

Federal Awards Compliance Audit Guidance

NAME OF CLIENT:	
YEAR ENDED:	12/31/2014

FEDERAL AWARD NAME:	Medicaid Cluster (Title XIX)
CFDA#:	#93.775 / 93.777 / 93.778

This Guidance File has been broken into following sections:

- **Introduction- Materiality Sheet – Page 2 (Note the full materiality sheet to be completed by auditors is included in the testing file)**
- Part I- General OMB Compliance Supplement Information,
- Part II- ODJFS Program Specific Information,
- Part III- Applicable Compliance Requirement Guidance
 - OMB compliance requirements
 - ODJFS compliance requirements

No ARRA guidance has been included, there should be no ARRA funding or expenditures for this audit cycle.

A separate file has been created to document control procedures that address applicable compliance requirements, suggested audit procedures and the results of testing. The file name is 93.775_93.777_93.778_Medicaid Cluster_2014_audit program_County FY JFS only_March 2015.docx

Note: In many cases, if Medicaid is a major program, you will need to test both the JFS and non-JFS Medicaid FACCR's. As stated in step 5 of the RSAR, quantitative federal program materiality is typically 5% of total program expenditures. Since most Counties receive Medicaid for JFS, and from ODODD, both the JFS and non-JFS FACCR's would need tested if expenditures from both funding streams exceeded 5% of total Medicaid expenditures.

PART I – OMB Compliance Supplement Information

I. Program Objectives

Note: In accordance with OMB Circular A-133, §____.525(c)(2), when the auditor is using the risk-based approach for determining major programs, the auditor should consider that the Department of Health and Human Services (HHS) has identified the Medical Assistance Program (Medicaid) as a program of higher risk.

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 payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and includes any payment to an ineligible recipient, and any payment for an ineligible service, any duplicate payment, payments for services not received, and any payments that does not account for credit for applicable discounts. In addition, the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. No. 111-148, as amended) will result in significant expansion of the program in the future (see IV, "Other Information," in this program supplement).

While not precluding an auditor from determining that the Medicaid cluster qualifies as a low-risk program (e.g., because prior audits have shown strong internal controls and compliance with Medicaid requirements), the above should be considered as part of the risk assessment process and audit documentation should support the consideration.

Medical Assistance Program

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

State Medicaid Fraud Control Units (**AOS Note: This is not tested at the local level.**)

States are required as part of their Medicaid State plans to maintain a State Medicaid Fraud Control (Unit (MFCUs), unless the Secretary of HHS determines that certain safeguards are met regarding fraud and abuse and waives the requirement. The mission of the MFCUs is to investigate and prosecute fraud by Medicaid providers. The State MFCUs also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan, and may review complaints of misappropriation of patients' private funds in such facilities. States are required to refer all suspected violations of applicable Medicaid laws and regulations by providers to the MFCU. Federal requirements for the establishment and continued operations of the units are contained in 42 USC 1396b (a) (6), 1396b (b) (3), and 1396b (q); and 42 CFR part 1007. A key requirement of the governing regulations is that a unit must be a single identifiable entity of State government.

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

The recently enacted Affordable Care Act provides additional tools and resources to fight fraud in the health care system by providing an additional \$350 million over the next 10 years through the Health Care Fraud and Abuse Control Account. The Affordable Care Act toughened sentencing for criminal activity, enhanced screenings and enrollment requirements, encouraged increased sharing of data across government, expanded overpayment recovery efforts, and provided greater oversight of private insurance abuses. The Affordable Care Act also included tools and resources to help States reduce improper payments through the establishment of recovery audit contractors (RACs).

State Survey and Certification of Health Care Providers and Suppliers (**AOS Note: This is not tested at the local level.**)

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

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

II. Program Procedures

Although the below information may not impact counties directly, to effectively audit these program auditors should understand all aspects of each program. This information is directly from the OMB Compliance Supplement and gives the auditors information on how Medicaid operates. There are a few AOS notes included in this section for auditors information.

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

Administration

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

State Plans

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

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

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

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

Waivers

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

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

Payments to States

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

State Expenditure Reporting

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

Eligibility (AOS Note: This is not tested at the local level.)

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

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

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

Services (AOS Note: Medicaid benefits will not be tested at the local level.)

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

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

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

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

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

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

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

Maintenance of Effort

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

Statutory Changes Affecting the Future Direction of the Medicaid Program

The Affordable Care Act includes numerous health-related provisions affecting the Medicaid program.

The provisions of the ACA have varying implementation dates. The ACA allows flexibility in (1) implementing certain provisions and (2) tailoring the individual State's program to comply.

This information is not provided within the faccr but can be obtained at the following web address http://www.whitehouse.gov/sites/default/files/omb/assets/OMB/circulars/a133_compliance/2014/hhs.pdf please see pdf pages 245-254.

Control Systems (AOS Note: This is not tested at the local level.)

Utilization Control and Program Integrity

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

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

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

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

Inpatient Hospital and Long-Term Care Facility Audits

States are required to establish as part of the State plan standards and methodology for reimbursing inpatient hospital and long-term care facilities based on payment rates that represent the cost to efficiently and economically operate such facilities and provide Medicaid services. The State Medicaid agency must provide for

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the filing of uniform cost reports by each participating provider. These cost reports are used by the State Medicaid agency to aid in the establishment of payment rates. The State Medicaid agency must provide for periodic audits of the financial and statistical records of the participating providers. Such audits could include desk audits of cost reports in addition to field audits. These audits are an important control for the State Medicaid agency in ensuring that established payment rates are proper.

ADP Risk Analyses and System Security Reviews

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

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

As part of complying with the above requirement, a state may obtain a Statement on Standards for Attestation Engagements No. 16, Reporting on Controls at a Service Organization (SSAE 16) Type II report from its service organization (if the state has a service organization). The Statement on Auditing Standards No. 70, Service Organizations (SAS 70) is superseded by SSAE 16. A SSAE 16 Type I 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 SSAE 16 report differ according to each individual service organization's operations; however, in every instance, the Type II report procedures assess the sufficiency of the design of an organization's controls and test their effectiveness. A number of commonly covered areas include:

- Control Environment
- Systems Development and Maintenance
- Logical Security
- Physical Access
- Computer Operations
- Input Controls
- Output Controls
- Processing Controls

Medicaid Management Information System (MMIS)

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

The MMIS is normally used to process payments for most medical assistance services. The MMIS' Operations Management business area supports the Claims Receipt, Claims Adjudication, and Point-of-Service subsystems to process provider claims for Medicaid care and services to eligible medical assistance recipients. The MMIS

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incorporates many edits and controls to identify aberrant billing practices for follow-up by State staffs. However, the State may use systems other than MMIS to process medical assistance payments. In many cases the operation and maintenance of the MMIS is contracted out to a private contractor. The State plan will describe the administration of each State's claims-processing subsystems.

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

AOS note: Medicaid Information Technology System (MITS) has replaced MMIS in Ohio. MITS automated many processes that were performed manually. MITS went live on August 2, 2011. Effective 1/1/2013 no paper claim documents will be accepted, all previous paper claims forms must be processed in MITS which was communicated in MHTL 3334-13-01.

Federal Oversight and Compliance Mechanisms

CMS oversees State operations through its organization consisting of a headquarters and 10 regional offices. CMS program oversight includes budget review, reviews of financial and program reports, and on-site reviews, which are normally targeted to cover a specific area of concern. CMS conveys areas of national and local concerns to the States through the regions. Technical assistance is used extensively to promote improvements in State operation of the program but enforcement mechanisms are available. CMS considers the single audit as an important internal control in its monitoring of States.

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

Medicaid Program Payment Error Rate Measurement

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

Source of Governing Requirements

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

Awards under the Medical Assistance Program (CFDA 93.778) are subject to the HHS implementation of the A-102 Common Rule, 45 CFR part 92. This program also is subject to the requirements of 45 CFR part 95 and the cost principles under Office of Management and Budget Circular A-87 (2 CFR part 225).

Availability of Other Program Information

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

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

Other Sources:

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- **2 CFR 225 is the codification of OMB Circular A-87 (Cost Principles for State, Local, and Indian Tribal Governments)**
- **45 CFR 92 includes the Health and Human Services OMB Circular A-102 Grants Management Common Rule (State & Local Governments)**
- **45 CFR 74 includes the Health and Human Services OMB Circular A-110 (universities & non-profit organizations). OMB Circular A-110 was codified into 2 CFR 215 (references to A-110 / 2 CFR 215 have been eliminated as this FACCR is not for universities or non-profit organizations)**

Auditors should cite using the applicable codified CFR references and not the OMB Circulars for noncompliance.

Other Information

Transfers into Medicaid (Title XIX)

As described in Part 4, CHIP (CFDA 93.767), III.A.1, 'Activities Allowed or Unallowed,' qualifying States **may apply certain Medicaid program expenditures against their available CHIP allotments. In particular, qualifying States may use such Medicaid expenditures in amounts up to 20 percent of their available CHIP allotments through 2008 and, beginning April 1, 2009, as authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA), Public Law 111-3 of 2009, up to 100 percent of their available CHIP allotments for FY 2009 and following fiscal years.** The qualifying States, determined by CMS using the criteria in Pub. L. No. 108-74, Section 1(g)(2) and Pub. L. No. 108-127, Section 1, are: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin.

Amounts transferred into the State's Medicaid program are subject to the requirements of the Medicaid program when expended and should be included in the audit universe and total expenditures of this program when determining Type A programs. On the Schedule of Expenditures of Federal Awards, the amounts transferred in should be shown as expenditures of this program when such amounts are expended.

Improper Payments

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

1. *Eligibility Determinations*

Findings related to eligibility determinations found internal control deficiencies including:

- eligibility determination and renewal were not performed timely or performed within the timeliness standards,
- lack of internal controls over obtaining adequate documentation used to support eligibility determinations,
- the data inputted into the eligibility system were not accurate,
- clients information were not verified according to the State's verification plan, and
- program staff did not have sufficient knowledge of program requirements and policies due to high turnover and lack of training.

2. *Medicaid Claims Processing*

Findings related to Medicaid claims processing found significant weaknesses including:

- inadequate documentation to support the payments claimed in the CMS-64;
- payments reported on the CMS-64 were not readily traceable to the individual claims or information in the sub-system or the financial statements;
- inadequate internal control over utilization, fraud and accuracy of the Medicaid claims;

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- lack of understanding of when to report payments in the CMS-64;
 - lack of internal control in drawing down ARRA funds;
 - inadequate internal control to assure that payments to providers were made in compliance with Federal regulations, e.g. payments for services that were not medically necessary and providers were not eligible Medicaid providers; and
 - review of cost report and recoupment of rate adjustments were not timely.
3. *Other areas of weaknesses* identified included-
- inadequate monitoring and oversight of subcontractors;
 - inadequate monitoring and oversight to assure provider licensing, agreements or required certification were in effect and up-to-date, and that the related documentation were in file or in the Medicaid Management Information System (MMIS);
 - inadequate internal control related to implementation of MMIS replacement system;
 - inadequate internal control regarding user access to the MMIS including terminated employees' user access rights; and
 - MMIS was not programmed and updated timely and accurately with proper information.

Medicaid EHR Incentive Payment Program

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

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

Auditors should be aware that funds made available to States for the Medicaid incentive program and the State's expenditure of those funds, including payments to eligible providers and costs of State administration of the program, are subject to the audit provisions of OMB Circular A-133. Providers and other eligible entities receiving incentive funds are not subject to the audit provisions of OMB Circular A-133 by virtue of receipt of those funds.

Medicaid Part II

ODJFS Specific Information

Part II- The ODJFS Program Specific Information is broken into 5 sections: (1) Program Overview, (2) Program Funding, (3) AOS Testing Considerations, (4) Reporting in the Schedule of Expenditures of Federal Awards, (5) Information Systems, Including a description on how they operate (i.e. CRIS-E, CFIS Web, PET)

Additional ODJFS Program Information can be obtained (http://jfs.ohio.gov/factsheets/Medicaid_factsheets.pdf)

(1.) 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 CRIS-E, and issue Medical cards to recipients determined eligible by CRIS-E based on the application information entered. 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 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. Claims are processed by OMA at the State level (Claim submission is detailed in OAC 5160-1-19). MITS verifies patients' eligibility through uploads of information from CRIS-E and determines allowability of the service provided. 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 CRIS-E), will be performed by ODJFS/Medicaid Eligibility Quality Control (MEQC) Unit 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 weblinks at http://jfs.ohio.gov/County/County_Directory.pdf .

Medicaid Part II

ODJFS Specific Information

County Collaborations

Collabor8

During 2011, Collabor8 was formed. The Collabor8 project involves seven county department and family services that will work together under a common agreement to process and manage administrative workloads as one project area. Wood and Knox counties started in December 2011, Hancock, Marion, Morrow & Sandusky came on 1/2/12 and Delaware in February 2012. The MOU was extended to June 30, 2017. The fiscal sharing splits for SFY 13 & 14 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 any other costs allocated as a result of this collaborative effort. See [FATL 341](#), dated 9-27-13 and OAC 5101:4-1-16.

<u>County</u>	State Fiscal Year 14 IM Allocations	Percentage	State Fiscal Year 14 IM Allocations	Percentage
Delaware	\$330,931	11.46%	\$316,689	10.89%
Hancock	390,760	13.53%	400,841	13.79%
Knox	389,378	13.48%	406,772	13.99%
Marion	540,893	18.72%	543,024	18.68%
Marrow	230,785	7.99%	244,871	8.42%
Sandusky	386,290	13.37%	401,454	13.81%
Wood	619,760	21.45%	594,059	20.43%
Total	\$2,888,797		\$2,907,710	

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 mentions and should also obtain the agreement establishing the district; perform a GASB 61 evaluation to determine if the district is a legally separate entity and if they are a subrecipient of ODJFS or of the contributing counties. Also keep in mind ORC329.44 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 non-ARRA boiler plate 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 2 CFR 225, Appendix B, Section 15 (b) (1). We are aware of two districts that have currently formed (see also [FATL 341](#), dated 9-27-13 and OAC 5101:4-1-16)

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.

Defiance/Paulding Consolidated Department of Job and Family Services is a combination of Defiance and Paulding Counties and it is operating on a 9/30 federal fiscal year end.

Subgrant Agreement

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ODJFS Specific Information

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.

Medicaid Transition

On July 1, 2013 Medicaid became a separate state agency, the Ohio Department of Medicaid or ODM. ODM still passes money through ODJFS and down to the County JFS offices. In our conversations with ODJFS and ODM, there should not be any programmatic changes at the county level. There were some changes in reporting because of budget separations. This impacted the 504 report only for 2013 and was detailed in the SEFA spreadsheet.

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 ODJFS website.
- ODJFS Bureau of Monitoring and Consulting Services (BMCS) performs ODJFS program County compliance reviews. The Counties do receive written results of these reviews. Auditors should consider the results of the reviews for planning purposes. In addition, BMCS has also developed a number of templates (procurement, subgrant agreements, subrecipient monitoring) available to help the counties with program compliance. See tools provided at <http://jfs.ohio.gov/ofs/bmcs/index.stm> & <http://jfs.ohio.gov/ofs/bcfta/TOOLS/TOOLS.stm>
- ODJFS in preparation for the transition of the Counties becoming subrecipients in 2009, provided to each county a "Guided Self Assessment for County Family Services Agencies" (GSA). This is a comprehensive guide that incorporates the OMB compliance requirements, CFR and OAC requirements, identifies processes and controls ODJFS determined should be in place to meet specific federal requirements and corresponding risk assumed by the agency. The instructions request Counties to provide or attach policies and procedures to address the answers on the questionnaire.
 - Auditors should note the GSA is a tool developed by the ODJFS Bureau of Monitoring and Consulting Services (BMCS) to communicate compliance requirements imposed on the State and counties by Federal/State law or administrative rule (OAC). While the GSA does include authoritative guidance references, the GSA is not authoritative support for the requirements. In addition, the internal controls discussed throughout the GSA are only suggestions not required controls or ODJFS policy. The BMCS does not have authority to require specific internal controls without establishing an administrative rule. Therefore, auditors should not cite the GSA for reporting noncompliance or control deficiencies but cite the applicable law or rule governing the requirement.

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 submit their monthly expenditure reports. County JFS

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sends a drawdown request for their anticipated needs and then report their expenditures monthly 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 5101:9-6-31, the County Share of Public Assistance Expenditures and the Mandated Share Budget is 105%.

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, program 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 (5101:9-6-44). An agency may request an increase at any time during the fiscal year. Counties receive notification of their allocation via CFIS Web. The ODJFS receives funding for the following pass throughs: food assistance (FA), food and nutrition services (FNS), Medicaid and CHIP.

See also BCFTA update 2013-23 (<http://jfs.ohio.gov/ofs/bcfta/BB/20130626-BCFTA-Update-2013-23-Medicaid-Allocation-Change.stm>) which outlines the Medicaid Allocation changes. Effective July 1, 2013 Medicaid funding originates from the Department of Medical Assistance (MCD). However, in our conversations with MCD and ODJFS beyond the initial coding changes, counties should not see any additional compliance requirement changes due to the change. Also ODJFS is still acting as the pass through agency and should be listed as such on the SEFA.

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 disability financial assistance (DFA), food assistance (FA), and a separate allocation for medical assistance (MA) including the Medicaid program and the state children's health insurance program (SCHIP). 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 using the JFS 02725. The request must be submitted to ODJFS no later than the last day of the liquidation period for a closing grant. A County JFS may also elect to transfer all or a portion of its IM allocations to the CSEA. The creation of the two separate IM allocations was communicated in FAPMTL 276 and was effective 7-5-13. For further information see <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=FAPMTL276>, OAC 5101:9-6-05 and BCFTA update 2013-24 at <http://jfs.ohio.gov/ofs/bcfta/BB/20130626-BCFTA-Update-2013-24-SFY-14-Medicaid-and-IM-Changes.stm>.

FAPMTL 272 (dated 4/10/2013) updated the Non-Emergency Transportation (NET), Pregnancy Related Services and Healthchek Services Funding Rule. Changes were for funding clarifications due to the implementation of CFIS Web, for more information see <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=FAPMTL272>.

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FAPMTL 290 (dated 4/11/2014) communicated an amendment to AOC rule 5101:9-6-05.1 concerning the Medicaid Enhanced Eligibility Allocation. The change was made to clarify that training costs are eligible for the enhanced match rate for the entire period of availability. A CDJFS may claim training and testing activity at 75% of the ffp for the entire grant period. 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. For more information see <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=FAPMTL290>.

4. Other program specific State Allocations

- In addition to their County JFS allocations, there are two opportunities for County JFS 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) In January or April they can apply for additional funds or to free up monies allocated to other grants. 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 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 of the Administrative Code. See the ICAA section of the BCFTA Tools website for details of the process at <http://jfs.ohio.gov/ofs/bcfta/Allocations.stm>
- For most grants, the County JFS can draw down funds on a weekly basis from the ODJFS (see Reporting L section of this document). Public Children Services Agency (PCSA) grants (Adoption Assistance and Foster Care) are reimbursement grants. There may be portions of a program that are on a reimbursement basis however, the remainder of the programs the County JFS agency draws down an advance of funds for anticipated needs and monthly report expenditures. Quarterly adjustments are made for the differences.
- County JFS file quarterly reports with ODJFS via CFIS. There is a quarterly reconciliation process performed by ODJFS. ODJFS issues a response to the initial report, County JFS may make corrections and then a final report (settlement) is issued after all corrections are made. See also **OAC 5101:9-7-03 and 5101:9-7-03.1** 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 was updated with CFIS Web and communicated to CDJFS in FAPMTL 258 effective 10/9/12 (see <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=FAPMTL258> and OAC 5101:9-7-03.1)** 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 file quarterly the certification of monthly expenditure reports with ODJFS via CFIS Web. 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. 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 shall make any allowable changes that arise after

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ODJFS Specific Information

the five-day review period to open grants in the current quarter. The Ohio department of job and family services (ODJFS) notifies the CDJFS when the quarter reconciliation process is completed. The CDJFS shall review reports for accuracy and immediately notify ODJFS of any discrepancies. 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 availability. The period of availability 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, such as PET (Maximus Program). 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 2013-21 regarding costs associated with county lay-off of staff at <http://jfs.ohio.gov/ofs/bcfta/BB/20130514-BCFTA-Update-2013-21-County-Lay-off-SFY14.stm>**
- **See BCFTA Update 2014-14 regarding costs associated with county lay-off of staff at http://jfs.ohio.gov/ofs/bcfta/BB/BCFTAUpdate_2014-14_SF15_CountyLayoff.stm**
- **See also FAPL No. 34, Abnormal or Mass Severance Pay at <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=FAPL34>**

(2.) Program Funding

See ODJFS Programs SFAE Testing Spreadsheet for Program Funding.

(3.) AOS 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, CCBG	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.

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ODJFS Specific Information

(4.) Reporting in the Schedule of Expenditures of Federal Awards

Medicaid benefits are paid by the State ODJFS; therefore, eligibility and recipient benefit payments will be audited by the State Region.

The County federal schedule will report direct administrative and other expenditures (whether charged directly to the program or allocated through a cost allocation plan or cost pool) paid by the County.

For guidance on testing the County JFS Schedule of Federal Awards Expenditures (SFAE), auditors should refer to the 'County JFS SFAE Testing Spreadsheet' (separately posted). While the CR 504 CFDA report is a good starting point for counties to determine the expenditures to be reported on the SFAE, there are some programs or parts of program that are not reflected in either of these reports. The spreadsheet provides program specific information for testing the SFAE.

Per ODJFS, all grants are reported on a cash basis and should be presented likewise on the SFAE.

To ensure expenditures are reported accurately by CFDA#, auditors should also determine how multi-agency contract expenditures are recorded on the schedule of federal awards expenditures.

The local government should report federal expenditures for CFDA #93.775, 93.777, 93.778. A-133.310(b)(2) requires including pass-through numbers (if any) on the Schedule. Counties should report the subgrant agreement number (i.e. G-1011-11-5006) as the pass through number and roll the grants up in total by CFDA. Please note there may be two subgrant agreements in place for the calendar year. If that is the case then report both numbers (i.e. G-1011-11-5006 / G-1011-11-5007).

Grant Title	CFDA number	Pass through number	Expenditures
Medicaid Cluster Program (list program individually within cluster w/ applicable CFDA #)	#93.775, 93.777, 93.778	G-1011-11-5006 / G-1011-11-5007	\$XXX,XXX

(5.) Information systems, including a description on how they operate (i.e. CRIS-E, CFIS Web, PET)

Computer Systems

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

- CRIS-E - 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) January 1, 2008 County JFS finance offices began using CFIS which drives the financial reporting (Forms 2827, 2750, and 2820, RMS activity, etc.). 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. Most information flows from the county system through CFIS and up to OAKS with

Medicaid Part II

ODJFS Specific Information

the exception of draw information. Each grant is coded separately. ODJFS has a spreadsheet for coding in CFIS. ODJFS updates this information each year.

ISA 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 2014.

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, such as PET (Maximus Program). The State Region does not look at PET (or similar programs). Auditors will need to test the information in the PET system to the amounts recorded in the County Auditor's records for accuracy.
- Maximus notified several counties in 2013 that it would remove the PET system from its business line. ODJFS has responded to this decision by developing a Ledger Reporting solution to replace the PET system and it will be a new module in CFIS Web and available for all ODJFS subrecipients. This change will not impact any of our 2014 audits. Please see BCFTA update at http://jfs.ohio.gov/ofs/bcfta/BB/2014011314_-BCFTAUpdateCountyLedgerSystem.stm for further information. In a correspondence with ODJFS on 3/3/14 we were told that the time line has changed to a January 1, 2015 implementation with Oct-Dec 2014 being the testing quarter, additionally Maximus indicated it will continue to support the PET system until Dec 2014.
- With the implementation of CFIS Web, ODJFS has developed a new process to replace the function of the Configuration File. The new process is called "Adjustment to a Prior Period Allocated and Approved Expenditure" or APAA. Agencies will utilize this process in instances where an adjustment needs to occur and direct coding is not available (i.e. audit, 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 dated 2/28/13 for further information <http://jfs.ohio.gov/ofs/bcfta/BB/20130228-BCFTA-Update-2013-17-APAA.stm>.

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, 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."

PART III

A. Activities Allowed or Unallowed

OMB Compliance Requirements

Compliance Requirements

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 contract or grant agreements pertaining to the program. This type of compliance requirement specifies the activities that can or cannot be funded under a specific program.

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 225's allowable cost guidelines. 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 225 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 2 CFR 225 to determine if pension costs (an object cost classification) are permissible. (2 CFR 225, Appendix B states they are allowable, with restrictions, so we would need to determine if the auditee met the restrictions.) Both the client and we should look at 2 CFR 225 even if the grant agreement includes a budget by object code approved by the grantor agency.

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.

OMB Specific Information

1. Funds can be used only for Medicaid benefit payments (as specified in the State plan, Federal regulations, or an approved waiver), expenditures for administration and training, expenditures for the State Survey and Certification Program, and expenditures for State Medicaid Fraud Control Units (42 CFR sections 435.10, 440.210, 440.220, and 440.180).
2. *Case Management Services* - The State plan may provide for case management services as an optional medical assistance service. The term 'case management services' means services that will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

Medicaid case management services are divided into two separate categories:

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

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

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

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

PART III

A. Activities Allowed or Unallowed

OMB Compliance Requirements

3. *Managed Care* - A State may obtain a waiver of statutory requirements in order to develop a system that more effectively addresses the health care needs of its population. For example, a waiver may involve the use of a program of managed care for selected elements of the client population or allow the use of program funds to serve specified populations that would be otherwise ineligible (Section 1115 of the Social Security Act (42 USC 1315)). Managed care providers must be eligible to participate in the program at the time services are rendered, payments to managed care plans should only be for eligible clients for the proper period, and the capitation payment should be properly calculated. Medicaid medical services payments (e.g., hospital and doctors charges) should not be made for services that are covered by managed care. States should ensure that capitated payments to providers are discontinued when a beneficiary is no longer enrolled for services.
4. *Medicaid Health Insurance Premiums* - A State may enroll certain Medicare-eligible recipients under Medicare Part B and pay the premium, deductibles, cost sharing, and other charges (42 CFR section 431.625).
5. *Disproportionate Share Hospital* - Federal financial participation is available for aggregate payments to hospitals that serve a disproportionate number of low-income patients with special needs. The State plan must specifically define a disproportionate share hospital and the method of calculating the rate for these hospitals. Specific limits for the total disproportionate share hospital payments for the State and the individual hospitals are contained in the legislation (42 USC 1396r-4)..
6. *Home and Community-Based Services* - A State may obtain a waiver of statutory requirements to provide an array of home and community-based services which may permit an individual to avoid institutionalization (42 CFR part 441, subpart G). The HHS OIG has issued a special fraud alert concerning home health care. Problems noted include cost report frauds, billing for excessive services or services not rendered, and use of unlicensed staff. The full alert was published in the *Federal Register* on August 10, 1995, (page 40847) and is available from the HHS OIG home page, Special Fraud Alerts section (<http://oig.hhs.gov/fraud/fraudalerts.asp>).
7. Medicare Part B Buy-In - 42 CFR section 431.625(d)(1) and CMS Medicaid Manual - State Buy-in (Pub24) Sections 110 and 180 specify that Federal Financial Participation (FFP) is not available for States buy-in for non-cash Medical Assistance Only groups, e.g. the special income level group or the medically needy. FFP is available only for those individuals who are considered as some class of cash recipients or deemed to be a cash recipient or one of the Medicare Savings Program (MSP) groups.
8. Electronic Health Records (EHR) – States participating in the EHR incentive program can receive 90 percent FFP for approved processes, systems, and activities necessary to ensure the EHR incentive payments are being properly made (Section 1903t of the Social Security Act, as amended by Section 4201 of the Health Information Technology for Economic and Clinical Health (HITECH) Act(42 USC 1396b)).

PART III

A. Activities Allowed or Unallowed

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 Child Support Random Moment Sample (RMS) Time Study
 - See FAPMTL No. 229 (eff 12/29/11) at <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=FAPMTL229>
- OAC 5101:9-7-20 Income Maintenance, Workforce, Social Services, and Child Welfare Random Moment Sample (RMS) Time Studies
 - See FAPMTL No. 248 (eff 6/11/12) at <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=FAPMTL248>

See also BCFTA Web WebRMS reports at http://jfs.ohio.gov/ofs/bcfta/TOOLS/Regional-Quarterly-Meeting/Jul-Sept-2011/WebRMS_ReportList.pdf also <http://jfs.ohio.gov/ofs/bcfta/TOOLS/RMS/RMSTADocument.pdf> and the desk guide at <http://jfs.ohio.gov/ofs/bcfta/TOOLS/RMS/RMSDeskGuide.pdf> . The Web RMS user manual was updated December 2013 and is available here http://jfs.ohio.gov/ofs/bcfta/TOOLS/RMS/RMS_UserManual.stm.

The Ohio Department of Medicaid received federal clarification of activities that are allowable for 75% FFP versus activities that are allowable for 50% FFP, therefore BCFTA has revised RMS activity codes 200 and 208. See BCFTA update 2015-03 (dated 11/24/14) for further information at http://jfs.ohio.gov/ofs/bcfta/BB/BCFTA_updateMedicaidRMS_Coding2015_03.stm .

The RMS 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 the staff rosters (FTE reporting) submitted by the county RMS coordinators and determines the sampling times. 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:

Medicaid, CFDA 93.775 / 93.777 / 93.778

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PART III

A. Activities Allowed or Unallowed

ODJFS Compliance Requirements

RMS Type	Agency Size	# of Observations
Income Maintenance (IMRMS)	Metro	Minimum of 2,300
Income Maintenance (IMRMS)	Suburban & Rural	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)		Minimum of 354

AOS Additional Testing Considerations

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:

- PRC direct expenses
- OWF direct expenses
- Administrative expenses
- FTE/RMS/Cost pools

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

Beginning July 1, 2013, ODJFS and MCD partnered on the Medicaid Integrated Eligibility Project. Only select counties participated in this project. Counties selected to participate were reimbursed for staff time and travel costs. Staff participating in the project were not RMS participants at the county level. See FAPL 44 for details on staff cost allocations for reimbursements <http://jfs.ohio.gov/ofs/bcfta/BB/20130626-BCFTA-Update-2013-24-SFY-14-Medicaid-and-IM-Changes.stm>.

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.

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, CCBG	Public Assistance (PA) Fund	IMRMS / SSRMS

PART III

A. Activities Allowed or Unallowed

ODJFS Compliance Requirements

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 titled CR520 reports, they will however, 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. The FTE reporting and RMS testing is included in the audit program file due to its impact on the allocation of expenditures.

Auditors can determine population for RMS testing from a summary report for the quarter on CFIS that uploads from 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 EPSDT (non-NET contract) activities. Auditors should review this plan when testing EPSDT expenditures.

PART III

B. Allowable Costs/Cost Principles OMB Compliance Requirements

Applicability of OMB Cost Principles Circular

The following OMB cost principle circular prescribes the cost accounting policies associated with the administration of Federal awards by States, local governments, and Indian tribal governments (State rules for expenditures of State funds apply for block grants authorized by the Omnibus Budget Reconciliation Act of 1981 and for other programs specified in Appendix I). Federal awards administered by publicly-owned hospitals and other providers of medical care are exempt from OMB's cost principles circulars, but are subject to requirements promulgated by the sponsoring Federal agencies (e.g., the Department of Health and Human Services 45 CFR, part 74, Appendix E). 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 Government or indirectly through a pass-through entity. The circular describes selected cost items, allowable and unallowable costs, and standard methodologies for calculating indirect costs rates (e.g., methodologies used to recover facilities and administrative costs (F&A) at institutions of higher education). Federal awards include Federal programs and cost-type contracts and may be in the form of grants, contracts, and other agreements.

Source of Governing Requirements

The requirements for allowable costs/cost principles are contained in the A-102 Common Rule (§____.22) (**45 CFR part 92**), program legislation, Federal awarding agency regulations, and the terms and conditions of the award.

The applicable cost principle circular is:

- **OMB Circular A-87, 'Cost Principles for State, Local and Indian Tribal Governments' (2 CFR part 225).**

Although this cost principle circular has been reissued in Title 2 of the CFR for ease of access, the OMB Circular A-133 Compliance Supplement refers to it by the circular title and numbering. However, auditors should use the authoritative reference of 2 CFR Part 225 ... when citing noncompliance.

Note: This FACCR is designed for County Governments (based on the requirements of OMB Circular A-87). It is not intended for use when performing a Single Audit for a Higher Educational Institution or a Non-Profit Organization.

Important Note: For a cost to be allowable, it must (1) be for a purpose the specific award permits and (2) fall within A-87's (codified in 2 CFR Part 225) allowable cost guidelines. 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 225 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 2 CFR Part 225 to determine if pension costs (an object cost classification) are permissible. (2 CFR Part 225, Appendix B states they are allowable, with restrictions, so we would need to determine if the auditee met the restrictions.) Both the client and we should look at 2 CFR Part 225 even if the grant agreement includes a budget by object code approved by the grantor agency.

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

end of Part B to this FACCR, lists the treatment of the selected costs items in the circular.

OMB CIRCULAR A-87COST PRINCIPLES FOR STATE, LOCAL, AND INDIAN TRIBAL GOVERNMENTS

Introduction

OMB Circular A-87 (A-87) establishes principles and standards for determining allowable direct and indirect costs for Federal awards. This section is organized into the following areas of allowable costs: State/Local-Wide Central Service Costs; State/Local Department or Agency Costs (Direct and Indirect); and State Public Assistance Agency Costs.

Cognizant Agency

A-87, Attachment A, paragraph B.6. defines 'cognizant agency' as the Federal agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed under A-87 on behalf of all Federal agencies. OMB publishes a listing of cognizant agencies (*Federal Register*, 51 FR 552, January 6, 1986). This listing is available at http://www.whitehouse.gov/sites/default/files/omb/assets/financial_pdf/fr-notice_cost_negotiation_010686.pdf. References to cognizant agency in this section should not be confused with the cognizant Federal agency for audit responsibilities, which is defined in OMB Circular A-133, Subpart D. §____.400(a).

Availability of Other Information

Additional information on cost allocation plans and indirect cost rates is found in the Department of Health and Human Services (HHS) publications: *A Guide for State, Local and Indian Tribal Governments* (ASMB C-10); *Review Guide for State and Local Governments State/Local-Wide Central Service Cost Allocation Plans and Indirect Cost Rates*; and the *DCA Best Practices Manual for Reviewing Public Assistance Cost Allocation Plans* which are available at <https://rates.psc.gov/fms/dca/revisedslguide.pdf> , <https://rates.psc.gov/fms/dca/PA%20BPM.pdf> and <https://rates.psc.gov/fms/dca/revisedslguide.pdf> , respectively. , respectively.

OMB Specific Information

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

1. States must have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Such third-party resources should be exhausted prior to paying claims with program funds. Where a third-party liability is established after the claim is paid, reimbursement from the third party should be sought (42 USC 1396K; 42 CFR sections 433.135 through 433.154).
2. The State is required to credit the Medicaid program for (1) State warrants that are canceled and uncashed checks beyond 180 days of issuance (escheated warrants) and (2) overpayments made to providers of medical services within specified time frames (42 CFR sections 433.300 through 433.320, and 433.40).
Under Section 6506 of the Affordable Care Act (42 USC 1396b(d)(2)), States now have up to 1 year (rather than 60 days) from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment. Except in the case of overpayments resulting from fraud , the adjustment to refund the Federal share must be made no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the 1-year period ends, regardless of whether the State recovers the overpayment.
3. Before calculating the amount of Federal financial participation, certain revenues received by a State will be deducted from the State's medical assistance expenditures. The revenues to be deducted are (1) donations made by health providers and entities related to providers (except for

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

bona fide donations and, subject to a limitation, donations made by providers for the direct costs of out-stationed eligibility workers); and (2) impermissible health care-related taxes that exceed a specified limit

(42 USC 1396b(w); 42 CFR section 433.57).

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

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

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

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

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

Allowable Costs - State/Local-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-wide central service cost allocation plan (CAP) provides that process. (Refer to A-87, Attachment C, State/Local-Wide Central Service Cost Allocation Plans, 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-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-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.

Compliance Requirements - State/Local-Wide Central Service Costs

1. Basic Guidelines

- a. The basic guidelines affecting allowability of costs (direct and indirect) are identified in A-87, Attachment A, paragraph C.
- b. To be allowable under Federal awards, costs must meet the following general criteria (A-87, Attachment A, paragraph C.1):
 1. Be necessary and reasonable for the performance and administration of Federal awards. (Refer to A-87, Attachment A, paragraph C.2 for additional information on reasonableness of costs.)
 2. Be allocable to Federal awards under the provisions of A-87. (Refer to A-87, Attachment A, paragraph C.3 for additional information on allocable costs.)
 3. Be authorized or not prohibited under State or local laws or regulations.
 4. Conform to any limitations or exclusions set forth in A-87, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
 5. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
 6. 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.

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B. Allowable Costs/Cost Principles

OMB Compliance Requirements

7. Be determined in accordance with generally accepted accounting principles, except as otherwise provided in A-87.
8. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award, except as specifically provided by Federal law or regulation.
9. Be net of all applicable credits. (Refer to A-87, Attachment A, paragraph C.4 for additional information on applicable credits.)
10. Be adequately documented.

2. *Selected Items of Cost*

- a. Sections 1 through 43 of A-87, Attachment B, provide the principles to be applied in establishing the allowability or unallowability of certain items of cost. (For a listing of costs, refer to Exhibit 1 of this part of the Supplement.) These principles apply whether a cost is treated as direct or indirect. Failure to mention a particular item of cost in this section of A-87 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 or standards provided for similar or related items of cost.
- b. A cost is allowable for Federal reimbursement only to the extent of benefits received by Federal awards and its conformance with the general policies and principles stated in A-87, Attachment A.

3. *Submission Requirements*

- a. Submission requirements are identified in A-87, Attachment C, paragraph D.
- b. 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.
- c. A local government that has been designated as a 'major local government' by OMB is required to submit a central service CAP to its cognizant agency annually. This listing is posted on the OMB website (<http://www.whitehouse.gov/omb/management>). All other local governments claiming central service costs must develop a CAP in accordance with the requirements described in A-87 and maintain the plan and related supporting documentation for audit. Local governments are not required to submit the plan for Federal approval unless they are specifically requested to do so by the cognizant agency. If a local government receives funds as a subrecipient only, the primary recipient will be responsible for negotiating and/or monitoring the local government's plan.
- d. 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.

4. *Documentation Requirements*

- a. 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.
- b. The documentation requirements for all central service CAPs are contained in A-87, Attachment C, 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 the A-102 Common Rule (45 CFR part 92).

5. *Required Certification* - No proposal to establish a central service CAP, whether submitted to a Federal cognizant agency or maintained on file by the governmental unit, shall 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 A-87, Attachment C.

6. *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 previously approved plan or for unallowable costs that must be reimbursed immediately (A-87, Attachment C, paragraph G.3).

7. *Billed Central Service Costs (Section II Costs)*

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

- a. Internal service funds for central service activities are allowed a working capital reserve of up to 60 days cash expenses for normal operating purposes (A-87, Attachment C, paragraph G.2). A working capital reserve exceeding 60 days may be approved by the cognizant Federal agency in exceptional cases.
- b. 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 (A-87, Attachment C, paragraph G.4). The adjustments will be made through one of the following methods:
 - 1. A cash refund to the Federal Government for the Federal share of the adjustment, if revenue exceeds costs,
 - 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 does not exceed \$500,000.
- c. Whenever funds are transferred from a self-insurance reserve to other accounts (e.g., general fund), refunds shall be made to the Federal Government for its share of funds transferred, including earned or imputed interest from the date of transfer (A-87, Attachment B, paragraph 22).

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

Allowable Costs - State/Local Department or Agency Costs - Direct and Indirect

The individual State/local 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 A-87.

While direct costs are those that can be identified specifically with a particular final cost objective, the indirect costs are those that have been incurred for common or joint purposes, and not readily assignable to the cost objectives specifically benefited without effort disproportionate to the results achieved. Indirect costs are normally charged to Federal awards by the use of an indirect cost rate.

The indirect cost rate proposal (ICRP) provides the documentation prepared by a State/local 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 carrying out Federal awards, and (2) costs of central governmental services distributed through the State/local-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 A-87, Attachment E, paragraph B).

Compliance Requirements - State/Local Department or Agency Costs - Direct and Indirect

1. *Basic Guidelines* - Refer to the previous section, 'Allowable Costs - State/Local-Wide Central Service Costs, 1.a - Compliance Requirements-Basic Guidelines,' for the guidelines affecting the allowability of costs (direct and indirect) under Federal awards.
2. *Selected Items of Cost* - Refer to the previous section, 'Allowable Costs - State/Local-Wide Central Service Costs, 1.b - Compliance Requirements-Selected Items of Cost,' for the principles to establish allowability or unallowability of certain items of cost. These principles apply whether a cost is treated as direct or indirect.
3. *Allocation of Indirect Costs and Determination of Indirect Cost Rates*
 - a. The specific methods for allocating indirect costs and computing indirect cost rates are as follows:
 1. *Simplified Method* - This method is applicable where a governmental unit's department or agency has only one major function, or where all its major functions benefit from the indirect cost to approximately the same degree. The allocation of indirect costs and the computation of an indirect cost rate may be accomplished through simplified allocation procedures described in the circular (A-87, Attachment E, paragraph C.2).
 2. *Multiple Allocation Base Method* - This method is applicable where a governmental unit's department or agency has several major functions that benefit from its indirect costs in varying degrees. The allocation of indirect costs may require the accumulation of such costs into separate groupings which are then allocated individually to benefiting functions by means of a base which best measures the relative degree of benefit. (For detailed information, refer to A-87, Attachment E, paragraph C.3.)
 3. *Special Indirect Cost Rates* - In some instances, a single indirect cost rate for all activities of a department or agency may not be appropriate. Different factors may substantially affect the indirect costs applicable to a particular program or group of programs, e.g., the physical location of the work, the nature of the facilities, or level of administrative support required. (For the requirements for a separate indirect cost rate, refer to A-87, Attachment E, paragraph C.4.)
 4. *Cost Allocation Plans* - In certain cases, the cognizant agency may require a State or local governmental unit's department or agency to prepare a CAP instead of an ICRP.

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B. Allowable Costs/Cost Principles

OMB Compliance Requirements

These are infrequently occurring cases in which the nature of the department or agency's Federal awards makes impracticable the use of a rate to recover indirect costs. A CAP required in such cases consists of narrative descriptions of the methods the department or agency uses to allocate indirect costs to programs, awards, or other cost objectives. Like an ICRP, the CAP must be either submitted to the cognizant agency for review, negotiation and approval, or retained on file for inspection during audits.

4. *Submission Requirements*

- a. Submission requirements are identified in A-87, Attachment E, paragraph D.1. All departments or agencies of a governmental unit claiming indirect costs under Federal awards must prepare an ICRP and related documentation to support those costs.
- b. A State/local department or agency for which a cognizant Federal agency has been assigned by OMB must submit its ICRP to its cognizant agency. Smaller local government departments or agencies which are not required to submit a proposal to the cognizant Federal agency must develop an ICRP in accordance with the requirements of A-87, and maintain the proposal and related supporting documentation for audit. Where a local government receives funds as a subrecipient only, the primary recipient will be responsible for negotiating and/or monitoring the subrecipient's plan.
- c. Each Indian tribal government desiring reimbursement of indirect costs must submit its ICRP to its cognizant agency, which generally is the Department of the Interior.
- d. ICRPs must be developed (and, when required, submitted) within 6 months after the close of the governmental unit's fiscal year.

5. *Documentation and Certification Requirements*

The documentation and certification requirements for ICRPs are included in A-87, Attachment E, paragraphs D.2 and 3, respectively. The proposal and related documentation must be retained for audit in accordance with the record retention requirements contained in the A-102 Common Rule (45 CFR part 92).

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

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.

Attachment D of A-87 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 published in Subpart E of 45 CFR part 95.

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

Compliance Requirements - State Public Assistance Agency Costs

1. *Basic Guidelines* - Refer to the previous section, 'Allowable Costs - State/Local-Wide Central Service Costs, 1.a, Compliance Requirements-Basic Guidelines,' for the guidelines affecting the allowability of costs (direct and indirect) under Federal awards.
2. *Selected Items of Cost* - Refer to the previous section, 'Allowable Costs - State/Local-Wide Central Service Costs 1.b, Compliance Requirements-Selected Items of Cost,' for the principles to establish allowability or unallowability of certain items of cost. These principles apply whether a cost is treated as direct or indirect.
3. *Submission Requirements*

Unlike most State/local-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):

- a. The procedures shown in the existing cost allocation plan 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.
- b. A material defect is discovered in the cost allocation plan.
- c. The State plan for public assistance programs is amended so as to affect the allocation of costs.
- d. Other changes occur which make the allocation basis or procedures in the approved cost allocation plan invalid.

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

4. *Documentation Requirements* - A State must claim Federal financial participation for costs associated with a program only in accordance with its approved cost allocation plan. The public assistance CAP requirements are contained in 45 CFR section 95.507.
5. *Implementation of Approved Public Assistance CAPs* - Since public assistance CAPs are of a narrative nature, the Federal Government needs assurance that the cost allocation plan has been implemented as approved. This is accomplished by funding agencies' reviews, single audits, or audits conducted by the cognizant audit agency (A-87, Attachment D, paragraph E.1).

PART III

B. Allowable Costs/Cost Principles

ODJFS Compliance Requirements

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

As noted in the Guided Self Assessment (GSA), 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 (OMB Circular A-87 / 2 CFR 225). 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, 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, 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 arms length transactions (see example rent issue discussed below).

As noted in the ODJFS GSA, County family services agencies are not authorized under Ohio law to 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 OMB Circular A-87, Attachment B, item 37. 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 2 CFR 225 (OMB Circular A-87). As the county family services agency and the board of county

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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 2 CFR 225, and the excessive amount would not be an allowable cost to federal programs.

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

See also OAC 5101:9-4-11 (eff. 2-17-12) Rental Costs and Lease Agreements for the rule governing this requirement. This rule is also referred to in FACCR Section F - Equipment and Real Property Management.

Note: ORC329.44 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 non-ARRA boiler plate 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 2 CFR 225, Appendix B, Section 15 (b) (1).

OAC 5101:9-1-15 (eff. 1-30-09) states the expenditure of funds received by grantees of federal funds and their subrecipients must follow cost principles established in 2 C.F.R. part 225 and be in accordance with state and local requirements. Where federal, state, or local requirements differ, the most restrictive shall apply. Part (H) of this section lists selected items of costs where there is more restrictive policy based on Ohio law and/or where policy clarifications have been received.

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OMB Compliance Requirements

ICRP (Testing of the Program)

The ICRP is based upon costs charged to cost pools representing costs of a base year. The base year often precedes the year in which the ICRP is prepared and the year the resulting Indirect Cost Rate Agreement (IDCRA) is used to charge indirect costs. For example, a non-federal entity may submit an ICRP in January 2013, based upon costs incurred and charged to cost pools during fiscal year ending June 30, 2012 (2012), the base year. The resulting IDCRA negotiated during year ending June 30, 2013 (2013) would be used as the basis for charging indirect costs to federal awards in the year ended June 30, 2014 (2014). For this example, the term IDCRA will also include an ICRP which is not required to be submitted to the federal agency for indirect cost negotiation but is retained on file is first used to charge indirect costs to federal awards the same as an approved plan resulting in an IDCRA.

An audit timing consideration is that the audit for 2012 (which covers the applicable cost pools) may be completed before the ICRP is submitted. Therefore, as part of the audit, the auditor cannot complete testing of the ICRP. Also, if the auditor waits to test the ICRP until 2014 (the year when this ICRP is first used to charge federal awards), the auditor would be testing 2012 records which would then be two years old.

Continuing this example, when the IDCRA is the basis of material charges to a major program in 2014, the auditor for 2014 is required to obtain appropriate assurance that the costs collected in the cost pools and allocation methods are in compliance with 2 CFR 225 cost principles. The following are some acceptable options the auditor may use to obtain this assurance.

- Perform interim testing of the costs charged to cost pools (e.g., determine from management the cost pools that management expects to include the ICRP and test the costs charged to those pools for compliance with the cost principles of 2 CFR 225 during the 2012 audit. As part of the 2013 audit, complete testing and verify management's representation against the ICRP finally submitted in 2013.
- Test costs charged to the cost pools underlying the ICRP during the audit of 2013, the year immediately following the base year. This would require testing of 2012 transactions.
- Wait until 2014, the year in which charges from the IDCRA are material to a major program and test costs charged to cost pools (2012) used to prepare the ICRP. This is a much more difficult approach because it requires going back two years to audit the cost charged to cost pools of the base year.

Advantages of the first two methods are that the testing of the costs charged to the cost pools occurs closer to the time when the transactions occur (which makes audit exceptions easier to resolve). When material indirect costs are charged to any Type A program (determined in accordance with Circular A-133), auditors are strongly encouraged to use one of the first two methods. This is because under the risk-based approach, described in OMB Circular A-133, all Type A programs are required to be considered major programs at least in every three years and the IDCRA is usually used to charge federal awards for at least three years.

When the government submits an IDCRA, the government provides written assurance to the federal government that the plan includes only allowable costs. Accordingly, any material unallowable costs reflected in the ICRP should be reported as an audit finding in the year in which they are first found by audit.

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

An ICRP may result in an IDCRA that covers one year, but most often results in a multi-year IDCRA. When an ICRP has been tested in an prior year and this testing provides the auditor appropriate audit assurance, in subsequent years the auditor is only required to perform tests to ascertain if there have been material changes to the cost accounting practices and, if so, that the federal cognizant agency for indirect cost negotiation has been informed.

The auditor should take appropriate steps to coordinate testing of costs charges to cost pools supporting an ICRP with the client and, as appropriate, with the federal cognizant agency for indirect cost negotiation.

The auditor should consult with the client in the base year and the year in which the ICRP is submitted to determine the best (e.g., most efficient) alternative under the circumstances.

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

LIST OF SELECTED ITEMS OF COST CONTAINED IN 2 CFR 225 (codified OMB Circular A-87) (Effective August 31, 2005)

The following exhibit provides an updated listing of selected items of costs contained in 2 CFR 225 based on the changes contained in the *Federal Register* notice dated August 31, 2005. This is available at the following link:

http://www.whitehouse.gov/omb/fedreg/2005/083105_a87.pdf.

This exhibit lists the selected items of costs along with a cursory description of its allowability. The numbers in parentheses refer to the cost item in Appendix B of 2 CFR 225. The reader is strongly cautioned not to rely exclusively on this summary exhibit but to place primary reliance on the reference circular text. There are also cost items listed auditors may identify in the testing that are not specifically addressed in the CFR.

Selected Items of Cost	
Exhibit 1	
Selected Cost Item	2 CFR 225, Appendix B State, Local, & Indian Tribal Governments
Advertising and public relation costs	(1) – Allowable with restrictions
Advisory councils	(2) – Allowable with restrictions
Alcoholic beverages	(3) – Unallowable
Alumni/ae activities	Not specifically addressed
Audit costs and related services	(4) – Allowable with restrictions and as addressed in OMB Circular A-133
Bad debts	(5) – Unallowable
Bonding costs	(6) – Allowable with restrictions
Commencement and convocation costs	Not specifically addressed
Communication costs	(7) – Allowable
Compensation for personal services	(8) – Unique criteria for support
Compensation for personal services – organization furnished automobile	Not specifically addressed
Compensation for personal services - sabbatical leave costs	Not specifically addressed
Compensation for personal services - severance pay	(8)(g) - Allowable with restrictions
Contingency provisions	(9) – Unallowable with exceptions
Deans of faculty and graduate schools	Not specifically addressed
Defense and prosecution of criminal and civil proceedings	(10) – Allowable with restrictions
Depreciation and use allowances	(11) – Allowable with qualifications
Donations and contributions	(12) – Unallowable (made by recipient); not reimbursable but value may be used as cost sharing or matching (made to recipient)
Employee morale, health, and welfare costs	(13) – Allowable with restrictions
Entertainment costs	(14) – Unallowable
Equipment and other capital expenditures	(15) – Allowability based on specific requirements

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

Fines and penalties	(16) – Unallowable with exceptions
Fundraising and investment management costs	(17) – Unallowable with restrictions
Gains and losses depreciable assets	(18) – Allowable with restrictions (Gains and losses on disposition of depreciable property and other capital assets and substantial relocation of Federal programs)
General government expenses	(19) – Unallowable with exceptions
Goods or services for personal use	(20) – Unallowable
Housing and personal living expenses	Not specifically addressed
Idle facilities and idle capacity	(21) – Idle facilities - unallowable with exceptions; idle capacity - allowable with restrictions
Insurance and indemnification	(22) – Allowable with restrictions
Interest	(23) – Allowable with restrictions
Interest - substantial relocation	Not specifically addressed
Labor Relations Costs	Not specifically addressed
Lobbying	(24)-Unallowable
Lobbying - executive lobbying costs	(24.b.) – Unallowable
Losses on other sponsored agreements or contracts	Not specifically addressed (<i>Unallowable</i>)
Maintenance, operations and repairs	(25) – Allowable with restrictions (Maintenance, operations, and repairs)
Materials and supplies costs	(26) – Allowable with restrictions
Meetings and conferences	(27) – Allowable with restrictions
Memberships, subscriptions, and professional activity costs	(28) – Allowable as a direct cost for civic, community and social organizations with Federal approval; unallowable for lobbying organizations
Organizational costs	Not specifically addressed
Page charges in professional journals	(34.b)-Allowable with restrictions (addressed under “Publication and printing costs”)
Participant support costs	Not specifically addressed
Patent costs	(29) – Allowable with restrictions
Pension plans	(8e) – Allowable with restrictions
Plant and homeland security costs	(30) – Allowable with restrictions
Pre-award costs	(31) – Allowable with restrictions (Pre-award costs)
Professional services costs	(32) – Allowable with restrictions
Proposal costs	(33) – Allowable with restrictions
Publication and printing costs	(34) – Allowable with restrictions
Rearrangement and alteration costs	(35) – Allowable (ordinary and normal); Allowable with Federal prior approval (special)
Reconversion costs	(36) – Allowable with restrictions
Recruiting costs	(1.c.(1)) – Allowable with restrictions (addresses costs of advertising only)
Relocation costs	Not specifically addressed

PART III

B. Allowable Costs/Cost Principles

OMB Compliance Requirements

Rental cost of buildings and equipment	(37) – Allowable with restrictions
Royalties and other costs for use of patents	(38) – Allowable with restrictions
Scholarship and student aid costs	Not specifically addressed
Selling and marketing costs	(39) – Unallowable with exceptions
Specialized service facilities	Not specifically addressed
Student activity costs	Not specifically addressed
Taxes	(40) – Allowable with restrictions
Termination costs applicable to sponsored agreements	(41) – Allowable with restrictions
Training costs	(42) – Allowable for employee development
Transportation costs	Not specifically addressed
Travel costs	(43) – Allowable with restrictions
Trustees	Not specifically addressed

PART III

C. Cash Management

OMB Compliance Requirements

Compliance Requirements

When awards provide for advance payments, recipient must follow procedures to minimize the time elapsing between the transfer of funds from the U.S. Treasury and disbursement and establish similar procedures for subrecipients. Pass-through entities must establish reasonable procedures to ensure receipt of reports on subrecipients' cash balances and cash disbursements in sufficient time to enable the pass-through entities to submit complete and accurate cash transactions reports to the Federal awarding agency or pass-through entity. Pass-through entities must monitor cash drawdowns by their subrecipients to ensure that subrecipients conform substantially to the same standards of timing and amount as apply to the pass-through entity.

U.S. department of the Treasury (Treasury) regulations at 31 CFR part 205, which implement the Cash Management Improvement Act of 1990 (CMIA), as amended (Pub. L. 101-453; 31 USC 6501 *et seq.*), require State recipients to enter into agreements that prescribe specific methods of drawing down Federal funds (funding techniques) for selected large programs. The agreements also specify the terms and conditions under which an interest liability would be incurred. Programs not covered by a Treasury-State Agreement are subject to procedures prescribed by Treasury is Subpart B of 31 CFR part 205 (Subpart B).

Except for interest earned on advances of funds exempt under the Intergovernmental Cooperation Act (31 USC 6501 *et seq.*) and the Indian Self-Determination Act (23 USC 450), interest earned by local government and Indian tribal government grantees and subgrantees on advances is required to be submitted promptly, but at least quarterly, to the Federal agency. Up to \$100 per year may be kept for administrative expenses. Interest earned by non-State non-profit entities on Federal fund balances in excess of \$250, regardless of the funding agency, is required to be remitted to Department of Health and Human Services, Payment Management System, P.O. Box 6021, Rockville, MD 20852.

When entities are funded on a reimbursement basis, program costs must be paid for by entity funds before reimbursement is requested from the Federal Government.

Note: Violations of cash management rules alone generally should not result in a questioned cost unless the entity spent the interest earnings related to the excess grant cash balances on hand throughout the year (these monies would be payable back to the pass-through/federal agency). Further, the interest earnings expended must exceed \$10,000 in a single major program to be a questioned cost. (Source: AOS CFAE)

Source of Governing Requirements

The requirements for cash management are contained in the A-102 Common Rule (§____.21) (45 CFR part 92), Treasury regulations at 31 CFR part 205, program legislation, Federal awarding agency regulations, and the terms and conditions of the award.

Availability of Other Information

Treasury's Bureau of the Fiscal Service maintains a Cash Management Improvement Act web page (<http://www.fms.treas.gov/cmia/>).

PART III

C. Cash Management

ODJFS Compliance Requirements

Please note: NET, PRS and Healthchek are NOT on a reimbursement basis. These are also on an advance basis like other Medicaid programs.

Therefore, all County Medicaid funding is on an advance basis.

Subgrant Agreement, Article V. Amount of Grant/Payments, Section B indicates the “SUBGRANTEE will limit cash draws from ODJFS to the minimum amount needed for actual, immediate requirements in accordance with Cash Management Improvement Act, 31 CFR Part 205, 45 CFR Parts 74 and 92, 7 CFR Part 3016, Transmittal No. TANF-ACF-PI-01-02 issued by the United States Department of Health and Human Services, and ODJFS requirements including Chapter 7 (OAC 5101:9-7-03) of the Fiscal Administrative Procedures Manual.”

OAC 5101:9-7-03 Public assistance (PA) financing and cash management is the State rule for cash management. The rule can be found in chapter 7 of the Fiscal Administrative Procedures Manual, which is available <http://emanuals.odjfs.state.oh.us/emanuals/> .

For federal references see [7 CFR 3016](#), [45 CFR 92.20](#) (Part 74 is for Higher Ed) and [31 CFR 205](#) or here [CFR lookup](#) (select year 2013 if using the CFR lookup).

The requirements for cash management for the Department of Health and Human Services are contained in **45 CFR 92.20**, as follows:

Cash management. Procedures for minimizing the time elapsing between the transfer of funds from the U.S. Treasury and disbursement by grantees and subgrantees must be followed whenever advance payment procedures are used. Grantees must establish reasonable procedures to ensure the receipt of reports on subgrantees' cash balances and cash disbursements in sufficient time to enable them to prepare complete and accurate cash transactions reports to the awarding agency. When advances are made by letter-of-credit or electronic transfer of funds methods, the grantee must make drawdowns as close as possible to the time of making disbursements. Grantees must monitor cash drawdowns by their subgrantees to assure that they conform substantially to the same standards of timing and amount as apply to advances to the grantees.

See also Section L (Reporting). Funding is based on expenditures but is not on a reimbursement basis.

PART III

G. MATCHING, LEVEL OF EFFORT, EARMARKING

OMB Compliance Requirements

Compliance Requirements

The OMB Compliance requirements are either tested by the State Region or not applicable per ODJFS; however, there are ODJFS matching requirements. County/District JFS costs of administering the program are part of the state cost allocation plan and mandated share. If the County/District needs more, they have to show a match is available.

The specific requirements for matching, level of effort, and earmarking are unique to each Federal program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program.

However, for matching, the A-102 Common Rule (§ _____.24) (codified in 45 CFR 92) provide 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 federally-assisted project or program, unless specifically allowed by Federal program laws and regulations.
- Are necessary and reasonable for proper and efficient accomplishment of project or program objectives.
- Are allowed under the applicable cost principles.
- Are not paid by the Federal Government under another award, except where authorized by Federal statute to be allowable for cost sharing or matching.
- Are provided for in the approved budget when required by the Federal awarding agency.
- Conform to other applicable provisions of the A-102 Common Rule and OMB Circular A-110 and the laws, regulations, and provisions of contract or grant agreements applicable to the program.

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* - Not Applicable
3. *Earmarking* - Not Applicable

Source of Governing Requirements

The requirements for matching are contained in the A-102 Common Rule (§ _____.24) (codified under 45 CFR part 92), 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.

OMB Specific Information

Matching - This OMB requirement will be tested by the State Region. See ODJFS compliance requirements below.

The State is required to pay part of the costs of providing health care to the poor and part of the costs of administering the program. Different State participation rates apply to medical assistance payments. There are also different Federal financial participation rates for the different types of costs incurred in administering the Medicaid program, such as administration (including administration of family planning services), training, Medicaid, CFDA 93.775 / 93.777 / 93.778

PART III

G. MATCHING, LEVEL OF EFFORT, EARMARKING

OMB Compliance Requirements

computer, and other costs (42 CFR sections 433.10 and 433.15). The auditor should refer to the State plan for the matching rates.

Level of Effort

A State waiver may contain a level of effort requirement. **Per ODJFS, there are no County level of effort requirements**

Earmarking

A State waiver may contain an earmarking requirement. **Per ODJFS, there are no County earmarking requirements.**

PART III

G. MATCHING, LEVEL OF EFFORT, EARMARKING

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. 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 50% 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.

PART III

H. Period of Availability of Federal Funds

OMB Compliance Requirements

Federal awards may specify a time period during which the non-Federal entity may use the Federal funds. Where a funding period is specified, a non-Federal entity may charge to the award only costs resulting from obligations incurred during the funding period and any pre-award costs authorized by the Federal awarding agency. Also, if authorized by the Federal program, unobligated balances may be carried over and charged for obligations of a subsequent funding period. Obligations means the amounts of orders placed, contracts and subgrants awarded, goods and services received, and similar transactions during a given period that will require payment by the non-Federal entity during the same or a future period (A-102 Common Rule, § ____.23 (45 CFR part 92)).

Non-Federal entities shall liquidate all obligations incurred under the award not later than 90 days after the end of the funding period (or as specified in a program regulation). The Federal agency may extend this deadline upon request (A-102 Common Rule, § ____.23 (45 CFR part 92)).

An example used by a program to determine when an obligation occurs (is made) is found under Part 4, Department of Education, CFDA 84.000 (Cross-Cutting Section).

Source of Governing Requirements

The requirements for period of availability of Federal funds are contained in the A-102 Common Rule (§ ____.23 (45 CFR part 92)), program legislation Federal awarding agency regulations, and the terms and conditions of the award.

Definition of Obligation - An obligation is not necessarily a liability in accordance with generally accepted accounting principles. When an obligation occurs (is made) depends on the type of property or services that the obligation is for (34 CFR section 76.707) (OMB Circular A-133 Compliance Supplement, Part 4, Department of Education Cross-Cutting –is referred to in Part 3 as an example for all federal agencies):

IF AN OBLIGATION IS FOR --	THE OBLIGATION IS MADE --
(a) Acquisition of real or personal property.	On the date on which the State or subgrantee makes a binding written commitment to acquire the property.
(b) Personal services by an employee of the State or subgrantee.	When the services are performed.
(c) Personal services by a contractor who is not an employee of the State or subgrantee.	On the date on which the State or subgrantee makes a binding written commitment to obtain the services.
(d) Performance of work other than personal services.	On the date on which the State or subgrantee makes a binding written commitment to obtain the work.
(e) Public utility services.	When the State or subgrantee receives the services.
(f) Travel.	When the travel is taken.
(g) Rental of real or personal property.	When the State or subgrantee uses the property.
(h) A pre-agreement cost that was properly approved by the State under the applicable cost principles.	On the first day of the subgrant period.

The act of an SEA or other grantee awarding Federal funds to an LEA or other eligible entity within a State does not constitute an obligation for the purposes of this compliance requirement. An SEA or other grantee may not reallocate grant funds from one subrecipient to another after the period of availability.

PART III

H. Period of Availability of Federal Funds

OMB Compliance Requirements

If a grantee or subgrantee uses a different accounting system or accounting principles from one year to the next, it shall demonstrate that the system or principle was not improperly changed to avoid returning funds that were not timely obligated. A grantee or subgrantee may not make accounting adjustments after the period of availability in an attempt to offset audit disallowances. The disallowed costs must be refunded.

PART III

H. Period of Availability of Federal Funds

ODJFS Compliance Requirements

Agencies may occasionally have 2 grants open at the same time. (Example: Both TANF FFY 13 and TANF FFY 14 will be available during the Oct 2013 – Dec 2013 quarter.) It is important for agencies to consider the period of availability and the liquidation period of those grants, as entered into CFIS, in order to make the appropriate grant choice during this time.

Other than claims for Title XX funding, DHHS allows a State to file a claim for FFP within 2 years after the calendar quarter in which the expenditure was made (45 CFR 95.7.) See OMB Specific Information on previous page. County agencies must report those expenditures to ODJFS within 7 calendar quarters after the expenditure was made to ensure the State reports the expenditure within the time frames. (Please refer to 45 CFR 95.13 regarding how to determine when an expenditure was made.)

Per ODJFS, Federal regulations in 45 CFR 95.13 define incurred as the quarter in which a payment was made even if the payment was for a month in a previous quarter. And for depreciation – the quarter the expenditure was recorded in the accounting records.

Because of the two-year time limit, agencies have the option of posting expenditures incurred prior to 9/30/13 (and after 10/1/12) to either the FFY 13 grants or FFY 14 grants. Expenditures may be charged to a future grant (within 2 years) but cannot be charged to a grant that is past its period of availability.

- Agencies are encouraged to utilize FFY 13 allocation balances by completing a Post Allocated Adjustment (PAA) for expenditures that occurred for services as of 9/30/2013,
- Agencies may not, under any circumstances, post expenditures incurred after 9/30/12 to a FFY 13 grant. FFY 14 grants must be used for expenditures incurred on or after the beginning of the new FFY (10/1/13.)

Accessing FFY 13 Grants

- FFY 13 grants began on 10/01/2012 and are available through 9/30/2013. The liquidation period for the FFY 13 grants is 10/01/2013 – 12/31/2013; agencies may draw through Week 52 and report expenditures against this grant through the Oct – Dec reporting period.
- During the liquidation period, agencies may post expenditures for services which occurred prior to 9-30-2013 to FFY 13 grants through a Post Allocated Adjustment (PAA).
- It is important to note that when doing a PAA to access FFY 13 grants that have a match that only the FFP portion is moved through the PAA adjustment. Examples of grants that have match are IV-B, ESSA, Caseworker Visits etc.

Accessing FFY 14 Grants

- FFY 14 grants begin on 10/01/2013 are available for expenditures incurred through 9/30/2014. FFY 14 grants will have a liquidation period of 10/01/2014 – 12/31/2014; agencies may post expenditures and submit draw requests until 12/31/2014.
- Since the FFY 14 grants begin on 10/01/2013 expenditures posted via PET or CFIS Web will automatically be mapped to the FFY 14 grants.
- Agencies only need to do a PAA for those expenditures that they are opting to move to the FFY 13 grant (those incurred before 10/1/13). Again, a PAA for this purpose is not a requirement; it is an option for those with remaining FFY13 balances.

PART III

I. Procurement and Suspension and Debarment

OMB Compliance Requirements

Compliance Requirements

Procurement

States, and governmental subrecipients of States, will use the same State policies and procedures used for procurements from non-Federal funds. They also must ensure that every purchase order or other contract includes any clauses required by Federal statutes and executive orders and their implementing regulations.

All non-Federal entities shall follow Federal laws and implementing regulations applicable to procurements, as noted in Federal agency implementation of the A-102 Common Rule (45 CFR part 92).

Source of Governing Requirements-Procurement

The requirements for procurement are contained in the A-102 Common Rule (§ _____.36) (45 CFR part 92)), program legislation;, Federal awarding agency regulations, and the terms and conditions of the award. The specific references for the A-102 Common Rule (45 CFR part 92), respectively are given for each suggested audit procedure indicated below.

Suspension and Debarment

Non-Federal entities are prohibited from contracting with or making subawards under covered transactions to parties that are suspended or debarred. "Covered transactions" include those procurement contracts for goods and services awarded under a nonprocurement transaction (e.g., grant or cooperative agreement) that are expected to equal or exceed \$25,000 or meet certain other criteria as specified in 2 CFR section 180.220. All nonprocurement transactions entered into by a recipient (i.e., subawards to subrecipients), irrespective of award amount, are considered covered transactions, unless they are exempt as provided in 2 CFR section 180.215.

When a non-federal entity enters into a covered transaction with an entity at a lower tier, the non-federal entity must verify that the entity, as defined in 2 CFR section 180.995 and agency adopting regulations, is not suspended or debarred or otherwise excluded from participating in the transaction. This verification may be accomplished by (1) checking the *Excluded Parties List System (EPLS)* maintained by the General Services Administration (GSA) and available at <https://www.sam.gov/portal/public/SAM/> (note: **EPLS is no longer a separate system; however, the OMB guidance and agency implementing regulations still refer to it as EPLS**), (2) collecting a certification from the entity, or (3) adding a clause or condition to the covered transaction with that entity (2 CFR section 180.300).

Non-profit entities receiving contracts from the Federal Government are required to comply with the contract clause at Federal Acquisition Regulation (FAR) 52.209-6 before entering into a subcontract that will exceed \$30,000, other than a subcontract for a commercially available off-the-shelf item.

Source of Governing Requirements - Suspension and Debarment

The requirements for nonprocurement suspension and debarment are contained OMB guidance in 2 CFR part 180, which implements Executive Orders 12549 and 12689, Debarment and Suspension; Federal agency regulations in 2 CFR adopting the OMB guidance; the A-102 Common Rule (§ _____.36) (45 CFR part 92); program legislation; Federal awarding agency regulations; and the terms and conditions of the award. Most of the Federal agencies have adopted this guidance and relocated their associated agency rules in Title 2 of the CFR as final rules. For any agency that has not completed its adoption of 2 CFR part 180, pending completion of that adoption, agency implementations of the common rule remain in effect. Appendix II includes the current CFR citations for all agencies. In either case, the applicable requirements are specified in the terms and conditions of award.

PART III

I. Procurement and Suspension and Debarment ODJFS Compliance Requirements

See OAC 5101:9-4-02 Standards for Acquisition (eff.1-22-10).

As noted in ODJFS' Guided Self-Assessment (GSA):

45 CFR 92.36 includes procurement requirements.

Section (d) currently authorizes the use of four procurement methods. These methods are:

- Small purchase procedures;
- Sealed bids;
- Competitive proposals; and
- Noncompetitive proposals.

The federal regulation provides specific requirements as to the circumstances under which each procurement method may be used and as to the manner in which each procurement method is applied. All procurements with federal monies are to be made in accordance with one of the four approved procedures.

OAC 5101:9-4-07 (eff. 1-30-12) also includes the procurement requirements as noted below in GSA under 45 CFR 92.36. Auditors should review these requirements for specific information on the procurement methods.

OAC 5101:9-4-07.1 (eff. 1-30-12) provides a detailed procurement methods.

Auditors should review OAC 5101:9-4-07, 5101:9-4-07.1 and 45 CFR 92.36 for further detail on the procurement methods above as well as other procurement requirements. The rule updates do not change the requirements or allowable methods of procurement, but have only been formatted to provide a better understanding of the competitive and noncompetitive process. The ODJFS Guided Self-Assessment (GSA) includes specific references for 45 CFR 92.36.

See also Procurement resources available on ODJFS BCFTA Tools website at:

<http://jfs.ohio.gov/ofs/bmcs/Procurement.pdf>.

PART III

L. Reporting

OMB/ODJFS Compliance Requirements

OMB Specific Information

Financial Reporting

1. SF-269, *Financial Status Report* - Applicable for the administrative costs of the State MFCUs.
2. SF-425, *Federal Financial Report* - Applicable (cash status only).
3. CMS-64, *Quarterly Statement of Expenditures for the Medical Assistance Program (OMB No. 0938-0067)* - Required to be used in lieu of the SF-425, Federal Financial Report (for all components of the cluster other administrative costs of the State MFCUs), prepared quarterly, and submitted electronically to CMS within 30 days after the end of the quarter.

There are currently no OMB reporting requirements for Counties, the above specific OMB reporting requirements are tested at the state level.

ODJFS Specific Requirements

OAC 5101:9-7-03 and **5101:9-7-03.1**, provide guidance on the financing, cash management, and quarterly reconciliation (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 JFS 02827 codes and expenditures. Quarterly close - The PA fund is reconciled each quarter based on the final reconciliation reports.

Please note: Counties often refer to the grant reconciliation reports as the Over / Under Reports.

As the result of an internal five-year rule review and to reflect the most current funding practices available, ODJFS communicated in FAPMTL 241 (dated 3-28-12) rule 5101:9-7-06 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. To ensure reporting is correct at the state level, it is imperative that the CDJFS report collections of benefits from past years separately from the collection of benefits that were issued during the current state fiscal year (SFY). This requirement is paragraph (F) in the rule. ODJFS established coding and communicated that coding via a Bureau of County Finance Technical Assistance (BCFTA) update 2013-15 (dated 1/10/2013). See <http://www.odjfs.state.oh.us/lpc/calendar/fileLINKNAME.asp?ID=FAPMTL241> and <http://jfs.ohio.gov/ofs/bcfta/BB/20130110-BCFTA-Update-2013-15-New-Receipt-Coding.stm>

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.

PART III

L. Reporting

OMB/ODJFS Compliance Requirements

OAC 5101:9-7-06 Reporting Collections and Earning on Erroneous Payment Recoveries (*Eff. 3-30-12*)

- A. When a public assistance recipient has received a cash or benefit overpayment for general assistance (GA), disability financial assistance (DFA), temporary assistance for needy families (TANF) or aid to dependent children (ADC) assistance, family emergency assistance (FEA) medical, child care, Medicaid, food assistance (FA), early learning initiative (ELI), employment retention incentive program (ERI) or prevention, retention and contingency (PRC);, the county department of job and family services (CDJFS) shall recover the funds.
- B. As outlined in section 5107.76 of the Revised Code, a CDJFS is entitled to earnings for the recovery of erroneous payments. Earnings for recovery of erroneous payments do not apply to participant expense allowances or other support service cash benefits. The CDJFS may recover erroneous payments through benefit reduction or through cash collections.
- C. Earnings for recovery of erroneous payments apply to overpayments recovered through benefit reduction. Net overpayment amounts result in earnings when collected and appropriately reported. The CDJFS may verify earnings from collections amounts using its own county's "GRP670RA" report. This is a detailed report of all Ohio works first (OWF) and ADC erroneous payments collected through benefit reduction.
- D. The CDJFS reports erroneous payment collections that qualify for earnings and the Ohio department of job and family services (ODJFS) issues earnings as follows:
 - 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 CR 520/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.
- E. In addition to collections that are eligible for earnings, the CDJFS shall also report the following erroneous payment collections as receipts on the CR 520/JFS 02827:
 - a. Cancellations, collections, refunds, or other GA receipts;
 - b. Collections of erroneous payments for FEA medical;
 - c. Collections of ADC erroneous payments made prior to October 1, 1987;
 - d. Cancellations, collections, refunds, or other child care receipts;
 - e. Collections of erroneous payments of ELI funds;
 - f. Collections of erroneous payments of ERI funds; and
 - g. Collections of PRC.
- F. The CDJFS will report collections of benefits that were issued in a previous fiscal year separately than the collections of benefits that were issued during the current SFY.
- G. ODJFS will include the erroneous payment collections, as reported on the CR 520/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 CR 520/ JFS 02827 is loaded into CFIS web, however the County Auditor still needs to sign and certify the final report. If the report in CFIS web is not signed is not considered final. After the report is signed it cannot be changed. The signed report itself cannot be uploaded into CFIS Web, it is submitted to ODJFS. See

PART III

L. Reporting

OMB/ODJFS Compliance Requirements

OAC 5101:9-7-03, 5101:9-7-03.1 & 5101:9-7-29. Tests related to reporting at the county level for public assistance will be limited to the CR 520/ 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/ CR 520 should be reported on a cash basis.

The Counties are also required to include cash or benefit overpayments on CR 520/ JFS 02827. Counties retain benefit recoveries monies (incentive monies) and report quarterly on the CR 520/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.

CR 520/ 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)

Auditors should test the ODJFS 02827 Form/ CR 520 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 Cluster
Social Service Block Grant

PART III

M. Subrecipient Monitoring

OMB Compliance Requirements

Compliance Requirements

NOTE: Transfers of Federal awards to another component of the same auditee under OMB Circular A-133 do not constitute a subrecipient or vendor relationship.

A pass-through entity is responsible for:

- *Determining Subrecipient Eligibility* - In addition to any programmatic eligibility criteria under E, "Eligibility for Subrecipients," for subawards made on or after October 1, 2010, determining whether an applicant for a non-ARRA subaward has provided a Dun and Bradstreet Data Universal Numbering System (DUNS) number as part of its subaward application or, if not, before award (2 CFR section 25.110 and Appendix A to 2 CFR part 25).
- *Award Identification*- At the time of the subaward, identifying to the subrecipient the Federal award information (i.e., CFDA title and number; award name, and number; if the award is research and development; and name of Federal awarding agency) and applicable compliance requirements.
- *During-the-Award Monitoring*- Monitoring the subrecipient's use of Federal awards through reporting, site visits, regular contact, or other means to provide reasonable assurance that the subrecipient administers Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.
- *Subrecipient Audits*- (1) Ensuring that subrecipients expending \$500,000 or more in Federal awards during the subrecipient's fiscal year for fiscal years ending after December 31, 2003 as provided in OMB Circular A-133 have met the audit requirements of OMB Circular A-133 (the circular is available at <http://www.whitehouse.gov/omb/circulars/a133/a133.html>) and that the required audits are completed within 9 months of the end of the subrecipient's audit period; (2) issuing a management decision on audit findings within 6 months after receipt of the subrecipient's audit report; and (3) ensuring that the subrecipient takes timely and appropriate corrective action on all audit findings. In cases of continued inability or unwillingness of a subrecipient to have the required audits, the pass-through entity shall take appropriate action using sanctions.
Ensuring Accountability of For-Profit Subrecipients - Awards also may be passed through to for-profit entities. For-profit subrecipients are accountable to the pass-through entity for the use of Federal funds provided. Because for-profit subrecipients are not subject to the audit requirements of OMB Circular A-133, pass-through entities are responsible for establishing requirements, as needed, to ensure for-profit subrecipient accountability for the use of funds.
- *Pass-Through Entity Impact*- Evaluating the impact of subrecipient activities on the pass-through entity's ability to comply with applicable Federal regulations.

During-the-Award Monitoring

Following are examples of factors that may affect the nature, timing, and extent of during-the-award monitoring:

- *Program complexity*- Programs with complex compliance requirements have a higher risk of non-compliance.
- *Percentage passed through*- The larger the percentage of program awards passed through the greater the need for subrecipient monitoring.
- *Amount of awards*- Larger dollar awards are of greater risk.
- *Subrecipient risk*- Subrecipients may be evaluated as higher risk or lower risk to determine the need for closer monitoring. Generally, new subrecipients would require closer monitoring. For existing subrecipients, based on results of during-the-award monitoring and subrecipient audits, a subrecipient may warrant closer monitoring [e.g., the subrecipient has (1) a history of non-compliance as either a recipient or subrecipient, (2) new personnel, or (3) new or substantially changed systems].

PART III

M. Subrecipient Monitoring

OMB Compliance Requirements

Monitoring activities normally occur throughout the year and may take various forms, such as:

- *Reporting*- Reviewing financial and performance reports submitted by the subrecipient.
- *Site Visits*- Performing site visits at the subrecipient to review financial and programmatic records and observe operations.
- *Regular Contact*- Regular contacts with subrecipients and appropriate inquiries concerning program activities.

Agreed-upon procedures engagements

A pass-through entity may arrange for agreed-upon procedures engagements for certain aspects of subrecipient activities, such as eligibility determinations. Since the pass-through entity determines the procedures to be used and compliance areas to be tested, these agreed-upon procedures engagements enable the pass-through entity to target the coverage to areas of greatest risk. The costs of agreed-upon procedures engagements is an allowable cost to the pass-through entity if the agreed-upon procedures are performed for subrecipients below the A-133 threshold for audit (currently at \$500,000 for fiscal years ending after December 31, 2003) for the following types of compliance requirements: activities allowed or unallowed; allowable costs/cost principles; eligibility; matching, level of effort, earmarking; and reporting (OMB Circular A-133 (§ ____.230(b)(2)).

Source of Governing Requirements

The requirements for subrecipient monitoring are contained in 31 USC 7502(f)(2)(B) (Single Audit Act Amendments of 1996 (Pub. L. No. 104-156)), OMB Circular A-133 (§ ____.225, § ____.310(d)(5), § ____.400(d)), A-102 Common Rule (§ ____.37 and § ____.40(a)) (45 CFR part 92), 2 CFR parts 25 and 170, and 48 CFR parts 4, 42, and 52 Federal awarding agency regulations, and the terms and conditions of the award.

PART III

M. Subrecipient Monitoring

ODJFS Compliance Requirements

Counties should never contract out eligibility determinations or Healthchek services. Counties can however, contract out for support or outreach services, EPSDT services (non-NET contract) and NET services (non-emergency transportation). Contracts (whether vendor or subrecipient) are not required to be submitted or approved by ODJFS. Auditors should review contracts entered into by the County JFS for services to determine if a vendor or subrecipient relationship exists. Auditors should also look for reoccurring expenditures to determine if such a relationship exists without entering into a formal contract.

ODJFS subrecipient monitoring tools 1) Subrecipient / Vendor Checklist; 2) Subrecipient / Vendor Example (Criteria Summary); 3) (Subrecipient) Monitoring Checklist; 4) Risk Assessment Tool are all available at <http://jfs.ohio.gov/ofs/bmcs/TechMaterial.stm> ..

OAC 5101:9-1-88 Subrecipient annual risk assessment review and subrecipient monitoring process.

PART III

N. Special Tests and Provisions

OMB Compliance Requirements

Per ODJFS, there are no OMB Special Tests and Provisions for Medicaid at the County level. However, ODJFS included a requirement for LPMD – see at the end of this section.

OMB Specific Information

Utilization Control and Program Integrity **Not tested at the County Level**

Compliance Requirements - The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services, including long-term care institutions. In addition, the State must have: (1) methods or criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials (42 CFR parts 455, 456, and 1002).

Suspected fraud should be referred to the State Medicaid Fraud Control Units (42 CFR part 1007).

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

Inpatient Hospital and Long-Term Care Facility Audits **Not tested at the County Level**

Compliance Requirement - The State Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers. The State Medicaid agency must provide for the filing of uniform cost reports for each participating provider. These cost reports are used to establish payment rates. The State Medicaid agency must provide for the periodic audits of financial and statistical records of participating providers. The specific audit requirements will be established by the State Plan (42 CFR section 447.253).

ADP Risk Analysis and System Security Review **Not tested at the County Level**

Compliance Requirement - State agencies must establish and maintain a program for conducting periodic risk analyses to ensure that appropriate, cost effective safeguards are incorporated into new and existing systems. State agencies must perform risk analyses whenever significant system changes occur. State agencies shall review the ADP system security installations involved in the administration of HHS programs on a biennial basis. At a minimum, the reviews shall include an evaluation of physical and data security operating procedures, and personnel practices. The State agency shall maintain reports on its biennial ADP system security reviews, together with pertinent supporting documentation, for HHS on-site reviews (45 CFR section 95.621).

Provider Eligibility **Not tested at the County Level**

Compliance Requirement - In order to receive Medicaid payments, providers of medical services furnishing services must be licensed in accordance with Federal, State, and local laws and regulations to participate in the Medicaid program (42 CFR sections 431.107 and 447.10; and Section 1902(a)(9) of the Social Security Act (42 USC 1396a(a)(9)) and the providers must make certain disclosures to the State (42 CFR part 455, subpart B, sections 455.100 through 455.106).

Provider Health and Safety Standards **Not tested at the County Level**

PART III

N. Special Tests and Provisions

OMB Compliance Requirements

Compliance Requirement - Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/MR (42 CFR part 442). The standards may be modified in the State plan.

Medicaid Fraud Control Unit **Not tested at the County Level**

Compliance Requirement - States are required as part of their Medicaid State plans to maintain a MFCU, unless the Secretary of HHS determines that certain safeguards are met regarding fraud and abuse.

PART III

N. Special Tests and Provisions

ODJFS Compliance Requirements

The Healthchek program is a child health care program which offers every Medicaid recipient under 21 years of age medically necessary comprehensive health services and assistance with access to services. Pregnancy-Related Services (PRS) is a program which provides reimbursement for services to all pregnant Medicaid-eligible women and assistance with access to services.

The Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program, known in Ohio as Healthchek, and the Pregnancy-Related Services (PRS) program are federally mandated programs. In order to provide accurate information to the federal government, the Ohio Department of Job and Family Services requires that each County Department of Job and Family Services (CDJFS) complete and submit a Local Program Management Description (LPMD) for these programs. As communicated in MEPL transmittal letter 73, effective 7/1/13, the LPMD was reformatted as the JFS 03517 Healthchek Services Implementation Plan (HSIP). The intent is to provide a form through which county agencies report the administration of Healthchek (EPSDT) services in their county. The LPMD was a suggested format. The JFS 03517 replaces the LPMD as the official form and will be the required format for submission. If the CDJFS needs to submit a new or updated Healthchek (EPSDT) Services report, they will need to complete the JFS 03517 HSIP form. Agencies must discontinue the use of the LPMD suggested format. An example of the form can be found at <http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03517> and the law detailing HSIP (although not directly mentioned, is OAC 5160:1-2-05 (formerly 5101:1-38-05).

The Federal law supporting state-wideness of the program is the Omnibus Reconciliation Act of 1989 and 42 USC 1396(a)(a)(1). This requirement is part of the corrective action plan from CMS. Everyone has identified they are operating consistently throughout the State, thus meeting minimum requirements.

Per ODJFS, counties do submit these plans to the ODJFS, however, these plans will change over time. Auditors should obtain the plans for their testing period from the County JFS. Auditors should determine that any new submissions after 7/1/13 are made using the JFS 03517.

Counties should be sharing JFS 3528 documentation with Managed Care Plans documentation. If the Medicaid-enrolled individual participates in a managed care plan (MCP), the JFS 03528 form is required to be shared with the MCP. The only occasion where the sharing of the JFS 03528 is not required is if the individual is "fee-for-service", and therefore not enrolled in managed care. For reference, please see OAC 5160:1-2-05(D)(1)(c) (formerly OAC 5101:1-38-05), which requires coordination of services with the individual's managed care plan. Counties may also share data with the Managed Care Plans via a screen print of the CRIS-E – electronic eligibility system - screen known as AEIHC. This screen captures information from the JFS 03528 form, or it may be obtained verbally by the caseworker – via telephone or face-to-face interview – and entered manually onto the screen by the worker. The screen is then printed and shared with the MCPs. Form 3528 are completed for EPSDT and PRS (pregnancy). They are sent to the consumer and then returned to County JFS. The information should be shared with the managed care plan. This is an information sharing tool. ODJFS is looking for how the County JFS is sharing information. Managed Care Plans are specific to regions and recipients choose MCP. If not they are assigned to a plan.

ODJFS also requested we look at documentation of the County JFS following up on JFS 3535's for high risk pregnancies (for PRS program). This form is used as a tool for working with individual to get special types of services for at risk services (i.e. under/over weight – nutritional services, smokers, homeless). It is initiated by the provider who determines at risk pregnancy. The form goes to eligibility worker or EPSDT (depends on LPMD). If no form is filed there is no follow-up. However, if a form is on file, the County JFS should show follow-up with client.

PART III

N. Special Tests and Provisions

ODJFS Compliance Requirements

MEDICAID - HEALTHCHEK PROGRAM

OAC 5160:1-2-05 (F) (formerly OAC 5101:1-38-05) (**effective 02/14/2011**)

Each CDJFS shall submit a proposed plan to ODJFS within ten business days of a change in director, healthcek coordinator or where the responsibility for healthcek resides in in the agency. The proposed plan must include the following information:

- Identify where, in the CDJFS table of organization, the responsibility for the Healthcek program is located and the name(s) and title(s) of the contact person or Coordinator.
- A description of all assigned duties (Healthcek related AND unrelated duties, if any) of the staff/unit responsible for administration of administrative healthcek support services.
- Provide a description in the plan of the electronic and/or hard-copy methods for ensuring permanent records and documentation are maintained in a case file for each recipient.
- Identify any services or functions required in the rule which are contracted out to other entities. A copy of the contract shall be provided to ODJFS. The County CDJFS shall also describe accountability and monitoring measures, along with timeframes when monitoring takes place to ensure the contracted entities are achieving all required functions and that these functions are in accordance with applicable state and federal rules.

County Departments of Job and family services are responsible for informing recipients about healthcek. Each shall use a combination of written and oral methods to effectively inform recipients within sixty days of eligibility determination and at least once each year thereafter.

The CDJFS is required to enter data into the electronic eligibility system for Healthcek frp, the completed form JFS 03528 "HEALTHCHEK and Pregnancy Related Services Information Sheet" (rev. 2/2011).

FORM:

The JFS 03528 is formatted in a manner that will help the individual fill out the form and interact with the individual's Healthcek Coordinator. The form also includes a cover letter providing more detailed information about the services available through Healthcek. Once completed, this form is shared with the individual's managed care plan (MCP), if applicable . Instructions for the form can be found at <http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03528>

If the Medicaid-enrolled individual participates in a managed care plan (MCP), the JFS 03528 form is required to be shared with the MCP. The only occasion where the sharing of the JFS 03528 is not required is if the individual is "fee-for-service", and therefore not enrolled in managed care.

MEDICAID - PREGNANCY RELATED SERVICES (PRS) PROGRAM

OAC 5160:1-2-06 (K) (formerly OAC 5101:1-38-06)

The CDJFS shall submit in writing, under signature of the CDJFS director, a description of the process and structure of the management of the local PRS program including the name of the contact person and/or coordinator for the program. The information submitted, shall include the following:

- Identify where in the CDJFS table of organization the responsibility for the Pregnancy Related Services (PRS) program is located and the name(s) and title(s) of the contact person or Coordinator.
- A description of all assigned duties (PRS related AND unrelated duties, if any) of the staff/unit responsible for informing women identified as pregnant of the following:
 - a. The Pregnancy Related Services Program.

PART III

N. Special Tests and Provisions

ODJFS Compliance Requirements

- b. The importance of prenatal care.
- c. The availability to assist eligible pregnant women in receiving an initial physician visit
- Identify the staff/unit responsible for the submission of pregnancy related services quarterly reports to ODJFS
- Identify how the CDJFS tracks women identified as pregnant
- Information as to whether the agency will provide transportation to infants during the first year of life.
- In counties with Medicaid-contracting MCPs, the information submitted under the CDJFS director's signature shall include plans for coordination of efforts between the CDJFS and the MCPs. This can include written agreements between the CDJFS and the Medicaid-contracting MCPs with provisions for regularly scheduled meetings, as well as other ideas for county and plan coordination.
- All changes or amendments to the CDJFS's description of the process and/or structure shall be submitted in writing to ODJFS under the signature of the CDJFS director within ten working days.
- Information submitted under the signature of the CDJFS director can be combined or included with the information submitted as per paragraph (M) of rule 5101:1-38-05 of the Administrative Code.

ADDITIONAL REQUIREMENTS

- The LPMD must include copies of your agency's version of the forms used for both programs if your agency chooses not to use ODJFS state-issued forms for these programs. The county agency must obtain a waiver from ODJFS, Children's Health Section, prior to using any documents that stand in place of state-required forms, brochures or documents. Required forms include the following:
 - JFS 03528, "Healthchek and Pregnancy Related Services Information Sheet"
 - JFS 08009, Healthchek Services brochure
 - JFS 08062, Healthy Start for a Healthy Baby brochure.

Note: As communicated in MEPL transmittal letter 73, effective 7/1/13, the LPMD was reformatted as the JFS 03517 Healthchek Services Implementation Plan (HSIP). The intent is to provide a form through which county agencies report the administration of Healthchek (EPSDT) services in their county. The LPMD was a suggested format. The JFS 03517 replaces the LPMD as the official form and will be the required format for submission. If the CDJFS needs to submit a new or updated Healthchek (EPSDT) Services report, they will need to complete the JFS 03517 HSIP form. Agencies must discontinue the use of the LPMD suggested format.

- Mandatory enrollment in managed care is now statewide. All counties are required to establish and maintain a means of communication with their managed care plans. The following Healthchek and PRS information must be included:
 - a. Names of each MCP's contact person
 - b. All written agreements the agency has made with any of the MCPs related to Healthchek and PRS
 - c. Provisions for regularly scheduled meetings with MCPs
 - d. How data is obtained from MCP's to support outreach efforts, blood lead level follow ups, etc...

PART III

N. Special Tests and Provisions

ODJFS Compliance Requirements

- The LPMD for Healthchek and Pregnancy Related Services and the after July 2013 the JFS 03517 HSIP form must be **signed by the agency's Director** and submitted to the Bureau of Health Plan Policy, Outreach and Technical Assistance Section, by any of the following methods:
 - a. email at Healthchek_PRS@medicaid.ohio.gov
 - b. Fax 614-466-2908, ATTN: Outreach and Technical Assistance Section
 - c. Regular mail at: Office of Medical Assistance
Bureau of Health Plan Policy
Attn: Outreach and Technical Assistance
P.O. Box 182709, Columbus, OH 43218-2709