**Federal Awards Compliance Audit Guidance and Testing**

|  |  |
| --- | --- |
| **NAME OF CLIENT:** |  |
| **YEAR ENDED:** | 2022 |

|  |  |
| --- | --- |
| **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.]* |
| **AL#:** | 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.**

**If your program had COVID funding expenditures, please refer to the terms and conditions of the grant to determine if any additional requirements were imposed. If additional material requirements are identified, auditors will need to create procedures to test those requirements. If you have questions, AOS Auditors please open a Spiceworks ticket for assistance (IPAs email** [**AOSFederal@ohioauditor.gov**](mailto:AOSFederal@ohioauditor.gov)**).**

**Also see guidance in** [**Appendix VII**](OMB_Appendix%20VII.pdf) **of the Compliance Supplement.**

**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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**On the table of contents page, users can also click on listed sections to go directly to that section. Please note that as information is added into the unrestricted portions of the FACCRs, page numbering can change and won’t necessarily reflect the footer page numbers. The table of contents can be updated to reflect the proper footer page numbers by clicking on word “contents” directly above the line starting with Important Information, which will bring up the icon “update table”. Clicking on the update table icon will allow users to update the page numbers to reflect current footer page numbers.**

# 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 code sections where ED, HHS, USDA, DOT, EPA, DOL and HUD have adopted the Uniform Guidance in 2 CFR Part 200 are located in the hyperlinked document below. For the complete list of agencies adopting 2 CFR Part 200, as of the date of the OMB Compliance Supplement, see [**Appendix II**](OMB_Appendix%20II.pdf)**.**

In implementing the UG, agencies were able to make certain changes to 2 CFR 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 exceptions 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

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | No |  |  |  |  |  |  |  |  |
| **D** |  | ***RESERVED*** |  |  |  |  |  |  |  |  |  |
| **E** |  | **Eligibility** | Yes – Tested  at State Level |  |  |  |  |  |  |  |  |
| **F** |  | **Equipment & Real Property Mgmt** | No |  |  |  |  |  |  |  |  |
| **G** |  | **Matching, Level of Effort, Earmark** | Yes |  | M |  |  |  |  |  | *5%* |
| **H** |  | **Period of Performance** | No |  |  |  |  |  |  |  |  |
| **I** |  | **Procurement & Sus. & Debarment** | No |  |  |  |  |  |  |  |  |
| **J** |  | **Program Income** | No |  |  |  |  |  |  |  |  |
| **K** |  | ***RESERVED*** |  |  |  |  |  |  |  |  |  |
| **L** |  | **Reporting** | Yes |  | N |  |  |  |  |  | *5%* |
| **M** |  | **Subrecipient Monitoring** | No |  |  |  |  |  |  |  |  |
| **N** |  | **Special Tests & Provisions** | Yes - Tested  at State Level |  |  |  |  |  |  |  |  |

**NOTE: For all compliance requirements marked as applicable in Column (1) you MUST document in your working papers or this FACCR why a requirement is not direct and material to your program/entity as marked in Column (2). When making that determination all parts of that compliance requirement have to be considered. For example, Equipment and Real Property contains procedures regarding Acquisitions, Dispositions, and Inventory Management. The documentation on why the compliance requirement is not be applicable to the program/entity must cover all parts of that compliance requirement.**

**(1)** Taken form Part 2, Matrix of Compliance Requirements, of the [OMB Compliance Supplement](https://www.whitehouse.gov/wp-content/uploads/2022/05/2022-Compliance-Supplement_PDF_Rev_05.11.22.pdf). 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 AICPA Single Audit Guide, 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 AICPA Single Audit Guide, 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 type 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. A “Low” assessment of Detection Risk in this matrix means that the risk has been reduced to an acceptable level.

**(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 AICPA Single Audit Guide 10.55 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***

Auditors should consider the following when evaluating, documenting, and testing the effectiveness of controls throughout this FACCR:

As noted in paragraph 9.08, the Uniform Guidance provides that the auditors must perform tests of internal controls over compliance as planned. (Paragraphs 9.40-9.42 of the *AICPA Single Audit Guide* discuss an exception related to ineffective internal control over compliance.) In addition, AU-C 330.08 states the auditor should design and perform tests of controls to obtain sufficient appropriate audit evidence about the operating effectiveness of relevant controls. Further, AU-C 330.09 states in designing and performing tests of controls, the auditor should obtain more persuasive audit evidence the greater the reliance the auditor places on the effectiveness of a control.

Testing of the operating effectiveness of controls ordinarily includes procedures such as (a) inquiries of appropriate entity personnel, including grant and contract managers; (b) the inspection of documents, reports, or electronic files indicating performance of the control; (c) the observation of the application of the specific controls; and (d) reperformance of the application of the control by the auditor. The auditor should perform such procedures regardless of whether he or she would otherwise choose to obtain evidence to support an assessment of control risk below the maximum level.

Paragraph .A24 of AU-C section 330 provides guidance related to the testing of controls. When responding to the risk assessment, the auditor may design a test of controls to be performed concurrently with a test of details on the same transactions. Although the purpose of a test of controls is different from the purpose of a test of details, both may be accomplished concurrently by performing a test of controls and a test of details on the same transaction (a dual-purpose test). For example, the auditor may examine an invoice to determine whether it has been approved and whether it provides substantive evidence of a transaction. A dual purpose test is designed and evaluated by considering each purpose of the test separately.

Also, when performing the tests, the auditor should consider how the outcome of the test of controls may affect the auditor's determination about the extent of substantive procedures to be performed. See chapter 11 of the AICPA Single Audit Guide for a discussion of the use of dual purpose samples in a compliance audit.

*(Source: Paragraphs 9.08 and 9.40 through 9.42 of the AICPA Single Audit Guide and AU-C 330.)*

[Part 6](OMB_Part%206.pdf) of the 2022 OMB Compliance Supplement provides detailed guidance on assessing internal controls over the compliance requirements.

*(Source: 2022 OMB Compliance Supplement)*

**Improper Payments**

Under OMB guidance, Public Law (Pub. L.) No. 107-300, the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010 Presidential memorandum to enhance payment accuracy, federal agencies are required to take actions to prevent improper payments, review federal awards for such payments, and, as applicable, reclaim improper payments. Improper payments include the following:

1. Any payment that should not have been made or that was made in an incorrect amount, including an overpayment or underpayment, under a statutory, contractual, administrative, or other legally applicable requirement; and includes -- (i) any payment to an ineligible recipient;(ii) any payment for an ineligible good or service; (iii) any duplicate payment; (iv) any payment for a good or service not received, except for those payments where authorized by law; and (v) any payment that does not account for credit for applicable discounts.
2. A payment that could be either proper or improper, but the agency is unable to discern whether the payment was proper or improper as a result of insufficient or lack of documentation.

Auditors must be alert to improper payments, particularly when testing the following parts of section III. – A, “Activities Allowed or Unallowed;” B, “Allowable Costs/Cost Principles;” E, “Eligibility;” and, in some cases, N, “Special Tests and Provisions.”

*(Source: 2022 OMB Compliance Supplement Part 3)*

# Part I – OMB Compliance Supplement Information

### I. Program Objectives

Note: This program is considered a "higher risk" program for 2022, pursuant to 2 CFR section 200.519. Refer to the "Programs with Higher Risk Designation" section of Part 8, Appendix IV, Internal Reference Tables, for a discussion of the impact of the "higher risk" designation on the major program determination process.

**Medical Assistance Program**

The Social Security Amendments of 1965 created Medicaid by adding Title XIX to the Social Security Act, 42 USC 1396 et seq. Under the program, the federal government provides matching funds to states to enable them to provide medical assistance to residents who meet certain eligibility requirements. The objective is to help states provide medical assistance to residents whose incomes and resources are insufficient to meet the costs of necessary medical services. Medicaid serves as the nation's primary source of health coverage for low-income populations.

States are not required to participate. Those that do must comply with federal Medicaid laws under which each participating state administers its own Medicaid program, establishes eligibility standards, determines the scope and types of services it will cover, and sets the rate of payment. Eligibility requirements vary from state to state, and because someone qualifies for Medicaid in one state, it does not mean he or she will qualify in another. The federal Centers for Medicare & Medicaid Services (CMS) monitors the state-run Medicaid programs and establishes requirements for service delivery, quality, funding, and eligibility standards.

While not precluding an auditor from determining that the Medicaid cluster qualifies as a low- risk program (if 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. In addition, even though the state Medicaid Fraud Control Units (MFCUs) and State Survey and Certification of Health Care Providers and Suppliers have substantially fewer federal expenditures than Medicaid, 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.

**Medicaid Fraud Control Units (MFCUs)**

Under section 1902(a)(61) of the Social Security Act, states are required as part of their Medicaid state plans to maintain a MFCU, unless the secretary of HHS waives the requirement after making the determination that a MFCU would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the state plan and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of medical assistance under the plan without a MFCU. The primary mission of the MFCUs is to investigate and prosecute fraud by Medicaid providers, to review and investigate complaints alleging abuse or neglect of patients in Medicaid-funded health care facilities, and, as an optional authority, to review and investigate complaints of patient abuse or neglect in board and care facilities or involving Medicaid beneficiaries in non-institutional and other settings. States are required to refer to the MFCU all cases of suspected provider fraud.

**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 are also required as a condition of Medicaid participation, and the Medicaid program contributes to program costs accordingly.

*(Source: 2022 OMB Compliance Supplement, Part 4, Department of Health and Human Services AL #93.778 Medical Assistance Program (Medicaid; Title XIX))*

### II. Program Procedures

**A. Overview**

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 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 United States territories: the US Virgin Islands, Puerto Rico, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. Medicaid operates through state Medicaid agencies, with states paying providers of medical services directly or through the use of managed care plans. Participating providers must accept the Medicaid payment amount as payment in full. Federal law and regulation set forth mandatory and optional eligibility groups and services. States are required to cover mandatory eligibility groups and services and may elect to cover optional groups and services. Within these broad federal rules, each state decides eligible beneficiary groups, types and range of services, payment levels for services, and administrative and operating procedures. CMS administers the Medicaid program in cooperation with state governments. CMS oversees state operations through its organization consisting of a headquarters and field offices. CMS uses technical assistance extensively to promote improvements in state operation of the program, and compliance with federal rules, as well as enforcement mechanisms as the agency deems appropriate. The HHS Office of Inspector General (OIG) is the agency responsible for the federal oversight of the state MFCUs. As stated in 42 CFR 1007.5, a key requirement of the governing regulations is that a unit must be a single identifiable entity of the state government. In order to receive the federal grant funds necessary to sustain their operations, the MFCUs must submit a reapplication for federal assistance to the OIG on an annual basis.

The State Survey and Certification of Health Care Providers and Suppliers program is administered by CMS in a manner similar to Medicaid and includes an approved state plan that addresses federal requirements.

*Medicaid State Plans*

States administer the Medicaid program under a CMS-approved state plan for each state. The Medicaid state plan is a comprehensive written statement submitted by the State Medicaid Agency (SMA) 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 references the applicable federal regulation and statute for each requirement.

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 availability of federal financial participation. The state plan must specify a single state agency (hereinafter referred to as the “State Medicaid Agency – SMA”) 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 SMA to administer or supervise the administration of the state plan and make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

The state plan also describes methodologies to pay providers for covered care and services under the Medicaid program. The payment methodologies must be clear and auditable to ensure that payments are disbursed only to qualified providers, in the appropriate amount, for medically necessary services covered by the Medicaid program and provided to eligible beneficiaries under a fee-for-service arrangement. Payments must also be based on claims that are adequately supported by medical records, and payments must not be duplicated.

At any time, a state may propose changes to the state plan through a state plan amendment (SPA). A state submits a SPA to CMS when a state proposes to modify its state plan to make changes to its Medicaid program design, policies, or operational approach. States must submit SPAs to CMS to reflect changes in federal and state law, regulation, policy, or court decisions. Federal and state governments use the SPA process to negotiate and agree on the terms of the amendment. The SPA submission is reviewed by CMS to determine whether the proposal meets federal requirements. If more information is required to determine whether the proposal can be approved, CMS sends the state a request for additional information (RAI) within 90 days after receipt of the SPA. States have 90 days from the issuance of the RAI to provide a response to CMS. If the state does not respond within this 90-day period, CMS may choose to disapprove the SPA. Once the state submits the requested information, a new 90-day review clock begins and CMS must decide to approve or disapprove the SPA. While CMS maintains state submission records, copies of approved SPAs are available on CMS’ Medicaid.gov website <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html> or can be obtained from the SMA. More information about SPA and 1915 waiver processing can also be found at Medicaid.gov at <https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html>.

In accordance with an approved state plan or approved waiver (see the Waivers and Demonstrations section below), CMS makes quarterly grant awards to the state to cover the federal share of Medicaid expenditures for services and program administration. The grant award authorizes the state to draw federal funds as needed to pay the federal portion, as determined through the application of the Federal Medical Assistance Percentage (FMAP) or other applicable federal matching rate set by statute, of approved Medicaid expenditures. The amount of the quarterly grant is initially determined on the basis of quarterly budget estimates submitted by the SMA on the Form CMS-37. Thirty days after the end of the quarter, states must submit the Form CMS-64, which includes expenditures and recoveries and other items that reduce expenditures for the quarter and prior period expenditures. Quarterly, CMS reviews the state’s expenditures for accuracy and allowability, then CMS issues a finalization grant reconciling the initial grant award determined on the basis of budget estimates to the actual expenditures reported on the Form CMS-64. The amounts reported on the Form 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 (MBES) to electronically submit the Form CMS-37 and Form CMS-64 directly to CMS.

*Waivers and Demonstrations*

The SMA may apply for a waiver of federal requirements, subject to CMS approval. The most common modes to waive federal requirements are under the authority of section 1115 called demonstrations and waivers under section 1915 of the Social Security Act (the Act). Additionally, section 1115(a) demonstration authority permits states to request federal financial participation for costs that would not otherwise be included as expenditures under section 1903 of the Act, and to request waiver authority of requirements under section 1902(a) of the Act.

Section 1115(a) demonstrations and section 1915 waivers are intended to provide the flexibility needed to enable states to test new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs or groups of beneficiaries. Demonstrations and waivers are not interchangeable. However, both of them allow exceptions to state plan requirements and permit a state to implement innovative programs or activities on a time-limited basis, subject to specific safeguards for the protection of beneficiaries and the program, and provided that there is an evaluation of the program.

Actions that states may take if waivers of section 1915 of the Act are obtained include, but are not limited to: (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) 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 (4) including as medical assistance, under its state plan, home and community-based services (HCBS) furnished to beneficiaries who would otherwise need inpatient care that is furnished in a hospital, nursing facility or other institutional settings, and is reimbursable under the state plan. A state may also obtain a waiver of statutory requirements to provide an array of HCBS, 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 two to five years, with varying renewal periods. Copies of approved SPAs are available on CMS’ Medicaid.gov website <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html>. More information about SPA and 1915 waiver processing can also be found at Medicaid.gov at <https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html>. The section 1115 demonstrations main page is located at <https://www.medicaid.gov/medicaid/section-1115-demonstrations/index.html>. Lists of states 1115 demonstrations can be found at [https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver- list/index.html](https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-%20list/index.html).

Actions that states may take within the confines of a section 1115 demonstration include, but are not limited to: (1) removing barriers to coverage and care; (2) sharing with beneficiaries (through the provision of additional services) cost-savings made possible through the beneficiaries’ use of more cost effective medical care; (3) enhancing alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and (4) advancing innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

*Beneficiary Eligibility*

Beneficiary eligibility for Medicaid is generally based on financial (e.g., income and resources, as applicable) and non-financial (e.g., age, pregnancy, disability, and citizenship/immigration status, as applicable) criteria. Income eligibility is most often expressed in terms of a percent of the Federal Poverty Level (FPL), which is defined and updated by the HHS on an annual basis. Resources may include things such as savings, non-home property, stocks, and other non-cash assets.

States must cover mandatory eligibility groups. States may provide coverage to members of optional groups and medically needy individuals (i.e., individuals who are eligible for Medicaid after deducting medical expenditures from their income). The eligibility groups covered in a state and the eligibility criteria are specified in the state plan. The state plan will also describe the income methodology used for determining eligibility.

States must provide payment for Medicare premiums and cost-sharing for certain older adults and people with disabilities who are entitled to Medicare Part A, and whose income and resources do not exceed specified standards (Section1902(a)(10)(E)) of the Act (42 USC1396a(a)(10)(E )). There are four mandatory eligibility groups, collectively called the Medicare savings program eligibility groups, each of which has its own eligibility requirements and coverage limitations. Depending on the group, the medical assistance available ranges from payment of all Medicare premiums and cost-sharing expenses to payment of only the Medicare Part A or Part B premiums.

The state plan will specify if determinations of eligibility are made by agencies other than the SMA and will define the relationships and respective responsibilities of the SMA 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 be signed under penalty of perjury. Electronic signatures, including those that are telephonically recorded, and handwritten signatures transmitted via any other electronic method, must be accepted. The state agency must have facts in the case record to support the agency’s eligibility determination, including a record of citizenship or immigration status verification for each individual. The state must provide notice of its decision concerning eligibility and provide timely and adequate notice of the basis for denial or terminating assistance (42 CFR sections 431.17, 431.210, 431.211, 435.907, 435.914, 435.917, 435.918; 42 USC 1320b-7).

*Services*

Medicaid expenditures include payments for services rendered to eligible beneficiaries, such as hospitalizations, prescription drugs, nursing home stays, outpatient hospital care, and physicians’ services. A listing of mandatory and optional Medicaid benefits can be found at <https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html>. For a Medicaid 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 a managed care plan, such as an insurance company, to arrange for or provide medical services. The state pays a risk-based periodic fixed rate per person (capitation payment) to the managed care plan for each beneficiary enrolled in that plan; the capitation payment is paid without regard to the actual medical services utilized by each beneficiary for the time period covered by the payment. There are three types of managed care plans that can be paid capitation rates: managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (42 CFR 438.2). Managed care plans are required to provide covered services in accordance with the managed care plan’s contract with the state and pursuant to federal regulations at 42 CFR Part 438.

Medicaid expenditures also include administration and training, the State Survey and Certification Program, and the establishment and operation of state MFCUs.

*Addendum for the Public Health Emergency (PHE)*

Medicaid and the Children’s Health Insurance Program (CHIP) play critical roles in helping states and territories respond to public health emergencies (PHEs) and disasters, including the outbreak of the Novel Coronavirus Disease 2019 (COVID-19). Over the course of the COVID-19 PHE, state Medicaid and CHIP agencies adopted many flexibilities offered by the CMS to respond effectively to local outbreaks, including changes to modify eligibility requirements and benefit packages, ensure access to home and community-based services (HCBS), and support health care providers’ access by adjusting enrollment and screening processes. In addition, states made program changes to comply with the requirements of the Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127), as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No. 116-136). Section 6008 of the FFCRA provides states with a temporary 6.2 percentage increase to the Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Act for certain Medicaid expenditures if states meet certain conditions, including a continuous enrollment requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

CMS provided for program flexibilities and federal matching funds for certain services that should be considered when planning single audits, as described below In some instances, certain compliance requirements may not be relevant during this review period in light of the flexibilities offered to states. The flexibilities are unique to individual states and follow the typical documentation process, including CMS approval of state plans and waivers, in accordance with regulations and guidance. Note that [CMS guidance](https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/index.html) on COVID-related flexibilities is updated regularly, and auditors should reference the latest CMS guidance available on Medicaid.gov at [Tools and Checklists for States | Medicaid](https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/tools-and-checklists-for-states/index.html). It is important for auditors to be aware of the requirements and flexibilities implemented by the state Medicaid or CHIP agency in response to the COVID-19 PHE so that a state is not determined to be out of compliance with requirements that would have been in place absent the PHE. In addition, to be eligible to receive the increased federal matching percentage (FMAP) funding, states were required to maintain the enrollment of all Medicaid beneficiaries who were enrolled as of or after March 18, 2020, through the end of the month in which the PHE ends, with certain exceptions. This requirement, described at section 6008(b)(3) of the FFCRA, is often referred to as the continuous enrollment requirement. The continuous enrollment requirement does not impact a state’s obligation to continue to conduct renewals of eligibility and to act on changes in beneficiary circumstances, but it does prohibit a state from disenrolling a beneficiary who is determined ineligible, except under certain circumstances.

Initial CMS guidance on section 6008(b)(3) of the FFCRA prohibited states both from disenrolling a beneficiary and from making any changes to the benefits available to a beneficiary or to a beneficiary’s required cost-sharing or, in the case of institutionalized beneficiaries, to their financial responsibility for the cost of care under the post-eligibility treatment of income (PETI) rules. If a beneficiary became ineligible for one group and eligible for another group with greater financial responsibility or lesser benefits, the state was required to maintain the beneficiary’s coverage in the original eligibility group. Likewise, if a beneficiary reached age 21, and would no longer be eligible for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, the state was required to continue to provide EPSDT services to the beneficiary when medically necessary.

CMS issued an interim final rule with comment (CMS-9912-IFC), effective November 2, 2020, that provided states with greater flexibility in implementing the continuous enrollment requirement. This rule is effective prospectively and does not apply to periods prior to November 2, 2020. Under the new regulation at 42 CFR 433.400, in order to claim the temporary FMAP increase, states must maintain the Medicaid enrollment of validly enrolled beneficiaries in one of three tiers of coverage (minimum essential coverage (MEC), non-MEC coverage that includes testing and treatment for COVID-19, and non-MEC with limited benefits); states are permitted to make changes to beneficiary coverage, cost-sharing and PETI without violating the condition in section 6008(b)(3) of the FFCRA. While the IFC became effective on November 2, 2020, it will take time for states to implement the necessary system and operational changes to begin transitioning beneficiaries between eligibility groups and adjusting beneficiaries’ financial responsibilities as appropriate. Depending on the flexibilities adopted and the extent of the impact on state systems and processes, some states will need more time than others to implement the necessary changes. The CMS-9912-Interim Final Rule with Comment Factsheet on Updated Policy for Maintaining Medicaid Enrollment during the Public Health Emergency for COVID-19, which is available online at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-tech-factsheet-ifc-433400.pdf>, provides additional information on these changes. Further details were also provided by CMS stakeholder calls following issuance of the IFC; transcripts of these calls are available at [Podcast and Transcripts | CMS](https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts).

*Background*

On January 31, 2020, the secretary of Health and Human Services (HHS) declared a PHE, effective as of January 27, 2020, for the entire United States to aid the nation’s health care community in responding to COVID-19. On March 13, 2020, the president declared the ongoing COVID-19 pandemic of sufficient severity and magnitude to warrant an emergency declaration for all states, tribes, territories, and the District of Columbia pursuant to section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 USC 5121-5207 (the “Stafford Act”), with a retroactive effective date of March 1, 2020. Since the initial declaration, the PHE has been renewed several times, with the latest renewal effective as of January 14, 2022 in the authoritarian context of China, for an additional 90 days. During a PHE or disaster, CMS can rely on various legal authorities to grant states emergency flexibilities critical to ensuring that states can respond to the crisis expeditiously to protect and serve the general public.

On December 22, 2020, CMS issued State Health Official (SHO) letter #20-004, entitled Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>).

This SHO letter provided guidance on returning to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent where legally permissible and otherwise appropriate, ending the expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE. As the PHE has been extended, both states and stakeholders raised concerns about the additional time that will be needed for states to address the growing backlog of work. Based on this feedback, the December 2020 guidance was updated and a new SHO letter #21-002 was issued on August 13, 2021, which revised timelines and requirements (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>). States should have documentation available to describe the temporary changes made to their programs in response to the PHE, as well as their plans for returning to normal operations following the PHE.

Some of the major areas to note include the following:

*1. Telehealth*

Federal telehealth requirements provide states with significant flexibility, and states have broad variability in their approaches to incorporating telehealth into their Medicaid and CHIP programs. CMS also recognizes that in many circumstances, states have adopted Medicaid and CHIP telehealth policies that mirror Medicare telehealth policies, for which regulatory flexibilities have been provided during the COVID-19 PHE. To assist states with understanding the flexibilities regarding Medicaid and CHIP telehealth policy as it relates to COVID-19, CMS issued a COVID-19 Telehealth Toolkit, which was updated on October 14, 2020, that highlighted policy and operational questions that a state may consider when designing their approach (State Medicaid & CHIP Telehealth Toolkit, *Policy Considerations for States Expanding Use of Telehealth* *- COVID- 19 Version* <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>) (State Medicaid & CHIP Telehealth Toolkit, *Policy Considerations for States Expanding Use of Telehealth - COVID-19 Version*: Supplement #1 <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf>). To support health care delivery while minimizing face-to-face encounters during the COVID-19 PHE, many states have significantly accelerated adoption of telehealth, including through telephonic modalities, across a wide variety of disciplines.

*2. Beneficiary Eligibility and Enrollment*

States are facing a number of challenges due to the ongoing COVID-19 PHE that will leave many states with large volumes of pending eligibility and enrollment actions when the PHE ends. Different states have utilized different approaches to implement the continuous enrollment requirement and the eligibility and enrollment flexibilities available during the PHE. For example, some states adopted the optional eligibility group for COVID-19 testing (extended under the American Rescue Plan (Pub. L. No. 117-2) to include treatments for COVID-19) and other states adopted new income and/or resource disregards under the state plan for the period of the PHE. As each state determines which flexibilities to maintain and which flexibilities to end, states are expected to develop an operational plan that documents and tracks compliance, including the timelines for making changes to application and renewal processing and verifications. Additional information is provided in SHO letter #21-002 on planning for the resumption of normal operations at the conclusion of the PHE, which is available on Medicaid.gov at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>.

The flexibilities afforded to states as they respond to the PHE related to beneficiary eligibility and enrollment could lead to unintended vulnerabilities and risks. CMS reiterates the importance of states considering the appropriate program integrity activities related to beneficiary eligibility and enrollment. When considering statutory changes and other beneficiary eligibility waivers and flexibilities, CMS particularly encourages states to consider FFCRA requirements for the 6.2 percentage increase FMAP and other related provisions, as described below, when designing program integrity actions.

*3. Managed Care*

As previously described in CMS guidance <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>, if a benefit or other identified flexibility is covered under the Medicaid state plan, Medicaid waiver, or a state demonstration, CMS encourages states to amend their managed care plan contracts, if not already included, to extend the same flexibilities to managed care plans (MCPs) during the COVID-19 PHE. States may also amend their managed care contracts and assess if changes are needed to capitation rates to: (1) reflect temporary increases in Medicaid fee-for-service (FFS) provider payment rates where an approved state directed payment requires plans to pay FFS rates; (2) require MCPs to make certain retainer payments allowable under existing authorities to certain habilitation and personal care providers; and (3) utilize state directed payments, when in compliance with 42 CFR 438.6(c) and CMS guidance, to require MCPs to temporarily enhance provider payment under the MCP contract.

States must obtain prior approval from CMS to contractually require MCPs to make state directed payments to providers; in addition to other requirements specified in 42 CFR 438.6(c), such state-directed payments must be tied to the delivery of services under the contract. To help mitigate the impacts of the COVID-19 PHE, in May 2020, CMS provided a framework through a CMCS Informational Bulletin for states to use in developing state directed payments (<https://www.medicaid.gov/federal-policy-guidance/downloads/cib051420.pdf>). In addition, on January 8, 2021, CMS released additional guidance that discusses enhanced program integrity in the use of state directed payments, such as requiring additional documentation and justification from states as to their rationale for incorporating state directed payments through means other than adjustments to the base capitation rates as part of the preprint review (<https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf>).

*4. Other Benefits and Changes*

In response to the COVID-19 PHE, many states have implemented emergency measures to ensure that Medicaid and CHIP beneficiaries continue to have access to essential health services. States have submitted disaster relief state plan amendments (SPAs), 1915(c) waiver Appendix K amendments, and requests for flexibilities under section 1115(a) demonstrations to suspend, add, and revise policies that could prevent enrollees from accessing needed care during the PHE.

American Rescue Plan Act of 2021 (ARP) section 9817 provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community- based services (HCBS) beginning April 1, 2021 and ending March 31, 2022.CMS released State Medicaid Director SMD letter #21-003, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>, on May 13, 2021, to provide guidance to states on the implementation of section 9817 of the ARP. As described in SMD #21-003, states must comply with two program requirements to receive the increased FMAP for HCBS expenditures: (1) federal funds attributable to the increased FMAP must be used to supplement existing state funds expended for Medicaid HCBS in effect as of April 1, 2021; and (2) states must use the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. CMS requires participating states to submit both an initial and quarterly HCBS spending plan and narrative to CMS on the activities that the state has implemented and/or intends to implement to enhance, expand, or strengthen HCBS under the Medicaid program to demonstrate that the state is supplementing, but not supplanting, existing state funds expended for Medicaid HCBS.

**B. Control Systems**

*Utilization Control and Program Integrity*

The state plan must provide methods and procedures to safeguard against unnecessary or improper utilization of care and services.

In addition, the state must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring credible allegation of fraud cases to law enforcement officials. Credible allegations of provider fraud must be referred to the state MFCU or an appropriate law enforcement agency in states with no certified MFCU.

*Inpatient Hospital and Long-Term Care Facility Audits*

States are required to establish, as part of the state plan, standards and methodologies for reimbursing inpatient hospital and long-term care facilities based on payment rates that represent the cost to operate such facilities efficiently and economically and provide services to Medicaid beneficiaries. The SMA must provide for the filing of uniform cost reports by each participating provider. These cost reports are used by the SMA to aid in the establishment of payment rates. The SMA 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 SMA in ensuring that established payment rates are proper.

*Automated Data Processing (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 Service Organization Control (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–Enterprise Systems*

The MES are the set of required mechanized claims processing and information retrieval systems, including the eligibility and enrollment systems and other supporting systems, unless this requirement is waived. CMS provides general systems guidelines (42 CFR 433.110 through 433.131) but does not provide detailed system requirements or specifications for states to use in the development of MES systems. As a result, these systems will vary from state to state. The system may be maintained and operated by the state or a contractor overseen by the state.

A module of the MES is normally used to process payments for most Medicaid services. The 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. Many edits and controls are generally implemented to identify aberrant billing practices for follow-up by the state. The state plan will describe the administration of each state’s claims-processing subsystems.

The state may use other MES modules, or other systems, to process some or all Medicaid payments, such as claims from state agencies (e.g., state-operated intermediate care facility for individuals with intellectual disabilities (ICF/IID) and certain selected types of claims). The claims payments processed these ways may be material to the Medicaid program.

**C. Related Programs**

*Medicare Savings Program*

The Medicare Buy-In Program, which includes QMB (Qualified Medicare Beneficiary), SLMB (Specified Low-Income Medicare Beneficiary), QI (Qualified Individual), and Qualified Disabled and Working Individuals (QDWI), commonly referred to as the Medicare savings program, is designed to protect low-income Medicare beneficiaries from the significant and growing costs required to cover Medicare premiums, deductibles, coinsurance, and copayments. 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/or cost-sharing 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 example, in 2021 the asset limit for the QMB program is $7, 970/individual and $11, 960/couple and the monthly income limits in 2021 are $1,094/individual and $1, 472/couple for all states excluding Alaska and Hawaii. If individuals are eligible for the QMB program, the state Medicaid program pays their Medicare Part B premiums as well as Medicare Part A premiums for those who are not eligible for premium-free Part A, and their Medicare deductibles, coinsurance, and copayments.

For individuals with slightly higher incomes, the SLMB program pays only the Part B premium. To be eligible for the SLMB program, an individual must have income that exceeds 100 percent but is less than 120 percent of the federal poverty level. The SLMB program has the same asset limits as the QMB program.

The QI program also pays only the Part B premium. The QI program serves individuals with income at or above 120 percent but less than 135 percent of the federal poverty level. The QI program has annual allotments for each state. The QI program has the same asset limits as the QMB program.

QDWI program pays the Part A premium for working disabled persons under 65 who lost their premium-free Part A when they went back to work. These individuals are eligible for the QDWI program if their income does not exceed 200 percent of the federal poverty level and their resources do not exceed two times the SSI resource limit.

*Indian Health Care*

Federal Medicaid statute includes several protections specific to American Indians and Alaska Natives (AI/AN). These include:

a. Special treatment for certain AI/AN financial interests—as described at 42 CFR 435.603(e)(3), certain types of AI/AN income are excluded when determining household income based on modified adjusted gross income (MAGI).

b. Protections related to the imposition of enrollment fees, premiums, and cost sharing charges—as described at 42 CFR 447.56(a)(1)(x), AI/ANs cannot be charged any enrollment fees or premiums if they are eligible to receive items or services furnished by an Indian health care provider, and they are exempt from all cost sharing if they are both eligible to receive and have received items or services furnished by an Indian health care provider or through referral under contract health services (CHS), now, Purchased Referred Care (PRC). In addition, 42 CFR 447.56(c)(2) prohibits any cost sharing-related reduction in payment due under Medicaid to the Indian health care provider serving an AI/AN (i.e., a state must pay these providers the full Medicaid payment rate for furnishing the service).

c. Managed care protections – Network and coverage requirements related to AI/AN protections within managed care are codified at 42 CFR 438.14(b). These protections address network adequacy, access, claims payment, and disenrollment for AI/AN beneficiaries.

d. Requirements for payment to Indian Health Service (IHS) and tribal facilities – States receive 100 percent FMAP for Medicaid services provided to AI/ANs through an IHS or tribal facility. Per SHO letter #16-002, states receive 100 percent FMAP for services provided to AI/ANs by non-IHS/tribal providers when a care coordination agreement is in place between an IHS/tribal facility and a non- IHS provider, and other requirements of the SHO letter are met. Payment methodologies, including rates, for all services provided by IHS/tribal facilities and non-IHS/tribal providers are described in the Medicaid state plan. CMS was scheduled to begin enforcing, effective January 1, 2021, the requirement prohibiting IHS and Tribal facilities from claiming Medicaid reimbursement under the clinic services benefit at 42 CFR 440.90 (including at the IHS All Inclusive Rate) for services provided outside of the “four walls” of the facilities. Recognizing the need to focus limited resources on addressing the COVID-19 PHE, CMS extended a grace period previously granted to permit such claims through October 31, 2021; a CMCS Informational Bulletin issued on October 4, 2021, further extended this grace period to nine months after the COVID-19 PHE ends (<https://www.medicaid.gov/sites/default/files/2021-10/cib10421.pdf>).

*Payment Error Rate Measurement (PERM) Program*

The PERM program is utilized by HHS to calculate national improper payment rates in Medicaid and CHIP. The regulations at 42 CFR Part 431, Subpart Q, specify requirements for estimating improper payments in Medicaid and CHIP. The PERM program annually measures the national Medicaid and CHIP improper payment rates and uses a 17-state three-year rotation process. The national Medicaid and CHIP improper payment rates include findings from the most recent three cycle measurements so that all states are captured in one rate. The national improper payment rates are comprised of three components: fee-for-service, managed care, and eligibility. States are expected to issue state-specific corrective action plans to address the root cause of errors and deficiencies.

*Medicaid Eligibility Quality Control (MEQC) Program*

The regulations at 42 CFR Part 431, Subpart Q, specify the requirements for the MEQC program, which is designed to reduce erroneous expenditures by monitoring the accuracy of eligibility determinations, and work in conjunction with the PERM program. The MEQC program requires each state to conduct a MEQC pilot in the two years between the state’s PERM review periods and report case findings to CMS and implement corrective actions to address all errors and technical deficiencies found to ensure continuous oversight of both Medicaid and CHIP state eligibility determinations. States have flexibility to review error prone areas identified through their PERM findings and must review areas not reviewed under the PERM program, such as denials and terminations.

*(Source: 2022 OMB Compliance Supplement, Part 4, Department of Health and Human Services AL #93.778 Medical Assistance Program (Medicaid; Title XIX))*

### III. Source of Governing Requirements

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.

The Families First Coronavirus Response Act (Pub. L. No. 116-127), as amended by section 9811 of the American Rescue Plan (Pub. L. No. 117-2).

Awards under the Medical Assistance Program (Assistance Listing 93.778) are 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.

Federal requirements for the establishment and continued operations of the MFCUs are contained in 42 USC 1396b(a)(6), 1396b(b)(3), and 1396b(q); and 42 CFR Part 1007.

This program is subject to the requirements of 45 CFR Part 75 (the HHS implementation of 2 CFR Part 200) and 45 CFR Part 95.

*(Source: 2022 OMB Compliance Supplement, Part 4, Department of Health and Human Services AL #93.778 Medical Assistance Program (Medicaid; Title XIX))*

### IV. Other Information

Medicaid is the largest dollar federal grant program and, under OMB budgetary guidance and Pub. L. No. 107-300, HHS is required to provide an estimate of improper payments for Medicaid. Improper payments mean any payments that should not have been made or that were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes payments for services provided to ineligible providers, payments for an ineligible service, duplicate payments, payments for services not received, payments for ineligible or unenrolled individuals, claims that do not have necessary documentation, and payments that do not account for credit for applicable discounts.

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>.

Up-to-date information on Medical Loss Ratio is available at <https://www.medicaid.gov/medicaid/managed-care/guidance/medical-loss-ratio/index.html>.

**General Audit Approach for Medicaid Payments**

To be allowable, Medicaid costs for medical services must be (1) covered by the state plan or CMS approved waivers/demonstrations; (2) reviewed by the state consistent with the state’s documented procedures and system for determining medical necessity of claims; (3) properly coded; and (4) paid at the rate allowed by the state plan. Furthermore, beneficiaries must be eligible (or presumptively eligible) at the time of service, whether covered under fee-for-service or managed care. Additionally, Medicaid costs must be net of beneficiary cost-sharing obligations and applicable credits (e.g., insurance, recoveries from other third parties who are responsible for covering the Medicaid costs, and drug rebates), paid to eligible providers, and only provided on behalf of eligible individuals.

Due to the complexity of Medicaid program operations, it is unlikely the auditor will be able to support an opinion that Medicaid expenditures are in compliance with applicable laws and regulations (i.e., are allowable under the state plan) without relying upon the systems and internal controls. Examples of complexities include:

1. Dependence upon large and complex ADP systems to process the large volume of Medicaid transactions for fee for services arrangements.

2. Medical services are normally provided directly to an eligible beneficiary without prior approval by the state.

3. Medical service providers normally determine the scope and medical necessity of the services.

4. Notice to the state that a service was rendered is after-the-fact when a claim for payment is issued.

5. Payments systems do not include a review of original detailed documentation supporting the claim prior to payment.

6. Complex payment structures for various medical services may exist, including significance of proper coding of services for fee for service (e.g., billing by diagnosis- related groupings (DRG)). Managed care and waiver based programs are dependent on the respective SPA and resulting agreements with the providers. Managed care programs are dependent on the authority for the program and the contracts with the managed care plans.

7. Payment rates and policies differ among service types and delivery methods, such as fee for service arrangements, managed care, and waivers (e.g., inpatient hospital, physicians, prescription drugs and drug rebates, and risk-based capitation payments for a specific set of covered services).

8. State contracts with third parties, such as managed care plans, to provide or arrange for services for all or part of beneficiary care. Managed care plans have contracts with providers to create a network. Managed care plan may also subcontract with other managed care plans and/or administrative services organizations to delegate some of their contractual obligations.

Medicaid has required control systems that should aid the auditor in obtaining sufficient audit evidence for Medicaid expenditures. These control systems are discussed in the preceding Program Procedures section under Control Systems and are: (1) utilization control and program integrity; (2) inpatient hospital and long-term care facility audits; (3) ADP risk analyses and system security reviews (e.g., of the MES); and (4) MES claims processing and other modules normally include edits and controls that identify unusual items for follow up by the utilization control and program integrity function. The first three generally are performed by specialists retained by the SMA. The following table indicates the major types of Medicaid services (i.e., excludes administrative expenses) to which these controls will likely relate:

Table

Description automatically generated

Each of the above Medicaid payment types is tested for compliance with applicable laws and regulations under one of the following: III.A, “Activities Allowed or Unallowed;” III.B, “Allowable Costs/Cost Principles;” or III.E.1, “Eligibility – Eligibility for Individuals.” Based on the assessed level of control risk, the auditor should design appropriate tests of the allow-ability of Medicaid payments, which may include a sample of medical claims. Given the complexity of medical records, if medical claims are sampled, the auditor should consider engaging the assistance of specialists in the medical community to assist in the review. The auditor may consider using the same specialists used by the state. Appropriative privacy measures must be taken to protect health information (i.e., medical claims).

*(Source: 2022 OMB Compliance Supplement, Part 4, Department of Health and Human Services AL #93.778 Medical Assistance Program (Medicaid; Title XIX))*

# Part II – Pass through Agency and Grant Specific Information

Additional ODM Program Information can be obtained <http://medicaid.ohio.gov/RESOURCES/Publications/Materials.aspx>)

### Program Overview

**Medicaid Cluster**

This cluster consists of three individual programs, including Medicaid, State Survey and Certification, and Medicaid Fraud Control (See Program Objectives Section). The latter two of the three programs are administered by the Department of Health and the Attorney General Office, respectively, and selected testing will be performed by those individual Agency audit teams and forwarded to the State level JFS audit team for inclusion in the working papers. The function of the Medicaid program is shared between the County and State levels within JFS, as with all of the other programs.

Counties accept applications, enter data into statewide automated eligibility system, and the system issues Medical cards to recipients enrolled in Medicaid fee-for-service (FFS) who are determined eligible by statewide automated eligibility system based on the application information entered. Approximately 90% of the Medicaid population is enrolled into a managed care plan with one of the contracted managed care organizations (MCOs.) If enrolled in an MCO, the medical card will be distributed by that MCO. Individual Medicaid recipients go to Medical Service providers (doctors, hospitals, pharmacies, nursing homes, etc.) who also must meet certain criteria to be eligible to provide services for Medicaid. Eligible Medicaid service providers providing services to FFS members have three methods of submitting claims, (1) electronic data interchange (EDI), (2) the Medicaid Information Technology System (MITS) or (3) the point of sale system for pharmacy claims. If the individual is enrolled in managed care, all claims are submitted to the MCO. Claims are processed by Ohio Department of Medicaid (ODM) at the State level (Claim submission is detailed in [OAC 5160-1-19](http://codes.ohio.gov/oac/5160-1-19v1)) or by the MCO. MITS verifies patients’ eligibility through uploads of information from the statewide automated eligibility system and determines allowability of the service provided. MCOs receive a file with eligibility information for their members from MITS. All Medicaid payments are paid at the State level; therefore, the audit sample for tests of expenditures will be determined and tested by the State level audit team. Substantive tests of Eligibility (recalculations of determinations made by statewide automated eligibility system), will be performed by Medicaid Eligibility Quality Control (MEQC) Unit that is a part of ODM under the direction of the State level audit team.

**County Structure**

Each County is segregated into the following three areas:

• County Department of Job and Family Services (CDJFS) - Administers the Food Assistance (SNAP) Cluster, TANF, Child Care Cluster, Social Services Block Grant, SCHIP, and Medicaid (i.e. all Public Assistance programs).

• Public Children Services Agency (PCSA) - Administers the Foster Care and Adoption Assistance programs.

• Child Support Enforcement Agency (CSEA) - Administers the Child Support Enforcement program.

*Note: In some Counties, all three areas are combined (Combined Agencies), whereas in other Counties, there may be two or three separate agencies.*

ODJFS has county profiles and web links at <http://jfs.ohio.gov/County/County_Directory.pdf>.

**County Collaborations**

**Collabor8**

Collabor8, formed in 2011, is a project that involves nine county departments of job and family services that will work together under a common agreement to process and manage administrative workloads as one project area.   The MOU was extended indefinitely, and there have not been any changes to participants for SFY 23 or SFY 22.  The fiscal sharing splits for SFY 23 & 22 obtained from Collabor8 documentation provided are below.  This information is unaudited.  Auditors should evaluate for accuracy / reasonableness not only the fiscal split percentages used below but also but also any other costs allocated as a result of this collaborative effort. [OAC 5101:4-1-16](https://emanuals.jfs.ohio.gov/CashFoodAssist/FACM/FAH1000/5101-4-1-16.stm) states that ODJFS issues the names of the approved county collaborations that can be found in the food assistance certification manual on the ODJFS website.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **County** | **State Fiscal Year 22**  **IM Allocations** | **Percentage** | **State Fiscal Year 23**  **IM Allocations** | **Percentage** |
| Carroll | $278,076 | 7.28% | $288,586 | 7.65% |
| Delaware | 438,058 | 11.47% | 307,202 | 8.14% |
| Hancock | 409,280 | 10.72% | 423,853 | 11.23% |
| Holmes | 283,569 | 7.43% | 287,118 | 7.61% |
| Knox | 421,931 | 11.05% | 427,798 | 11.34% |
| Marion | 605,734 | 15.87% | 607,651 | 16.11% |
| Morrow | 283,651 | 7.43% | 286,094 | 7.58% |
| Sandusky | 438,058 | 11.47% | 450,852 | 11.95% |
| Wood | 659,530 | 17.27% | 693,812 | 18.39% |
| Total | $3,817,887 |  | $3,772,966 |  |

**Joint County Department of Job and Family Services**

Ohio Revised Code § 329.40-329.46 allows for the formation of joint county departments of job and family services. The boards of county commissioners of any two or more counties may enter into a written agreement to form a joint county department of job and family services. Once the agreement is in effect, the department should operate a single new entity replacing the contributing counties JFS offices. The agreements will specify the reporting periods for the new departments, which are not required to be on a 12/31 reporting timeframe. If auditors are aware of the formation of a new district they should inquire as soon as possible with the district to determine the reporting period that was established. Auditors should familiarize themselves with the ORC code sections mentioned and should also obtain the agreement establishing the district; perform a potential component unit evaluation to determine if the district is a legally separate entity. Also, keep in mind ORC § 329.44 allows for JFS Districts to hold title to real property. Auditors will need to evaluate if the district is holding title to real property and will need to import testing procedures from the General boilerplate Federal Award Compliance Control Records (FACCR). Also keep in mind costs incurred for the acquisition of buildings and land, as “capital expenditures,” are unallowable as direct charges, except where approved in advance by the awarding agency. See 45 CFR 75.318, 75.343, and 75.439(b)(1) ([2 CFR 200.311](https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-D/subject-group-ECFR8feb98c2e3e5ad2/section-200.311), [200.329](https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-D/subject-group-ECFR36520e4111dce32/section-200.329) and [200.439](https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E/subject-group-ECFRed1f39f9b3d4e72/section-200.439)(b)(1)). We are aware of two districts that have currently formed See below. [OAC 5101:4-1-16](https://emanuals.jfs.ohio.gov/CashFoodAssist/FACM/FAH1000/5101-4-1-16.stm) was updated and designated county collaborations as certification offices responsible for program operations which include, but not limited to: application processing; eligibility determinations; and operation of employment and training programs. Approved counties were removed from the code section and OAC 5101:4-1-16(B) indicates that approved county collaborations can be found in the food assistance change transmittal letters, which can be found in [food assistance certification manual](https://emanuals.jfs.ohio.gov/CashFoodAssist/FACM/) at the ODJFS website.

1. South Central Job and Family Services District is a combination of Ross, Vinton and Hocking Counties and it is operating on a 6/30 state fiscal year end and,

2. Defiance/Paulding Consolidated Department of Job and Family Services is a combination of Defiance and Paulding Counties and it is operating on a 12/31 federal fiscal year end.

**Subgrant Agreement**

Each County agency (or agencies) enters into an Ohio Department of Job and Family Services Subgrant Agreement. This agreement describes the subgrant duties, ODJFS & subgrantee responsibilities, effective date of the subgrant, amount of grant/payments, audits of subgrantee, suspension and termination, breach and default, etc. Auditors should review their applicable County’s subgrant agreement. This agreement indicates if each agency (Public Assistance (PA), Public Children Services Agency (PCSA), Child Support (CS)) is a stand-alone agency or if they are combined agencies. This will determine the cost pools that will need tested as part of the RMS process tested in Section A. The grants passed down from ODJFS are funded on a federal fiscal year. The various CFIS reports indicate grant years so receipt and expenditure of awards is identifiable.

**Additional information per ODJFS:**

• Counties cannot adopt policies to broaden or restrict the Medicaid program, including eligibility of recipients or services provided. Counties must follow the State Plan. The State Plan is available on the [ODM website](http://medicaid.ohio.gov/MEDICAID101/MedicaidStatePlan.aspx).

• ODJFS Bureau of Monitoring and Consulting Services (BMCS) performs program County compliance reviews. The Counties do receive written results of these reviews. Auditors should consider the results of the reviews for planning purposes.

**This is a brief description of the Fiscal Process:**

The County JFS receives different types of Funding:

1. Mandated Share - ORC requires the county commissioners to share in the cost of the certain programs (known as mandated share). County JFS receive a mandated share from the County Commissioners. Mandated share is calculated by ODJFS and ODJFS enters the amounts for each funding source as a budget into the CFIS (fiscal computer system). ODJFS notifies the County Commissioners in May or June of their mandated share for the next calendar year so the Counties have time to budget accordingly. Counties are required to make an adjustment equal to 1/12 of the total mandated share when they enter their monthly expenditure reports. County JFS sends a drawdown request for their anticipated needs and then enter their expenditures monthly and submit their expenditures quarterly to ODJFS. ODJFS quarterly reconciliation evaluates and adjusts for the differences. While some counties may not pay their mandated share to the County JFS monthly, the County JFS must deduct no less than 1/12th of the amount on their monthly reporting of expenditures to ODJFS. (For example, if the County’s mandated share is $1,200, the County JFS would include $100 or more on the monthly reporting of expenditures regardless when the county paid the $1,200.)

Per [OAC 5101:9-6-31](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter06/5101-9-6-31.stm), Commissioners are required to appropriate the County Share of Public Assistance Expenditures and the Mandated Share Budget.

2. Federal Allocation – There are two ways federal monies are allocated by the State (There are no local requirements for the calculating or receiving of these allocations.):

• Allocation specific to the grant – Adoption, Foster Care, Child Care Block Grant, Social Services Block Grant and TANF receive allocations specific to their grants. These allocations are based on mandated methodology guidelines, including demographics, expenditure information pulled from CFIS, etc. The County receives notification of their grant allocation from ODJFS via the CFIS web system.

• ODJFS issues initial pass-through allocations based on the greater of:

a. The average expenditures of the last two years reported expenditures: or

b. The total of the last four completed quarters’ reported expenditures.

An agency with no reported expenditures over either time period will receive a minimum budget ([OAC 5101:9-6-44](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter06/5101-9-6-44.stm)). An agency may request an increase at any time during the fiscal year. Counties receive notification of their allocation via CFIS Web.

3. Income Maintenance (State Allocation) - County JFS also receives Income Maintenance (IM) monies. These are State monies County JFS can use to meet matching requirements or reimburse the county for administrative expenditures incurred in the administration of certain programs (See Section A of this document). There are two IM allocations. One allocation for administrative expenditures incurred in the administration of the supplemental nutrition assistance program (SNAP), and a separate allocation for medical assistance (MA) including the Medicaid program and the state children's health insurance program (SCHIP) on behalf of the Ohio Department of Medicaid. IM amounts for each county are also entered into CFIS as budgets by ODJFS. County JFS offices can request to move funding between the allocations. The request must be submitted to ODJFS no later than the last day of the liquidation period. A County JFS may also elect to transfer all or a portion of its IM allocations to the CSEA. Clarification on the two separate IM allocations is included in [OAC 5101:9-6-05](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter06/5101-9-6-05.stm).

Non-Emergency Transportation (NET), Pregnancy Related Services and Healthchek Services Funding Rule is under [OAC 5101:9-6-44.1](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter06/5101-9-6-44-1.stm).

[OAC 5101:9-6-05](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter06/5101-9-6-05.stm) states that CDJFS may claim training and testing activity based on the current FFP rate. The funding is provided to meet match fund requirements for costs related to the implementation and operation of the integrated eligibility (IE) system. The funding is 100% state sources. The CDJFS may move eligible expenditures in excess of this allocation to the county's income maintenance (IM) allocation by performing a coding adjustment. Twenty-five per cent will be charged to the county's IM allocation and seventy-five per cent will be charged to the federal Medicaid pass-through funding. If a county exceeds the IM allocation, the CDJFS shall provide matching funds in order to qualify for federal pass-through funding.

4. Other program specific State Allocations

In addition to their County JFS allocations, there are two opportunities for County agencies to release or receive monies: 1) They can swap funds with other counties, (this process must be approved by evidence of County Commissioners sign off) which goes through ODJFS to change the allocations in CFIS; or 2) There are at least 2 opportunities in the fiscal year in which they can apply for additional funds or to release excess funds for re-distribution to other counties. In this case, the County JFS must indicate need and ODJFS may provide additional funds as made available by other counties; however, the pass-through allocations are not included in either process. ODJFS changes the allocation in the CFIS system. While this does not require testing at the local level, auditors should be aware this may be the reason for any such re-allocations in the system. Note: The Ohio Department of Job and Family Services developed a process to allow for specific allocated funds to be exchanged between counties. The process is detailed in rule [5101:9-6-82](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter06/5101-9-6-82.stm) of the Administrative Code.

For most grants, the County JFS can draw down funds on a weekly basis from the ODJFS (see Section L Reporting of this document). However, federal grants received by the Public Children Services Agency (PCSA) (Adoption Assistance and Foster Care) are reimbursement grants. There may be portions of a program that are on a reimbursement basis however, for the remainder of the programs, the County JFS agency draws down an advance of funds for anticipated needs. Quarterly adjustments are made for the differences between funds drawn and actual expenditures.

County JFS submit quarterly reports with ODJFS via CFIS. There is a quarterly reconciliation process performed by ODJFS. See also OAC [5101:9-7-03](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-03.stm) and [5101:9-7-03.1](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-03-1.stm) for additional information on the financing, reconciliation and closeout procedures. Auditors should review these sections for specific details on this process. See also Reporting Section L. The reconciliation process with CFIS Web is reflected in [OAC 5101:9-7-03.1](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-03-1.stm).

The CDJFS has access to system reporting throughout the quarter in order to make ongoing adjustments/corrections. County JFS enters expenditures monthly into CFIS Web and submit to OAKS quarterly. They file quarterly the certification of monthly expenditure reports with ODJFS. The CDJFS is given five business days after the eighteenth day of the month following the last month of the quarter to review reports for accuracy. No later than five business days after the eighteenth day of the month following the last month of the quarter, the CDJFS shall submit any final adjustments and/or revisions to OAKS. When the eighteenth day of the month falls on a weekend or state recognized holiday, the CDJFS shall submit on the first business day following the weekend or recognized holiday. Once the five-day review period is complete, ODJFS suspends reporting access to OAKS for the closing quarter in order to begin the quarter reconciliation process. The CDJFS can complete adjusting draws in CFIS prior to the end of the five-day review period. ODJFS reconciles refunds and collections at the end of each quarter. ODJFS reconciles state funded allocations and federally funded subgrants at the end of their period of performance. The period of performance includes the funding period and the liquidation period.

The CFIS Web system does not link information into the county auditor’s expenditure ledgers. Counties can manually reenter the information or they may use a computer program for this upload process. Auditors should check to see if the information uploads to the County Auditor’s system accurately by reconciling Form 2827 (C/R 520 in CFIS Web) to the County Auditor’s & JFS records (see Reporting L section of this document).

See [BCFTA Update 2017-03](http://jfs.ohio.gov/ofs/bcfta/BB/BCFTA_Update_Cost_Associated_with_County_Lay_off_or_SFY18.stm) and [BCFTA Update 2018-01](http://jfs.ohio.gov/ofs/bcfta/BB/2018-Updates/2018-01_cost-associated-with-staff-lay-offs.stm) regarding costs associated with county lay-off of staff.

See also [FAPL No. 34](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/FAPL/FAPL-34.stm), Abnormal or Mass Severance Pay.

*(Source: Ohio Department of Medicaid)*

### Testing Considerations

Auditors should evaluate cost pools and reporting requirements that are consistent between ODJFS grant programs and only test these once rather than with each grant program. The following table shows where some efficiencies can be gained for common cost pools (FACCR Section A) and reports (FACCR Section L):

|  |  |  |  |
| --- | --- | --- | --- |
| **Reported on:** | **Program:** | **County Fund Paid from:** | **RMS Cost Pool** |
| JFS 02827 | Medicaid, CHIP, Food Assistance, TANF, SSBG, CCDF | Public Assistance (PA) Fund | IMRMS / SSRMS |
| JFS 02750 | Child Support Enforcement | Child Support Administrative Fund | CSRMS |
| JFS 02820 | Foster Care & Adoption | Children Services Workers | CWRMS or SSRMS (if combined agency) |

For an overview of requirements tested by program: see AOS spreadsheet, ODJFS list of program & applicable requirements. These reports are in CFIS Web, the reports for each agency are CR520 reports, however on the electronic report in CFIS Web, the report will still be designated at the bottom as 2827, 2750 or 2820.

*(Source: Ohio Department of Medicaid)*

### Information systems, including a description on how they operate (i.e. statewide automated eligibility system, CFIS Web, CFIS Web LR)

**Computer Systems**

The following State-level systems are utilized by Counties for these programs:

* Statewide automated eligibility system - Used primarily to determine eligibility and benefit amounts for Food Assistance, TANF, SCHIP, and Medicaid; and generates the voucher summary detail for these programs. It also maintains data entered by the case workers related to the recipients and their cases.
* CFIS – (County Finance Information System) July 1, 2009 County JFS finance offices began using CFIS which drives the financial reporting (Forms 2827, 2750, and 2820, RMS activity, etc.). The CFIS application became a web-based application in 2012. The current and archived CFIS information can be accessed at the County JFS site. At the county level financial data is imported (pulled) from templates or from interfaced systems like WebRMS into the CFIS Web reporting system. Information flows from the county system through CFIS and up to OAKS. Each grant is coded separately. ODJFS has a spreadsheet for coding in CFIS. ODJFS updates this information each year.

DITA will be testing CFIS Web (including the RMS System used to track Random Moment Sampling activity and allocation of program expenditure. A recap of that work performed and any user control considerations will be sent out when available for 2021.

The OAKS general controls portion tested as part of the Statewide SSAE 16 SOC 1, however, will continue to be on a state fiscal year (6/30).

* County JFS fiscal offices use CFIS Web to record their expenditures. However, this system does not link the information into the county auditor’s expenditure ledgers. The counties can manually reenter the information or they may use a computer program for this upload process. The State Region does not look at these type of programs. Based on our review of the LR system and entities using it for 2020, we determined it was widely adopted for 2020 and it was not tested by DITA.
* The process known as “Adjustment to a Prior Period Allocated and Approved Expenditure” or APAA, allows agencies to make adjustments in instances when direct coding is not available (i.e. audit, early retirement incentive program (ERIP), and errors).This process can be initiated by the local agency or by ODJFS and is recorded on form JFS 01179. See [BCFTA updated 2013-17](http://jfs.ohio.gov/ofs/bcfta/BB/20130228-BCFTA-Update-2013-17-APAA.stm) dated 2/28/13 for further information.

**NOTE**:ODJFS is not granting auditors of County JFS programs access to the JFS systems. ODJFS is encouraging County JFS offices to cooperate with audit requests. Per [Office of Fiscal and Monitoring Services’ County Monitoring Advisory Bulletin 2012-01 / Workforce Investment Act Advisory Bulletin 2012-01](https://jfs.ohio.gov/ofs/bmcs/County-Monitoring-Advisory-Bulletin-2012-01.pdf), dated February 13, 2012, in part:

“County agency management personnel are obligated to provide the necessary data to the regional auditors or their designees. However, due care must be taken to safeguard the information provided to the AOS and its contractors. Under no circumstances should agency management or staff give the AOS audit staff access to any ODJFS systems. Each agency must make a reasonable effort to limit the disclosure of protected health information to the minimum necessary to accomplish the intended purpose of the disclosure. The agencies must provide the data to the AOS via encrypted media, i.e. memory sticks, CDs or DVDs, external hard drives etc., in accordance with state guidelines on secure portable media. The method through which data are transferred is at the sole discretion of each local director.”

*(Source: Ohio Department of Medicaid and Center for Audit Excellence (CFAE)*

### Reporting

Additional SEFA and Footnote resources available for AOS Staff in the Audit Employees Briefcase and on the [IPA Resource Internet Page](http://www.ohioauditor.gov/references/practiceaids.html):

* Examples SEFA and Footnote shells
* Additional SEFA Guidance in the “Single Audit SEFA 2022 Completeness Guide”

*(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.**

All references to sections within 2 CFR Part 200 can be found [here](2%20CFR%20Part%20200.pdf)

### 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 Part 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 § 200.420-200.476) 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 Part 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 Part 200 and some agencies have been granted exceptions to provisions within 2 CFR Part 200.

*(Source: AOS CFAE)*

The specific requirements for activities allowed or unallowed are unique to each Federal program and are found in the laws, regulations, and the provisions of the Federal award contracts or grant agreements 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: 2022 OMB Compliance Supplement Part 3)*

**Agency Codification Adjustments/Exceptions:**

The most recent compilation of agency additions and exceptions is provided on the CFO website here: <https://www.cfo.gov/wp-content/uploads/2014/12/Agency-Exceptions.pdf>. However, this list is only updated through 12/2014. AOS evaluated agency exceptions through June 2022. AOS auditors only will need to reference our internal AOS evaluation process [at the following link](https://ohauditor.sharepoint.com/sites/Intranet/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x0120002FFBFB1F4A3C3F47AE37C7A44E1C1EDE&id=%2Fsites%2FIntranet%2FShared%20Documents%2FAudit%5FResources%2FFederal%2FOther%20Federal%20Resources&viewid=68cb3ab2%2D567e%2D456a%2D975c%2Da88f3e9c3727).

**Part 4 OMB Program Specific Requirements**

1. *Summary* – FFP funds can be used only for Medicaid benefit payments (as specified in the state plan, federal regulations, or an approved waiver/demonstration), expenditures for administration and training, expenditures for the State Survey and Certification Program, and expenditures for the establishment and operation of state MFCUs (42 CFR 435.10, 440.210, 440.220, and 440.180). Payments may only be made to providers determined by the SMA to be eligible to participate in the Medicaid program. See III.N.4., “Provider Eligibility (Screening and Enrollment)” for related testing.

2. *Case Management Services* – Medicaid case management services may fall under the category of an administrative expense or as an optional medical state plan benefit. 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. Services, programs, and providers to which the individual is gaining access do not have to be specifically medical in nature and may include services for securing shelter, personal needs, and so forth (e.g., services provided by community mental health boards, county offices of aging). Case management services are 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 (covered under a periodic payment (usually monthly) for each beneficiary) or risk-based managed care, 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 (section 1915(g) of the Act (42 USC 1396n(g)); 42 CFR Part 434).

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

Case Management/targeted case management provided as an optional state plan service – Services must be provided to an eligible Medicaid recipient, and must include: a comprehensive assessment and periodic reassessment of individual needs, development (and periodic revision) of a care plan that is based on the information collected through the assessment, making referrals to help the eligible individual obtain needed services and monitoring to ensure that the care plan is implemented and services are meeting the individual’s needs.

3. *Managed Care* – A state may obtain a waiver of statutory requirements under 1915(a) or (b)waivers, or amend its state plan under 1932(a) authority, or use1115(a) demonstration authority, in order to develop a managed care delivery system that is intended to more effectively addresses the health care needs of its population. For example, a waiver/SPA/Demonstration may involve the use of managed care plans for the delivery of some or all Medicaid benefits for selected beneficiaries. Managed care plans use networks of 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 beneficiaries for the proper period and use the proper rate cell, and the capitation rates must be actuarially sound. Generally, FFS Medicaid should not pay claims for services that are covered by managed care plan contract. States should ensure that capitated payments to managed care plans are discontinued when a beneficiary is no longer enrolled in a plan. All Medicaid managed care guidance can be found at <https://www.medicaid.gov/medicaid/managed-care/guidance/index.html>.

Examples of payment risks in Medicaid managed care can exist at the state level plan level, and the network provider level. At the state level, inaccurate state payments can be made to plans/managed care organizations because of inaccurate data or because the rate setting includes costs that should be excluded when calculating and setting payment rates.

4. *Medicaid Health Insurance Premiums* – A state may pay premiums for employer sponsored insurance or private group health insurance, on behalf of a Medicaid beneficiary, if it is cost effective to do so. When providing premium assistance, states must ensure that participating beneficiaries have access to all benefits available to other Medicaid beneficiaries, and that they are not required to incur greater out-of-pocket costs for premiums, deductibles, co-payments, or similar cost sharing charges than other Medicaid beneficiaries. A state’s policy related to premium assistance is described in the Medicaid state plan.

5. *Disproportionate Share Hospital* – FFP is available for payments to qualifying 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. Section 1923 of the Act limits DSH payments on a state-wide basis to annual DSH allotments and on a hospital-specific basis to each qualifying hospital’s uncompensated care costs. Section 1923(j) of the Act (42 USC 1396r(4) (OMB PRA 0938-0746)) also requires each state to obtain, and submit to CMS, an annual independent certified audit of their Medicaid DSH program.

6. *Home and Community-Based Services (HCBS)* – A state may obtain a waiver of statutory requirements to provide an array of HCBS which may permit an individual to avoid institutionalization primarily through 1915(c) of the Act (42 CFR Part 441, Subpart G). States may also offer HCBS under their state plan under authority provided by section 1915(i) of the Act. States must operate their HCBS programs in accordance with certain “assurances,” including three assurances related to quality of care. To meet these assurances, states must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries.

7. *Medicare Part B Buy-In* – 42 CFR 431.625(d)(1) specify FFP funds are available for state payment of

• Medicare Part B premiums for cash assistance recipients (SSI/SSP) and “deemed” cash recipients;

• Part A or B premiums, deductibles, coinsurance, and copays for QMBs; and

• Part B premiums for SLMBs and QIs.

FFP is not available for state payment of Part B premiums for other categories of Medicaid for individuals 65 years old and older or who have blindness and disability.

*(Source: 2022 OMB Compliance Supplement, Part 4, Department of Health and Human Services AL #93.778 Medical Assistance Program (Medicaid; Title XIX))*

### Additional Program Specific Information

**ODJFS Compliance Requirements**

**RMS**

The following transmittal letters communicate the most recent changes to the OAC rules concerning the web-based RMS system:

* [OAC 5101:9-7-23](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-23.stm) Child Support Random Moment Sample (RMS) Time Study – See code section for tracked changes
* [OAC 5101:9-7-20](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-20.stm) Income Maintenance, Workforce, Social Services, and Child Welfare Random Moment Sample (RMS) Time Studies – See code section for tracked changes

See also BCFTA Web WebRMS reports at:

* <http://jfs.ohio.gov/ofs/bcfta/TOOLS/RMS/RMSTADocument.pdf>
* Desk Guide at <http://jfs.ohio.gov/ofs/bcfta/TOOLS/RMS/RMSDeskGuide.pdf> .
* RMS user manual is available here [RMS User Manual](http://jfs.ohio.gov/ofs/bcfta/BB/2018-Updates/RMS-Manual-Final-10302020.stm) .

The RMS observations are time studies which are designed to measure county staff activity regarding income maintenance and social services programs. Both the Income Maintenance RMS (IMRMS) and the Social Services RMS (SSRMS) are completed on a quarterly basis by all positions performing directly related program functions, with the exception of positions performing administrative support or supervisory functions unless the person actually provides direct services. The RMS system selects the staff sample for completing the RMS from FTE reporting done in CFIS. Data collected from these time studies are used to calculate the percentage of time spent on the program. The percentages are used by the County agency system to allocate expenditures reported on the ODHS 2827 (CFIS Web CR 520) financial statements.

County expenditures primarily consist of administrative expenses, most of which are captured through the RMS process discussed above; however, there may be non-RMS related expenditures as noted above performing administrative support or supervisory functions only, such as the JFS Director, human resource employees, etc. These are the administrative staff whose expenses belong in the shared cost pool. If it can be determined that a supervisor only supervises staff in one program- type cost pool, that supervisor’s expenses are included in the program-type cost pool and allocated along with their staff’s expenses by the RMS statistics for that particular program type.

RMS based funding has a one month lag time. For example, RMS reporting for September, October and November drives the quarterly funding for October, November and December.

**RMS sample sizes required per OAC:**

**IMRMS/SSRMS/CWRMS:** [OAC 5101:9-7-20](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-20.stm)(G) – effective 1/18/2020

**CSRMS:** [OAC 5101:9-7-23](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-23.stm)(G) – effective 3/23/2020

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| --- | --- | --- |
| RMS Type | Agency Size | # of Observations |
| Income Maintenance (IMRMS) | Ten County Agencies with the Largest IM Cost Pool Expenditures | Minimum of 2,300 |
| Income Maintenance (IMRMS) | All Other County Agencies | Minimum of 354 |
| Social Services (SSRMS), Child Welfare (CWRMS), Juvenile Ct | 1-10 Participating Positions | Minimum of 33 per worker |
| Social Services (SSRMS), Child Welfare (CWRMS), Juvenile Ct | 11-74 Participating Positions | Minimum of 354 |
| Social Services (SSRMS), Child Welfare (CWRMS), Juvenile Ct | 75 or more Participating Positions | Minimum of 2,400 |
| Child Support (CSRMS) | 1-10 Participating positions | Minimum of 33 per worker |
| Child Support (CSRMS) | 11 or more Participating positions | Minimum of 354 |

**AOS Additional Testing Consideration**

Sections A & B are most often tested using the same sample. Additional program specific requirements / testing considerations are included in Section A that would also affect Section B.

County testing will primarily consist of the following:

* Administrative expenses
* FTE/RMS/Cost pools
* Direct expenditures, such as NET (non-emergency transportation), contracts (note: Counties should not contract out eligibility or Medicaid services. See Section M.), etc.

Auditors will need to test pooled costs separately (RMS) from direct charges (County ledgers).

All salaries and indirect expenses are included in cost pools. There are two levels of allocation for County JFS expenditures. Costs benefiting all programs (rent, leases, utilities, supplies, indirect employee costs for positions such as the agency director, personnel, fiscal, related compensation, etc.) are included in the Shared Costs Pool and are allocated based on the Quarterly Report of County JFS Full Time Equivalent (FTE) Positions submitted to ODJFS. Shared costs are distributed in CFIS Web based on the IM, SS, and CSEA FTE percentages.

More information regarding FTE reporting is available at <http://jfs.ohio.gov/ofs/bcfta/TOOLS/TOOLS.stm>. FTE reporting was previously accomplished on Form 4290, which has been replaced by CFIS Web form CR 445.

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| **Allowable costs on FTE Report associated with Employees** | | | |
| **Reported on:** | **Program:** | **County Fund Paid from:** | **RMS Cost Pool** |
| JFS 02827 | Medicaid, CHIP, Food Assistance, TANF, SSBG, CCDF | Public Assistance (PA) Fund | IMRMS / SSRMS |
| JFS 02750 | Child Support Enforcement | Child Support Administrative Fund | CSRMS |
| JFS 02820 | Foster Care & Adoption | Children Services Workers | CWRMS or SSRMS (if combined agency) |

These electronic reports in CFIS Web are designated as CR520 reports; they will still be designated at the bottom as 2827, 2750 or 2820.

Costs are then allocated to the program level based on the RMS studies.

Auditors will need to test both FTE reporting and RMS.

Auditors can determine population for RMS testing from a summary report for the quarter on CFIS that uploads into the RMS system. There is a data file with this information in CFIS that can be downloaded at the County JFS site.

County JFS must complete and submit a plan to define Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (non-NET contract) activities. Auditors should review this plan when testing EPSDT expenditures.

*(Source: Ohio Department of Medicaid and CFAE)*

### Audit Objectives and Control Testing

**Please see the following guidance links applicable to this section:**

* [Part 6](OMB_Part%206.pdf) (Internal Control) of the OMB Compliance Supplement
* [2013 COSO](https://www.coso.org/Shared%20Documents/Framework-Executive-Summary.pdf)
* [GAO’s 2014 Green Book](https://www.gao.gov/assets/gao-14-704g.pdf)

**Audit Objectives**

1. Obtain an understanding of internal control, assess risk, and test internal control as required by 2 CFR section 200.514(c).

Consider the results of the testing of internal control in assessing the remaining 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 whether Federal awards were expended only for allowable activities.

*(Source: 2022 OMB Compliance Supplement Part 3)*

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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):  **Here are some questions that can help in documenting the above control requirements:**  **(Note: The County/District JFS Policies should document controls for meeting compliance requirements. Auditors should review the information provided by the County/District JFS to gain an understanding of the procedures in place.)**   1. Does the County/district JFS pay expenditures to the County via a cost allocation plan (CAP)? 2. How does the County ensure only applicable costs are included in the CAP? 3. What procedures does the County/district JFS have in place to ensure they are only paying for allowable activities? 4. What controls does the County/district JFS have to ensure costs are not paid through the CAP and directly to the County/Fiscal Agent? 5. What procedures does the County/district JFS have in place for only allowable costs input into CFIS? 6. What procedures does the County/district JFS have to ensure administrative employees / costs are not reported as part of RMS, unless these employees provide direct services? 7. How does the County ensure that:  * Employees are properly completing the RMS observation; * Documentation is available to support the program and activity claimed; * Observations for absent employees are properly completed; * FTE allocations for the shared cost pool are correct; * Employees are assigned to the correct cost pool; and * Employees are completing the correct RMS observation.  1. Interview the RMS Coordinator. Document RMS coordinator name and date of interview. Document any weaknesses noted. Interview could include questions such as the following:    1. Are you familiar with the RMS procedures summarized in the [RMS User Manual](http://jfs.ohio.gov/ofs/bcfta/BB/2018-Updates/RMS-Manual-Final-10302020.stm)?    2. What is your role in the RMS process?    3. What do you do if you receive an RMS observation for an employee who no longer works in your office?    4. How do you ensure the observation is filled out correctly?    5. Have you received any special training or instructions on RMS procedures within the past 12 months?    6. How do you complete the RMS control sample? What is the purpose of the control sample? 2. Interview case workers who participate in RMS. Document employee name and date of interview. Interview could include questions such as the following:    * 1. Are you familiar with the RMS procedures summarized in the [RMS User Manual](http://jfs.ohio.gov/ofs/bcfta/BB/2018-Updates/RMS-Manual-Final-10302020.stm)?      2. What do you do when you receive an observation?         1. Complete immediately         2. Hold until appropriate time         3. Complete at my convenience         4. Other (explain)      3. What items need to be completed for the observation?         1. What program you are working with         2. Activity code         3. Case number (or unique identifier)         4. Comment section completed |

### Suggested Audit Procedures – Compliance

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| **Suggested Audit Procedures – Compliance (Substantive Tests)**  **(Reference / link to documentation where testing was performed testing):** |
| **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 the laws, regulations, and the provisions of the contract or grant agreements 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.  **Additional ODJFS Steps**  5. If the client has made subawards under the program, select a representative number of awards and determine whether they were only approved for activities as identified in step 1 above. See also Section M.  6. Obtain management’s explanation for any significant questionable expenditures/subawards. Analyze responses and obtain any additional documentation considered necessary.  7. In conjunction with Allowable Costs/Cost Principles in Section B, determine if the disbursements met 45 CFR 75 Subpart E ([2 CFR 200 Subpart E Cost Principles](https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E?toc=1)).  Other Attributes:   * Charges were properly coded. * Voucher was properly computed. * Invoice amount agrees to voucher amount * Invoice date precedes voucher date. * If a reimbursement, reimbursement was not claimed greater than 21 months following the payment of the expenditure. * Payments can be made on behalf of eligible and non-eligible children, allowable activities and non-allowable activities per federal terms and conditions.   **CAP (see also CAP testing in Section B)**   1. Summarize monthly payments to the County and review CAP for accuracy of payment. Ensure that payments made were for the current or prior period and they were within the current biennium. 2. Review CAP for reasonableness of County/district JFS expenditures.   **FTE Reporting- the roster is uploaded through the WebRMS system (See** [**OAC 5101:9-7-23**](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-23.stm) **&** [**OAC 5101:9-7-20**](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-20.stm) **for additional information.)**   1. Determine if the number of FTE by program area category is consistent with the payroll in the previous quarter. 2. Select employees and determine if they are reported in the correct program area category based on documentation. (i.e. job duties, job description, personnel file, employee interview, etc.)   **RMS**   1. Determine RMS cost pools that require testing (i.e. Income Maintenance, Social Services, Child Support, Child Welfare). 2. Scan all 4 quarterly RMS Tabulation Reports to identify any indications of misuse or manipulation of RMS codes (could help determine which quarter to test in step 3):    1. High instances of un-funded codes    2. Large variances (over 20%) in RMS coding between quarters    3. Distribution of RMS codes between programs 3. The information that was previously included in the County RMS Sample Reference list (the list was a recap from ODJFS of the RMS observations information input into the system by the County/district JFS) is available in the WebRMS system.   o Determine if the required number of observations were performed   1. Obtain RMS observations for each cost pool being tested (i.e. Income Maintenance, Social Services, Child Support, Child Welfare)   Select one sample of observations across all applicable cost pools, test for the following attributes and note any exceptions.   * + 1. Observation includes a case number or other identifier     2. Observation includes the activity, where applicable     3. Determine if documentation exists to substantiate the claimed program and/or activity on the RMS sample observation     4. Employee must respond to the observation within 48 business hours.     5. The RMS Coordinator reviewed and approved all observation moment responses within 72 hours.     6. If the observation had been flagged as part of the quality assurance control group, determine the supervisor/supervisor designee validated the response within the same forty-eight-hour response period that is available to the employee.   Also, determine if it was approved by the supervisor/supervisor designee, and that the response was accepted by the RMS coordinator.     7. No unauthorized or vacant positions were included in the RMS sample     8. Obtain payroll listing with job titles and compare to RMS observations completed        1. Review job duties from observation and / or interview with employee        2. Match job activities from RMS with job descriptions in personnel file     9. If employee is administrative or supervisory, determine whether they are appropriately completing the RMS observations        1. Administrative support employees can participate in RMS if they provide direct services 50% of the time        2. Supervisory employees can participate in RMS if they provide direct services over 50% of the time   **Reminder:** Auditors should not put confidential information in the current working papers and should follow established procedures for protection of confidential information. |

### 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 \_\_\_\_\_\_\_\_\_\_** |

## 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.**

All references to sections within 2 CFR Part 200 can be found [here](2%20CFR%20Part%20200.pdf)

### 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 Part 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 Part 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 Part 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 Part 200 and some agencies have been granted exceptions to provisions within 2 CFR Part 200.

*(Source: AOS CFAE)*

The cost principles in 2 CFR Part 200, Subpart E (Cost Principles), prescribe the cost accounting requirements associated with the administration of Federal awards by:

1. States, local governments and Indian tribes
2. Institutions of higher education (IHEs)
3. Nonprofit organizations

As provided in 2 CFR 200.101, 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 200.101(e) (see Appendix I 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](Appendix%20IX%20to%20Part%2075_%20Title%2045.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, 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 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: 2022 OMB Compliance Supplement Part 3)*

**Agency Codification Adjustments/Exceptions:**

The most recent compilation of agency additions and exceptions is provided on the CFO website here: <https://www.cfo.gov/wp-content/uploads/2014/12/Agency-Exceptions.pdf>. However, this list is only updated through 12/2014. AOS evaluated agency exceptions through June 2022. AOS auditors only will need to reference our internal AOS evaluation process [at the following link](https://ohauditor.sharepoint.com/sites/Intranet/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x0120002FFBFB1F4A3C3F47AE37C7A44E1C1EDE&id=%2Fsites%2FIntranet%2FShared%20Documents%2FAudit%5FResources%2FFederal%2FOther%20Federal%20Resources&viewid=68cb3ab2%2D567e%2D456a%2D975c%2Da88f3e9c3727).

**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.

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 200.420 - 200.476 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 200.402 - 200.411.

[List of Selected Items of Cost Contained in 2 CFR Part 200](Selected_Items_of_Cost_Part_3_ComplianceSupplement.pdf)

*(Source: 2022 OMB Compliance Supplement Part 3)*

**Part 4 OMB Program Specific Requirements**

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 third party liability is established after the claim is paid, reimbursement from the third party should be sought (section 1915 of the Act 42 USC 1396k; 42 CFR 433.135 through 433.154).

2. Before calculating the amount of FFP, 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 care providers or related entities (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. The requirements for provider-related donations and health care-related taxes are specified in section 1903(w) of the Act and implementing regulations at 42 CFR 433 Subpart B.

These provisions apply to the 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 433.50(c)).

3. Section 1927 of the Act (42 USC 1396r-8) requires manufacturers that wish to have their covered outpatient drugs covered by Medicaid to enter into an agreement with CMS under which the manufacturers agree to pay rebates for drugs dispensed and paid for by state Medicaid agencies under the state plan (“rebate agreement”). Those rebates are shared between the state and federal governments. Claims are submitted on a National Council of Prescription Drug Program (NCPDP) transaction using a National Drug Code (NDC) or a medical claim transaction using either Healthcare Common Procedure Coding System (HCPCS) or revenue codes in the authoritarian context of China. In addition to identifying the claims that are for covered outpatient drugs (CODs), the units need to be appropriate to the definition of the rebate program. Within 30 days of state invoicing, manufacturers are required to pay the rebate or provide the state with written notice of disputed units not paid because of discrepancies found.

In addition, to receive FFP states must invoice for covered outpatient single source and certain multiple (top 20 multiple source drugs as published by the secretary) source physician-administered drugs (42 USC 1396r-8(a)(7)), states must also provide for collection and submission of such utilization data using the NDC pursuant to Section 1927 (a)(7) of the Act and codified under 42 CFR 447.520. Physician-administered drugs include both injectable and non-injectable drugs. They are typically administered by medical professionals in physicians’ offices, clinics, or hospital outpatient departments.

Generally, in order for payment to be available for covered outpatient drugs, drug manufacturers are required to have entered into a rebate agreement and meet various product and price reporting requirements, in addition to paying rebates. As part of the product and price reporting requirements, manufacturers must certify to CMS all covered outpatient drugs and, on a quarterly basis, are required to provide their average manufacturer’s price and their best price for each covered outpatient drug, as applicable. 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 SMA must provide drug utilization data to manufacturers, including drug utilization data of those Medicaid beneficiaries enrolled in managed care plans.

4. In the “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability” final rule, published in the Federal Register on May 6, 2016 (81 FR 27498), CMS adopted medical loss ratio (MLR) requirements for Medicaid and CHIP managed care programs. The state must require each Medicaid managed care plan to calculate and report a MLR for rating periods starting on or after July 1, 2017; and require each CHIP managed care plan to calculate and report a MLR for rating periods in CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018. If a state elects to mandate a minimum MLR, that minimum MLR must be at least 85 percent. The regulation, at 42 CFR 438.8(e)(4), incorporates the standards adopted for the private insurance market MLR (45 CFR 158.150) for the treatment of fraud prevention expenses in the numerator of the MLR calculation. The MLR is reported for a rating period, using data from that rating period.

With regard to capitation rate setting for Medicaid managed care plans, under 42 CFR sections 438.4 and 438.5, several requirements exist: (1) states must provide all the validated encounter data, FFS data (as appropriate), and audited financial reports to be served by the managed care organization (MCO), prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) to the actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period, (2) the rates must be approved by CMS, which uses the services and expertise of the Office of the Actuary, and (3) the rate adjustments must be approved and valid. In addition, for Medicaid and CHIP managed care plans, the rates must be developed so that the managed care plan is projected to meet an 85 percent MLR (42 CFR 438.4(b)(9) and 457.1203(c)(1)).

5. *Non-Disproportionate Share Hospital Supplemental Payments* – States make supplemental payments to hospitals and other providers such as nursing homes and physician groups that serve high-cost Medicaid beneficiaries. The upper payment limit (UPL) against which non-disproportionate share hospital supplemental payments are measured is codified at 42 CFR 447.272 for Institutional Services and 42 CFR 447.321 for Outpatient Hospital and Clinic Services.

6. *Non-Risk Contracts* – Non-risk contracts are defined in 42 CFR 438.2 as contracts between a state and a PIHP or PAHP under which the contractor (1) is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362 of this chapter; and (2) may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

*(Source: 2022 OMB Compliance Supplement, Part 4, Department of Health and Human Services AL #93.778 Medical Assistance Program (Medicaid; Title XIX))*

**Written Procedure Requirements:**

2 CFR 200.302(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 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 requires established written leave policies if the entity intends to pay fringe benefits.

2 CFR 200.464(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 200.475 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

**ODJFS Compliance Requirements**

**Sections A & B are most often test together using the same sample. See also Section A.**

The most significant administrative costs of the County JFS is compensation. Costs of compensation must be allocated by means of full-time equivalents (FTEs) and the RMS system, as set forth in the state cost allocation plan. The costs of providers should normally be charged directly to the benefiting program. Provider costs, including provider administrative costs, should not be charged to a cost pool as this would likely cause costs to be charged to non-benefiting programs, contrary to the federal cost allocation principles (45 CFR 75 Subpart E and [2 CFR 200 Subpart E](https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E?toc=1)). Costs which are readily assignable as direct costs should be charged in that manner and not charged to a cost pool, unless required by the statewide cost allocation plan. Costs, whether charged directly or indirectly, should be charged only to benefiting federal programs. Subrecipients may not be paid any amounts in excess of allowable costs, whether as a fee or any other increment. For example, where a contractor is providing both WIA and TANF program services (if it is assignable to each program), each cost should be allocated by the contractor to the appropriate program and charged as direct program costs. On the other hand, where a contractor is providing general administrative services, such as the development of an agency-wide classification system for employees and is not assignable to individual programs, those costs are not direct program costs. As the costs benefit all programs within the agency, they should be charged to the shared cost pool.

Counties have a cost allocation plan (CAP) for centralized services that includes County JFS Agencies. County JFS pays the County Auditor for their portion of the CAP.

Agencies place administrative expenditures in a pool; for combined agencies it is referred to as the shared cost pool. ODJFS allocates funding from the shared cost pool through FTE statistics and divides the expenditures into program cost pools (IM, SS, CS). Random Moment Sampling (RMS) statistics are used to allocate the expenditures in each of the separate program (IM, SS, CS) cost pools.

Auditors should be alert for the following:

* Expenditures reimbursed as part of the County CAP and being paid directly (could be charged directly to the program or allocated to a cost pool). Many County CAPs include rent therefore the County JFS should not be paying for rent as a direct expense. The County JFS could be paying the County twice for the same expenditure.
* Instances where County JFS offices may show these County CAP expenditures in the CFIS system even when they did not pay them to the County (offset by a negative expenditure in order to balance to the county auditor’s records).
* Less than arm’s length transactions (see example rent issue discussed below).

County family services agencies are not authorized under Ohio law to hold title to real properly; however, joint county departments of Job and Family Services organized under ORC § 329 can hold title to real property. The agencies routinely rent or lease (for federal grants management purposes, the terms are interchangeable) the facilities necessary for their operation. Rental costs are allowable costs to federal programs under 45 CFR 75.465 ([2 CFR 200.465](https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E?toc=1)). However, rates must be reasonable in light of such factors as:

* + Rental costs of comparable property, if any;
  + Market conditions in the area;
  + Alternatives available; and
  + The type, life expectancy, condition, and value of the property leased.

If the County JFS rents facilities from the board of county commissioners, they are subject to additional restrictions under 45 CFR 75.465 ([2 CFR 200.465](https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E?toc=1)). As the county family services agency and the board of county commissioners are “related parties,” a rental transaction between the two is considered a “less-than-arm’s-length” transaction. As a result, allowable rental costs are limited to the amount that would be allowed had title to the property vested in the governmental unit; i.e., depreciation, maintenance, taxes and insurance. If the lease amount is tied to a bond schedule for the repayment of the county’s indebtedness on the building in question, this amount may be more than the allowable rental costs under 45 CFR 75.465 (2 CFR 200.465), and the excessive amount would not be an allowable cost to federal programs.

ODJFS issued [County Monitoring Advisory Bulletin 2008-001](http://jfs.ohio.gov/ofs/bcfta/TOOLS/LEASE/CountyMonitoringAdvisoryBulletin2008-001.pdf) regarding this matter.

Please note if the County capitalizes the interest, they cannot charge the JFS depreciation + interest as this would result in the County double-charging for the interest.

See also [OAC 5101:9-4-11](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter04/5101-9-4-11.stm), Rental Costs and Lease Agreements for the rule governing this requirement.

*(Source: Ohio Department of Medicaid)*

### Indirect Cost Rate

Except for those non-Federal entities described in 2 CFR Part 200, Appendix VII, paragraph D.1.b, 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). Effective on November 12, 2020, any non-federal entity can use the de minimus rate. 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 200.403, costs must be consistently charged as either indirect or direct, but may not be double charged or inconsistently charged as both. In accordance with 2 CFR 200.400(g), 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. A non-federal entity can always choose to charge the federal award less than the negotiated rates or the de minimis rate.

*(Source: 2022 OMB Compliance Supplement Part 3)*

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

**Please see the following guidance links applicable to this section:**

* [Part 6](OMB_Part%206.pdf) (Internal Control) of the OMB Compliance Supplement
* [2013 COSO](https://www.coso.org/Shared%20Documents/Framework-Executive-Summary.pdf)
* [GAO’s 2014 Green Book](https://www.gao.gov/assets/gao-14-704g.pdf)

**Audit Objectives**

1. Obtain an understanding of internal control, assess risk, and test internal control as required by 2 CFR section 200.514(c).

Consider the results of the testing of internal control in assessing the remaining 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 de minimis rate is applied to the appropriate base amount.
2. Determine that the de minimis rate is used consistently by a non-federal entity under its federal awards.

*(Source: 2022 OMB Compliance Supplement Part 3)*

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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 200.414(f).  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 and Appendices III-VII 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, 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 200.1\_Cognizant\_Agency.

For indirect cost rates and departmental indirect cost allocation plans, the cognizant agency is generally 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: 2022 OMB Compliance Supplement Part 3)*

#### 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.

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).

*(Source: 2022 OMB Compliance Supplement Part 3)*

**Please see the following guidance links applicable to this section:**

* [Part 6](OMB_Part%206.pdf) (Internal Control) of the OMB Compliance Supplement
* [2013 COSO](https://www.coso.org/Shared%20Documents/Framework-Executive-Summary.pdf)
* [GAO’s 2014 Green Book](https://www.gao.gov/assets/gao-14-704g.pdf)

**Audit Objectives**

Obtain an understanding of internal control, assess risk, and test internal control as required by 2 CFR section 200.514(c).

Consider the results of the testing of internal control in assessing the remaining 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.

**Audit Objectives: Direct Costs**

Determine whether the organization complied with the provisions of 2 CFR Part 200 as follows:

1. Direct charges to federal awards were for allowable costs.
2. Unallowable costs determined to be direct costs were included in the allocation base for the purpose of computing an indirect cost rate.

**Audit Objectives: Indirect Costs**

Determine whether the governmental unit complied with the provisions of 2 CFR Part 200 as follows:

1. Charges to cost pools used in calculating indirect cost rates were for allowable costs.
2. The methods for allocating the costs are in accordance with the cost principles, and produce an equitable and consistent distribution of costs (e.g., all activities that benefit from the indirect cost, including unallowable activities, must receive an appropriate allocation of indirect costs).
3. Indirect cost rates were applied in accordance with negotiated indirect cost rate agreements (ICRA).
4. For State/local departments or agencies that do not have to submit an ICRP to the cognizant agency for indirect costs (those that receive less than $35 million in direct Federal awards), indirect cost rates were applied in accordance with the ICRP maintained on file.

*(Source: 2022 OMB Compliance Supplement Part 3)*

**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(b)(7), 2 CFR 200.430, 2 CFR 200.431, 2 CFR 200.464(a)(2), and 2 CFR 200.475*.*
* 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 200.475 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 200.475.
  + 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):** |
| **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 200.407 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.  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 200.402 - 200.411.  (b) The principles to establish allowability or unallowability of certain items of cost (2 CFR 200.420 - 200.476).  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.  (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.  (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:  (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 200.430 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. When 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. |

### 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, 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: 2022 OMB Compliance Supplement Part 3)*

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

**Please see the following guidance links applicable to this section:**

* [Part 6](OMB_Part%206.pdf) (Internal Control) of the OMB Compliance Supplement
* [2013 COSO](https://www.coso.org/Shared%20Documents/Framework-Executive-Summary.pdf)
* [GAO’s 2014 Green Book](https://www.gao.gov/assets/gao-14-704g.pdf)

**Audit Objectives**

1. Obtain an understanding of internal control, assess risk, and test internal control as required by 2 CFR section 200.514(c).

Consider the results of the testing of internal control in assessing the remaining 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 whether the governmental unit complied with the provisions of 2 CFR part 200 as follows:
   1. Charges to cost pools allocated to Federal awards through the central service CAPs were for allowable costs.
   2. The methods of allocating the costs are in accordance with the cost principles, and produce an equitable and consistent distribution of costs, which benefit from the central service costs being allocated (e.g., cost allocation bases include all activities, including all State departments and agencies and, if appropriate, non-State organizations which receive services).
2. Cost allocations were in accordance with central service CAPs approved by the cognizant agency for indirect costs or, in cases where such plans are not subject to approval, in accordance with the plan on file.

**Compliance Requirements – State/Local Government-Wide Central Service Costs**

1. *Submission Requirements*
   1. Submission requirements are identified in 2 CFR Part 200, Appendix V, paragraph D.
   2. A State is required to submit a State-wide central service CAP to HHS for each year in which it claims central service costs under Federal awards.
   3. A “major local government” is required to submit a central service CAP to its cognizant agency for indirect costs annually. *Major local government* means a local government that receives more than $100 million in direct Federal awards (not including pass-through awards) subject to 2 CFR Part 200, Subpart E. All other local governments claiming central service costs must develop a CAP in accordance with the requirements described in 2 CFR part 200 and maintain the plan and related supporting documentation for audit. These local governments are not required to submit the plan for Federal approval unless they are specifically requested to do so by the cognizant agency for indirect costs.
   4. All central service CAPs will be prepared and, when required, submitted within the 6 months prior to the beginning of the governmental unit’s fiscal years in which it proposes to claim central service costs. Extensions may be granted by the cognizant agency for indirect costs on a case-by-case basis.
2. *Documentation Requirements*
   1. The central service CAP must include all central service costs that will be claimed (either as an allocated or a billed cost) under Federal awards. Costs of central services omitted from the CAP will not be reimbursed.
   2. The documentation requirements for all central service CAPs are contained in 2 CFR Part 200, Appendix V, paragraph E. All plans and related documentation used as a basis for claiming costs under Federal awards must be retained for audit in accordance with the record retention requirements contained in 2 CFR section 200.334(f).
3. *Required Certification –* No proposal to establish a central service CAP, whether submitted to the cognizant agency for indirect costs or maintained on file by the governmental unit, must be accepted and approved unless such costs have been certified by the governmental unit using the Certificate of Cost Allocation Plan as set forth in 2 CFR Part 200, Appendix V, paragraph E.4.
4. *Allocated Central Service Costs (Section I Costs)* – A carry-forward adjustment is not permitted for a central service activity that was not included in the approved plan, or for unallowable costs that must be reimbursed immediately (2 CFR Part 200, Appendix V, paragraph G.3).
5. *Billed Central Service Costs (Section II Costs)*
   1. Each billed central service activity must separately account for all revenues (including imputed revenues) generated by the service, expenses incurred to furnish the service, and profit/loss (2 CFR Part 200, Appendix V, paragraph G.1).
   2. Internal service funds for central service activities are allowed a working capital reserve of up to 60 calendar days cash expenses for normal operating purposes (2 CFR Part 200, Appendix V, paragraph G.2). A working capital reserve exceeding 60 calendar days may be approved by the cognizant agency for indirect costs in exceptional cases.
   3. Adjustments of billed central services are required when there is a difference between the revenue generated by each billed service and the actual allowable costs (2 CFR Part 200, Appendix V, paragraph G.4). A comparison of the revenue generated by each billed service (including total revenues whether or not billed or collected) to the actual allowable costs of the service will be made at least annually, and an adjustment will be made for the difference between the revenue and the allowable costs. The adjustments will be made through one of the following methods, at the option of the cognizant agency:
      1. If revenue exceeds costs, a cash refund to the Federal Government for the Federal share of the adjustment, including earned or imputed interest from the date of expenditure and debt interest, if applicable, chargeable in accordance with applicable cognizant agency for indirect costs regulations;
      2. Credits to the amounts charged to the individual programs;
      3. Adjustments to future billing rates; or
      4. Adjustments to allocated central service costs (Section I) if the total amount of the adjustment for a particular service (Federal share and non-Federal share) does not exceed $500,000.
   4. Whenever funds are transferred from a self-insurance reserve to other accounts (e.g., general fund), refunds must be made to the Federal Government for its share of funds transferred, including earned or imputed interest from the date of transfer and debt interest, if applicable, chargeable in accordance with applicable cognizant agency for indirect cost claims collection regulations (2 CFR section 200.447(d)(5)).

*(Source: 2022 OMB Compliance Supplement Part 3)*

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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):** |
| **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 (200.402 – 200.411).  (b) The principles to establish allowability or unallowability of certain items of cost (2 CFR 200.420 – 200.476).  (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.  (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.  (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.

The 2 CFR Part 200, Appendix VI, paragraph A, 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](45%20CFR%20Part%2095.pdf).

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

*(Source: 2022 OMB Compliance Supplement Part 3)*

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

**Please see the following guidance links applicable to this section:**

* [Part 6](OMB_Part%206.pdf) (Internal Control) of the OMB Compliance Supplement
* [2013 COSO](https://www.coso.org/Shared%20Documents/Framework-Executive-Summary.pdf)
* [GAO’s 2014 Green Book](https://www.gao.gov/assets/gao-14-704g.pdf)

**Audit Objectives – State Public Assistance Agency Costs**

1. Obtain an understanding of internal control, assess risk, and test internal control as required by 2 CFR section 200.514(c).

Consider the results of the testing of internal control in assessing the remaining 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 whether the governmental unit complied with the provisions of 2 CFR Part 200 as follows:
   1. Direct charges to Federal awards were for allowable costs.
   2. Charges to cost pools allocated to federal awards through the public assistance CAP were for allowable costs.
   3. The approved public assistance CAP correctly describes the actual procedures used to identify, measure, and allocate costs to each of the programs operated by the State public assistance agency. However, the actual procedures or methods of allocating costs must be in accordance with the cost principles, and produce an equitable and consistent distribution of costs.
   4. Charges to federal awards are in accordance with the approved public assistance CAP. This does not apply if the auditor first determines that the approved CAP is not in compliance with the cost principles and/or produces an inequitable distribution of costs.
   5. The employee compensation reporting systems are implemented and operated in accordance with the methodologies described in the approved public assistance CAP.

**Compliance Requirements – State/Local Government-Wide Central Service Costs**

1. *Submission Requirements*

Unlike most State/local government-wide central service CAPs and ICRPs, an annual submission of the public assistance CAP is not required. Once a public assistance CAP is approved, State public assistance agencies are required to promptly submit amendments to the plan if any of the following events occur (45 CFR section 95.509):

* 1. The procedures shown in the existing CAP become outdated because of organizational changes, changes to the Federal law or regulations, or significant changes in the program levels, affecting the validity of the approved cost allocation procedures.
  2. A material defect is discovered in the CAP.
  3. The CAP for public assistance programs is amended so as to affect the allocation of costs.
  4. Other changes occur which make the allocation basis or procedures in the approved CAP invalid.

The amendments must be submitted to HHS for review and approval.

1. *Documentation Requirements* – A State may claim Federal financial participation for costs associated with a program only in accordance with its approved CAP. The public assistance CAP requirements are contained in 45 CFR section 95.507.
2. *Implementation of Approved Public Assistance CAPs* – Since public assistance CAPs are of a narrative nature, the Federal Government needs assurance that the CAP has been implemented as approved. This is accomplished by funding agencies’ reviews, single audits, or audits conducted by the cognizant agency for audit (2 CFR Part 200 Appendix VI, paragraph E.1).

*(Source: 2022 OMB Compliance Supplement Part 3)*

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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):** |
| **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 level  a. 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 200.402 - 200.411.  (b) The principles to establish allowability or unallowability of certain items of cost (2 CFR 200.420 - 200.476).  (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 95.509](45%20CFR%20Part%2095.pdf) occur.  (2) Verify that public assistance CAP includes the required documentation in accordance with [45 CFR 95.507](45%20CFR%20Part%2095.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, review the 2022 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 your working papers and the cross referenced section can also be added on this page.

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

*(Source: 2022 OMB Compliance Supplement Part 3)*

### 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 \_\_\_\_\_\_\_\_\_\_** |

## 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.**

**All references to sections within 2 CFR Part 200 can be found** [**here**](2%20CFR%20Part%20200.pdf)

### 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 200.306 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 under2 CFR Part 200, Subpart E (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 200.306, 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: 2022 OMB Compliance Supplement Part 3)*

**Agency Codification Adjustments/Exceptions:**

The most recent compilation of agency additions and exceptions is provided on the CFO website here: <https://www.cfo.gov/wp-content/uploads/2014/12/Agency-Exceptions.pdf>. However, this list is only updated through 12/2014. AOS evaluated agency exceptions through June 2022. AOS auditors only will need to reference our internal AOS evaluation process [at the following link](https://ohauditor.sharepoint.com/sites/Intranet/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x0120002FFBFB1F4A3C3F47AE37C7A44E1C1EDE&id=%2Fsites%2FIntranet%2FShared%20Documents%2FAudit%5FResources%2FFederal%2FOther%20Federal%20Resources&viewid=68cb3ab2%2D567e%2D456a%2D975c%2Da88f3e9c3727).

**Part 4 OMB Program Specific Requirements**

**1. Matching**

The state is required to pay part of the costs of providing Medicaid services and part of the costs of administering the program. The percentage of federal funding is determined based on the amount of the expenditure and the application of the FMAP that is determined for each state using a formula set forth in section 1905(b) of the Act (42 USC 1396d), or other applicable federal matching rates specified by the statute. In particular, the matching rates for states’ administrative expenditures authorized by the Act are found in section 1903(a) of the Act (42 USC 1396b).

**2. Level of Effort**

American Rescue Plan Act of 2021 (ARP) Section 9817. To demonstrate compliance with the requirement to supplement, not to supplant existing state funds expended for Medicaid HCBS, states must: not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021; preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021. These requirements are commonly referred to as “maintenance of effort” (MOE) requirements for ARP section 9817.

Please note that these requirements do not supersede other statutory or regulatory requirements that apply to section 1915(c) waivers, or other requirements under other provisions authorizing HCBS, including requirements set forth in Special Terms and Conditions under section 1115 demonstrations and managed care authorities under which states are delivering HCBS. For example, if states have implemented temporary changes to HCBS eligibility, covered services, and/or payment rates through the Appendix K template for section 1915(c) waivers, a disaster relief state plan amendment for section 1915(i) or (k) programs, or an Attachment K for HCBS services under a section 1115 demonstration, states are expected to retain those changes for as long as allowable under those authorities (e.g., according to the end date approved under an Appendix K but no later than six months post PHE). However, CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP once the authority for those temporary changes has expired or if the state needs to implement changes to comply with other federal statutory or regulatory requirements.

**3. Earmarking -** A state waiver may contain an earmarking requirement.

*(Source: 2022 OMB Compliance Supplement, Part 4, Department of Health and Human Services AL #93.778 Medical Assistance Program (Medicaid; Title XIX))*

### Additional Program Specific Information

**ODJFS Compliance Requirements**

For Medicaid, for administrative expenses the Federal Share is 50% so the County JFS would be reimbursed 50% from the Federal share and use 50% from State (IM) or use local monies for match requirements. Costs related to eligibility determination within the Ohio Benefits system are reimbursed 75% federal share and use 25% from State (IM) or use local monies for match requirements. When the County requests funding, the required match of IM funding is automatically sent with the Federal share (until the IM allocation is exhausted). This IM allocation is programmed into CFIS so auditors are not required to test the IM allocation. The amount of Federal funding is unlimited as long as the County can provide the matching funds.

Once the County uses all their IM allocation, they must use local funding for the match. County JFS share of administering the program is included in the County’s mandated share amount. If the mandated share is exhausted, the County may use additional allowable local monies to meet the required share.

*(Source: Ohio Department of Medicaid)*

### Audit Objectives and Control Testing

**Please see the following guidance links applicable to this section:**

* [Part 6](OMB_Part%206.pdf) (Internal Control) of the OMB Compliance Supplement
* [2013 COSO](https://www.coso.org/Shared%20Documents/Framework-Executive-Summary.pdf)
* [GAO’s 2014 Green Book](https://www.gao.gov/assets/gao-14-704g.pdf)

**Audit Objectives**

1. Obtain an understanding of internal control, assess risk, and test internal control as required by 2 CFR section 200.514(c).

Consider the results of the testing of internal control in assessing the remaining 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.

2. *Matching* – Determine whether the minimum amount or percentage of contributions or matching funds was provided.

3. *Level of Effort* – Determine whether specified service or expenditure levels were maintained.

4. *Earmarking* – Determine whether minimum or maximum limits for specified purposes or types of participants were met.

*(Source: 2022 OMB Compliance Supplement Part 3)*

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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

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| **Suggested Audit Procedures – Compliance (Substantive Tests)**  **(Reference / link to documentation where testing was performed testing):** |
| **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 200.306, 200.434, and 200.414, 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.  **2. Level of Effort**  **2.1** **Level of Effort** – *Maintenance of Effort*  a. Identify the required level of effort and perform tests to verify that the level of effort requirement was met.  b. Perform test to verify that only allowable categories of expenditures or other effort indicators (e.g., hours, number of people served) were included in the computation and that the categories were consistent from year to year. For example, in some programs, capital expenditures may not be included in the computation.  c. Perform procedures to verify that the amounts used in the computation were derived from the books and records from which the audited financial statements were prepared.  d. Perform procedures to verify that non-monetary effort indicators were supported by official records.  **2.2** **Level of Effort** – *Supplement Not Supplant*  a. Ascertain if the non-Federal entity used Federal funds to provide services which they were required to make available under Federal, State, or local law and were also made available by funds subject to a supplement not supplant requirement.  b. Ascertain if the non-Federal entity used Federal funds to provide services which were provided with non-Federal funds in the prior year.  (1) Identify the federally funded services.  (2) Perform procedures to determine whether the Federal program funded services that were previously provided with non-Federal funds.  (3) Perform procedures to ascertain if the total level of services applicable to the requirement increased in proportion to the level of Federal contribution.  **3. Earmarking**  a. Identify the applicable percentage or dollar requirements for earmarking.  b. Perform procedures to verify that the amounts recorded in the financial records met the requirements (e.g., when a minimum amount is required to be spent for a specified type of service, perform procedures to verify that the financial records show that at least the minimum amount for this type of service was charged to the program; or, when the amount spent on a specified type of service may not exceed a maximum amount, perform procedures to verify that the financial records show no more than this maximum amount for the specified type of service was charged to the program).  c. When earmarking requirements specify a minimum percentage or amount, select a sample of transactions supporting the specified amount or percentage and perform tests to verify proper classification to meet the minimum percentage or amount.  d. When the earmarking requirements specify a maximum percentage or amount, review the financial records to identify transactions for the specified activity which were improperly classified in another account (e.g., if only 10 percent may be spent for administrative costs, review accounts for other than administrative costs to identify administrative costs which were improperly classified elsewhere and cause the maximum percentage or amount to be exceeded).  e. When earmarking requirements prescribe the minimum number or percentage of specified types of participants that can be served, select a sample of participants that are counted toward meeting the minimum requirement and perform tests to verify that they were properly classified.  f. When earmarking requirements prescribe the maximum number or percentage of specified types of participants that can be served, select a sample of other participants and perform tests to verify that they were not of the specified type. |

### 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 \_\_\_\_\_\_\_\_\_\_** |

## 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.**

**All references to sections within 2 CFR Part 200 can be found** [**here**](2%20CFR%20Part%20200.pdf)

### OMB Compliance Requirements

*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 agency’s home page. 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 200.329(c)(1)). 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 is only included in Part 4, “Agency Program Requirements” and Part 5, “Clusters of Programs,” if such reporting has been identified by a federal agency as subject to audit. Further, compliance testing of performance and special reports is only required for data, identified by agencies in parts 4 and 5 as key line items, that are quantifiable and are capable of evaluation against objective criteria stated in the statutes, regulations, contract or grant agreements pertaining to the program.

Performance and special reports in parts 4 and 5 are assumed to meet the above criteria. However, if an agency does not identify key line items for a performance or special report, auditors are only required to test that the report was submitted in a timely manner and no other procedures are required. Similarly, if key line items are identified in parts 4 and 5 that would not be quantifiable and capable of evaluation against objective criteria (e.g., narratives, futuristic information, information that would require verification at the program beneficiary level), auditors are not required to perform testing of such items.

**Federal Funding Accountability and Transparency Act**

Under the requirements of the Federal Funding Accountability and Transparency Act (Pub. L. No. 109-282), as amended by Section 6202 of Pub. L. No. 110-252, hereafter referred as the “Transparency Act” that are codified in 2 CFR Part 170, recipients (i.e., direct recipients) of grants or cooperative agreements are required to report first-tier subawards of $30,000 or more to the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS). In accordance with OMB Memorandum M-20-21, Implementation Guidance for Supplementing Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19), existing Transparency Act subaward reporting requirements may be leveraged to meet the transparency requirements outlined in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Information input to FSRS is available at USASpending.gov as the publicly available website for viewing this information (https://www.usaspending.gov/search).

Where the Reporting type of compliance requirement is marked as a “Y” in the Part 2 Matrix of Compliance Requirements, indicating it is subject to audit, auditors must test the compliance with the reporting requirements of 2 CFR Part 170 using the guidance in this section when the auditor determines Reporting to be direct and material and the recipient makes first tier awards.

*Federal Funding Accountability and Transparency Act*

Aspects of the Transparency Act that relate to subaward reporting (1) under grants and cooperative agreements were implemented in OMB in 2 CFR Part 170 and (2) under contracts, by the regulatory agencies responsible for the Federal Acquisition Regulation (FAR at 5 FR 39414 et seq., July 8, 2010). The requirements pertain to recipients (i.e., direct recipients) of grants or cooperative agreements who make first-tier subawards and contractors (i.e., prime contractors) that award first-tier subcontracts. There are limited exceptions as specified in 2 CFR Part 170 and the FAR. The guidance at 2 CFR Part 170 currently applies only to federal financial assistance awards in the form of grants and cooperative agreements (e.g., it does not apply to loans made by a federal agency to a recipient), however the subaward reporting requirement applies to all types of first-tier subawards under a grant or cooperative agreement.

As provided in 2 CFR Part 170 and FAR Subpart 4.14, respectively, federal agencies are required to include the award term specified in Appendix A to 2 CFR Part 170 or the contract clause in FAR 52.204-10, Reporting Executive Compensation and First-Tier Subcontract Awards, as applicable, in awards subject to the Transparency Act.

Consistent with the OMB guidance,

• 2 CFR Part 170 “subaward” has the meaning given in 2 CFR 200.1 and means an award provided by a pass-through entity to a subrecipient for the subrecipient to carry out part of a federal award received by the pass-through entity. It does not include payments to a contractor or payments to an individual that is a beneficiary of a federal program. A subaward may be provided through any form of legal agreement, including an agreement that the pass-through entity considers a contract.

• FAR 52.204-10(a) defines “first-tier subcontract” to mean a subcontract awarded directly by a contractor to acquire supplies or services (including construction) for performance of a prime contract, but excludes the contractor’s supplier agreements with vendors, such as long-term arrangements for materials or supplies that benefit multiple contracts or the costs of which would normally be applied to a contractor's general and administrative expenses or indirect cost.

While 2 CFR Part 170 and the FAR implement several distinct Transparency Act reporting requirements, including reporting of executive compensation, the Supplement addresses only the following requirements: (1) recipient reporting of each first-tier subaward or subaward amendment that results in an obligation of $30,000 or more in federal funds; and (2) contractor reporting of each first-tier subcontract award of $30,000 or more in federal funds (this requirement was phased in based on the value of the new prime contract as specified below under “Effective Date of Reporting Requirements”).

*Reporting Site*

Grant and cooperative agreement recipients and contractors are required to register FSRS and report subaward data through FSRS. To do so, they will first be required to register in the System for Award Management (SAM) (if they have not done so previously for another purpose (e.g., submission of applications through Grants.gov) and actively maintain that registration. Prime contractors have previously been required to register in SAM. Information input to FSRS is available at USASpending.gov as the publicly available website for viewing this information (<https://www.usaspending.gov/search> ).

*Key Data Elements*

Compliance testing of the Transparency Act reporting requirements must include the following key data elements about the first-tier subrecipients and subawards under grants and cooperative agreements.

|  |  |
| --- | --- |
| **Subaward Data Element** | **Definition** |
| Subawardee Name | This is the Sub-Awardee’s Name |
| Subawardee DUNS # | The subawardee organization’s nine-digit Data Universal Numbering System (DUNS) number. |
| Amount of Subaward | The net dollar amount of federal funds awarded to the  subawardee including modifications. |
| Subaward Obligation/Action Date | Date the subaward agreement was signed. |
| Date of Report Submission | Date the recipient entered the action/obligation into FSRS. |
| Subaward Number | Subaward number or other identifying number assigned by the prime awardee organization to facilitate the tracking of its  subawards. |
| Subaward Project Description | Describes the subaward project. |
| Subawardee Names and Compensation of Highly  Compensated Officers | Names of officers if thresholds are met. |

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.

**Source of Governing Requirements**

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

1. Financial reporting, 2 CFR 200.328
2. Monitoring and reporting program performance, 2 CFR 200.329
3. Program legislation.
4. Transparency Act, implementing requirements in 2 CFR Part 170 and the FAR, and the previously listed OMB guidance documents.
5. Federal awarding agency regulations.
6. The terms and conditions of the award.

*(Source: 2022 OMB Compliance Supplement Part 3)*

**Agency Codification Adjustments/Exceptions:**

The most recent compilation of agency additions and exceptions is provided on the CFO website here: <https://www.cfo.gov/wp-content/uploads/2014/12/Agency-Exceptions.pdf>. However, this list is only updated through 12/2014. AOS evaluated agency exceptions through June 2022. AOS auditors only will need to reference our internal AOS evaluation process [at the following link](https://ohauditor.sharepoint.com/sites/Intranet/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x0120002FFBFB1F4A3C3F47AE37C7A44E1C1EDE&id=%2Fsites%2FIntranet%2FShared%20Documents%2FAudit%5FResources%2FFederal%2FOther%20Federal%20Resources&viewid=68cb3ab2%2D567e%2D456a%2D975c%2Da88f3e9c3727).

**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. 0938-1265)* – 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.

**2. Performance Reporting** - Not Applicable

**3. Special Reporting** - Not Applicable

**4. Special Reporting for Federal Funding Accountability and Transparency Act** - See OMB Compliance Requirements section above for audit guidance.

*(Source: 2022 OMB Compliance Supplement, Part 4, Department of Health and Human Services AL #93.778 Medical Assistance Program (Medicaid; Title XIX))*

### Additional Program Specific Information

**ODJFS Compliance Requirements**

[OAC 5101:9-7-03](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-03.stm) and [5101:9-7-03.1](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-03-1.stm), provide guidance on the financing, cash management, quarterly reconciliation, and grant closeout procedures (including some Form 02827 reporting requirements). Public Assistance (PA) funds are determined quarterly and disbursed weekly to the County JFS, upon receipt of the county cash draw request for funds. Available funds are limited by state appropriation and federal grant awards. All payments are issued via electronic funds transfer (EFT). County JFS shall report receipt of revenue, disbursements of funds and provide documentation to justify the allocation of costs and various funds by the submission of the Income Maintenance RMS – Random Moment Sample Observations or the Social Services Random Moment Sample Observations. A state expenditure reconciliation report of the PA data subset is prepared quarterly to show a summary of net expenditures and receipts. The county agency is given the opportunity to review the reconciliation (over / under) reports for accuracy. The quarterly PA fund reconciliation review requirement is intended to correct instances where ODJFS or the county agency discover errors, i.e. incorrect splits of shared costs or wrong allocations, incorrect time study codes, and/or codes and expenditures. Quarterly close - The PA fund is reconciled each quarter based on the final reconciliation reports.

To reflect the most current funding practices available, in [OAC 5101:9-7-06](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-06.stm) titled "Reporting Collections and Earnings on Erroneous Payment Recoveries" which includes information on the earnings for the recovery of erroneous payments in addition to current reporting procedures. ODJFS established coding and communicated that coding via a [Bureau of County Finance Technical Assistance (BCFTA) update 2013-15](http://jfs.ohio.gov/ofs/bcfta/BB/20130110-BCFTA-Update-2013-15-New-Receipt-Coding.stm) (dated 1/10/2013).

The Rule governing county collections is as follows. Please note AOS only included Medicaid specific requirements. If auditors need additional information on reporting county collections, they should review the entire OAC requirement.

[OAC 5101:9-7-06](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-06.stm) Reporting Collections and Earning on Erroneous Payment Recoveries

A. An erroneous payment is a benefit payment or portion of a payment that was issued in error to an assistance group. When it has been determined that an erroneous payment has occurred, the county department of job and family services (CDJFS) shall attempt to recover the funds. The CDJFS may recover erroneous payments through benefit reduction or through cash collections. Erroneous payments collected by the CDJFS may qualify for additional earnings on the payments. Earnings for recovery of erroneous payments do not apply to participant expense allowances or other support service cash benefits.

B. The CDJFS reports erroneous payment collections that qualify for earnings and the Ohio department of job and family services (ODJFS) issues earnings as follows:

1. Disability Financial Assistance - (N/A for Medicaid)

2. Temporary Assistance for Needy Families (Tanf) - (N/A for Medicaid)

3. Aid to Dependent Children (ADC) - (N/A for Medicaid)

4. Medicaid collections reported on or after July 1, 2004:

a. The CDJFS shall deposit collections of erroneous payments in the PA fund and report the cash collections as earnings from Medicaid collections on the JFS 02827.

b. After the close of each quarter, ODJFS calculates the reported amounts and multiplies by the current non-federal share percentage, which changes every FFY, effective October first, and then multiplies the product of that calculation by fifty per cent.

c. ODJFS issues the amount as an EFT to the county.

5. Food Assistance (FA) - (N/A for Medicaid)

C. In addition to collections that are eligible for earnings, the CDJFS shall also report the following erroneous payment collections as receipts on the JFS 02827:

1. Cancellations, collections, refunds, or other General Assistance (GA) receipts;

2. Collections of erroneous payments for Family Emergency Assistance (FEA) medical;

3. Collections of ADC erroneous payments made prior to October 1, 1987;

4. Cancellations, collections, refunds, or other childcare receipts;

5. Collections of erroneous payments of Early Learning Initiative (ELI) funds;

6. Collections of erroneous payments of Employment Retention Incentive (ERI) funds; and

7. Collections of Prevention, Retention, and Contingency (PRC).

D. ODJFS will include the erroneous payment collections, as reported on the /JFS 02827, on the over/under report and collect them as part of the quarterly close calculation.

County Level Requirements – can be tested in conjunction with other programs requiring the same form.

In order for ODJFS to prepare the financial reports required, they must obtain financial information from the counties. The JFS 02827 is generated in CFIS web, however the County Auditor still needs to sign and certify the final report. If the report generated from CFIS web is not signed, it is not considered final. See [OAC 5101:9-7-03](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-03.stm), [5101:9-7-03.1](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-03-1.stm) & [5101:9-7-29](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-29.stm). Tests related to reporting at the county level for public assistance will be limited to the JFS 02827 form and include the following:

1. The CDJFS director must certify the accuracy and amount of disbursements in Section C.

2. The signed quarterly financial statement (CR 520 report) shall be submitted to ODJFS no later than the 10th day of the second month following the quarter the report represents.

Please note: The 02827 should be reported on a cash basis.

The Counties are also required to include cash or benefit overpayments on JFS 02827. Counties retain benefit recoveries monies (incentive monies) and report quarterly on the JFS 02827 to offset future draws from ODJFS. Most recoveries are from court convictions, and many are uncollectible. The County recovers collectible benefits via payback plans or a reduction in benefits.

ODJFS 02827 form and instructions can be found at <http://jfs.ohio.gov/ofs/bcfta/TOOLS/TOOLS.stm> .

Counties are still required to submit monthly financial data as an upload in CFIS no later than the eighteenth day of the month following the month of the transaction (see [OAC 5101:9-7-29](https://emanuals.jfs.ohio.gov/LocalAdmin/FAPM/Chapter07/5101-9-7-29.stm))

Auditors should test the ODJFS 02827 Form in conjunction with other programs also reported on the Form. The following is a list of programs reported on the ODJFS 02827/ CR 520 Quarterly Financial Statement Public Assistance Fund Certification Sheet:

Medicaid

CHIP / SCHIP

Food Assistance / SNAP

TANF

Child Care Development Cluster

Social Service Block Grant

*(Source: Ohio Department of Medicaid)*

### Audit Objectives and Control Testing

**Please see the following guidance links applicable to this section:**

* [Part 6](OMB_Part%206.pdf) (Internal Control) of the OMB Compliance Supplement
* [2013 COSO](https://www.coso.org/Shared%20Documents/Framework-Executive-Summary.pdf)
* [GAO’s 2014 Green Book](https://www.gao.gov/assets/gao-14-704g.pdf)

**Audit Objectives**

1. Obtain an understanding of internal control, assess risk, and test internal control as required by 2 CFR section 200.514(c).

Consider the results of the testing of internal control in assessing the remaining 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.

2. Determine whether required reports for federal awards include all activity of the reporting period, are supported by applicable accounting or performance records, and are fairly presented in accordance with governing requirements.

*(Source: 2022 OMB Compliance Supplement Part 3)*

|  |
| --- |
| **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.  **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 –* ***Not Applicable***  c. Special reports for FFATA  (1) Gain an understanding of the recipient’s methodology used to identify which, if any, awards were subject to the Transparency Act based on inclusion of the award term, the assignment by the federal awarding agency of a new FAIN, the effective date of the reporting requirement, and whether the entity passed funds through to first-tier subrecipients.  (2) Select a sample of first-tier subawards. Obtain related subaward agreements/amendments/modifications and determine if the subaward/subcontract was subject to reporting under the Transparency Act based on (a) the date of the award and (b) the amount of the obligating action for subawards or face value of the first-tier subcontracts (inclusive of modifications).  If the subaward/subcontract was subject to reporting under the Transparency Act:  (a) Using the FAIN, find the award in FSRS.  FSRS is the portal where the recipient enters the award information; it is only accessible by the recipient. Therefore, in order for recipients to demonstrate that information has been properly input, they should coordinate with the auditor regarding the auditor’s review of the information, physically or virtually (e.g. by logging into its FSRS account either in the auditor’s presence or remotely using technology such as screensharing, screenshot evidence, etc.) so that the auditor is able to find the awards in the system as required in this procedure).  (b) Compare the award information accessed in step 2.a to the subaward/subcontract documents maintained by the recipient to assess if—  (i) applicable subaward obligations /modifications have been reported,  (ii) the key data elements (see above) were accurately reported and are supported by the source documentation, and  (iii) the action was reported in FSRS no later than the last day of the month following the month in which the subaward/subaward amendment obligation was made or the subcontract award/subcontract modification was made.  (c) The auditor must provide the following information for non- compliance finding (s) as the results of step 2.b.  (i) The non-federal entity did not report the subaward information  (ii) The non-federal entity did not report the subaward information timely  (iii) The non-federal entity reported incorrect amount  (iv) The non-federal entity did not report all the key data elements  The following format is recommended to report non-compliance findings and included in the audit report. Data is included for illustration purposes only.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Transactions Tested** | **Subaward not reported** | **Report not timely** | **Subaward amount incorrect** | **Subaward missing key elements** | | 25 | 2 | 10 | 13 | 0 | | **Dollar Amount of Tested Transactions** | **Subaward not reported** | **Report not timely** | **Subaward amount incorrect** | **Subaward missing key elements** | | $5,000,000 | $200,000 | $4,000,000 | $800,000 | $0 |   d. *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.  **Additional ODJFS Steps**  **ODJFS 02827:**   * + - 1. Based on the results of the test of controls, select the quarterly ODJFS 02827 reports and perform the following:   Review each report to determine if:   * All amounts reported are traceable to appropriate supporting documentation and appear to be coded properly. * All amounts reported agree to the Quarterly CFIS reconciliation from ODJFS. * All amounts reported agree to the County Auditors/fiscal agents records. * Form 2827 was signed by County Auditor/fiscal agent and Director and imported into CFIS Web no later than the tenth calendar day of the second month following the quarter the report represents   **Other**  1. Determine if the County/district JFS reviewed the grant reconciliation (over / under) report and responded to ODJFS.  2. 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. |

### 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 \_\_\_\_\_\_\_\_\_\_** |

## 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.)

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

Per paragraph 13.39 of the **AICPA Single Audit Guide[Permalink to here](https://checkpoint.riag.com/app/view/docPermaLink?DocID=iAICPAIGS:767.2440&docTid=T0AICPAIGS:767.2440-1&feature=ttoc&lastCpReqId=97899&tlltype=AICPAIGS:767.2668)**, the **following are required to be reported** as audit findings in the federal awards section of the schedule of findings and questioned costs **(2 CFR 200.516):**

1. Significant deficiencies and material weaknesses in internal control over major programs.
2. Material noncompliance with the federal statues, regulations, or the terms and conditions of federal awards related to a major program.
3. 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.
4. Known questioned costs that are greater than $25,000 for programs that are not audited as major.
5. 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.
6. Significant instances of abuse relating to major programs.
7. 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 example, a scope limitation that is not otherwise reported as a finding).
8. 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 2 CFR 200.511(b) of the Uniform Guidance, materially misrepresents the status of any prior audit finding.

[Appendix I](2%20CFR%20Part%20200.pdf) lists block grants and other programs excluded from the requirements of specified portions of 2 CFR Part 200.

[Appendix II](OMB_Appendix%20II.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://www.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 13.50 of the AICPA Single Audit Guide,** the schedule of findings and questioned costs must 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 13.34 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 verbally. 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.
* 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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