirements or editing/modifying the existing language within certain sections of the UG. OMB does not maintain a complete listing of approved agency exception to the UG. Auditors should review the OMB Compliance Supplement and, as necessary, agency regulations adopting/implementing the OMB uniform guidance in 2 CFR part 200 to determine if there is any exception related to the compliance requirements that apply to the program (see link below)

**Auditors should review this** [**link**](Agency%20Adoption%20of%20the%20UG%20and%20Example%20Citations.pdf) **for a full discussion of agency adoption of the UG and how to cite non-compliance exception.**

*(Source: AOS CFAE)*

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# Introduction: Materiality by Compliance Requirement Matrix

|  |
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| **Planning Federal Materiality by Compliance Requirement**See Footnotes 1-6 below the matrix table for further explanation, in particular, review note 6 which discusses tailoring the matrix assessments. |
|  |  |  | **(1)** | **(2)** | **(6)** | **(6)** | **(3)** | **(4)** | **(5)** | **(5)** | **(6)** |
| **Compliance Requirement** | **Applicable per Compl.****Suppl.** | **Direct & material to program / entity** | **Monetary or nonmonetary** | **If monetary, population subject to require.** | **Inherent risk (IR) assess.** | **Final control risk (CR) assess.** | **Detection risk of noncompl.** | **Overall audit risk of noncompl.** | **Federal materiality by compl. requirement** |
|
|
|
| *(Yes or No)* | *(Yes or No)* | *(M/N)* | *(Dollars)* | *(High/Low)* | *(High/Low)* | *(High/Low)* | *(High/Low)* | *typically 5% of population subject to requirement* |
| **A** |   | **Activities Allowed or Unallowed** | Yes |  | M |  |  |  |  |  | *5%* |
| **B** |   | **Allowable Costs/Cost Principles** | Yes |  | M |  |  |  |  |  | *5%* |
| **C** |   | **Cash Management** | Yes | No – See NoteIn Section |  |  |  |  |  |  |  |
| **D** |   | ***RESERVED*** |  |  |  |  |  |  |  |  |  |
| **E**  |   | **Eligibility** | Yes | No – See NoteIn Section |  |  |  |  |  |  |  |
| **F** |   | **Equipment & Real Property Mgmt** | No |  |  |  |  |  |  |  |  |
| **G** |   | **Matching, Level of Effort, Earmark** | Yes |  | M |  |  |  |  |  | *5%* |
| **H** |   | **Period of Availability (Performance)** | Yes | No – See NoteIn Section |  |  |  |  |  |  |  |
| **I** |   | **Procurement & Sus. & Debarment** | Yes | No – See Note’In Section |  |  |  |  |  |  |  |
| **J** |   | **Program Income** | No |  |  |  |  |  |  |  |  |
| **K** |   | ***RESERVED*** |  |  |  |  |  |  |  |  |  |
| **L** |   | **Reporting** | Yes |  | N |  |  |  |  |  | *5%* |
| **M** |   | **Subrecipient Monitoring** | Yes | No – See NoteIn Section |  |  |  |  |  |  |  |
| **N** |   | **Special Tests & Provisions - All** | Yes | No – See NoteIn Section |  |  |  |  |  |  |  |

**(1)** Taken form Part 2, Matrix of Compliance Requirements, of the OMB Compliance Supplement (<https://www.whitehouse.gov/omb/information-for-agencies/circulars> ). When Part 2 of the Compliance Supplement indicates that a type of compliance requirement is not applicable, the remaining assessments for the compliance requirement are not applicable.

**(2)** If the Supplement notes a compliance requirement as being applicable to the program in column (1), it still may not apply at a particular entity either because that entity does not have activity subject to that type of compliance requirement, or the activity could not have a material effect on a major program. If the Compliance Supplement indicates that a type of compliance requirement is applicable and the auditor determines it also is direct and material to the program at the specific entity being audited, the auditor should answer this question “Yes,” and then complete the remainder of the line to document the various risk assessments, sample sizes, and references to testing. Alternatively, if the auditor determines that a particular type of compliance requirement that normally would be applicable to a program (as per part 2 of the Compliance Supplement) is not direct and material to the program at the specific entity being audited, the auditor should answer this question “No.” Along with that response, the auditor should document the basis for the determination (for example, "per the Compliance Supplement, eligibility requirements only apply at the state level").

**(3)** Refer to the 2018 AICPA Audit Guide, Government Auditing Standards and Single Audits, chapter 10, Compliance Auditing Applicable to Major Programs, for considerations relating to assessing inherent risk of noncompliance for each direct and material type of compliance requirement. The auditor is expected to document the inherent risk assessment for each direct and material compliance requirement.

**(4)** Refer to the 2018 AICPA Audit Guide, Government Auditing Standards and Single Audits, chapter 9, Consideration of Internal Control over Compliance for Major Programs, for considerations relating to assessing control risk of noncompliance for each direct and material types of compliance requirement. To determine the control risk assessment, the auditor is to document the five internal control components of the Committee of Sponsoring Organizations of the Treadway Commission (COSO) (that is, control environment, risk assessment, control activities, information and communication, and monitoring) for each direct and material type of compliance requirement. Keep in mind that the auditor is expected to perform procedures to obtain an understanding of internal control over compliance for federal programs that is sufficient to plan the audit to support a low assessed level of control risk. If internal control over compliance for a type of compliance requirement is likely to be ineffective in preventing or detecting noncompliance, then the auditor is not required to plan and perform tests of internal control over compliance. Rather, the auditor must assess control risk at maximum, determine whether additional compliance tests are required, and report a significant deficiency (or material weakness) as part of the audit findings. The control risk assessment is based upon the auditor's understanding of controls, which would be documented outside of this template. Auditors may use the practice aid, Controls Overview Document, to support their control assessment. The Controls Overview Document assists the auditor in documenting the elements of COSO, identifying key controls, testing of those controls, and concluding on control risk. The practice aid is available in either a checklist or narrative format.

**(5)** Audit risk of noncompliance is defined in AICPA, Professional Standards, vol. 1, AU-C 935, as the risk that the auditor expresses an inappropriate opinion on the entity's compliance when material noncompliance exists. Audit risk of noncompliance is a function of the risks of material noncompliance and detection risk of noncompliance.

**(6)** CFAE included the typical monetary vs. nonmonetary determinations for each compliance requirement in this program. However, auditors should tailor these assessments as appropriate based on the facts and circumstances of their entity’s operations. The 2018 AICPA Single Audit Guide 10.54 states the auditor's tests of compliance with compliance requirements may disclose instances of noncompliance. The Uniform Guidance refers to these instances of noncompliance, among other matters, as “audit findings.” Such findings may be of a monetary nature and involve questioned costs or may be nonmonetary and not result in questioned costs. AU-C 935.13 & .A7 require auditors to establish and document two materiality levels: (1) a materiality level for the program as a whole. The column above documents quantitative materiality at the COMPLIANCE REQUIREMENT LEVEL for each major program; and (2) a second materiality level for the each of the applicable 12 compliance requirement listed in Appendix XI to Part 200.

*Note:*

a. If the compliance requirement is of a monetary nature, and

b. The requirement applies to the ***total*** population of program expenditure,

Then the compliance materiality amount for the program also equals materiality for the requirement. For example, the population for allowable costs and cost principles will usually equal the total Federal expenditures for the major program as a whole. Conversely, the population for some monetary compliance requirements may be less than the total Federal expenditures. Auditors must carefully determine the population subject to the compliance requirement to properly assess Federal materiality. Auditors should also consider the qualitative aspects of materiality. For example, in some cases, noncompliance and internal control deficiencies that might otherwise be immaterial could be significant to the major program because they involve fraud, abuse, or illegal acts. Auditors should document PROGRAM LEVEL materiality in the Record of Single Audit Risk (RSAR).

*(Source: AOS CFAE)*

[***Performing Tests to Evaluate the Effectiveness of Controls throughout this FACCR***](Performing%20Tests%20to%20Evaluate%20the%20Effectiveness%20of%20Controls%20throughout%20this%20FACCR.pdf)

[***Improper Payments***](Improper%20Payments.pdf)

# Part I – OMB Compliance Supplement Information

### I. Program Objectives

**Medical Assistance Program**

The objective of the Medical Assistance Program (Medicaid or Title XIX of the Social Security Act, as amended, (42 USC 1396 et seq.)) is to provide payments for medical assistance to low- income persons.

**State Medicaid Fraud Control Units**

States are required as part of their Medicaid State plans to maintain a State Medicaid Fraud Control Unit (MFCU), unless the Secretary of HHS determines that certain safeguards are met regarding fraud and abuse and waives the requirement. The mission of the MFCUs is to investigate and prosecute fraud by Medicaid providers. The State MFCUs also review

complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan, and may review complaints of misappropriation of patients’ private funds in such facilities. States are required to refer all suspected violations of applicable Medicaid laws and regulations by providers to the MFCU. Federal requirements for the establishment and continued operations of the units are contained in 42 USC 1396b(a)(6), 1396b(b)(3), and 1396b(q); and 42 CFR part 1007. A key requirement of the governing regulations is that a unit must be a single identifiable entity of State government.

The HHS Office of the Inspector General (OIG) is the agency responsible for the Federal oversight of the State MFCUs. In order to receive the Federal grant funds necessary to sustain their operations, the units must submit a re-application for Federal assistance to the OIG on an annual basis.

**State Survey and Certification of Health Care Providers and Suppliers**

The objective of the State Survey and Certification of Health Care Providers and Suppliers program is to determine whether the providers and suppliers of health care services under the Medicare program are in compliance with regulatory health and safety standards and conditions of participation/coverage. For certain types of providers, compliance with these health and safety standards also are required as a condition of Medicaid participation, and the Medicaid program contributes to covering program costs accordingly. This program is administered in a manner similar to Medicaid and includes an approved State plan that addresses Federal requirements.

Even though the State MFCUs and State Survey and Certification of Health Care Providers and Suppliers have substantially less Federal expenditures than the Medicaid Assistance Program, they are clustered with Medicaid because these programs provide significant controls over the expenditures of Medicaid funds. It is unlikely that the expenditures for these two programs would be material to the Medicaid cluster; however, noncompliance with the requirements to administer these controls may be material.

*(Source: 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX))*

### II. Program Procedures

The following paragraphs are intended to provide a high-level, overall description of how Medicaid generally operates. It is not practical to provide a complete description of program procedures because Medicaid operates under both Federal and State laws and regulations and States are afforded flexibility in program administration. Accordingly, the following paragraphs are not intended to be used in lieu of or as a substitute for the Federal and State laws and regulations applicable to this program.

**Administration**

The U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) administers the Medicaid program in cooperation with State governments. The Medicaid program is jointly financed by the Federal and State governments and administered by the States. For purposes of this program, the term “State” includes the 50 States, the District of Columbia, and five U.S. Territories: Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Medicaid operates as a vendor payment program, with States paying providers of medical services directly. Participating providers must accept the Medicaid reimbursement level as payment in full. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.

*State Plans*

States administer the Medicaid program under a State plan approved by CMS. The Medicaid State plan is a comprehensive written statement submitted by the State Medicaid agency describing the nature and scope of its Medicaid program. A State plan for Medicaid consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of each particular State’s program. The State plan is referenced to the applicable Federal regulation for each requirement and will contain references to applicable State regulations.

The State plan contains all information necessary for CMS to determine whether the State plan can be approved to serve as a basis for determining the level of Federal financial participation in the State program. The State plan must specify a single State agency (hereinafter referred to as the “State Medicaid agency”) established or designated to administer or supervise the administration of the State plan. The State plan must also include a certification by the State Attorney General that cites the legal authority for the State Medicaid agency to determine eligibility.

The State plan also specifies the criteria for determining the validity of payments disbursed under the Medicaid program. This encompasses the system the State will use to ensure that payments are disbursed only to eligible providers for appropriately priced services that are covered by the Medicaid program and provided to eligible beneficiaries. Payments must also be based on claims that are adequately supported by medical records, and payments must not be duplicated.

A State plan or plan amendment will be considered approved unless CMS sends the State written notice of disapproval or a request for additional information within 90 days after receipt of the State plan or plan amendment. Copies of the State plan are available from the State Medicaid agency.

*Waivers*

The State Medicaid agency may apply for a waiver of Federal requirements. Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of beneficiaries. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time- limited basis, and are subject to specific safeguards for the protection of beneficiaries and the program.

Actions that States may take if waivers are obtained include (1) implementing a primary care case-management system or a specialty physician system; (2) designating an entity to act as a central broker in assisting Medicaid beneficiaries to choose among competing health care plans; (3) sharing with beneficiaries (through the provision of additional services) cost-savings made possible through the beneficiaries’ use of more cost effective medical care; (4) limiting beneficiaries’ choice of providers to providers that fully meet reimbursement, quality, and utilization standards, which are established under the State plan and are consistent with access, quality, and efficient and economical furnishing of care; and (5) including as medical assistance, under its State plan, home and community-based services furnished to beneficiaries who would otherwise need inpatient care that is furnished in a hospital or nursing facility, and is reimbursable under the State plan. A State may also obtain a waiver of statutory requirements to provide an array of home and community-based services, which may permit an individual to avoid institutionalization (42 CFR part 441, subpart G). Depending on the type of requirement being waived, a waiver may be effective for initial periods ranging from 2 to 5 years, with varying renewal periods. Copies of waivers are available from the State Medicaid agency.

**Payments to States**

Once CMS has approved a State plan and waivers, it makes quarterly grant awards to the State to cover the Federal share of Medicaid expenditures for services, training, and administration. The amount of the quarterly grant is determined on the basis of information submitted by the State Medicaid agency (in quarterly estimate and quarterly expenditure reporting). The grant award authorizes the State to draw Federal funds as needed to pay the Federal financial participation portion of qualified Medicaid expenditures. The HHS Payment Management System, Division of Payment Management (PMS-DPM) in Rockville, Maryland, disburses Federal funds to States, including funding under Medicaid.

**State Expenditure Reporting**

Thirty days after the end of the quarter, States electronically submit the CMS-64, Quarterly Statement of Expenditures for the Medical Assistance Program. The CMS-64 presents expenditures and recoveries and other items that reduce expenditures for the quarter and prior period expenditures. The amounts reported on the CMS-64 and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. States use the Medicaid Budget and Expenditure System to electronically submit the CMS-64 directly to CMS.

**Eligibility** *(AOS CFAE NOTE: This is not tested at the local level.)*

Eligibility for Medicaid is based on financial (e.g., income/resources) and non-financial (e.g., age, pregnancy, disability, citizenship/immigration status) criteria. The States must cover mandatory eligibility groups. States may provide coverage to members of optional groups and medically needy individuals (individuals who are eligible for Medicaid after deducting medical expenditures from their income). Eligibility criteria will be specified in the individual State plan.

States must provide limited Medicaid coverage for “Qualified Medicare Beneficiaries” (QMB). These are aged and disabled persons who are entitled to Medicare Part A, whose income does not exceed 100 percent of the Federal poverty level, and whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index (Section 1860D-14(a)(3)(D) of the Social Security Act (42 USC 1395w-114)).

The State plan will specify if determinations of eligibility are made by agencies other than the State Medicaid agency and will define the relationships and respective responsibilities of the State Medicaid agency and the other agencies. States must allow individuals and families to apply online, by telephone, via mail, or in person and must require that all initial applications are signed under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission must be accepted. The State agency must have facts in the case record to support the agency’s eligibility determination, including a record of having verified citizenship or immigration status for each individual. The State must provide notice of its decision concerning eligibility and provide timely and adequate notice of the basis for discontinuing assistance. (42 CFR sections 435.907, 435.913, and 435.914; 42 USC 1320b-7).

**Services** *(AOS CFAE NOTE: This is not tested at the local level.)*

Medicaid expenditures include medical assistance payments for eligible recipients for such services as hospitalization, prescription drugs, nursing home stays, outpatient hospital care, and physicians’ services, and expenditures for administration and training. In order for a medical assistance payment to be considered valid, it must comply with the requirements of Title XIX, as amended, (42 USC 1396 et seq.) and implementing Federal regulations. Determinations of payment validity are made by individual States in accordance with approved State plans under broad Federal guidelines.

Some States have managed care arrangements under which the State enters into a contract with an entity, such as an insurance company, to arrange for medical services to be available for beneficiaries. The State pays a fixed rate per person (capitation rate) without regard to the actual medical services utilized by each beneficiary.

Medicaid expenditures also include administration and training, the State Survey and Certification Program, and State Medicaid Fraud Control Units.

**Medicare Buy-In Program** *(AOS CFAE NOTE: This is not tested at the local level.)*

The Medicare Buy-In Program, also known as QMB (Qualified Medicare Beneficiary) and SLMB (Specified Low-Income Medicare Beneficiary), is designed to protect low-income Medicare beneficiaries from the significant and growing costs required to receive Medicare coverage, including out-of-pocket cost sharing expenses (deductibles and co-payments). The program connects the two largest public health programs in the country, Medicare and Medicaid, as Medicaid pays for all or part of the Medicare premium and deductible amounts for individuals who are financially eligible.

The QMB Program serves individuals with modest assets with combined incomes that do not exceed 100 percent of the Federal poverty level. For 2013, the asset limit for the QMB program is $6,680/individual and $10,020/couple. If individuals are eligible for the QMB program, the State Medicaid program pays their Medicare Part B premiums and cost-sharing amounts.

For individuals with slightly higher incomes, the SLMB Program pays only the Part B premium. To be eligible for the SLMB program, the individual/couple can have incomes between 100 and 120 percent of the poverty level. The SLMB program has the same asset limits as the QMB program.

**Maintenance of Effort**

The maintenance of effort (MOE) provisions in the Affordable Care Act generally ensure that States’ coverage for adults under the Medicaid program remains in place until January 1, 2014 and that coverage for children remains in place through September 30, 2019. Sections 1902(a)(74) and 1902(gg) of the Social Security Act require that, as a condition of receiving Federal Medicaid funding, States maintain Medicaid “eligibility standards, methodologies, and procedures” that are not more restrictive than those in effect on March 23, 2010. Certain exceptions may apply for States experiencing or projecting a deficit, which would permit Medicaid eligibility restrictions for certain non-pregnant, nondisabled adults.

**Indian Care**

Although Medicaid allows States to impose enrollment fees, premiums, and cost-sharing charges on Medicaid and Children’s Health Insurance Program (CHIP) participants, Section 5006 of ARRA precludes them from imposing these charges on Indian applicants, according to the guidance released by CMS. Medicaid regulations at 42 CFR section 447.56(a)(1)(x), which are effective January 1, 2014:

a. exempt Indians from paying enrollment fees, premiums or similar charges if they are eligible to receive or have received an item or service furnished by an Indian health care provider or through referral under contract health services (CHS);

b. exempt Indians from paying cost sharing (deductibles, coinsurance, copayments or similar charges) for Medicaid-covered services if they are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under CHS; and

c. prohibit any reduction in payment due under Medicaid to the Indian health care provider serving an Indian (i.e., a State must pay these providers the full Medicaid payment rate for furnishing the service).

**Control Systems** *(AOS CFAE NOTE: This is not tested at the local level.)*

*Utilization Control and Program Integrity*

The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services, including those provided by long-term care institutions. In addition, the State must have (1) methods of criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials.

These requirements may be met by the State Medicaid agency assuming direct responsibility for assuring the requirements or by contracting with a quality improvement organization (QIO) (formerly known as peer review organization (PRO)) to perform such reviews. The reviewer must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services.

The State Medicaid agency must have procedures for the ongoing post-payment review, on a sample basis, for the necessity, quality, and timeliness of Medicaid services. The State Medicaid agency may conduct this review directly or may contract with a QIO.

Suspected fraud identified by utilization control and program integrity should be referred to the State Medicaid Fraud Control Units.

*Inpatient Hospital and Long-Term Care Facility Audits*

States are required to establish as part of the State plan standards and methodology for reimbursing inpatient hospital and long-term care facilities based on payment rates that represent the cost to efficiently and economically operate such facilities and provide Medicaid services. The State Medicaid agency must provide for the filing of uniform cost reports by each participating provider. These cost reports are used by the State Medicaid agency to aid in the establishment of payment rates. The State Medicaid agency must provide for periodic audits of the financial and statistical records of the participating providers. Such audits could include desk audits of cost reports in addition to field audits. These audits are an important control for the State Medicaid agency in ensuring that established payment rates are proper.

*ADP Risk Analyses and System Security Reviews*

The Medicaid program is highly dependent on extensive and complex computer systems that include controls for ensuring the proper payment of Medicaid benefits. States are required to establish a security plan for ADP systems that include policies and procedures to address (1) physical security of ADP resources; (2) equipment security to protect equipment from theft and unauthorized use; (3) software and data security; (4) telecommunications security; (5) personnel security; (6) contingency plans to meet critical processing needs in the event of short- or long-term interruption of service; (7) emergency preparedness; and (8) designation of an agency ADP security manager.

State agencies must establish and maintain a program for conducting periodic risk analyses to ensure appropriate, cost effective safeguards are incorporated into new and existing systems. State agencies must perform risk analyses whenever significant system changes occur. On a biennial basis state agencies shall review the ADP system security of installations involved in the administration of HHS programs. At a minimum, the reviews shall include an evaluation of physical and data security operating procedures, and personnel practices.

As part of complying with the above requirement, a state may obtain a Statement on Standards for Attestation Engagements (AT) Section 801, Reporting on Controls at a Service Organization SOC 1 type 2 report from its service organization (if the State has a service organization). A SOC 1 type 1 report does not address the effectiveness of a service organization’s controls and would need to be supplemented by additional testing of controls at the service organization.

The specific areas covered by a SOC 1 type 2 report differ according to each individual service organization’s operations; however, in every instance, the type 2 report procedures assess the sufficiency of the design of an organization’s controls and test their effectiveness. A number of commonly covered areas include:

a. Control Environment

b. Systems Development and Maintenance

c. Logical Security

d. Physical Access

e. Computer Operations f. Input Controls

g. Output Controls

h. Processing Controls

*Medicaid Management Information System (MMIS)*

The MMIS is the mechanized Medicaid benefit claims processing and information retrieval system that States are required to have, unless this requirement is waived by the Secretary of HHS. HHS provides general systems guidelines (42 CFR sections 433.110 through 433.131) but it does not provide detailed system requirements or specifications for States to use in the development of MMIS systems. As a result, MMIS systems will vary from State to State. The system may be maintained and operated by the State or a contractor.

The MMIS is normally used to process payments for most medical assistance services. The MMIS’ Operations Management business area supports the Claims Receipt, Claims Adjudication, and Point-of-Service subsystems to process provider claims for Medicaid care and services to eligible medical assistance recipients. The MMIS incorporates many edits and controls to identify aberrant billing practices for follow-up by State staffs. However, the State may use systems other than MMIS to process medical assistance payments. In many cases the operation and maintenance of the MMIS is contracted out to a private contractor. The State plan will describe the administration of each State’s claims-processing subsystems.

Generally, the MMIS does not process claims from State agencies (e.g., State-operated intermediate care facility for the mentally retarded (ICF/MR)) and certain selected types of claims. The claims payments that are not processed through MMIS may be material to the Medicaid program.

Note: The Medicaid Information Technology System (MITS) has replaced the MMIS in Ohio.

*(Source: AOS CFAE)*

**Federal Oversight and Compliance Mechanisms**

CMS oversees State operations through its organization consisting of a headquarters and 10 regional offices.

CMS program oversight includes budget review, reviews of financial and program reports, and on-site reviews, which are normally targeted to cover a specific area of concern. CMS conveys areas of national and local concerns to the States through the regions. Technical assistance is used extensively to promote improvements in State operation of the program but enforcement mechanisms are available. CMS considers the single audit as an important internal control in its monitoring of States.

Federal program oversight, because of its targeted nature, should not be used as a substitute for audit evidence gained through transaction testing.

**Medicaid Program Payment Error Rate Measurement**

The regulations at 42 CFR part 431, subpart Q, specify requirements for estimating improper payments in Medicaid.

*(Source: 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX))*

### III. Source of Governing Requirements

The auditor is expected to use the applicable laws and regulations (including the applicable State-approved plan) when auditing this program. The Federal law that authorizes these programs is Title XIX of the Social Security Act (Title XIX), enacted in 1965 and subsequently amended (42 USC 1396 et seq.). The Federal regulations applicable to the Medicaid program are found in 42 CFR parts 430 through 456, 1002, and 1007.

Awards under the Medical Assistance Program (CFDA 93.778) are subject to the HHS implementation of the A-102 Common Rule, 45 CFR part 92/the HHS implementation of 2 CFR part 200, 45 CFR part 75. This program also is subject to the requirements of 45 CFR part 95 and the cost principles under Office of Management and Budget Circular A-87/2 CFR part 200, subpart E.

*(Source: 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX))*

### IV. Other Information

***Improper Payments***

Auditors should be alert to the following which have been identified in audit findings both as non-compliance and material weaknesses.

1. Eligibility Determinations

Findings related to eligibility determinations found internal control deficiencies including:

• eligibility determination and renewal were not performed timely or performed within the timeliness standards,

• lack of internal controls over obtaining adequate documentation used to support eligibility determinations,

• the data inputted into the eligibility system were not accurate,

• clients information were not verified according to the State’s verification plan, and

• program staff did not have sufficient knowledge of program requirements and policies due to high turnover and lack of training.

2. Medicaid Claims Processing

Findings related to Medicaid claims processing found significant weaknesses including:

• inadequate documentation to support the payments claimed in the CMS-64;

• payments reported on the CMS-64 were not readily traceable to the individual claims or information in the sub-system or the financial statements;

• inadequate internal control over utilization, fraud and accuracy of the Medicaid claims;

• lack of understanding of when to report payments in the CMS-64;

• lack of internal control in drawing down ARRA funds;

• inadequate internal control to assure that payments to providers were made in compliance with Federal regulations, e.g. payments for services that were not medically necessary and providers were not eligible Medicaid providers; and

• review of cost report and recoupment of rate adjustments were not timely.

3. Other areas of weaknesses identified included--

• inadequate monitoring and oversight of subcontractors;

• inadequate monitoring and oversight to assure provider licensing, agreements or required certification were in effect and up-to-date, and that the related documentation were in file or in the Medicaid Management Information System (MMIS);

• inadequate internal control related to implementation of MMIS replacement system;

• inadequate internal control regarding user access to the MMIS including terminated employees’ user access rights; and

• MMIS was not programmed and updated timely and accurately with proper information.

***Medicaid EHR Incentive Payment Program***

Title IV, Division B of ARRA established voluntary Medicare and Medicaid EHR incentive payments to eligible professionals, eligible hospitals and critical access hospitals, and certain Medicare Advantage organizations for the adoption and demonstration of meaningful use of certified EHR technology, as one component of the HITECH Act.

Section 4201 of the HITECH Act amends section 1903 of the Act to provide 100 percent Federal financial participation (FFP) to States for incentive payments to certain eligible providers participating in the Medicaid program to purchase, implement, operate (including support services and training for staff) and meaningfully use certified EHR technology.

Auditors should be aware that funds made available to States for the Medicaid incentive program and the State’s expenditure of those funds, including payments to eligible providers and costs of State administration of the program, are subject to the audit provisions of 2 CFR part 200,

subpart F. Providers and other eligible entities receiving incentive funds are not subject to the audit provisions of 2 CFR part 200, subpart F by virtue of receipt of those funds.

**Availability of Other Program Information**

The HHS OIG issues fraud alerts, some of which relate to the Medicaid program. These alerts are available from the HHS OIG home page, Special Fraud Alerts section (<https://oig.hhs.gov/compliance/alerts/index.asp>).

Up-to-date program information, including State Medicaid Director and State Health Official Letters, is available through Medicaid.gov at [http://www.medicaid.gov/Federal-Policy- Guidance/Federal-Policy-Guidance.html.](http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html)

*(Source: 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX))*

# Part II – Pass through Agency and Grant Specific Information

### Program Overview and Testing Considerations

**Requirements included in Ohio Administrative Code Chapter 5123 govern the local Boards of DD.**

**Procedures related to all funding**

The Ohio Department of Medicaid (ODM) has the ultimate responsibility for the Medicaid Program in the State of Ohio. ODM has an interagency agreement with the Ohio Department of Developmental Disabilities (ODODD). The agreement allows ODODD to use their state dollars to pay for Medicaid services and then bill ODM for the Federal Financial Participation (FFP) as reimbursement (sometimes Local-level (e.g., county) funding is used within a system):

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Developmental Disabilities |  | Targeted Case Management (TCM)ICF – Public and PrivatePASSAR AdministrationCounty Board Waiver Administration (for Individual Options, Level 1, and SELF waivers)Intermediate Care Facilities |
|  |  |  |
|  |  |  |

**What is Medicaid and How is it Different from Medicare?**

In general, Medicaidcovers certain defined categories of low income people and many people with disabilities. Medicare covers the elderly and some persons with disabilities, regardless of income.

Both Medicaid and Medicare were created under the Social Security Amendment Act of 1965. Medicare is a health insurance program that covers the vast majority of Americans age 65 or older, and several million Americans under age 65 with disabilities. Unlike Medicaid, Medicare is financed and administered at the federal level. Ohio state government largely does not have a significant role in either administering or in funding Medicare. However, state Medicaid programs are required to pay for the Medicare out-of-pocket costs of some low income people (premiums, deductibles, and copayments).

Medicare also has a significant impact on Medicaid because of what Medicare does not cover. Medicare does not cover prescription drugs. Further, coverage of nursing home care is limited to 100 days (per spell of illness) and is only covered after a period of hospitalization. (In other words, the Medicare nursing home benefit covers only a small amount of long term care.)

Certain persons who are receiving monthly Social Security Disability Benefits become eligible for Medicare after a two year waiting period. Some of these people - those who have low enough income and resources to qualify - have most of their care covered by Medicaid during the two year waiting period for Medicare benefits.

The highest demand for long-term care services and prescription drug services comes from individuals who are aged or who have disabilities. The absence of Medicare coverage for these benefits has established Medicaid as the health care safety net for individuals with low income who are aged and for individuals with disabilities including chronic health needs.

*(Source: AOS CFAE)*

**An Overview of the Medicaid Funding/Billing Process When Local Governments Provide the Services Themselves**

(This generally applies to county boards of developmental disabilities)

Medicaid providers consist of local level boards (County Boards of DD) and private sector providers (i.e. Easter Seals). State Matching Funds requirements are met in the case of local level boards, by the use of state or local revenues to fund Medicaid service delivery staff positions and associated costs. There is no subrecipient relationship between the county board and the private sector provider. Claims for reimbursement are submitted electronically to ODODD by all service providers. ODODD validates all claims by reviewing service codes billed, Medicaid Recipient Numbers, and authorized providers of services for each claim. Validated claims are forwarded to ODJFS for claims adjudication. The FFP is billed to Medicaid by ODJFS for all successfully adjudicated claims. ODJFS then transfers the FFP for all adjudicated claims to ODODD. ODODD then issues disbursement warrants to public providers for payment of FFP for successfully adjudicated claims for reimbursement. ODODD issues disbursement warrants for full payment (FFP and match) for targeted case management. ODODD issues disbursement warrants to private providers for full payment (FFP and match) for successfully adjudicated claims.

Although the county board is providing the services, it is not necessary for an auditor to test for compliance with the requirements of “Activities Allowed or Unallowed” or “Allowable Costs/Cost Principles” since ODJFS ultimately determines what services are eligible for reimbursement through its adjudication process. Instead, auditors should focus on the “Reporting” requirement to determine that billing information submitted to the ODODD for reimbursement is supported by appropriate record of service documentation.

In addition, the Medicaid School Program (MSP) is jointly administered by the Ohio Department of Medicaid and Ohio Department of Education and is exempt from 2 CFR 200 Subpart F requirements. Meaning, MSP recipients are not required to report MSP expenditures on the Federal Schedule, etc.

Prior to working on this federal program the auditor should obtain and become familiar with the specific conditions of the client’s Medicaid contract agreement(s).

*(Source: AOS CFAE)*

### Reporting

Note: See examples SEFA and Footnote shells available at <http://www.ohioauditor.gov/references/practiceaids.html>.

See additional SEFA Guidance in the “Single Audit SEFA 2018 Completeness Guide” located at <http://www.ohioauditor.gov/references/practiceaids.html>.

*(Source: CFAE)*

# PART III – APPLICABLE COMPLIANCE REQUIREMENTS

## A. ACTIVITIES ALLOWED OR UNALLOWED

**Federal awarding agencies adopted/implemented the Uniform Guidance in 2 CFR part 200. The OMB guidance is directed to Federal agencies and, by itself, does not establish regulatory requirements binding on non-federal entities. Throughout the FACCR 2 CFR part 200 has been referenced, however in determining compliance auditors need to refer the applicable agency codification of 2 CFR Part 200. Auditors should review this** [**link**](Agency%20Adoption%20of%20the%20UG%20and%20Example%20Citations.pdf) **for a full discussion of agency adoption of the UG and how to cite non-compliance exceptions. Auditors will need to start with the agency codification of the UG when citing exceptions.**

### OMB Compliance Requirements

**Important Note:** For a cost to be allowable, it must (1) be for a purpose the specific award permits and (2) fall within [2 CFR 200 subpart E](2CFR200_Subpart%20E.pdf) Cost Principles. These two criteria are roughly analogous to classifying a cost by both program/function and object. That is, the grant award generally prescribes the allowable program/function while 2 CFR 200 subpart E prescribes allowable object cost categories and restrictions that may apply to certain object codes of expenditures.

For example, could a government use an imaginary Homeland Security grant to pay OP&F pension costs for its police force? To determine this, the client (and we) would look to the grant agreement to see if police activities (security of persons and property function cost classification) met the program objectives. Then, the auditor would look to Subpart E (provisions for selected items of cost [§ 200.420-200.475](2CFR200.420_thru_200.475.pdf)) to determine if pension costs (an object cost classification) are permissible. (200.431(g) states they are allowable, with certain provisions, so we would need to determine if the auditee met the provisions.) Both the client and we should look at 2 CFR 200 subpart E even if the grant agreement includes a budget by object code approved by the grantor agency. Also, keep in mind that granting agencies have codified 2 CFR 200 and some agencies have been granted exceptions to provisions within 2 CFR 200.

*(Source: AOS CFAE)*

The specific requirements for activities allowed or unallowed are unique to each Federal program and are found in the Federal statutes, regulations, and the terms and conditions of the Federal award pertaining to the program. For programs listed in this Supplement, the specific requirements of the governing statutes and regulations are included in Part 4, “Agency Program Requirements” or Part 5, “Clusters of Programs,” as applicable. This type of compliance requirement specifies the activities that can or cannot be funded under a specific program.

**Source of Governing Requirements**

The requirements for activities allowed or unallowed are contained in program legislation, Federal awarding agency regulations, and the terms and conditions of the award.

*(Source: 2017 OMB Compliance Supplement 3.2)*

**Agency Codification Adjustments/Exceptions:**

HHS, DOL, HUD, DOT, and EPA have not made any adjustments or exceptions that directly impact references within this compliance requirement.

**Part 4 OMB Program Specific Requirements**

1. Funds can be used only for Medicaid benefit payments (as specified in the State plan, Federal regulations, or an approved waiver), expenditures for administration and training, expenditures for the State Survey and Certification Program, and expenditures for State Medicaid Fraud Control Units (42 CFR sections 435.10, 440.210, 440.220, and 440.180).

2. *Case Management Services* – The State plan may provide for case management services as an optional medical assistance service. The term “case management services” means services that will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

Medicaid case management services are divided into two separate categories:

Administrative case management – Services must be identifiable with Title XIX benefit (e.g., outreach services provided by public school districts to Medicaid recipients).

Medical/targeted case management – Services must be provided to an eligible Medicaid recipient. Services do not have to be specifically medical in nature and can include securing shelter, personal needs, etc. (e.g., services provided by community mental health boards, county offices of aging).

Case management services is an area of risk because of the high growth of expenditures and prior experience that indicates problems with the documentation of case management expenditures.

With the exception of case management services provided through capitation (a process in which payment is made on a per beneficiary basis) or prepaid health plans, Federal regulations typically require the following documentation for case management services: date of service; name of recipient; name of provider agency and person providing the service; nature, extent, or units of service; and place of service (42 USC 1396n(g); 42 CFR part 434).

3. *Managed Care* – A State may obtain a waiver of statutory requirements in order to develop a system that more effectively addresses the health care needs of its population. For example, a waiver may involve the use of a program of managed care for selected elements of the client population or allow the use of program funds to serve specified populations that would be otherwise ineligible (Section 1115 of the Social Security Act (42 USC 1315)). Managed care providers must be eligible to participate in the program at the time services are rendered, payments to managed care plans should only be for eligible clients for the proper period, and the capitation payment should be properly calculated. Medicaid medical services payments (e.g., hospital and doctors charges) should not be made for services that are covered by managed care. States should ensure that capitated payments to providers are discontinued when a beneficiary is no longer enrolled for services.

4. *Medicaid Health Insurance Premiums* – A State may enroll certain Medicare- eligible recipients under Medicare Part B and pay the premium, deductibles, cost sharing, and other charges (42 CFR section 431.625).

5. *Disproportionate Share Hospital* – Federal financial participation is available for aggregate payments to hospitals that serve a disproportionate number of low- income patients with special needs. The State plan must specifically define a disproportionate share hospital and the method of calculating the rate for these hospitals. Specific limits for the total disproportionate share hospital payments for the State and the individual hospitals are contained in the legislation (42 USC 1396r-4).

6. *Home and Community-Based Services* – A State may obtain a waiver of statutory requirements to provide an array of home and community-based services which may permit an individual to avoid institutionalization (42 CFR part 441, subpart G). The HHS OIG has issued a special fraud alert concerning home health care. Problems noted include cost report frauds, billing for excessive services or services not rendered, and use of unlicensed staff. The full alert was published in the Federal Register on August 10, 1995, (page 40847) and is available from the HHS OIG home page, Special Fraud Alerts section (<http://oig.hhs.gov/fraud/fraudalerts.asp>).

7. *Medicare Part B Buy-In* – 42 CFR section 431.625(d)(1) and CMS Medicaid Manual – State Buy-in (Pub24) Sections 110 and 180 specify that Federal Financial Participation (FFP) is not available for States buy-in for non-cash Medical Assistance Only groups, e.g., the special income level group or the medically needy. FFP is available only for those individuals who are considered as some class of cash recipients or deemed to be a cash recipient or one of the Medicare Savings Program (MSP) groups.

8. *Electronic Health Records (EHR)* – States participating in the EHR incentive program can receive 90 percent FFP for approved processes, systems, and activities necessary to ensure the EHR incentive payments are being properly made (Section 1903t of the Social Security Act, as amended by Section 4201 of the Health Information Technology for Economic and Clinical Health (HITECH) Act (42 USC 1396b)).

*(Source: 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX))*

### Additional Program Specific Information

Compliance Requirements:

See the [ODODD Guide to MAC using the Random Moment Time Studies (RMTS) Methodology](MAC-RMTS_Guide_effective_4-2014.pdf).

* Pg. 5 - All staff that support Medicaid-funded programs for individuals with DD should participate in the MAC program. Medicaid-funded activities include, but are not limited to: Medicaid outreach; facilitating Medicaid eligibility determinations; translations related to Medicaid services; program planning, policy development and interagency coordination related to medical services; investigations of major unusual incidents (MUIs); referral, coordination and monitoring of Medicaid services. Staff who perform direct or professional services and whose activities are reimbursed through other federal programs may not participate in the MAC program.
* Pg. 9 & 10 - See examples of acceptable Random Moment documentation on pg. 10.

*(Source: Halina Schroeder and Beth Ridewood, ODODD, on 1/30/19.)*

**This section should contain program specific information and requirements for Activities Allowed and Unallowed that are applicable to the program CFDA being tested as contained within the individual grant application, agreement, and policies. Include any additional requirements and delete this yellow highlighted text. Be sure to indicate the source of your information. If no additional requirements are noted, indicate as such.**

### Audit Objectives and Control Testing

[**See here for the OMB Supplement Audit Objectives and Compliance Requirements**](Activities_Allowed_or_Unallowed_Audit_Objectives.pdf)

|  |
| --- |
| **What Control Procedures Address the Compliance Requirement (reference/link to documentation or where the testing was performed):** |
| **Basis for the control** (reports, resources, etc. providing information needed to understand requirements and prevent or identify and correct errors):**Control Procedure** (description of how auditee uses the “Basis” to prevent, or identify and correct or detect errors):**Person(s) responsible for performing the control procedure** (title):**Description of evidence documenting the control was applied** (i.e. sampling unit): |

### Suggested Audit Procedures – Compliance

|  |
| --- |
| **Suggested Audit Procedures – Compliance (Substantive Tests)****(Reference / link to documentation where testing was performed testing):** |
| **This FACCR was written for grants required to be tested under the UG, however if you have material non-UG transactions, you will need to contact CFAE via the** **FACCR Inbox****.****Consider the results of the testing of internal control in assessing the risk of noncompliance. Use this as the basis for determining the nature, timing, and extent (e.g., number of transactions to be selected) of substantive tests of compliance.** |
| 1. Identify the types of activities which are either specifically allowed or prohibited by Federal statutes, regulations, and the terms and conditions of the Federal award pertaining to the program.2. When allowability is determined based upon summary level data, perform procedures to verify that:a. Activities were allowable.b. Individual transactions were properly classified and accumulated into the activity total.3. When allowability is determined based upon individual transactions, select a sample of transactions and perform procedures to verify that the transaction was for an allowable activity.4. The auditor should be alert for large transfers of funds from program accounts which may have been used to fund unallowable activities.ODODD Specific Substantive Tests: 1. Select 2 quarters for testing and obtain a listing of the random moments charged (RMTS Participant Moments Questions and Answers report). Select a sample of random moments charged and:
	1. Verify the employee’s salary to supporting documentation.
	2. Verify the employee’s position was allowable to be charged to the MAC program.
 |

### Audit Implications Summary

|  |
| --- |
| **Audit Implications (adequacy of the system and controls, and the effect on sample size, significant deficiencies / material weaknesses, material non-compliance and management letter comments)** |
| 1. **Results of Test of Controls: (including material weaknesses, significant deficiencies and management letter items)**
2. **Assessment of Control Risk:**
3. **Effect on the Nature, Timing, and Extent of Compliance (Substantive Test) including Sample Size:**
4. **Results of Compliance (Substantive Tests) Tests:**
5. **Questioned Costs: Actual \_\_\_\_\_\_\_\_\_\_ Projected \_\_\_\_\_\_\_\_\_\_**
 |

## B. ALLOWABLE COSTS/COST PRINCIPLES

**Federal awarding agencies adopted/implemented the Uniform Guidance in 2 CFR part 200. The OMB guidance is directed to Federal agencies and, by itself, does not establish regulatory requirements binding on non-federal entities. Throughout the FACCR 2 CFR part 200 has been referenced, however in determining compliance auditors need to refer the applicable agency codification of 2 CFR Part 200. Auditors should review this** [**link**](Agency%20Adoption%20of%20the%20UG%20and%20Example%20Citations.pdf) **for a full discussion of agency adoption of the UG and how to cite non-compliance exceptions. Auditors will need to start with the agency codification of the UG when citing exceptions.**

### Applicability of Cost Principles

**Important Note:** For a cost to be allowable, it must (1) be for a purpose the specific award permits and (2) fall within 2 CFR 200 subpart E Cost Principles. These two criteria are roughly analogous to classifying a cost by both program/function and object. That is, the grant award generally prescribes the allowable program/function while 2 CFR 200 subpart E prescribes allowable object cost categories and restrictions that may apply to certain object codes of expenditures.

For example, could a government use an imaginary Homeland Security grant to pay OP&F pension costs for its police force? To determine this, the client (and we) would look to the grant agreement to see if police activities (security of persons and property function cost classification) met the program objectives. Then, the auditor would look to Subpart E (provisions for selected items of cost §200.420-200.475) to determine if pension costs (an object cost classification) are permissible. (200.431(g) states they are allowable, with certain provisions, so we would need to determine if the auditee met the provisions.) Both the client and we should look at 2 CFR 200 subpart E even if the grant agreement includes a budget by object code approved by the grantor agency. Also keep in mind that granting agencies have codified 2 CFR 200 and some agencies have been granted exceptions to provisions within 2 CFR 200.

*(Source: AOS CFAE)*

The cost principles in [2 CFR part 200, subpart E](2CFR200_Subpart%20E.PDF) (Cost Principles), prescribe the cost accounting requirements associated with the administration of Federal awards by:

* States, local governments and Indian tribes
* Institutions of higher education (IHEs)
* Nonprofit organizations

As provided in [2 CFR section 200.101](2CFR200.101.pdf), the cost principles requirements apply to all Federal awards with the exception of grant agreements and cooperative agreements providing food commodities; agreements for loans, loan guarantees, interest subsidies, insurance; and programs listed in [2 CFR section 200.101(d)](2CFR200.101%28d%29.pdf) (see [Appendix I](2CFR200_APPENDIX_I.pdf) of this Supplement). Federal awards administered by publicly owned hospitals and other providers of medical care are exempt from 2 CFR part 200, subpart E, but are subject to the requirements [45 CFR part 75, Appendix IX](45CFR75_Appendix_IX.pdf), the Department of Health and Human Services (HHS) implementation of 2 CFR part 200. The cost principles applicable to a non-Federal entity apply to all Federal awards received by the entity, regardless of whether the awards are received directly from the Federal awarding agency or indirectly through a pass-through entity. For this purpose, Federal awards include cost-reimbursement contacts under the Federal Acquisition Regulation (FAR). The cost principles do not apply to Federal awards under which a non-Federal entity is not required to account to the Federal awarding agency or pass-through entity for actual costs incurred.

**Source of Governing Requirements**

The requirements for allowable costs/cost principles are contained in [2 CFR part 200, subpart E](2CFR200_Subpart%20E.PDF), program legislation, Federal awarding agency regulations, and the terms and conditions of the award.

The requirements for the development and submission of indirect (facilities and administration (F&A)) cost rate proposals and cost allocation plans (CAPs) are contained in [2 CFR part 200, Appendices III-VII](2CFR200_Appendix_III_thru_VII.pdf) as follows:

* Appendix III to Part 200—Indirect (F&A) Const Identification and Assignment and Rate Determination for Institutions of Higher Education (IHEs)
* Appendix IV to Part 200—Indirect (F&A) Costs Identification and Assignment, and Rate Determination for Nonprofit Organizations
* Appendix V to Part 200—State/Local Government-Wide Central Service Cost Allocation Plans
* Appendix VI to Part 200—Public Assistance Cost Allocation Plans
* Appendix VII to Part 200—States and Local Government and Indian Tribe Indirect Cost Proposals

Except for the requirements identified below under “Basic Guidelines,” which are applicable to all types of non-Federal entities, this compliance requirement is divided into sections based on the type of non-Federal entity. The differences that exist are necessary because of the nature of the non-Federal entity organizational structures, programs administered, and breadth of services offered by some non-Federal entities and not others.

*(Source: 2017 OMB Compliance Supplement 3.2)*

**Agency Codification Adjustments/Exceptions:**

HHS, USDA, and DOL have made additions and edits to subpart E. The most recent compilation of agency additions and exceptions is provided on the COFAR website here <https://cfo.gov/wp-content/uploads/2014/12/Agency-Exceptions.pdf>. However, this list is only updated through 12/2014.

**Basic Guidelines**

Except where otherwise authorized by statute, cost must meet the following general criteria in order to be allowable under Federal awards;

1. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under the principles in [2 CFR part 200, subpart E](2CFR200_subpart%20E.PDF).

2. Conform to any limitations or exclusions set forth in 2 CFR part 200, subpart E or in the Federal award as to types or amount of cost items.

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

4. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.

5. Be determined in accordance with generally accepted accounting principles (GAAP), except, for State and local governments and Indian tribes only, as otherwise provided for in 2 CFR part 200.

6. 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.

7. Be adequately documented.

**Selected Items of Cost**

[2 CFR sections 200.420 through 200.475](2CFR200.420_thru_200.475.pdf) provide the principles to be applied in establishing the allowability of certain items of cost, in addition to the basic considerations identified above. These principles apply whether or not a particular item of cost is treated as a direct cost or indirect (F&A) cost. Failure to mention a particular item of cost is not intended to imply that it is either allowable or unallowable; rather, determination of allowability in each case should be based on the treatment provided for similar or related items of cost and the principles described in [2 CFR sections 200.402 through 200.411](2CFR200.402_thru_411.pdf).

[List of Selected Items of Cost Contained in 2 CFR Part 200](Selected_Items_of_Cost_Part_3.2_ComplianceSupplement.pdf)

*(Source: 2017 OMB Compliance Supplement 3.2)*

**Part 4 OMB Program Specific Requirements**

*Recoveries, Refunds, and Rebates (Costs must be the net of all applicable credits)*

1. States must have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Such third-party resources should be exhausted prior to paying claims with program funds. Where a third-party liability is established after the claim is paid, reimbursement from the third party should be sought (42 USC 1396K; 42 CFR sections 433.135 through 433.154).

2. The State is required to credit the Medicaid program for (1) State warrants that are canceled and uncashed checks beyond 180 days of issuance (escheated warrants) and (2) overpayments made to providers of medical services within specified time frames (42 CFR sections 433.300 through 433.320, and 433.40).

Under Section 6506 of the Affordable Care Act (42 USC 1396b(d)(2)), States now have up to 1 year (rather than 60 days) from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment. Except in the case of overpayments resulting from fraud, the adjustment to refund the Federal share must be made no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the 1-year period ends, regardless of whether the State recovers the overpayment.

3. Before calculating the amount of Federal financial participation, certain revenues received by a State will be deducted from the State’s medical assistance expenditures. The revenues to be deducted are (1) donations made by health providers and entities related to providers (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of out- stationed eligibility workers); and (2) impermissible health care-related taxes that exceed a specified limit (42 USC 1396b(w); 42 CFR section 433.57).

“Provider-related donations” are any donations or other voluntary payments (in- cash or in-kind) made directly or indirectly to a State or unit of local government by (1) a health care provider, (2) an entity related to a health care provider, or (3) an entity providing goods or services under the State plan and paid as administrative expenses. “Bona fide provider-related donations” are donations that have no direct or indirect relationship to payments made under Title XIX (42 USC 1396 et seq.) to (1) that provider, (2) providers furnishing the same class of items and services as that provider, or (3) any related entity (42 CFR sections 433.58(d) and 433.66(b)).

 Permissible health care-related taxes are those taxes which are broad-based taxes, uniformly applied to a class of health care items, services, or providers, and which do not hold a taxpayer harmless for the costs of the tax, or a tax program for which CMS has granted a waiver. Health care-related taxes that do not meet these requirements are impermissible health care-related taxes (42 CFR section 433.68(b)).

These provisions apply to all 50 States and the District of Columbia, except those States whose entire Medicaid program is operated under a waiver granted under Section 1115 of the Social Security Act (42 CFR part 433).

4. Section 1927 of the Social Security Act (42 USC 1396r-8) allows States to receive rebates for drug purchases the same as other payers receive. Drug manufacturers are required to provide a listing to CMS of all covered outpatient drugs and, on a quarterly basis, are required to provide their average manufacturer’s price and their best prices for each covered outpatient drug. Based on these data, CMS calculates a unit rebate amount for each drug, which it then provides to States. No later than 60 days after the end of the quarter, the State Medicaid agency must provide to manufacturers drug utilization data, including drug utilization data of those Medicaid beneficiaries enrolled in managed care organizations. Within 30 days of receipt of the utilization data from the State, the manufacturers are required to pay the rebate or provide the State with written notice of disputed items not paid because of discrepancies found.

*(Source: 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX))*

**Written Procedure Requirements:**

[2 CFR 200.302](2CFR200.302.pdf)(b)(7) requires written procedures for determining the allowability of costs in accordance with Subpart E-Cost Principles of this part and the terms and conditions of the Federal award.

[2 CFR 200.430](2CFR200.430.pdf) states that costs of compensation are allowable to the extent that they satisfy the specific requirements of this part, and that the total compensation for individual employees: (1) Is reasonable for the services rendered and conforms to the established written policy of the non-Federal entity consistently applied to both Federal and non-Federal activities; (2) Follows an appointment made in accordance with a non-Federal entity's laws and/or rules or written policies and meets the requirements of Federal statute, where applicable; and (3) Is determined and supported as provided in paragraph (i) of this section, Standards for Documentation of Personnel Expenses, when applicable.

[2 CFR 200.431](2CFR200.431.pdf) requires established written leave policies if the entity intends to pay fringe benefits.

[2 CFR 200.464](2CFR200.464.pdf)(a)(2) requires reimbursement of relocation costs to employees be in accordance with an established written policy must be consistently followed by the employer.

[2 CFR 200.474](2CFR200.474.pdf) requires reimbursement and/or charges to be consistent with those normally allowed in like circumstances in the non-Federal entity's non-federally-funded activities and in accordance with non-Federal entity's written travel reimbursement policies.

*(Source: CFAE/eCFR)*

### Additional Program Specific Information

Compliance Requirements:

See the [ODODD Guide to MAC using the Random Moment Time Studies (RMTS) Methodology](MAC-RMTS_Guide_effective_4-2014.pdf).

* Pg. 5 - All staff that support Medicaid-funded programs for individuals with DD should participate in the MAC program. Medicaid-funded activities include, but are not limited to: Medicaid outreach; facilitating Medicaid eligibility determinations; translations related to Medicaid services; program planning, policy development and interagency coordination related to medical services; investigations of major unusual incidents (MUIs); referral, coordination and monitoring of Medicaid services. Staff who perform direct or professional services and whose activities are reimbursed through other federal programs may not participate in the MAC program.
* Pg. 9 & 10 - See examples of acceptable Random Moment documentation on pg. 10.

*(Source: Halina Schroeder and Beth Ridewood, ODODD, on 1/30/19.)*

**This section should contain program specific information and requirements for Allowable Costs/Cost Principles that are applicable to the program CFDA being tested as contained within the individual grant application, agreement, and policies. Include any additional requirements and place that information with the related suggested audit procedures and delete the yellow highlighted text. Be sure to indicate the source of your information. If no additional requirements are noted, indicate as such.**

### Indirect Cost Rate

Except for those non-Federal entities described in [2 CFR part 200, Appendix VII, paragraph D.1.b](2CFR200_Appendix_VII_Para_D%281%29%28b%29.pdf), if a non-Federal entity has never received a negotiated indirect cost rate, it may elect to charge a de minimis rate of 10 percent of modified total direct costs (MTDC). Such a rate may be used indefinitely or until the non-Federal entity chooses to negotiate a rate, which the non-Federal entity may do at any time. If a non-Federal entity chooses to use the de minimis rate, that rate must be used consistently for all of its Federal awards. Also, as described in [2 CFR section 200.403](2CFR200.403.pdf), costs must be consistently charged as either indirect or direct, but may not be doubled charged or inconsistently charged as both. In accordance with [2 CFR section 200.400(g)](2CFR200.400%28g%29.pdf), a non-Federal entity may not earn or keep any profit resulting from Federal financial assistance, unless explicitly authorized by the terms and conditions of the award.

*(Source: 2017 OMB Compliance Supplement 3.2)*

#### Audit Objectives (Deminimis Indirect Cost Rate) and Control Testing Procedures

[**See here for the OMB Supplement Audit Objectives and Compliance Requirements**](Allowable%20Costs%20audit%20objectives_deminimis%20indirect%20cost%20rate.pdf)

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| **What Control Procedures Address the Compliance Requirement (reference/link to documentation or where the testing was performed):** |
| **Basis for the control** (reports, resources, etc. providing information needed to understand requirements and prevent or identify and correct errors):**Control Procedure** (description of how auditee uses the “Basis” to prevent, or identify and correct or detect errors):**Person(s) responsible for performing the control procedure** (title):**Description of evidence documenting the control was applied** (i.e. sampling unit): |

#### Suggested Compliance Audit Procedures – De Minimis Indirect Cost Rate

**Note**: The following subsections identify requirements specific to each type of non-Federal entity.

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| **Suggested Audit Procedures – Compliance (Substantive Tests)****(Reference / link to documentation where testing was performed testing):** |
| The following suggested audit procedures apply to any non-Federal entity using a de minimis indirect cost rate, whether as a recipient or a subrecipient. None of the procedures related to indirect costs in the sections organized by type of non-Federal entity apply when a de minimis rate is used. **Consider the results of the testing of internal control in assessing the risk of noncompliance. Use this as the basis for determining the nature, timing, and extent (e.g., number of transactions to be selected) of substantive tests of compliance.** |
| 1. Determine that the non-Federal entity has not previously claimed indirect costs on the basis of a negotiated rate. Auditors are required to test only for the three fiscal years immediately prior to the current audit period.2. Test a sample of transactions for conformance with [2 CFR section 200.414(f)](2CFR200.414%28f%29.pdf).a Select a sample of claims for reimbursement of indirect costs and verify that the de minimis rate was used consistently, the rate was applied to the appropriate base, and the amounts claimed were the product of applying the rate to a modified total direct costs base. b Verify that the costs included in the base are consistent with the costs that were included in the base year, i.e., verify that current year modified total direct costs do not include costs items that were treated as indirect costs in the base year. 3. For a non-Federal entity conducting a single function, which is predominately funded by Federal awards, determine whether use of the de minimis indirect cost rate resulted in the non-Federal entity double-charging or inconsistently charging costs as both direct and indirect. |

**2 CFR PART 200**

### Cost Principles for States, Local Governments and Indian Tribes

**Introduction**

[2 CFR part 200, subpart E](2CFR200_subpart%20E.PDF), and [Appendices III-VII](2CFR200_Appendix_III_thru_VII.pdf) establish principles and standards for determining allowable direct and indirect costs for Federal awards. This section is organized into the following areas of allowable costs: States and Local Government and Indian Tribe Costs (Direct and Indirect); State/Local Government Central Service Costs; and State Public Assistance Agency Costs.

***Cognizant Agency for Indirect Costs***

[2 CFR part 200, Appendix V, paragraph F](2CFR200_Appendix_V_Para_F.pdf), provides the guidelines to use when determining the Federal agency that will serve as the cognizant agency for indirect costs for States, local governments, and Indian tribes. References to the “cognizant agency for indirect costs” are not equivalent to the cognizant agency for audit responsibilities, which is defined in [2 CFR section 200.18](2CFR200.18.pdf). In addition, the change from the term “cognizant agency” in OMB Circular A-87 to the term “cognizant agency for indirect costs” in 2 CFR part 200 was not intended to change the scope of cognizance for central service or public assistance cist allocation plans.

For indirect cost rates and departmental indirect cost allocation plans, the cognizant agency is the Federal agency with the largest value of direct Federal awards (excluding pass-through awards) with a governmental unit or component, as appropriate. In general, unless different arrangements are agreed to by the concerned Federal agencies or described in 2 CFR part 200, Appendix V, paragraph F, the cognizant agency for central service cost allocation plans is the Federal agency with the largest dollar value of total Federal awards (including pass-through awards) with a governmental unit.

Once designated as the cognizant agency for indirect costs, the Federal agency remains so for a period of 5 years. In addition, 2 CFR part 200, Appendix V, paragraph F, lists the cognizant agencies for certain specific types of plans and the cognizant agencies for indirect costs for certain types of governmental entities. For example, HHS is cognizant for all public assistance and State-wide cost allocation plans for all States (including the District of Columbia and Puerto Rico), State and local hospitals, libraries, and health districts and the Department of the Interior (DOI) is cognizant for all Indian tribal governments, territorial governments, and State and local park and recreational districts.

*(Source: 2017 OMB Compliance Supplement 3.2)*

#### Audit Objectives/Compliance Requirements and Control Tests Allowable Costs –– Direct and Indirect Costs

The individual State/local government/Indian tribe departments or agencies (also known as “operating agencies”) are responsible for the performance or administration of Federal awards. In order to receive cost reimbursement under Federal awards, the department or agency usually submits claims asserting that allowable and eligible costs (direct and indirect) have been incurred in accordance with [2 CFR part 200, subpart E](2CFR200_subpart%20E.PDF).

The indirect cost rate proposal (ICRP) provides the documentation prepared by a State/local government/Indian tribe department or agency to substantiate its request for the establishment of an indirect cost rate. The indirect costs include (1) costs originating in the department or agency of the governmental unit carrying out Federal awards, and (2) for States and local governments, costs of central governmental services distributed through the State/local government-wide central service CAP that are not otherwise treated as direct costs. The ICRPs are based on the most current financial data and are used to either establish predetermined, fixed, or provisional indirect cost rates or to finalize provisional rates (for rate definitions refer to [2 CFR part 200, Appendix VII, paragraph B](2CFR200_Appendix_VII_Para_B.pdf)).

*(Source: 2017 OMB Compliance Supplement 3.2)*

[**See here for the OMB Supplement Audit Objectives and Compliance Requirements**](Allowable%20Costs_DirectandIndirect_ComplianceReq_Auditobjectives.pdf)

**Additional Control Test Objectives for Written Procedures**

When documenting and identifying the key control(s) in place to address the compliance requirement, consider if the client has written procedures to document the control process.

* UG requires written policies for the requirements outlined in [2 CFR 200.302](2CFR200.302.pdf)(b)(7), [2 CFR 200.430](2CFR200.430.pdf), [2 CFR 200.431](2CFR200.431.pdf), [2 CFR 200.464](2CFR200.464.pdf)(a)(2), and [2 CFR 200.474](2CFR200.474.pdf)*.*
* Document whether the non-Federal entity established written procedures consistent with the following requirements:
	+ 2 CFR 200.302(b)(7) for determining the allowability of costs in accordance with Subpart E-Cost Principles.
	+ 2 CFR 200.430 for allowability of compensation costs.
	+ 2 CFR 200.431 for written leave policies.
	+ 2 CFR 200.464(a)(2) for reimbursement of relocation costs.
	+ 2 CFR 200.474 for travel reimbursements.
* It is auditor judgment how to report instances where the entity either lacks having a written policy or their written policy is insufficient to meet the requirements of 2 CFR 200.302(b)(7), 2 CFR 200.430, 2 CFR 200.431, 2 CFR 200.464(a)(2), and 2 CFR 200.474.
	+ While auditors would normally use a written policy as the basis for the compliance control, there could be other key controls in place to ensure program compliance.
	+ The lack of a policy would be noncompliance, which could rise to the level of material noncompliance and even a control deficiency (SD / MW) if there were underlying internal control deficiencies.
		- If there are key controls in place operating effectively, AOS auditors would report the lack of the required UG policy as a management letter citation. However, in subsequent audits, evaluate if the noncompliance should be elevated if not adopted. Written policies aid in consistency and adherence to requirements strengthening internal control processes.

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| **What Control Procedures Address the Compliance Requirement (reference/link to documentation or where the testing was performed):** |
| **Basis for the control** (reports, resources, etc. providing information needed to understand requirements and prevent or identify and correct errors):**Control Procedure** (description of how auditee uses the “Basis” to prevent, or identify and correct or detect errors):**Person(s) responsible for performing the control procedure** (title):**Description of evidence documenting the control was applied** (i.e. sampling unit): |

#### Suggested Compliance Audit Procedures – Direct and Indirect Costs

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| **Suggested Audit Procedures – Compliance (Substantive Tests)****(Reference / link to documentation where testing was performed testing):** |
| **This FACCR was written for grants required to be tested under the UG, however if you have material non-UG transactions, you will need to contact CFAE via the** **FACCR Inbox****.****Consider the results of the testing of internal control in assessing the risk of noncompliance. Use this as the basis for determining the nature, timing, and extent (e.g., number of transactions to be selected) of substantive tests of compliance.** |
| ***Direct Costs*** Test a sample of transactions for conformance with the following criteria contained in 2 CFR part 200, as applicable:1. If the auditor identifies unallowable direct costs, the auditor should be aware that “directly associated costs” might have been charged. Directly associated costs are costs incurred solely as a result of incurring another cost, and would not have been incurred if the other cost had not been incurred. For example, fringe benefits are “directly associated” with payroll costs. When an unallowable cost is incurred, directly associated costs are also unallowable.
2. Costs were approved by the Federal awarding agency, if required (see the above table (Selected Items of Cost, Exhibit 1) or [2 CFR section 200.407](2CFR200.407.pdf) for selected items of cost that require prior written approval).
3. Costs did not consist of improper payments, including (1) payments that should not have been made or that were made in incorrect amounts (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; (2) payments that do not account for credit for applicable discounts; (3) duplicate payments; (4) payments that were made to an ineligible party or for an ineligible good or service; and (5) payments for goods or services not received (except for such payments where authorized by law).

d. Costs were necessary and reasonable for the performance of the Federal award and allocable under the principles of [2 CFR part 200, subpart E](2CFR200_subpart%20E.PDF).e. Costs conformed to any limitations or exclusions set forth in 2 CFR part 200, subpart E, or in the Federal award as to types or amount of cost items.f. Costs were consistent with policies and procedures that apply uniformly to both federally financed and other activities of the State/local government/Indian tribe department or agency.g. Costs were accorded consistent treatment. Costs were not assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances was allocated to the Federal award as an indirect cost.h. Costs were not included as a cost of any other federally financed program in either the current or a prior period.i. Costs were not used to meet the cost-sharing or matching requirements of another Federal program, except where authorized by Federal statute.j. Costs were adequately documented.***Indirect Costs***a. If the State/local department or agency is not required to submit an ICRP and related supporting documentation, the auditor should consider the risk of the reduced level of oversight in designing the nature, timing, and extent of compliance testing.b. *General Audit Procedures* – The following procedures apply to charges to cost pools that are allocated wholly or partially to Federal awards or used in formulating indirect cost rates used for recovering indirect costs under Federal awards.(1) Test a sample of transactions for conformance with:(a) The criteria contained in the “Basic Considerations” section of [2 CFR sections 200.402 through 200.411](2CFR200.402_thru_411.pdf).(b) The principles to establish allowability or unallowability of certain items of cost ([2 CFR sections 200.420 through 200.475](2CFR200.420_thru_200.475.pdf)).Note: While several selected items of cost are included in Exhibit 1, one item to note is *Compensation - Personnel Services*, (formally referred to as Time and Effort/Semi Annual Certification). See [2 CFR 200.430](2CFR200.430.pdf). (2) If the auditor identifies unallowable costs, the auditor should be aware that directly associated costs might have been charged. Directly associated costs are costs incurred solely as a result of incurring another cost, and would have not been incurred if the other cost had not been incurred. When an unallowable cost is incurred, directly associated costs are also unallowable. For example, occupancy costs related to unallowable general costs of government are also unallowable.c. *Special Audit Procedures for State, Local Government, and Indian Tribe ICRPs (see also the AOS discussion on* [*testing the ICRP*](Testing%20the%20ICRP%20discussion.pdf)*)*(1) Verify that the ICRP includes the required documentation in accordance with [2 CFR part 200, Appendix VII, paragraph D](2CFR200_Appendix_VII_Para_D.pdf).(2) *Testing of the ICRP* – There may be a timing consideration when the audit is completed before the ICRP is completed. In this instance, the auditor should consider performing interim testing of the costs charged to the cost pools and the allocation bases (e.g., determine from management the cost pools that management expects to include in the ICRP and test the costs for compliance with 2 CFR part 200). Should there be audit exceptions, corrective action may be taken earlier to minimize questioned costs. In the next year’s audit, the auditor should complete testing and verify management’s representations against the completed ICRP.The following procedures are some acceptable options the auditor may use to obtain assurance that the costs collected in the cost pools and the allocation methods used are in compliance with [2 CFR part 200, subpart E](2CFR200_subpart%20E.PDF):(a) *Indirect Cost Pool* – Test the indirect cost pool to ascertain if it includes only allowable costs in accordance with 2 CFR part 200.(i) Test to ensure that unallowable costs are identified and eliminated from the indirect cost pool (e.g., capital expenditures, general costs of government).(ii) Identify significant changes in expense categories between the prior ICRP and the current ICRP. Test a sample of transactions to verify the allowability of the costs.(iii) Trace the central service costs that are included in the indirect cost pool to the approved State/local government or central service CAP or to plans on file when submission is not required.(b) *Direct Cost Base* – Test the methods of allocating the costs to ascertain if they are in accordance with the applicable provisions of 2 CFR part 200 and produce an equitable distribution of costs.(i) Determine that the proposed base(s) includes all activities that benefit from the indirect costs being allocated.(ii) If the direct cost base is not limited to direct salaries and wages, determine that distorting items are excluded from the base. Examples of distorting items include capital expenditures, flow-through funds (such as benefit payments), and subaward costs in excess of $25,000 per subaward.(iii) Determine the appropriateness of the allocation base (e.g., salaries and wages, modified total direct costs).(c) *Other Procedures* (i) Examine the records for employee compensation to ascertain if they are accurate, and the costs are allowable and properly allocated to the various functional and programmatic activities to which salary and wage costs are charged. (Refer to [2 CFR section 200.430](2CFR200.430.pdf) for additional information on support of salaries and wages.)(ii) For an ICRP using the multiple allocation base method, test statistical data (e.g., square footage, audit hours, salaries and wages) to ascertain if the proposed allocation or rate bases are reasonable, updated as necessary, and do not contain any material omissions.(3) *Testing of Charges Based Upon the ICRA* – Perform the following procedures to test the application of charges to Federal awards based upon an ICRA:(a) Obtain and read the current ICRA and determine the terms in effect.(b) Select a sample of claims for reimbursement and verify that the rates used are in accordance with the rate agreement, that rates were applied to the appropriate bases, and that the amounts claimed were the product of applying the rate to the applicable base. Verify that the costs included in the base(s) are consistent with the costs that were included in the base year (e.g., if the allocation base is total direct costs, verify that current-year direct costs do not include costs items that were treated as indirect costs in the base year).(4) *Other Procedures* – No Negotiated ICRA(a) If an indirect cost rate has not been negotiated by a cognizant agency for indirect costs, the auditor should determine whether documentation exists to support the costs. Where the auditee has documentation, the suggested general audit procedures under paragraph 3.b above should be performed to determine the appropriateness of the indirect cost charges to awards.(b) If an indirect cost rate has not been negotiated by a cognizant agency for indirect costs, and documentation to support the indirect costs does not exist, the auditor should question the costs based on a lack of supporting documentation.ODODD Specific Substantive Tests: 1. Select 2 quarters for testing and obtain a listing of the random moments charged (RMTS Participant Moments Questions and Answers report). Select a sample of random moments charged and determine if applicable documentation of the random moment/responses were maintained.
 |

### Allowable Costs – State/Local Government-wide Central Service Costs

Most governmental entities provide services, such as accounting, purchasing, computer services, and fringe benefits, to operating agencies on a centralized basis. Since the Federal awards are performed within the individual operating agencies, there must be a process whereby these central service costs are identified and assigned to benefiting operating agency activities on a reasonable and consistent basis. The State/local government-wide central service cost allocation plan (CAP) provides that process. ([Refer to 2 CFR part 200, Appendix V](2CFR200_Appendix_V.pdf), for additional information and specific requirements.)

The allowable costs of central services that a governmental unit provides to its agencies may be allocated or billed to the user agencies. The State/local government-wide central service CAP is the required documentation of the methods used by the governmental unit to identify and accumulate these costs, and to allocate them or develop billing rates based on them.

Allocated central service costs (referred to as Section I costs) are allocated to benefiting operating agencies on some reasonable basis. These costs are usually negotiated and approved for a future year on a “fixed-with-carry-forward” basis. Examples of such services might include general accounting, personnel administration, and purchasing. Section I costs assigned to an operating agency through the State/local government-wide central service CAP are typically included in the agency’s indirect cost pool.

Billed central service costs (referred to as Section II costs) are billed to benefiting agencies and/or programs on an individual fee-for-service or similar basis. The billed rates are usually based on the estimated costs for providing the services. An adjustment will be made at least annually for the difference between the revenue generated by each billed service and the actual allowable costs. Examples of such billed services include computer services, transportation services, self- insurance, and fringe benefits. Section II costs billed to an operating agency may be charged as direct costs to the agency’s Federal awards or included in its indirect cost pool.

*(Source: 2017 OMB Compliance Supplement 3.2)*

#### Audit Objectives/Compliance Requirements and Control Tests Allowable Costs - State/Local Government-wide Central Service Costs

[**See here for the OMB Compliance Supplement Audit Objectives and Compliance Requirements**](Allowable%20Costs_StateLocal_Govtwide_Centralservicecosts_ComplianceReq_Auditobjectives.pdf)

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| **What Control Procedures Address the Compliance Requirement (reference/link to documentation or where the testing was performed):** |
| **Basis for the control** (reports, resources, etc. providing information needed to understand requirements and prevent or identify and correct errors):**Control Procedure** (description of how auditee uses the “Basis” to prevent, or identify and correct or detect errors):**Person(s) responsible for performing the control procedure** (title):**Description of evidence documenting the control was applied** (i.e. sampling unit): |

#### Suggested Compliance Audit Procedures – State/Local Government-Wide Central Service Costs

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| **Suggested Audit Procedures – Compliance (Substantive Tests)****(Reference / link to documentation where testing was performed testing):** |
| **This FACCR was written for grants required to be tested under the UG, however if you have material non-UG transactions, you will need to contact CFAE via the** **FACCR Inbox****.** **Consider the results of the testing of internal control in assessing the risk of noncompliance. Use this as the basis for determining the nature, timing, and extent (e.g., number of transactions to be selected) of substantive tests of compliance.** |
| a. For local governments that are not required to submit the central service CAP and related supporting documentation, the auditor should consider the risk of the reduced level of oversight in designing the nature, timing and extent of compliance testing.b. *General Audit Procedures for State/Local Government-Wide Central Service CAPs* – The following procedures apply to charges to cost pools that are allocated wholly or partially to Federal awards or used in formulating indirect cost rates used for recovering indirect costs under Federal awards.(1) Test a sample of transactions for conformance with:(a) The criteria contained in the “Basic Considerations” section of [2 CFR part 200, subpart E](2CFR200_subpart%20E.PDF) (sections [200.402 through 200.411](2CFR200.402_thru_411.pdf)).(b) The principles to establish allowability or unallowability of certain items of cost [(2 CFR sections 200.420 through 475](2CFR200.420_thru_200.475.pdf)).(2) If the auditor identifies unallowable costs, the auditor should be aware that directly associated costs might have been charged. Directly associated costs are costs incurred solely as a result of incurring another cost, and would have not been incurred if the other cost had not been incurred. When an unallowable cost is incurred, directly associated costs are also unallowable. For example, occupancy costs related to unallowable general costs of government are also unallowable.c. *Special Audit Procedures for State/Local Government-Wide Central Service CAPs*(1) Verify that the central service CAP includes the required documentation in accordance with [2 CFR part 200 Appendix V, paragraph E](2CFR200_Appendix_V_Para_E.pdf).(2) *Testing of the State/Local Government-Wide Central Service CAPs – Allocated Section I Costs*(a) If new allocated central service costs were added, review the justification for including the item as Section I costs to ascertain if the costs are allowable (e.g., if costs benefit Federal awards).(b) Identify the central service costs that incurred a significant increase in actual costs from the prior year’s costs. Test a sample of transactions to verify the allowability of the costs.(c) Ascertain if the bases used to allocate costs are appropriate, i.e., costs are allocated in accordance with relative benefits received.(d) Ascertain if the proposed bases include all activities that benefit from the central service costs being allocated, including all users that receive the services. For example, the State-wide central service CAP should allocate costs to all benefiting State departments and agencies, and, where appropriate, non-State organizations, such as local government agencies.(e) Perform an analysis of the allocation bases by selecting agencies with significant Federal awards to determine if the percentage of costs allocated to these agencies has increased from the prior year. For those selected agencies with significant allocation percentage increases, ascertain if the data included in the bases are current and accurate. (f) Verify that carry-forward adjustments are properly computed in accordance with [2 CFR part 200, Appendix V, paragraph G.3](2CFR200_Appendix_V_Para_G%283%29.pdf). (3) *Testing of the State/Local Government-Wide Central Service CAPs – Billed Section II Costs*(a) For billed central service activities accounted for in separate funds (e.g., internal service funds), ascertain if: (i) Retained earnings/fund balances (including reserves) are computed in accordance with the cost principles;(ii) Working capital reserves are not excessive in amount (generally not greater than 60 calendar days for cash expenses for normal operations incurred for the period exclusive of depreciation, capital costs, and debt principal costs); and(iii) Adjustments were made when there is a difference between the revenue generated by each billed service and the actual allowable costs.(b) Test to ensure that all users of services are billed in a consistent manner. For example, examine selected billings to determine if all users (including users outside the governmental unit) are charged the same rate for the same service.(c) Test that billing rates exclude unallowable costs, in accordance with the cost principles and Federal statutes.(d) Test, where billed central service activities are funded through general revenue appropriations, that the billing rates (or charges) were developed based on actual costs and were adjusted to eliminate profits.(e) For self-insurance and pension funds, ascertain if the fund contributions are appropriate for such activities as indicated in the current actuarial report.(f) Determine if refunds were made to the Federal Government for its share of funds transferred from the self-insurance reserve to other accounts, including imputed or earned interest from the date of the transfer. |

### Allowable Costs – State Public Assistance Agency Costs

State public assistance agency costs are (1) defined as all costs allocated or incurred by the State agency except expenditures for financial assistance, medical vendor payments, and payments for services and goods provided directly to program recipients (e.g., day care services); and (2) normally charged to Federal awards by implementing the public assistance cost allocation plan (CAP). The public assistance CAP provides a narrative description of the procedures that are used in identifying, measuring, and allocating all costs (direct and indirect) to each of the programs administered or supervised by State public assistance agencies.

[2 CFR part 200, Appendix VI, paragraph A](2CFR200_Appendix_VI_Para_A.pdf), states that, since the federally financed programs administered by State public assistance agencies are funded predominantly by HHS, HHS is responsible for the requirements for the development, documentation, submission, negotiation, and approval of public assistance CAPs. These requirements are specified in [45 CFR part 95, subpart E](45CFR95%20Subpart%20E.pdf).

Major Federal programs typically administered by State public assistance agencies include: Temporary Assistance for Needy Families (CFDA 93.558), Medicaid (CFDA 93.778), Supplemental Nutrition Assistance Program (CFDA 10.561), Child Support Enforcement (CFDA 93.563), Foster Care (CFDA 93.658), Adoption Assistance (CFDA 93.659), and Social Services Block Grant (CFDA 93.667).

*(Source: 2017 OMB Compliance Supplement 3.2)*

#### Audit Objectives/Compliance Requirements and Control Tests Allowable Costs - State Public Assistance Agency Costs

[**See here for the OMB Compliance Supplement Audit Objectives and Compliance Requirements**](Allowable%20Costs_State%20Public%20Assistance%20Agency%20Costs_OMB%20supplement.pdf)

|  |
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| **What Control Procedures Address the Compliance Requirement (reference/link to documentation or where the testing was performed):** |
| **Basis for the control** (reports, resources, etc. providing information needed to understand requirements and prevent or identify and correct errors):**Control Procedure** (description of how auditee uses the “Basis” to prevent, or identify and correct or detect errors):**Person(s) responsible for performing the control procedure** (title):**Description of evidence documenting the control was applied** (i.e. sampling unit): |

#### Suggested Compliance Audit Procedures – State Public Assistance Agency Costs

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| --- |
| **Suggested Audit Procedures – Compliance (Substantive Tests)****(Reference / link to documentation where testing was performed testing):** |
| **This FACCR was written for grants required to be tested under the UG, however if you have material non-UG transactions, you will need to contact CFAE via the** **FACCR Inbox****.** **Consider the results of the testing of internal control in assessing the risk of noncompliance. Use this as the basis for determining the nature, timing, and extent (e.g., number of transactions to be selected) of substantive tests of compliance.** |
| This may be applicable to public assistance programs at the local levela. Since a significant amount of the costs in the public assistance CAP are allocated based on employee compensation reporting systems, it is suggested that the auditor consider the risk when designing the nature, timing, and extent of compliance testing.b. *General Audit Procedures* – The following procedures apply to direct charges to Federal awards as well as charges to cost pools that are allocated wholly or partially to Federal awards.(1) Test a sample of transactions for conformance with:(a) The criteria contained in the “Basic Considerations” section of 2 CFR part 200 ([sections 200.402 through 200.411](2CFR200.402_thru_411.pdf)). (b) The principles to establish allowability or unallowability of certain items of cost ([2 CFR sections 200.420 through 200.475](2CFR200.420_thru_200.475.pdf)).(2) If the auditor identifies unallowable costs, the auditor should be aware that directly associated costs might have been charged. Directly associated costs are costs incurred solely as a result of incurring another cost, and would have not been incurred if the other cost had not been incurred. When an unallowable cost is incurred, directly associated costs are also unallowable. For example, occupancy costs related to unallowable general costs of government are also unallowable.c. *Special Audit Procedures for Public Assistance CAPs*(1) Verify that the State public assistance agency is complying with the submission requirements, i.e., an amendment is promptly submitted when any of the events identified in [45 CFR section 95.509](45CFR95.509.pdf) occur.(2) Verify that public assistance CAP includes the required documentation in accordance with [45 CFR section 95.507](45CFR95.507.pdf).(3) *Testing of the Public Assistance CAP* – Test the methods of allocating the costs to ascertain if they are in accordance with the applicable provisions of the cost principles and produce an equitable distribution of costs. Appropriate detailed tests may include:(a) Examining the results of the employee compensation system or in addition the records for employee compensation to ascertain if they are accurate, allowable, and properly allocated to the various functional and programmatic activities to which salary and wage costs are charged.(b) Since the most significant cost pools in terms of dollars are usually allocated based upon the distribution of income maintenance and social services workers’ efforts identified through random moment time studies, determining whether the time studies are implemented and operated in accordance with the methodologies described in the approved public assistance CAP. For example, verifying the adequacy of the controls governing the conduct and evaluation of the study, and determining that the sampled observations were properly selected and performed, the documentation of the observations was properly completed, and the results of the study were correctly accumulated and applied. Testing may include observing or interviewing staff who participate in the time studies to determine if they are correctly recording their activities.(c) Testing statistical data (e.g., square footage, case counts, salaries and wages) to ascertain if the proposed allocation bases are reasonable, updated as necessary, and do not contain any material omissions.(4) *Testing of Charges Based Upon the Public Assistance CAP* – If the approved public assistance CAP is determined to be in compliance with the cost principles and produces an equitable distribution of costs, verify that the methods of charging costs to Federal awards are in accordance with the approved CAP and the provisions of the approval documents issued by HHS. Detailed compliance tests may include:(a) Verifying that the cost allocation schedules, supporting documentation and allocation data are accurate and that the costs are allocated in compliance with the approved CAP.(b) Reconciling the allocation statistics of labor costs to employee compensation records (e.g., random moment sampling observation forms).(c) Reconciling the allocation statistics of non-labor costs to allocation data, (e.g., square footage or case counts).(d) Verifying direct charges to supporting documents (e.g., purchase orders).(e) Reconciling the costs to the Federal claims. |

### Cost Principles for Nonprofit Organizations

If the federal program is an NPO, pull up the 2017 OMB compliance supplement [Allowable Costs/Cost Principles section](Cost%20Principles%20for%20Nonprofit%20Organizations.pdf). This section can be completed as an addendum to the FACCR, saved within in your working papers and can the cross referenced section can also be added on this page.

Cross Reference to the NPO Allowable cost principles testing: \_\_\_\_\_\_\_\_\_\_\_\_\_

*(Source: 2017 OMB Compliance Supplement 3.2)*

### Audit Implications Summary

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| **Audit Implications (adequacy of the system and controls, and the effect on sample size, significant deficiencies / material weaknesses, material non-compliance and management letter comments)** |
| 1. **Results of Test of Controls: (including material weaknesses, significant deficiencies and management letter items)**
2. **Assessment of Control Risk:**
3. **Effect on the Nature, Timing, and Extent of Compliance (Substantive Test) including Sample Size:**
4. **Results of Compliance (Substantive Tests) Tests:**
5. **Questioned Costs: Actual \_\_\_\_\_\_\_\_\_\_ Projected \_\_\_\_\_\_\_\_\_\_**
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## C. CASH MANAGEMENT

### OMB Compliance Requirements – Not Applicable

This FACCR was written for only MAC reimbursements, which are indirect costs. Related requirements are tested as part of Section L – Reporting.

## E. ELIGIBILITY

### OMB Compliance Requirements – Not Applicable

Eligibility is not applicable at the local Board level. Eligibility for Medicaid recipients is determined by the Ohio Department of Medicaid through the Ohio Integrated Eligibility System (IE). The State Region Office of the Auditor of State tests this system.

## F. EQUIPMENT AND REAL PROPERTY MANAGEMENT

### OMB Compliance Requirements – Not Applicable

This compliance requirement is not applicable per the2017 OMB Compliance Supplement, Part 2.

## G. MATCHING, LEVEL OF EFFORT, EARMARKING

**Federal awarding agencies adopted/implemented the Uniform Guidance in 2 CFR part 200. The OMB guidance is directed to Federal agencies and, by itself, does not establish regulatory requirements binding on non-federal entities. Throughout the FACCR 2 CFR part 200 has been referenced, however in determining compliance auditors need to refer the applicable agency codification of 2 CFR Part 200. Auditors should review this** [**link**](Agency%20Adoption%20of%20the%20UG%20and%20Example%20Citations.pdf) **for a full discussion of agency adoption of the UG and how to cite non-compliance exceptions. Auditors will need to start with the agency codification of the UG when citing exceptions.**

### OMB Compliance Requirements

The specific requirements for matching, level of effort, and earmarking are unique to each Federal program and are found in the statutes, regulations, and the terms and conditions of awards pertaining to the program. For programs listed in this Supplement, these specific requirements are in Part 4, “Agency Program Requirements,” or Part 5, “Clusters of Programs,” as applicable.

However, for matching, [2 CFR section 200.306](2CFR200.306.pdf) provides detailed criteria for acceptable costs and contributions. The following is a list of the basic criteria for acceptable matching:

- Are verifiable from the non-Federal entity’s records;

- Are not included as contributions for any other Federal award;

- Are necessary and reasonable for accomplishment of project or program objectives;

- Are allowed under [2 CFR part 200, subpart E](2CFR200_subpart%20E.PDF) (Cost Principles);

- Are not paid by the Federal Government under another award, except where the Federal statute authorizing a program specifically provides that Federal funds made available for such program can be applied to matching or cost sharing requirements of other Federal programs;

- Are provided for in the approved budget when required by the Federal awarding agency; and

- Conform to other provisions of this part, as applicable.

“Matching,” “level of effort,” and “earmarking” are defined as follows:

1. *Matching* or cost sharing includes requirements to provide contributions (usually non-Federal) of a specified amount or percentage to match Federal awards. Matching may be in the form of allowable costs incurred or in-kind contributions (including third-party in-kind contributions).

2. *Level of effort* includes requirements for (a) a specified level of service to be provided from period to period, (b) a specified level of expenditures from non-Federal or Federal sources for specified activities to be maintained from period to period, and (c) Federal funds to supplement and not supplant non-Federal funding of services.

3. *Earmarking* includes requirements that specify the minimum and/or maximum amount or percentage of the program’s funding that must/may be used for specified activities, including funds provided to subrecipients. Earmarking may also be specified in relation to the types of participants covered.

**Source of Governing Requirements**

The requirements for matching are contained in [2 CFR section 200.306,](2CFR200.306.pdf) program legislation, Federal awarding agency regulations, and the terms and conditions of the award. The requirements for level of effort and earmarking are contained in program legislation, Federal awarding agency regulations, and the terms and conditions of the award.

*(Source: 2017 OMB Compliance Supplement 3.2)*

**Agency Codification Adjustments/Exceptions:**

USDA, HUD, DOT, HHS and EPA have not made any adjustments or exceptions that directly impact references within this compliance requirement.

**Part 4 OMB Program Specific Requirements**

**1. Matching**

The State is required to pay part of the costs of providing health care to the poor and part of the costs of administering the program. Different State participation rates apply to medical assistance payments. There are also different Federal financial participation rates for the different types of costs incurred in administering the Medicaid program, such as administration (including administration of family planning services), training, computer, and other costs (42 CFR sections 433.10 and 433.15). The auditor should refer to the State plan for the matching rates.

**2. Level of Effort**

A State waiver may contain a level-of-effort requirement.

**3. Earmarking**

A State waiver may contain an earmarking requirement.

*(Source: 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX))*

### Additional Program Specific Information

**Matching:**

Compliance Requirements:

Per DODD, The County Boards provide match via the expenses they report to DODD quarterly for the MAC claims. A large majority of these costs are payroll costs, but some may be related to contracts approved for inclusion in the claim. The County Boards are reimbursed for these costs in accordance with the claim calculation. So when the County Boards pay their staff, they pay the required match. The staff expense (match) is paid in full prior to the receipt of the MAC reimbursement.

*(Source: Halina Schroeder and Beth Ridewood, ODODD, on 1/30/19.)*

**Level of Effort and Earmarking:**

Refer to the grant agreement between the State agency and the local government to determine whether these requirements apply. If they do, contact CFAE using the Inbox for further guidance.

*(Source: AOS CFAE)*

**This section should contain program specific information and requirements for Matching, Level of Effort, Earmarking that are applicable to the program CFDA being tested as contained within the individual grant application, agreement, and policies. Include any additional material requirements and delete this yellow highlighted text. Be sure to indicate the source of your information. If no additional requirements are noted, indicate as such.**

### Audit Objectives and Control Testing

[**See here for the OMB Supplement Audit Objectives and Compliance Requirements**](Matching_LevelofEffort_Earmarking_Auditobjectives.pdf)

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| --- |
| **What Control Procedures Address the Compliance Requirement (reference/link to documentation or where the testing was performed):** |
| **Basis for the control** (reports, resources, etc. providing information needed to understand requirements and prevent or identify and correct errors):**Control Procedure** (description of how auditee uses the “Basis” to prevent, or identify and correct or detect errors):**Person(s) responsible for performing the control procedure** (title):**Description of evidence documenting the control was applied** (i.e. sampling unit): |

### Suggested Audit Procedures – Compliance

|  |
| --- |
| **Suggested Audit Procedures – Compliance (Substantive Tests)****(Reference / link to documentation where testing was performed testing):** |
| **This FACCR was written for grants required to be tested under the UG, however if you have material non-UG transactions, you will need to contact CFAE via the** **FACCR Inbox****.****Consider the results of the testing of internal control in assessing the risk of noncompliance. Use this as the basis for determining the nature, timing, and- extent (e.g., number of transactions to be selected) of substantive tests of compliance.** |
| **1.** **Matching**a. Perform tests to verify that the required matching contributions were met.b. Ascertain the sources of matching contributions and perform tests to verify that they were from an allowable source.c. Test records to corroborate that the values placed on in-kind contributions (including third party in-kind contributions) are in accordance with [2 CFR sections 200.306](2CFR200.306.pdf), [200.434](2CFR200.434.pdf), and [200.414](2CFR200.414.pdf), and the terms and conditions of the award.d. Test transactions used to match for compliance with the allowable costs/cost principles requirements. This test may be performed in conjunction with the testing of the requirements related to allowable costs/cost principles.ODoDD Specific Substantive Tests:1. Obtain the Medicaid Cost Report / Income and Expense Report, and related instructions from County. Agree line item 1 (salaries) (and 3 (service contracts) if material) reported on Worksheet 6 to costs in the County’s accounting records.

**2.1** **Level of Effort** – *Maintenance of Effort – Not Applicable***2.2** **Level of Effort** – *Supplement Not Supplant – Not Applicable***3. Earmarking – Not Applicable** |

### Audit Implications Summary

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| --- |
| **Audit Implications (adequacy of the system and controls, and the effect on sample size, significant deficiencies / material weaknesses, material non-compliance and management letter comments)** |
| 1. **Results of Test of Controls: (including material weaknesses, significant deficiencies and management letter items)**
2. **Assessment of Control Risk:**
3. **Effect on the Nature, Timing, and Extent of Compliance (Substantive Test) including Sample Size:**
4. **Results of Compliance (Substantive Tests) Tests:**
5. **Questioned Costs: Actual \_\_\_\_\_\_\_\_\_\_ Projected \_\_\_\_\_\_\_\_\_\_**
 |

## H. PERIOD OF PERFORMANCE

### OMB Compliance Requirements – Not Applicable

The Medicaid Program is an entitlement program, which means that it ongoing with uncapped federal funds as long as the state is able to provide matching funds and the expenditures are allowable and for eligible recipients. Due to the programs ongoing nature versus that of a block grant which has specific availability periods, the risk is extremely low that any claims greater than two years aged (45 CFR 95 Subpart A) would have a material impact on the Medicaid Program. If information to the contrary is noted, auditors should contact CFAE through the FACCR Inbox.

## I. PROCUREMENT AND SUSPENSION AND DEBARMENT

### OMB Compliance Requirements – Not Applicable

Almost all ODODD MAC monies are spent on salaries, and therefore this section would not be applicable at the County level. If information to the contrary is noted, auditors should contact CFAE through the FACCR Inbox.

## J. PROGRAM INCOME

### OMB Compliance Requirements – Not Applicable

This compliance requirement is not applicable per the2017 OMB Compliance Supplement, Part 2.

## L. REPORTING

**Federal awarding agencies adopted/implemented the Uniform Guidance in 2 CFR part 200. The OMB guidance is directed to Federal agencies and, by itself, does not establish regulatory requirements binding on non-federal entities. Throughout the FACCR 2 CFR part 200 has been referenced, however in determining compliance auditors need to refer the applicable agency codification of 2 CFR Part 200. Auditors should review this** [**link**](Agency%20Adoption%20of%20the%20UG%20and%20Example%20Citations.pdf) **for a full discussion of agency adoption of the UG and how to cite non-compliance exceptions. Auditors will need to start with the agency codification of the UG when citing exceptions.**

### OMB Compliance Requirements

For purposes of programs included in Parts 4 and 5 of this Supplement, the designation “Not Applicable” in relation to “Financial Reporting,” “Performance Reporting,” and “Special Reporting” means that the auditor is not expected to audit anything in these categories, whether or not award terms and conditions may require such reporting.

*Financial Reporting*

Recipients must use the standard financial reporting forms or such other forms as may be authorized by OMB (approval is indicated by an OMB paperwork control number on the form) when reporting to the Federal awarding agency. Each recipient must report program outlays and program income on a cash or accrual basis, as prescribed by the Federal awarding agency. If the Federal awarding agency requires reporting of accrual information and the recipient’s accounting records are not normally maintained on the accrual basis, the recipient is not required to convert its accounting system to an accrual basis but may develop such accrual information through analysis of available documentation. The Federal awarding agency may accept identical information from the recipient in machine-readable format, computer printouts, or electronic outputs in lieu of closed formats or on paper.

Similarly, a pass-through entity must not require a subrecipient to establish an accrual accounting system and must allow the subrecipient to develop accrual data for its reports on the basis of an analysis of available documentation.

The financial reporting requirements for subrecipients are as specified by the pass-through entity. In many cases, these will be the same as or similar to those for recipients.

The standard financial reporting forms for grants and cooperative agreements are as follows:

* *Request for Advance or Reimbursement (SF-270) (OMB No. 0348-0004))*. Recipients are required to use the SF-270 to request reimbursement payments under non-construction programs, and may be required to use it to request advance payments.
* *Outlay Report and Request for Reimbursement for Construction Programs (SF-271) (OMB No. 0348-0002))*. Recipients use the SF-271 to request funds for construction projects unless they are paid in advance or the SF-270 is used.
* *Federal Financial Report (FFR) (SF-425/SF-425A) (OMB No. 0348-0061)).* Recipients use the FFR as a standardized format to report expenditures under Federal awards, as well as, when applicable, cash status (Lines 10.a, 10.b, and 10c). References to this report include its applicability as both an expenditure and a cash status report unless otherwise indicated.

Electronic versions of the standard forms are located on OMB’s home page <http://www.whitehouse.gov/omb/grants_forms>).Financial reporting requirements for cost reimbursement contracts subject to the Federal Acquisition Regulation (FAR) are contained in the terms and conditions of the contract.

*Performance and Special Reporting*

Non-Federal entities may be required to submit performance reports at least annually but not more frequently than quarterly, except in unusual circumstances, using a form or format authorized by OMB ([2 CFR section 200.328(b)(1)](2CFR200.328%28b%29%281%29.pdf)). They also may be required to submit special reports as required by the terms and conditions of the Federal award.

Compliance testing of performance and special reporting are only required for data that are quantifiable and meet the following criteria:

1. Have a direct and material effect on the program.

2. Are capable of evaluation against objective criteria stated in the statutes, regulations, contract or grant agreements pertaining to the program.

Performance and special reporting data specified in Part 4, “Agency Program Requirements,” and Part 5, “Clusters of Programs,” meet the above criteria.

**Source of Governing Requirements**

**Reporting requirements are contained in the following:**

* Financial reporting, [2 CFR section 200.327](2CFR200.327.pdf)
* Monitoring and reporting program performance, [2 CFR section 200.328](2CFR200.328.pdf)
* Program legislation.
* Federal awarding agency regulations.
* The terms and conditions of the award.

*(Source: 2017 OMB Compliance Supplement 3.2)*

**Agency Codification Adjustments/Exceptions:**

USDA, HUD, EPA and HHS have not made any adjustments or exceptions that directly impact references within this compliance requirement.

**Part 4 OMB Program Specific Requirements**

**1. Financial Reporting**

a. SF-270*, Request for Advance or Reimbursement* – Not Applicable

b. SF-271*, Outlay Report and Request for Reimbursement for Construction* *Programs* – Not Applicable

c. SF-425, *Federal Financial Report* – Applicable for expenditure reporting for the administrative costs of the State MFCUs; Not Applicable for expenditure reporting all other components of the cluster

d. CMS-64, *Quarterly Statement of Expenditures for the Medical Assistance* *Program* (*OMB No. 0938-0067)* – Required to be used in lieu of the SF-425, Federal Financial Report (for all components of the cluster other administrative costs of the State MFCUs)*,* prepared quarterly, and submitted electronically to CMS within 30 days after the end of the quarter. (**Note**: The Paperwork Reduction Act clearance for this report expires in January 2015)

**2. Performance Reporting** – Not Applicable

**3. Special Reporting** – Not Applicable

*(Source: 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX))*

### Additional Program Specific Information

**ODODD Compliance Requirements:**

* Each year the County is required to submit the Medicaid Cost Report / Income and Expense Report to ODODD. Per ORC 5126.131(B)(1)(b) the deadline to submit this report to ODODD is established by ODODD – auditors should obtain the most recent available report based on the timing of your testing. Each County can obtain a .pdf or excel version of the cost report from the web for testing. (Note: While ODODD contracts with MCA to complete agreed-upon procedures for the Department, these procedures cannot be relied upon by Financial auditors in determining compliance with single audit requirements. Therefore, the additional Cost Report substantive procedures included below should be performed at each County subject to non-JFS Medicaid testing.)
* ODODD provides the County with a ‘Guide to Preparing Income & Expenditure Report – for use by County Boards of Developmental Disabilities’.

*(Source: Halina Schroeder and Beth Ridewood, ODODD, on 1/30/19)*

**This section should contain program specific information and requirements for Reporting that are applicable to the program CFDA being tested from as contained within the individual grant application, agreement, and policies. Include any additional material requirements and delete the yellow highlighted text. Be sure to indicate the source of your information. If no additional requirements are noted, indicate as such.**

### Audit Objectives and Control Testing

[**See here for the OMB Supplement Audit Objectives and Compliance Requirements**](Reporting_Auditobjectives.pdf)

|  |
| --- |
| **What Control Procedures Address the Compliance Requirement (reference/link to documentation or where the testing was performed):** |
| **Basis for the control** (reports, resources, etc. providing information needed to understand requirements and prevent or identify and correct errors):**Control Procedure** (description of how auditee uses the “Basis” to prevent, or identify and correct or detect errors):**Person(s) responsible for performing the control procedure** (title):**Description of evidence documenting the control was applied** (i.e. sampling unit): |

### Suggested Audit Procedures – Compliance

|  |
| --- |
| **Suggested Audit Procedures – Compliance (Substantive Tests)****(Reference / link to documentation where testing was performed testing):** |
| **Note for Direct Awards Only**: For recipients using HHS’ Payment Management System (PMS) to draw Federal funds, the auditor should consider the following steps numbered 1 through 4 as they pertain to the cash reporting portion of the SF-425A, regardless of the source of the data included in the PMS reports. (During FY2016, HHS is completing the transition from pooled payment to use of subaccounts.) Although certain data is supplied by the Federal awarding agency (e.g., award authorization amounts) and certain amounts are provided by HHS’ Payment Management Services, the auditor should ensure that such amounts are in agreement with the recipient’s records and are otherwise accurate.**This FACCR was written for grants required to be tested under the UG, however if you have material non-UG transactions, you will need to contact CFAE via the** **FACCR Inbox****.****Consider the results of the testing of internal control in assessing the risk of noncompliance. Use this as the basis for determining the nature, timing, and extent (e.g., number of transactions to be selected) of substantive tests of compliance.** |
| 1. Review applicable statutes, regulations, and the terms and conditions of the Federal award pertaining to reporting requirements. Determine the types and frequency of required reports. Obtain and review Federal awarding agency or pass-through entity, in the case of a subrecipient, instructions for completing the reports.a. For financial reports, ascertain the accounting basis used in reporting the data (e.g., cash or accrual).b. For performance and special reports, determine the criteria and methodology used in compiling and reporting the data.2. Select a sample of reports and perform appropriate analytical procedures and ascertain the reason for any unexpected differences. Examples of analytical procedures include:a. Comparing current period reports to prior period reports.b. Comparing anticipated results to the data included in the reports.c. Comparing information obtained during the audit of the financial statements to the reports.3. Select a sample of each of the following report types, and test for accuracy and completeness:a. *Financial reports*(1) Ascertain if the financial reports were prepared in accordance with the required accounting basis. (2) Review accounting records and ascertain if all applicable accounts were included in the sampled reports (e.g., program income, expenditure credits, loans, interest earned on Federal funds, and reserve funds).(3) Trace the amounts reported to accounting records that support the audited financial statements and the Schedule of Expenditures of Federal Awards and verify agreement or perform alternative procedures to verify the accuracy and completeness of the reports and that they agree with the accounting records. If reports require information on an accrual basis and the entity does not prepare its accounting records on an accrual basis, determine whether the reported information is supported by available documentation.(4) For any discrepancies noted in SF-425 reports concerning cash status when the advance payment method is used, review subsequent SF-425 reports to ascertain if the discrepancies were appropriately resolved with the applicable payment system.b. *Performance and special reports*(1) Review the supporting records and ascertain if all applicable data elements were included in the sampled reports. Trace the reported data to records that accumulate and summarize data.(2) Perform tests of the underlying data to verify that the data were accumulated and summarized in accordance with the required or stated criteria and methodology, including the accuracy and completeness of the reports.c. *For each type of report*(1) When intervening computations or calculations are required between the records and the reports, trace reported data elements to supporting worksheets or other documentation that link reports to the data.(2) Test mathematical accuracy of reports and supporting worksheets.4. Obtain written representation from management that the reports provided to the auditor are true copies of the reports submitted or electronically transmitted to the Federal awarding agency, the applicable payment system, or pass-through entity in the case of a subrecipient.ODDOD Specific Substantive Tests:5. Obtain the Medicaid Cost Report / Income and Expense Report, and related instructions from County. Agree total costs reported on Worksheet 6 to costs in the County’s accounting records. |

### Audit Implications Summary

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| **Audit Implications (adequacy of the system and controls, and the effect on sample size, significant deficiencies / material weaknesses, material non-compliance and management letter comments)** |
| 1. **Results of Test of Controls: (including material weaknesses, significant deficiencies and management letter items)**
2. **Assessment of Control Risk:**
3. **Effect on the Nature, Timing, and Extent of Compliance (Substantive Test) including Sample Size:**
4. **Results of Compliance (Substantive Tests) Tests:**
5. **Questioned Costs: Actual \_\_\_\_\_\_\_\_\_\_ Projected \_\_\_\_\_\_\_\_\_\_**
 |

## M. SUBRECIPIENT MONITORING

### OMB Compliance Requirements – Not Applicable

The County DD Boards do not pass the ODODD MAC monies down to subrecipients.

## N. SPECIAL TESTS AND PROVISIONS

### OMB Compliance Requirements – Not Applicable

Per review of the requirements included in the 2017 OMB Compliance Supplement, Part 4, Department of Health and Human Services CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX), none of the following Section N Special Tests and Provisions apply at the local level as they are State requirements or tested at the State level:

1. Utilization Control and Program Integrity
2. Inpatient Hospital and Long-Term Care Facilities Audits
3. ADP Risk Analysis and System Security Review
4. Provider Eligibility
5. Provider Health and Safety Standards
6. Medicaid Fraud Control Units

Auditors should contact CFAE through the FACCR Inbox if they believe any of the above applies to the local Board.

## Program Testing Conclusion

We have performed procedures sufficient to provide reasonable assurance for federal award program compliance requirements (to support our opinions). The procedures performed, relevant evidence obtained, and our conclusions are adequately documented. (If you are unable to conclude, prepare a memo documenting your reason and the implications for the engagement, including the audit reports.)

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| **Conclusion** |
| **The opinion on this major program should be:** |  |
| **Unmodified:** |  |
| **Qualified (describe):** |  |
| **Adverse (describe):** |  |
| **Disclaimer (describe):** |  |

Per paragraph 13.39 of the **2018** **AICPA Audit Guide, *Government Auditing Standards and Single Audits*,** ****, the **following are required to be reported** as audit findings in the federal awards section of the schedule of findings and questioned costs **(**[**see 2CFR200 section 516**](2CFR200.516.pdf)**):**

* Significant deficiencies and material weaknesses in internal control over major programs
* Material noncompliance with the federal statues, regulations, or the terms and conditions of federal awards related to major programs
* Known questioned costs that are greater than $25,000 for a type of compliance requirement for a major program. The auditor also must report (in the schedule of findings and questioned costs) known questioned costs when likely questioned costs are greater than $25,000 for a type of compliance requirement for a major program.
* Known questioned costs that are greater than $25,000 for programs that are not audited as major.
* The circumstances concerning why the opinion in the auditor's report on compliance for major programs is other than an unmodified opinion, unless such circumstances are otherwise reported as audit findings in the schedule of findings and questioned costs for federal awards (for example, a scope limitation that is not otherwise reported as a finding).
* Known or likely fraud affecting a federal award, unless such fraud is otherwise reported as an audit finding in the schedule of findings and questioned costs for federal awards.
* Significant instances of abuse relating to major programs
* Instances in which the results of audit follow-up procedures disclosed that the summary schedule\* of prior audit findings prepared by the auditee in accordance with [Section 200.511(b)](2CFR200.511%28b%29.pdf) of the Uniform Guidance, materially misrepresents the status of any prior audit finding.

[Appendix I](OMB_Compliance_Supplement_APP_I.pdf) lists block grants and other programs excluded from the requirements of specified portions of 2 CFR part 200.

[Appendix II](OMB_Compliance_Supplement_APP_II.pdf) provides regulatory citations for Federal agencies’ codification of the OMB guidance on “Uniform Administrative Requirements, Cost Principles, and Audit Requirements” (in 2 CFR part 200).

All departments and agencies other than the following have OMB-approved exceptions as part of their adoption/implementation: Departments of Commerce, Homeland Security, Housing and Urban Development, and Veterans Affairs; Gulf Coast Restoration Council; Institute of Museum and Library Services; National Endowments for the Arts and Humanities; Office of National Drug Control Policy; and Social Security Administration. The complete list of exceptions is available at <https://cfo.gov/wp-content/uploads/2014/12/Agency-Exceptions.pdf> and Appendix II of the OMB Compliance Supplement.

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| **Cross-reference to internal control matters (significant deficiencies or material weaknesses), if any, documented in the FACCR:** |
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| **Cross-reference to questioned costs and matter of noncompliance, if any, documented in this FACCR:** |
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**Per paragraph 13.49 of the 2018 AICPA Audit Guide, *Government Auditing Standards and Single Audits*,** the schedule of findings and questioned costs should include all audit findings required to be reported under the Uniform Guidance. A separate written communication (such as a communication sometimes referred to as a management letter) may not be used to communicate such matters to the auditee in lieu of reporting them as audit findings in accordance with the Uniform Guidance. See the discussion beginning at paragraph 13.33 for information on Uniform Guidance requirements for the schedule of findings and questioned costs. If there are other matters that do not meet the Uniform Guidance requirements for reporting but, in the auditor's judgment, warrant the attention those charged with governance, they should be communicated in writing or orally. If such a communication is provided in writing to the auditee, there is no requirement for that communication to be referenced in the Uniform Guidance compliance report. Per table 13-2 **a matter must meet the following in order to be communicated in the management letter:**

* Other deficiencies in internal control over compliance that are not significant deficiencies or material weaknesses required to be reported but, in the auditor's judgment, are of sufficient importance to be communicated to management.
* Noncompliance with federal statutes, regulations or terms and conditions of federal awards related to a major program that does not meet the criteria for reporting under the Uniform Guidance but, in the auditor's judgment, is of sufficient importance to communicate to management or those charged with governance.
* Abuse that is less than material to a major program and not otherwise required to be reported but that, in the auditor's judgment, is of sufficient importance to communicate to management and those charged with governance.
* Other findings or issues arising from the compliance audit that are not otherwise required to be reported but are, in the auditor's professional judgment, significant and relevant to those charged with governance.

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| **Cross-reference to any Management Letter items and explain why not included in the Single Audit Compliance Report:** |
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