

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- CFDA 93.044 SPECIAL PROGRAMS FOR THE AGING--TITLE III, PART B—
GRANTS FOR SUPPORTIVE SERVICES AND SENIOR CENTERS**
- CFDA 93.045 SPECIAL PROGRAMS FOR THE AGING--TITLE III, PART C—
NUTRITION SERVICES**
- CFDA 93.053 NUTRITION SERVICES INCENTIVE PROGRAM**
- CFDA 93.705 AGING HOME-DELIVERED NUTRITION SERVICES FOR STATES
(RECOVERY ACT)**
- CFDA 93.707 AGING CONGREGATE NUTRITION SERVICES FOR STATES
(RECOVERY ACT)**

I. PROGRAM OBJECTIVES**Grants for Supportive Services and Senior Centers**

The objective of this program is to assist States and area agencies on aging in facilitating the development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

- (A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;
- (B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—
 - (i) respond to the needs and preferences of older individuals and family caregivers;
 - (ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and
 - (iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;
- (C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and
- (D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—
 - (i) the need to plan in advance for long-term care; and

- (ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources (Older Americans Act [OAA] Section 305(a)(3)).

The target population for these supportive services is individuals with greatest economic and social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and older individuals at risk for institutional placement (OAA Section 306(a)(1)); however, proof of age (or income) is not required as a condition of receiving services.

Supportive services may include a full range of economic and social services, including, but not limited to: (1) access services (transportation, health services [including mental health services] outreach, information and assistance); (2) legal assistance and other counseling services; (3) health screening services (including mental health screening); (4) ombudsman services; (5) provision of services and assistive devices (including provision of assistive technology services and assistive technology devices); (6) services designed to support States, area agencies on aging, and local service providers in carrying out and coordinating activities for older individuals with respect to mental health services, including outreach for, education concerning, and screening for such services, and referral to such services for treatment; (7) activities to promote and disseminate information about life-long learning programs, including opportunities for distance learning; and (8) services designed to assist older individuals in avoiding institutionalization and to assist individuals in long-term care institutions who are able to return to their communities any other services necessary for the general welfare of older individuals (OAA Section 321). Nutrition services are provided under a separate authorization as described below.

Organizations funded under this program and the nutrition services program (see below) also receive funds from other Federal sources as well as from non-Federal sources.

Grants for Nutrition Services

The purposes of this grant program are to: (1) reduce hunger and food insecurity; (2) promote socialization of older individuals; and (3) promote the health and well-being of older individuals by helping them gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior (OAA Section 330). Services are provided through this program to individuals aged 60 or older, in a congregate setting or in-home. These services include meals, nutrition education, nutrition counseling, and nutrition screening and assessment, as appropriate (OAA Sections 331, 336, and 339). This program is clustered with the grants for supportive services and senior centers for purposes of this program supplement since these services, although separately earmarked, fall under the overall State planning process and process for allocation of funds.

Nutrition Services Incentive Program

The objective of this grant program is to provide resource incentives to encourage and reward effective and efficient performance in the delivery of nutritious meals to older individuals. The Administration on Aging (AoA) is responsible for this program (previously included in the Supplement as the Department of Agriculture's (USDA) Nutrition Services Incentive Program (CFDA 10.570)) as described in II, "Program Procedures – Administration and Services." This program is included as part of this cluster because of its direct relationship to the nutrition services program.

II. PROGRAM PROCEDURES

Administration and Services

The AoA, a component of the Department of Health and Human Services, administers the supportive services and senior centers program and the nutrition services program in cooperation with States, sub-State agencies, and other service providers. The States receive a formula grant from AoA, which is used by the State Unit on Aging (State Agency) both for its planning, administration, and evaluation of these programs as well as to pass through to other entities.

Planning and Service Areas (PSAs) are designated by the State Agency in accordance with AoA guidelines after considering the geographical distribution of the service populations, location of available services, available resources, other service area boundaries, location of units of general-purpose local government, and other factors. An Area Agency on Aging (Area Agency) is then designated by the State for each PSA after considering the views of affected local governments (States that had a single statewide planning and service area in place prior to fiscal year (FY) 1981 had the option to continue that method of operation; there are currently eight States in this category). A single Area Agency may serve more than one PSA. The Area Agencies, which may be public or private non-profit agencies or organizations, develop and administer counterpart area aging plans, as approved by the State Agency, and, in turn, provide subgrants to or contract with public or private service providers for the provision of services.

With limited exceptions (e.g., ombudsman services, information and assistance, case management¹), the State Agency and the Area Agencies are precluded from the direct provision of services, unless providing the services is necessary to ensure an adequate supply of services, the services are related to the agency's administrative functions, or where services of comparable quality can be provided more economically by the agency. Federal funds may pay for only a portion of the costs of administration and services with the State and subrecipients required to provide a matching share from other sources.

AoA administers NSIP in cooperation with States, sub-State agencies, and other service providers. Under Section 311(b) (1) and (d) (1) of the OAA, States receive a cash grant from AoA, based on the formula in the OAA. The amount of a State's grant is determined by dividing the number of meals served to eligible persons in the State during the preceding Federal fiscal year by the number of such meals served in all States and Tribes, and applying the resulting ratio to the amount of funds available. Under OAA Section 311(d)(1), a State may choose to use all or any part of its grant to obtain commodities distributed by the USDA through State Distributing Agencies. The amount a State chooses to use in commodities, as well as administrative costs from USDA associated with the purchase of commodities are deducted from the State's grant from AoA. AoA transfers funds to USDA. USDA remains responsible for the overall management of the commodities program, including ordering, purchase, and delivery of the requested commodities. (Also see "IV, Other Information.")

State Plan and Area Plans

A State plan, approved by AoA, is a prerequisite to funding of the supportive services and nutrition programs; however, the State Plan covers the totality of AoA programs for which the State is the recipient under the OAA. The State Plan is developed on the basis of input from the Area Agencies as well as input from the affected populations as a result of public hearings. The State Plan addresses how the State intends to comply with the various requirements of the OAA and, specifically for Title III, its program objectives, designation of Planning and Service Areas (PSAs), and specification of the intrastate allocation formula for distribution of funds to each PSA. The State Plan also contains assurances required by the Act and implementing regulations.

¹ The term "case management service" means a service provided to an older individual, at the direction of the older individual or a family member of the individual (i) by an individual who is trained or experienced in the case management skills that are required to deliver the services and coordination described below; and (ii) to assess the needs, and to arrange, coordinate, and monitor an optimum package of services to meet the needs, of the older individual. Case management includes services and coordination such as (i) comprehensive assessment of the older individual (including the physical, psychological, and social needs of the individual); (ii) development and implementation of a service plan with the older individual to mobilize the formal and informal resources and services identified in the assessment to meet the needs of the older individual, including coordination of the resources and services with any other plans that exist for various formal services, such as hospital discharge plans; and with the information and assistance services provided under the OAA; (iii) coordination and monitoring of formal and informal service delivery, including coordination and monitoring to ensure that services specified in the plan are being provided; (iv) periodic reassessment and revision of the status of the older individual with the older individual or, if necessary, a primary caregiver or family member of the older individual; and (v) in accordance with the wishes of the older individual, advocacy on behalf of the older individual for needed services or resources (OAA Section 102(11)).

Unless a State is not in compliance with Title III requirements, the State Plan may be submitted on a two-, three-, or four-year cycle, at the option of the State, with annual amendments, as appropriate; however, AoA funding is provided annually. States found to be in noncompliance may be required to submit their State Plans annually until they are determined to be in compliance. Area plans are prepared and submitted to the State for approval for either two, three, or four years, with annual adjustments, as necessary.

Source of Governing Requirements

These programs are authorized under Parts B and C, respectively, of Title III of the OAA, as amended, which is codified at 42 USC 3021-3030. These programs may also be referred to as Part B (supportive services and senior centers) and Part C1 (congregate nutrition services) and C2 (home-delivered nutrition services). Grants to Indian tribes for similar purposes are authorized under another title of the OAA and are not included in this Supplement. Implementing regulations are published at 45 CFR part 1321.

The Nutrition Services Incentive Program (NSIP) is authorized in Title III of the OAA, as amended, which is codified at 42 USC 3030a. There are no implementing regulations.

Availability of Other Program Information

Additional information about nutrition and supportive services as amended in 2006 is available at the AoA web site at http://aoa.gov/AoARoot/AoA_Programs/index.aspx

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. State Agency

- a. State Agencies may use any amount of Title III-B (supportive services) funding necessary to conduct an effective ombudsman program (42 USC 3024 (d)(1)(B)).
- b. Grant funds may be used for State plan administration, including State Plan preparation, evaluation of activities carried out under the Plan, the collection of data and the conduct of analyses related to the need for services, dissemination of information, short-term training, and demonstration projects (42 USC 3028 (a)).

- c. No supportive services, nutrition services, or in-home services may be provided directly by the State Agency unless the State Agency determines that direct provision of services is necessary to ensure an adequate supply of services, where such services are related to the agency's administrative functions, or where such services of comparable quality can be provided more economically by the State Agency (42 USC 3027(a)(8)(A)).

2. *Area Agency*

Supportive Services and Senior Centers and Nutrition Services

- a. Funds may be used for plan administration, operation of an advisory council, activities related to advocacy, planning, information sharing, and other activities leading to development or enhancement within the designated service area(s) of comprehensive and coordinated community-based systems of service delivery to older persons (45 CFR section 1321.53).
- b. If approved by the State Agency, an Area Agency may use service funds for program development and coordination activities (45 CFR section 1321.17(f)(14)(i)).
- c. No supportive services, nutrition services, or in-home services may be provided directly by an Area Agency except if, in the judgment of the State Agency, direct provision of services is necessary to ensure an adequate supply of services, where such services are related to the agency's administrative functions, or where such services of comparable quality can be provided more economically by the agency (42 USC 3027(a)(8)).

NSIP

Recipient agencies may use the cash received in lieu of commodities only to purchase domestically produced foods for their nutrition projects (42 USC 3030a(d)(4)).

3. *Service Providers*

Supportive Services and Senior Centers and Nutrition Services

- a. Funds may be used to assist in the operation of multi-purpose senior centers and to meet all or part of the costs of compensating professional and technical personnel required for center operation (42 USC 3030d(b)(2)).
- b. Funds may be used for nutrition services and supportive services consistent with the terms of the agreement between the Area Agency and the service provider (42 USC 3026(a)(1), 3030d(a), and 3030e).

- c. Funds may be used for services associated with access to supportive services for in-home services, and for legal assistance (42 USC 3026 (a)(2)).
- d. Nutrition services may be provided to older individuals' spouses, who may not be eligible for these services in their own right, on the same basis as they are provided to older individuals, and may be made available to handicapped or disabled individuals who are less than 60 years old but who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided (42 USC 3030g-21(2)(I)).
- e. In accordance with procedures established by the Area Agencies, nutrition project administrators may offer meals to individuals providing volunteer services during the meal hours and to individuals with disabilities who reside at home with eligible individuals (42 USC 3030g-21(2)(H)).
- f. Funds may be used for provision of home-delivered meals to older individuals (42 USC 3030f).
- g. Funds may be used to acquire (in fee simple or by lease for 10 years or more), alter, or renovate existing facilities or to construct new facilities to serve as multi-purpose senior centers for not less than 10 years after acquisition, or 20 years after completion of construction, unless waived by the Assistant Secretary for Aging (42 USC 3030b).

NSIP

Cash received in lieu of commodities may be used only to purchase domestically produced foods for their nutrition projects (42 USC 3030a(d)(4)).

E. Eligibility

- 1. Eligibility for Individuals – Not Applicable**
- 2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable**
- 3. Eligibility for Subrecipients**

Service providers may include profit-making organizations except that providers of case management services must be public or non-profit agencies (42 USC 3026(a)(8)(C)).

G. Matching, Level of Effort, Earmarking

1. Matching

a. *State*

- (1) States must contribute from State or local sources at least 25 percent of the cost of State Plan administration as their matching share. This may include cash or in-kind contributions by the State or third parties (42 USC 3028 (a)(1) and 42 USC 3029 (b); 45 CFR section 1321.47).
- (2) All services, whether provided by the State Agency, an Area Agency or other service provider (including any ombudsman services provided under the authority of 42 USC 3024 (d)(1)(D)) must be funded with a non-Federal match of at least 15 percent. This percentage must be met on a statewide basis. Funds for ombudsman services provided under the authority of 42 USC 3024 (d)(1)(B) are not required to be matched (42 USC 3024 (d)(1)(D); 45 CFR section 1321.47).

b. *State and Area Agencies*

Area Agencies, in the aggregate, must contribute at least 25 percent of the costs of administration of area plans (42 USC 3024 (d)(1)(A); 45 CFR section 1321.47).

- (1) *State* – Since this match is computed based on the aggregate of all Area Agencies in the State, the auditor’s testing of the amount of this match is performed at the State Agency.
- (2) *Area Agencies* – The auditor’s testing of the allowability of the matching (e.g., from an allowable source and in compliance with the administrative requirements and allowable costs/cost principles requirements) should be performed at the Area Agencies.

2.1 Level of Effort – *Maintenance of Effort*

State – The State Agency must spend for both services and administration at least the average amount of State funds it spent under the State plan for these activities for the three previous fiscal years. If the State Agency spends less than this amount, the Assistant Secretary for Aging reduces the State’s allotments for supportive and nutrition services under this part by a percentage equal to the percentage by which the State reduced its expenditures (42 USC 3029 (c); 45 CFR section 1321.49). See III. L.1, “Reporting – Financial Reporting,” for the reporting requirement regarding maintenance of effort.

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable

3. Earmarking

a. State

- (1) Overall expenditures for administration are limited to the greater of five percent (or \$300,000 or \$500,000 depending on the aggregate amount appropriated or a lesser amount for the U.S. territories) of the overall allotment to a State under Title III unless a waiver is granted by the Assistant Secretary on Aging (42 USC 3028 (b)(1), (2), and (3)).
- (2) After a State determines the amount to be applied to State plan administration under 42 USC 3028 (b), the State may:
 - (a) Make up to (and including) 10 percent of that amount available for the administration of Area Plans. The State may either calculate the 10 percent based on the total allotment from AoA or on the amount remaining after deducting the amount to be applied to State Plan administration (42 USC 3024(d)(1)(A)); and
 - (b) Use any amounts available to the State for State plan administration which the State determines are not needed for that purpose to supplement the amount available for administration of Area Plans (42 USC 3028(a)(2)).
- (3) Any State which has been designated as a single planning and service area may elect to be subject to the State Plan administration limit (five percent) or the Area Plan administration (10 percent) limit (42 USC 3028(a)(3)).
- (4) A State may transfer:
 - (a) Up to 40 percent of a State's separate allotments for congregate and home-delivered nutrition services between those two allotments without AoA approval (42 USC 3028 (b)).
 - (b) Not more than 30 percent between programs under Part B and Part C (Parts C1 and/or C2) for use as the State considers appropriate (42 USC 3028(b)).
 - (c) An additional 10 percent may be transferred between C1 and C2 with an AoA waiver (42 USC 3028(b)).
 - (d) A waiver may be requested to transfer an amount which is above the allowable 30 percent between Parts B and C (42 USC 3030c-3(b)(4)).

A State Agency may not delegate to an Area Agency or any other entity the authority to make such transfers (42 USC 3028(b)(6)).

- (5) The State agency will not fund program development and coordinated activities as a cost of supportive services for the administration of area plans until it has first spent 10 percent of the total of its combined allotments under this program on the administration of area plans (45 CFR section 1321.17(f)(14)).

b. *Area Agency*

As provided in agreements with the State Agency, Area Agencies earmark portions of their allotment. The typical earmarks are:

- (1) A maximum amount or percentage for program development and coordination activities by that agency (42 USC 3024(d)(1)(D); 45 CFR section 1321.17(f)(14)(i)).
- (2) A minimum amount or percentage for services related to access, in-home services, and legal assistance (42 USC 3026(a)(2)).

H. Period of Availability of Federal Funds

Funds are made available to the State annually and must be obligated by the State by the end of the Federal fiscal year in which they were awarded. The State has two years to liquidate all obligations for its administration of the State Plan and for awards to the Area Agencies consistent with its intrastate allocation formula. Therefore, in any given year, multiple years of funding are being used to provide services statewide.

Whenever the Assistant Secretary on Aging determines that any amount allotted to a State under Parts B or C for a fiscal year will not be used to carry out the purpose for which the allotment was made, the funds may be reallocated to one or more other States. Any amount made available to a State as the result of a reallocation shall be regarded as part of the State's allotment for the same fiscal year in which the funds were appropriated, but shall remain available for obligation by the State until the end of the succeeding fiscal year (42 USC 3024 (b)).

J. Program Income

1. Service providers are required to provide an opportunity to individuals being served under all Part B and C services program to make voluntary contributions for services received. These voluntary contributions are to be added to the amounts made available by the State or Area Agency and must be used to expand the service from which they are collected (42 USC 3030c-2(b)).

2. Cost-sharing fees may be collected from Title III-B services except information and assistance, outreach, benefits counseling, or case management services. Cost sharing is not allowed for Title III-C services or Title VII Elder Rights Services (Ombudsman, legal services, elder abuse prevention or other consumer protection services) (42 USC 3030c-2(a)(2)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Applicable

5. Subaward Reporting under the Transparency Act – Applicable for non-ARRA funds

M. Subrecipient Monitoring

1. State Agency

The State Agency is required to develop policies governing all aspects of programs operated under the State Plan and to monitor their implementation, including assessing performance for quality and effectiveness and specifying data system requirements to collect necessary and appropriate data (45 CFR sections 1321.11 and 1321.17(f)(9)).

2. Area Agencies

Area Agencies are required to oversee the activities of service providers with respect to provision of services, reporting, voluntary contributions, and coordination of services (45 CFR section 1321.65).

N. Special Tests and Provisions

Distribution of Cash

Compliance Requirement – States are required to promptly and equitably distribute NSIP cash to recipients of grants or contracts under OAA Title C1 and C2 (42 USC 3030a(d)(4)).

Audit Objective – Determine whether States are distributing cash promptly and equitably.

Suggested Audit Procedures

- a. Review the State's procedures for handling NSIP cash to determine whether there is a documented process for distributing cash, including established time frames.
- b. Review a sample of transactions during the audit period in which the State received NSIP cash and determine whether the State complied with its established process, including time frames.

IV. OTHER INFORMATION

The NSIP program may include both cash payments and use of cash to purchase commodities from USDA and for USDA administrative expenses. Assistance in the form of commodities is considered Federal awards expended in accordance with the OMB Circular A-133, §___.105, definition of Federal financial assistance and should be valued in accordance with §___.205(g). Therefore, both cash expenditures for the purchase of food and the value of commodities received from the State Distribution Agencies should be (1) used when determining Type A programs and (2) included in the Schedule of Expenditures of Federal Awards in accordance with §___.310(b).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.090 GUARDIANSHIP ASSISTANCE

I. PROGRAM OBJECTIVES

The objective of the Guardianship Assistance Program (GAP) is to help agencies authorized to administer title IV-E programs to provide kinship guardianship assistance payments under title IV-E of the Social Security Act, as amended, for relatives taking legal guardianship of children who have been in foster care.

II. PROGRAM PROCEDURES

Administration and Services

The Guardianship Assistance program is administered at the Federal level by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS). Funding is available (at the option of the title IV-E agency) to the 50 States, the District of Columbia, Puerto Rico and federally recognized Indian Tribes, Indian Tribal organizations, and Tribal consortia (hereinafter referred to as Tribes) with approved title IV-E plans, based on a IV-E plan and amendments, as required by changes in statutes, rules, and regulations submitted to and approved by the ACF Children's Bureau Associate Commissioner.

This funding became available beginning on October 7, 2008 with the enactment of amendments to the Social Security Act through the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Pub. L. No. 110-351). The State or Tribal title IV-E agency may implement and claim allowable guardianship assistance program costs beginning on the first day of the quarter in which an approvable title IV-E plan amendment is submitted to ACF to implement the GAP (45 CFR section 1356.20(d)(8)). The program is considered an open-ended entitlement program and allows the State (including the District of Columbia and Puerto Rico) or Tribe to be funded at a specified percentage (Federal financial participation (FFP)) for program costs for eligible children.

The designated IV-E agency for this program also administers ACF funding provided for other title IV-E programs, e.g., Adoption Assistance (CFDA 93.659); Foster Care (CFDA 93.658) and Independent Living Services (CFDA 93.674), as well as the Child Welfare Services (CFDA 93.645) and Promoting Safe and Stable Families (CFDA 93.556) programs (title IV-B of the Social Security Act, as amended); and (States only) the Social Services Block Grant program (CFDA 93.667) (title XX of the Social Security Act, as amended). The IV-E agency may either directly administer the GAP or supervise its administration by local level agencies. Where the program is administered by a State, in accordance with the approved IV-E plan, it must be in effect in all political subdivisions of the State, and, if administered by them, program requirements must be mandatory upon them. Where the program is administered by a Tribe, it must be in effect in all political subdivisions within the Tribal service area(s) and for all populations to be served under the plan. If the program is administered by a political subdivision of a Tribe, program requirements must be mandatory upon them (42 USC 671(a)(1-4) and 42 USC 679B(c)(1)(B)).

Source of Governing Requirements

The GAP is authorized by title IV-E of the Social Security Act, as amended (42 USC 670 *et seq.*). Implementing regulations are at 45 CFR parts 1355, 1356, and 1357. **Section 5001 of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. No. 111-5, 123 Stat 496), as amended by section 201 of Pub. L. No. 111-226, provided for temporary increases in the Federal Medical Assistance Percentage (FMAP) rates for expenditure periods between October 1, 2008 and June 30, 2011 to provide additional funding to IV-E agencies (see paragraph III.G.1.b of this program supplement).**

An interim final rule to implement statutory provisions related to the Tribal title IV-E program was published in the *Federal Register* on January 6, 2012 (77 FR 896 *et seq.*). The rule is effective on February 6, 2012; comments were invited until March 6, 2012.

Awards under the GAP are subject to the HHS implementation of the A-102 Common Rule. This program also is subject to 45 CFR part 95 (Subpart E Cost Allocation Plans is applicable to States) and the cost principles under Office of Management and Budget Circular A-87 (as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, HHS Publication ASMB C-10, available on the Internet at <http://rates.psc.gov/fms/dca/asmb%20c-10.pdf>).

States and Tribes are required to adopt and adhere to their own statutes and regulations for program implementation, consistent with the requirements of title IV-E and an approved IV-E plan.

Availability of Other Program Information

The Children's Bureau manages a policy issuance system that provides further clarification of the law and guides States and Tribes in implementing the Guardianship Assistance program. This information may be accessed on the Internet at http://www.acf.hhs.gov/programs/cb/laws_policies/index.htm.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look first to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Kinship Guardianship Assistance Payments* – Funds may be expended for kinship guardianship assistance payments made on behalf of eligible children (see III.E.1 below) in the amount (subject to limitations in this paragraph) and manner prescribed in a negotiated, written and binding kinship guardianship assistance agreement entered into with the prospective relative guardian (42 USC 673(d)(1)(A)(i)). Kinship guardianship assistance payments are made to relative guardians (as defined in an approved IV-E plan) based on the circumstances of

the relative guardian and the needs of the child (42 USC 673(d)(1)(B)(i)). Kinship guardianship assistance payments cannot exceed the amount of the foster care maintenance payment the child would have received in a foster family home; however, the amount of the payments may be up to 100 percent of the foster care maintenance payment rate which would have been paid on behalf of the child if the child had remained in a foster family home (42 USC 673(d)(2)).

2. *Administrative Costs*

- a. *Program Administration* – Funds may be expended for costs directly related to the administration of the program. Approved public assistance cost allocation plans (States) or approved cost allocation methodologies (Tribes) will identify which costs are allocated and claimed under this program (45 CFR section 1356.60(c)).
- b. *Nonrecurring Costs* – Funds may be expended as specified in a kinship guardianship assistance agreement for the total cost of nonrecurring expenses associated with obtaining legal guardianship of the child (if the child meets program eligibility requirements), to the extent the total cost does not exceed \$2,000 (42 USC 673(d)(1)(B)(iv)).
- c. *Guardianship Placement Costs* – Funds expended by the IV-E agency for guardianship placements (including nonrecurring costs) are considered an administrative expenditure and are subject to the matching requirements in section III.G.1.e(42 USC 674(a)(3)(E)).

3. *Training*

- a. Funds may be expended for training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the agency administering the plan (42 USC 674(a)(3)(A)).
- b. Funds may be expended for short-term training of: relative guardians; State/Tribe-licensed or State/Tribe-approved child welfare agencies providing services to children receiving title IV-E assistance; child abuse and neglect court personnel; agency, child or parent attorneys; guardians ad litem; and, court appointed special advocates (42 USC 674(a)(3)(B)).

B. Allowable Costs/Cost Principles

Both States and Tribes are subject to the requirements of OMB Circular A-87 (2 CFR part 225). States also are subject to the cost allocation provisions and rules governing allowable costs of equipment of 45 CFR part 95, which references OMB Circular A-87 at 45 CFR section 95.507(a)(2) (45 CFR sections 1355.57, 95.503, and 95.705).

E. Eligibility

1. Eligibility for Individuals

- a. Kinship guardianship assistance payments may be paid on behalf of a child only if program eligibility is established through one of the following methods:

(1) *General Eligibility*

All of the following requirements must be met to establish general eligibility:

- (a) *Removal from Home* – The child was removed from his or her home pursuant to a voluntary placement agreement or as a result of a judicial determination to the effect that continuation in the home would be contrary to the welfare of the child (42 USC 673(d)(3)(A)(i)(I)).
- (b) *Title IV-E Foster Care Connection* – The child was eligible for foster care maintenance payments under 42 USC 672 while residing for at least 6 consecutive months in the home of the prospective relative guardian (42 USC 673(d)(3)(A)(i)(II)).
- (c) *Non-Availability of Other Permanency Options* – The IV-E agency determined that being returned home or adopted are not appropriate permanency options for the child (42 USC 673(d)(3)(A)(ii)).
- (d) *Family Dynamics* – The IV-E agency determined that the child demonstrates a strong attachment to the prospective relative guardian and the relative guardian has a strong commitment to caring permanently for the child (42 USC 673(d)(3)(A)(iii)).
- (e) *Child Consultation* – With respect to a child who has attained 14 years of age, the child has been consulted regarding the kinship guardianship arrangement (42 USC 673(d)(3)(A)(iv)).
- (f) *Kinship Guardianship Assistance Agreement* – The kinship guardianship assistance agreement must be a written and binding document entered into through negotiations with the prospective relative guardian and contain information concerning; the amount of, and manner in which, each kinship guardianship assistance payment will be provided under the agreement, and the manner in which the payment

may be adjusted periodically, in consultation with the relative guardian, based on the circumstances of the relative guardian and the needs of the child

(42 USC 673(d)(1)(A)(i) and 673(d)(1)(B)(i)).

- (g) *Legal Guardianship* – A kinship guardianship assistance agreement that meets, or is amended to meet, all the requirements of 42 USC 673(d)(1) must be in place with a prospective relative guardian prior to the establishment of the legal guardianship. Payments may only begin once the relative guardian has committed to care for the child and has assumed legal guardianship for the child for whom they have cared as foster parents and for whom they have committed to care on a permanent basis (42 USC 671(a)(28) and 675(7)).
- (h) *Safety Requirements* – Any relative guardian must satisfactorily have met a criminal records check, including a fingerprint-based checks of national crime information databases (as defined in section 534(e)(3)(A) of title 28, United States Code), and for checks described in 42 USC 671(a)(20)(B) on any relative guardian and any other adult living in the home of any relative guardian, before the relative guardian may receive kinship guardianship assistance payments on behalf of the child (42 USC 671(a)(20)(C)).
- (i) *Age of Child* – Once a child is determined eligible to receive title IV-E kinship guardianship assistance payments, he or she remains eligible in accordance with the terms of the kinship guardianship assistance agreement and the payments can continue until: (i) attainment of the age of 18 (or attainment of age 21 if the IV-E agency determines that the child has a mental or physical disability which warrants the continuation of assistance); (ii) the IV-E agency determines that the relative guardian(s) is no longer legally responsible for the support of the child, or (iii) the IV-E agency determines the child is no longer receiving any support from the relative guardian(s) (42 USC 673(a)(4)(A) and (B)).

Beginning on October 1, 2010, a title IV-E agency may amend its title IV-E plan to provide for a definition of a “child” as an individual who has not attained 19, 20, or 21 years old (as the IV-E agency may elect) (42 USC 675(8)(B)(iii)). This definition of a child will then permit payment of kinship guardianship assistance for a child who

is over age 18 (where the IV-E agency does not determine that the child has a mental or physical disability which warrants the continuation of assistance up to age 21) only if such a youth is part of an kinship guardianship assistance agreement that is in effect under section 473 of the Social Security Act and the youth had attained 16 years of age before the agreement became effective. As an additional requirement, a youth over age 18 must also (as elected by the IV-E agency) be: (i) completing secondary school (or equivalent); (ii) enrolled in post-secondary or vocational school; (iii) participating in a program or activity that promotes or removes barriers to employment; (iv) employed 80 hours a month; or (v) incapable of any of these due to a documented medical condition (42 USC 675(8)(B)).

(2) *Sibling Eligibility*

- (a) The child and any sibling of the eligible child (established under the General Eligibility requirements listed in item E.1.a.(1) above) may be placed in the same kinship guardianship arrangement if the State/Tribal agency and the relative agree on the appropriateness of the arrangement for the siblings (42 USC 673(d)(3)(B)(i) and 42 USC 671(a)(31); and
- (b) Kinship guardianship assistance payments may be paid pursuant to a kinship guardianship assistance agreement (in accordance with requirements in item E.1.a.(1)(f) on behalf of each sibling so placed. If kinship guardianship assistance payments are paid on behalf of the sibling, the IV-E agency must pay (in accordance with a kinship guardianship assistance agreement) the total cost of nonrecurring expenses associated with obtaining legal guardianship of the child, to the extent the total cost does not exceed \$2,000. The sibling does not have to meet the eligibility criteria in 42 USC 673(d)(3)(A) to receive kinship guardianship assistance payments or for the legal guardian to be reimbursed for the nonrecurring expenses related to costs of the legal guardianship (42 USC 673(d)(3)(B)(ii)).
- (c) Siblings of an eligible child must also individually meet the requirements specified in items E.1.a.(1)(g), and (i) above (42 USC 671(a)(28); 675(7) 42 USC 673(a)(4)(A) and (B); and 42 USC 675(8)(B)).

(3) *Title IV-E Guardianship Waiver Post-Demonstration Projects*

- (a) After the termination of a demonstration project relating to guardianship conducted by a State under section 1130 of the Social Security Act, children who, as of September 30, 2008, were receiving assistance or services under the project are deemed to be eligible under the approved title IV-E State plan for the same assistance and services under the same terms and conditions that applied during the conduct of the project (42 USC 674(g)).
- (b) Post-demonstration assistance and services to eligible children assisted in accordance with terminated guardianship related demonstration projects as noted above in item E.1.a.(3)a is eligible for title IV-E claiming whether or not the State opts to operate a GAP pursuant to 42 USC 673(d) (42 USC 674(g)).

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable

3. Eligibility for Subrecipients – Not Applicable

F. Equipment and Real Property Management

Equipment that is capitalized and depreciated or is claimed in the period acquired and charged to more than one program is subject to 45 CFR section 95.707(b) in lieu of the requirements of the A-102 Common Rule (applies to States only).

G. Matching, Level of Effort, Earmarking

1. Matching

The percentage of required State/tribal funding and associated Federal funding (“Federal financial participation”) varies by type of expenditure as follows:

- a. Third party in-kind contributions cannot be used to meet the State’s cost sharing requirements (Child Welfare Policy Manual Section 8.1F.Q#2 8/16/02). 45 CFR section 92.24 is not applicable to this program (45 CFR sections 1355.30(c) and 1355.30(n)(1); 45 CFR section 201.5(e)). Tribes directly operating a title IV-E program are permitted to use in-kind funds from third-party sources as match for a portion of administrative and training costs consistent with statutory limits (unless further defined through applicable regulatory limits under regulations that are currently pending) on the percentage of in-kind expenditures and allowable third-party sources (42 USC 679c(c)(1)(D); 45 CFR section 1356.68).

- b. *Kinship Guardianship Assistance Payments* – The percentage of title IV-E funding in kinship guardianship assistance payments will be the FMAP percentage. This percentage varies by State and is available on the Internet at <http://www.aspe.hhs.gov/health/fmap.htm> (42 USC 674(a)(1); 45 CFR section 1356.60(a)). **ARRA provides for a temporary increase in FMAP percentages to provide additional funding to IV-E agencies (ARRA, Section 5001 as amended by Section 201 of the Education, Jobs and Medicaid Assistance Act, Pub. L No. 111-226). These temporary increases will affect rates for FYs 2009 and 2010 and the first three quarters of FY 2011 only (i.e., October 1, 2008 – June 30, 2011). Generally, aside from the possible applicability of a hold harmless provision, an increase of 6.2 percent will be added to the FMAP percentage rate of every State for quarters from October 1, 2008 through December 31, 2010. In accordance with Section 201 of Pub. L. No. 111-226, the ARRA temporary FMAP percentage rate increase was extended for an additional 6 months, but the level of increase is modified as follows: 3.2 percent for the quarter ending March 31, 2011 and 1.2 percent for the quarter ending June 30, 2011.**

Effective October 1, 2009, separate Tribal FMAP rates, which are based upon the Tribe's service area and population, apply to Guardianship Assistance program assistance payments incurred by Tribes that are participating in title IV-E programs through either direct operation of an approved title IV-E plan or through operation of a title IV-E agreement or contract with a State title IV-E agency. The methodology for calculating Tribal FMAP rates was provided through a final notice in the *Federal Register* that is available on the internet as follows: <http://www.gpo.gov/fdsys/pkg/FR-2011-08-01/pdf/2011-19358.pdf>. The calculated FMAP rate for each Tribe includes any statutory temporary percentage increase applicable to State FMAP rates and applies unless it is exceeded by the FMAP rate for any State in which the Tribe is located (42 USC 679B(d) and 42 USC 679B(e)).

- c. *Staff Training* – The percentage of Federal funding in expenditures for short- and long-term training at educational institutions of employees or prospective employees (including travel and per diem) is 75 percent (42 USC 674(a)(3)(A) and (B); 45 CFR section 1356.60(b)).
- d. *Professional Partner Training* – The percentage of Federal funding in expenditures for short-term training of: relative guardians; State/Tribe-licensed or State/Tribe-approved child welfare agencies providing services to children receiving title IV-E assistance; child abuse and neglect court personnel; agency, child or parent attorneys; guardians ad litem; and, court appointed special advocates is subject to an increasing FFP rate for these additional trainee groups as follows: 55 percent in FY 2009; 60 percent in FY 2010; 65 percent in FY 2011; 70 percent in FY 2012; 75 percent in FY 2013 and thereafter (42 USC 674(a)(3)(B)).

e. *Administrative Costs*

- (1) The percentage of Federal funding for non-recurring IV-E agency kinship guardianship placement expenditures (not to exceed \$2,000 for each kinship guardianship) is 50 percent (42 USC 674(a)(3)(E)).
- (2) The percentage of Federal funding of all other allowable administrative expenditures is 50 percent (42 USC 674(a)(3)(E)).

2. **Level of Effort** – Not Applicable

3. **Earmarking** – Not Applicable

H. Period of Availability of Federal Funds

GAP operates on a cash accounting basis and each year's funding and accounting is discrete. To be eligible for Federal funding, claims must be submitted to ACF within 2 years after the calendar quarter in which the IV-E agency made the expenditure. This limitation does not apply to prior period decreasing adjustments and any claim qualifying for a time limits exception in accordance with 45 CFR section 95.19 (42 USC 1320b-2; 45 CFR sections 95.7, 95.13, and 95.19).

L. Reporting

1. **Financial Reporting**

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Not Applicable
- d. For reporting periods through September 30, 2010: ACF-IV-E-1, *Foster Care and Adoption Assistance Financial Report (OMB No. 0970-0205)* – Title IV-E agencies report current expenditures for the previous quarter, and estimate costs for the next quarter. Prior quarter adjustment (increasing and decreasing) expenditures applicable to earlier quarters must also be separately reported on this form.

Key Line Items – The following items contain critical information:

Part 1, *Adoption Assistance Expenditures, columns (a) through (d)*

Part 2, *Prior Quarter Adjustments – Adoption Assistance, columns (a) through (d)*

- e. For reporting periods beginning October 1, 2010 or later: CB-496, *Title IV-E Programs Quarterly Financial Report (OMB No. 0970-0205)* – Title IV-E agencies report current expenditures and information on children assisted for the quarter that has just ended and estimates of expenditures and children to be assisted for the next quarter. Prior quarter adjustment (increasing and decreasing) expenditures applicable to earlier quarters must also be separately reported on this form.

Key Line Items – The following line items contain critical information.

Part 1, *Expenditures, Estimates and Caseload Data, columns (a) through (d) (Sections C and D (Guardianship Assistance Program))*

Part 2, *Prior Quarter Expenditure Adjustments – Guardianship Assistance, columns (a) through (d)*

2. **Performance Reporting** – Not Applicable
3. **Special Reporting** – Not Applicable
4. **Section 1512 ARRA Reporting** – Not Applicable
5. **Subaward Reporting under the Transparency Act** – Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES**CFDA 93.153 GRANTS FOR COORDINATED SERVICES AND ACCESS TO RESEARCH FOR WOMEN, INFANTS, CHILDREN, AND YOUTH (Ryan White Program)****I. PROGRAM OBJECTIVES**

The objective of this program is to improve access to primary medical care, research, and support services for Human Immunodeficiency Virus (HIV)-infected women, infants, children and youth, and affected family members, through the provision of coordinated, comprehensive, culturally and linguistically competent, family-centered services.

II. PROGRAM PROCEDURES**Administration and Services**

This program is administered at the Federal level by the HIV/Acquired Immunodeficiency Syndrome (AIDS) Bureau, Health Resources and Services Administration (HRSA), a component of the Department of Health and Human Services.

The Coordinated Services for Women, Infants, Children, and Youth (CSWICY) networks of health care and support services programs provide family-centered outpatient ambulatory health care for women, infants, children and youth with HIV/AIDS. Grantees can also provide additional support services to patients and affected family members.

Grants under this program are awarded to public and non-profit private entities, including health facilities operated by or pursuant to a contract with the Indian Health Service (42 USC 300ff-71(a)). Services may be provided directly by the grantee or through contractual agreements with other service providers. Many of these grantees/providers receive other Federal funding, e.g., other Ryan White HIV/AIDS program funding, community and migrant health centers, but this categorical funding allows them to provide adequate funding for these services.

Source of Governing Requirements

The CSWICY grant program is authorized under Part D of Title XXVI of the PHS Act, as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Pub. L. No. 109-415), and the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Program) (Pub. L. No. 111-87), and is codified at 42 USC 300ff-71. The program has no specific program regulations.

Availability of Other Program Information

Further information about this program is available at <http://www.hab.hrsa.gov/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look first to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Activities Allowed*

- a. Funds may be used for family-centered care involving outpatient or ambulatory care, directly or through contracts or memoranda of understanding, for women, infants, children and youth with HIV/AIDS. This includes provision of professional, diagnostic and therapeutic services by a primary care provider or a referral to and provision of specialty care; and services that sustain program activity and contribute to or help improve those services (42 USC 300ff-71(a) and (h)(3)).

Funds are not required to be used for primary care services when payments are available for such services from other sources (including Titles XVIII, XIX and XXI of the Social Security Act) (42 USC 300ff-71(i)).

- b. Funds may be used for support services for patients and affected family members, including: family-centered care including case management; referrals for additional inpatient hospital services, treatment for substance abuse and mental health services and for other social and support services as appropriate; other services as necessary to enable the patient and the family to participate in the program, including services to recruit and retain youth with HIV; and provision of information and education on opportunities to participate in HIV/AIDS-related clinical research (42 USC 300ff-71(b)(1)–(b)4)).
- c. Funds may be used for the establishment of a clinical quality management program to assess the extent to which medical services are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infections, to develop strategies for ensuring that such services are consistent with the guidelines and to ensure that improvements in the access to and quality of HIV health services are addressed (42 USC 300ff-71(f)(2)).
- d. Funds may be used for administrative expenses, which are defined as funds used by grantees for grant management and monitoring activities, including costs related to any staff or activity other than provision of services. Indirect costs included in a Federal negotiated indirect rate are not considered part of administrative costs (See III.G.3 for a limitation on

expenditures for administrative costs) (42 USC 300ff-71 (f)(1), (h)(1), and (h)(2)).

2. *Activities Unallowed*

- a. Grant funds may not be used for AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug abuse or sexual activity, homosexual or heterosexual (42 USC 300ff-84).
- b. None of the funds made available under this Act, or an amendment made by this Act, shall be used to provide individuals with hypodermic needles or syringes so that individuals may use illegal drugs (42 USC 300ff-1).

G. Matching, Level of Effort, Earmarking

1. Matching – Not Applicable

2.1 Level of Effort – *Maintenance of Effort* – Not Applicable

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable

3. Earmarking

Not more than 10 percent of the amount awarded may be used for administrative expenses. Costs related to provision of services and amounts for indirect costs included in a federally negotiated indirect rate are not considered administrative expenses for purposes of this limitation (42 USC 300ff-71(f)(1), (h)(1), and (h)(2)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Applicable.
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Not Applicable

5. Subaward Reporting under the Transparency Act – Not Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.210 TRIBAL SELF-GOVERNANCE PROGRAM – IHS COMPACTS/FUNDING AGREEMENTS

I. PROGRAM OBJECTIVES

The objective of this program is to “improve and perpetuate the government-to-government relationship between Indian tribes and the United States and to strengthen tribal control over Federal funding and program management” by enabling tribes to assume programs, services, functions, and activities (or portions thereof) (PSFAs) of the Indian Health Service (IHS), Department of Health and Human Services (HHS) that are otherwise available to Indian tribes (tribes) or Indians.

II. PROGRAM PROCEDURES

Title V of the Indian Self-Determination and Education Act (ISDEAA) (Pub. L. No. 106-260), which was signed into law August 18, 2000, provided permanent self-governance authority within the Indian Health Service. A Self-Governance compact is a legally binding and mutually enforceable written agreement, including such terms as the parties intend shall control year after year, that affirms the government-to-government relationship between a Self-Governance Tribe and the United States. As a result, the provisions of compacts vary significantly, with only minimal cross-cutting compliance requirements.

A funding agreement (FA) is a legally binding and mutually enforceable written agreement that identifies the PSFAs that the Self-Governance Tribe will carry out, the funds being transferred from Service Unit, Area and Headquarters levels in support of those PSFAs, and such other terms as are required, or may be agreed upon, pursuant to Title V. Funding under FAs may be multi-year agreements.

Tribal compactors may provide health care services directly at facilities operated by the compactor or by operating a contract health services program as part of the FA. Contract health services are services provided to IHS-eligible beneficiaries by private sector health-care providers, such as hospitals and physicians, under contract with the tribal compactor.

Source of Governing Requirements

Title V of the ISDEAA, as amended, is codified at 25 USC 458aaa.

Regulations concerning the general administration of Indian health programs are found at 42 CFR part 136. Regulations implementing ISDEAA Title V and establishing the IHS Tribal Self-Governance Program are found at 42 CFR part 137.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Funds may be used to carry out and deliver the health services PSFA. The FA generally identifies the PSFAs to be performed or administered by the tribe (25 USC 458aaa-4(d)).
2. A Self-Governance Tribe may incur costs that are reasonable in amount and appropriate to the investment responsibilities of the Self-Governance Tribe (42 CFR section 137.101(c)).
3. Funds may be used to meet matching or cost participation requirements under any other Federal or non-Federal program; when used in this manner they are considered non-Federal funds (42 CFR section 137.217).

B. Allowable Costs/Cost Principles

1. A Self-Governance Tribe must apply the cost principles of the applicable OMB circular, generally OMB Circular A-87, except as modified by 25 U.S.C. 450j-1, other provisions of law, or any exemptions to applicable OMB circulars subsequently granted by OMB (42 CFR section 137.167).
2. For contract health services, the Tribal compactor is the payer of last resort. Before seeking payment from the Tribal compactor, the contract provider must first seek payment from all alternate resources, such as health care providers and institutions; health care programs including programs under the Social Security Act (i.e., Medicare or Medicaid); State or local health care programs; and, private insurance. Where a third-party liability is established after the claim is paid, reimbursement from the third party should be sought (42 CFR section 136.61).

C. Cash Management

A Self-Governance Tribe may retain and spend interest earned on any funds paid under a compact or FA (25 USC 458aaa-7(h); 42 CFR section 137.100).

E. Eligibility

1. Eligibility for Individuals

- a. *Eligibility for services within facilities operated by the IHS (which are billed by IHS to the tribe) or run by a tribal organization for the Federal Government*
- (1) Individuals of Indian descent belonging to the Indian community served by the local facilities and program are eligible to receive services. An individual may be regarded as within the scope of the Indian health and medical service if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in Indian affairs, or other relevant factors in keeping with the general Bureau of Indian Affairs practices in the jurisdiction (42 CFR section 136.12(a)(2)).
 - (2) Non-Indian women pregnant with an eligible Indian's child are eligible for services. In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction. Services may be provided only during the period of her pregnancy through postpartum (generally 6 weeks after delivery) (42 CFR section 136.12(a)).
 - (3) Services may be provided to non-Indian members of an eligible Indian's household if a medical officer in charge determines that such services are needed to control an acute infectious disease or a public health hazard (42 CFR section 136.12(a)).
 - (4) Otherwise ineligible individuals may receive temporary care and treatment in case of an emergency, as an act of humanity (42 CFR section 136.14(a)).
 - (5) Services may be provided on a cost basis to otherwise ineligible persons in accordance with the criteria in Section 813 of the Indian Health Care Improvement Act (25 USC 1621e).
- b. *Eligibility for services in the Contract Health Services component of IHS*
- (1) In order to qualify for the Contract Health Services component of IHS:
 - (a) An individual must meet the requirements outlined in paragraph III.E.1.a above (42 CFR section 136.23(a)); and

- (b) Must either reside in the United States and on a reservation located within a Contract Health Service Delivery Area (CHSDA) as defined under 42 CFR section 136.22; or, if he/she does not reside on a reservation, reside within a CHSDA; and
 - (c) Be a member of the tribe or tribes located on that reservation or of the tribes or tribes for which the reservation was established; or maintain close economic and social ties with said tribe or tribes (42 CFR section 136.23(a)).
- (2) *Students* – Students continue to be eligible for contract health services during their full-time attendance at programs of vocational, technical, or academic education, including normal school breaks and for a period not to exceed 180 days after the completion of their studies (42 CFR section 136.23(b)).
 - (3) *Transients* – Transient persons, such as those who are in travel or are temporarily employed, remain eligible for contract health services during their absence (42 CFR section 136.23(b)).
 - (4) *Other Persons* – Other persons who leave the CHSDA in which they are eligible and are neither transients nor students remain eligible for contract health services for a period not to exceed 180 days from such departure (42 CFR section 136.23(c)).
 - (5) *Foster Children* – Indian children who are placed in foster care outside a CHSDA by order of a court of competent jurisdiction and who were eligible for contract health services at the time of the court order shall continue to be eligible for contract health services while in foster care (42 CFR section 136.23(d)).
- 2. **Eligibility for Group of Individuals or Area of Service Delivery** – Not Applicable
 - 3. **Eligibility for Subrecipients** – Not Applicable

H. Period of Availability of Federal Funds

- 1. An FA shall have the term mutually agreed to by the parties. Absent notification from a tribe that it is withdrawing or retroceding the operation of one or more PSFAs identified in the FA, the FA shall remain in full force and effect until a subsequent FA is executed (42 CFR section 137.55).
- 2. All funds paid to an Indian tribe in accordance with a compact or FA shall remain available until expended (25 USC 458aaa-7(i)).

J. Program Income

1. For direct care services, the tribal compactor is eligible to pursue reimbursement from all applicable sources (25 USC 1621e, 42 USC 1395qq, and 42 USC 1396j).
2. All Medicare, Medicaid, or other program income earned by a tribe shall be treated as supplemental funding to that negotiated in the FA. The tribe may retain all such income and expend such funds in the current year or in future years except to the extent that the Indian Health Care Improvement Act (25 USC 1601 *et seq.*) provides otherwise for Medicare and Medicaid receipts (25 USC 450j-1 and 25 USC 458 aaa-7(j)). Such funds shall not result in any offset or reduction in the amount of funds the Self-Governance Tribe is authorized to receive under its FA in the year the program income is received or for any subsequent fiscal year (42 CFR section 137.110).
3. *Use of Funds Collected through HHS* – Tribes electing to receive Medicare and Medicaid reimbursement through HHS shall first use such income for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under Medicare or Medicaid programs. (Pub. L. No. 106-291, 114 Stat. 978, 42 USC 1395qq, and 25 USC 1642).

IV. OTHER INFORMATION

Funds previously awarded for tribal self-governance planning and negotiation cooperative agreements under CFDA 93.210 are now funded under a separate CFDA number – CFDA 93.444. For purposes of the audit, CFDA 93.444 is considered a separate program and should not be clustered with CFDA 93.210.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.217 FAMILY PLANNING – SERVICES

I. PROGRAM OBJECTIVES

The purpose of the Family Planning – Services Project Grant (FPSPG) program is to provide funds for education, counseling, and comprehensive medical and social services necessary to enable individuals to freely determine the number and spacing of their children; and, by doing so, to help improve pregnancy outcomes, reduce infertility and promote the health of females, males and their families.

II. PROGRAM PROCEDURES

The FPSPG program is administered by the Office of the Secretary (OS), a component of the Department of Health and Human Services (HHS). Within the OS, the Office of Family Planning/Office of Population Affairs is responsible for the program. The program has no statutory funds allocation formula; HHS makes discretionary grant awards whose amounts are based on estimates of the amounts necessary for successful project performance.

Any public or non-profit private entity in a State (which includes each of the 50 States, District of Columbia, Commonwealth of Puerto Rico, U.S. Virgin Islands, Commonwealth of the Northern Mariana Islands, American Samoa, Guam, Republic of Palau, Federated States of Micronesia, and the Republic of the Marshall Islands) may apply for a project grant under the program. The entity applying for the grant must follow Public Health System Reporting Requirements and submit to the State a plan for a coordinated and comprehensive program of family planning services.

Family planning services under the FPSPG program must be voluntary and must be made available without coercion and with respect for the privacy, dignity, and social and religious beliefs of the individuals being served. To the extent possible, entities that receive grants shall encourage family participation in projects assisted under this program.

Source of Governing Requirements

The FPSPG is authorized under Title X of the Public Health Service Act, as amended (42 USC 300 *et seq.*). The implementing regulations are at 42 CFR part 59.

Availability of Other Program Information

Additional information is available on the HHS Office of Population Affairs web site at <http://www.hhs.gov/opa/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Activities Allowed*

- a. *Provision of services* – A project supported by the FPSPG must provide a broad range of family planning methods and services, including infertility services and services for adolescents. Services that may be funded for a particular project are identified in the grant application. They may include:
 - (1) *Medical services* – These include providing information on all FDA-approved methods of contraception (including natural family planning methods); counseling services; physical examinations, including cancer detection and laboratory tests; issuance of contraceptive supplies; periodic follow-up examinations; and referral to other medical facilities when medically indicated.
 - (2) *Social services* – These include counseling, referral to and from other social and medical service agencies, and such ancillary services as are necessary to facilitate clinic attendance.
 - (3) *Information and education* – These activities are designed to achieve community understanding of the program’s objectives, inform the community of the availability of program services, and promote continued participation in the project by persons likely to benefit from its services (42 CFR sections 59.5(a)(1) and (b)).
- b. *Purchase of services* – If the grantee obtains services for its clients by contract or other arrangements with service providers, it must do so according to agreements with the providers that specify payment rates and procedures (42 CFR section 59.5(b)(9)).

2. *Activities Unallowed* – No Title X funds shall be used in programs where abortion is a method of family planning (42 CFR section 59.5(a)(5)).

G. Matching, Level of Effort, Earmarking**1. Matching**

The Federal share of a FPSPG project's cost may never equal 100 percent nor be less than 90 percent (with certain exceptions). The Federal and non-Federal shares are stated in the Notice of Grant Award issued to the grantee (42 CFR sections 59.7(b) and (c)).

2. Level of Effort – Not Applicable**3. Earmarking – Not Applicable****J. Program Income**

A grantee must charge for family planning services according to the client's ability to pay. A person's inability to pay according to the prescribed fee schedule must not be a barrier to receiving services. A person from a low-income family may not be charged, except to the extent that payment will be made by a third party (such as an insurer or a government agency) which is authorized or under legal obligation to pay such charge. Individuals from other than low-income families are charged according to an established fee schedule which is based on the cost of services. For individuals from families with incomes between 101 and 250 percent of the published Income Poverty Guidelines, such a schedule must provide discounts based on ability to pay. Fees for individuals from families with higher incomes are set to recover the reasonable cost of providing the services (42 CFR sections 59.5(a)(7) and (8)).

A "low-income family" is one whose total annual family income does not exceed 100 percent of the most recent Income Poverty Guidelines published by HHS in the *Federal Register*. These guidelines may be found on the HHS web site at <http://aspe.hhs.gov/poverty/>. "Low-income family" also includes members of families whose annual family income exceeds the poverty level, but who the project director has determined are unable, for good reasons, to pay for family planning services. For example, unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources (42 CFR sections 59.2 and 59.5(a)(6)).

The Notice of Grant Award provides guidance on the use of program income. Generally the addition method is used for this program.

L. Reporting**1. Financial Reporting**

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable

- c SF-425, *Federal Financial Report* – Applicable
- 2. **Performance Reporting** – Not Applicable
- 3. **Special Reporting** – Not Applicable
- 4. **Section 1512 ARRA Reporting** – Not Applicable
- 5. **Subaward Reporting under the Transparency Act** – Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.224 CONSOLIDATED HEALTH CENTERS (COMMUNITY HEALTH CENTERS, MIGRANT HEALTH CENTERS, HEALTH CARE FOR THE HOMELESS, PUBLIC HOUSING PRIMARY CARE, AND SCHOOL BASED HEALTH CENTERS)

CFDA 93.527 AFFORDABLE CARE ACT (ACA) GRANTS FOR NEW AND EXPANDED SERVICES UNDER THE HEALTH CENTERS PROGRAM

I. PROGRAM OBJECTIVES

In general, the objective of the Consolidated Health Centers Program (CHCP) is to provide to populations that would ordinarily not have access to health care (1) primary and preventive health services, (2) referrals to other services, such as hospital and substance abuse services, and (3) case management and other services designed to assist health center patients in establishing eligibility and gaining access to Federal, State, and local programs that provide additional medical, social, or educational support or enabling services, such as transportation, translation and outreach services, and patient education services.

The CHCP typically provides family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities, e.g., those where economic, geographic or cultural barriers limit access to such services for a substantial portion of the population. Some health center delivery sites serve vulnerable populations, including homeless individuals, migrant farm workers, residents of public housing, and school children at risk of poor health outcomes.

Required health services for health centers include services related to family medicine, internal medicine, pediatrics, obstetrics/gynecology, lab and radiology services, and prenatal and perinatal services; cancer screening; well-child services; immunizations; screenings for elevated blood lead, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings; voluntary family planning services; preventive dental services; emergency medical services; referrals to providers of medical services; and, as appropriate, pharmaceutical services.

Some exceptions and special provisions for certain components of the CHCP are:

Health Care for the Homeless (HCH) – In addition to services required of all consolidated health centers, recipients of HCH funding must provide substance abuse services, including detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals.

Specific provisions of governance requirements for HCH funding can be waived by the Health Resources and Services Administration (HRSA) under a delegation from the Secretary, Department of Health and Human Services (HHS) (see II, “Program Procedures – Administration and Services”). These requirements also may be waived under Public Housing Primary Care (PHPC) and Migrant Health Centers (MHC) components (42 USC 254b(k)(3)(H)(iii)).

Migrant Health Centers – The requirement for an MHC to provide all the primary care services can be waived, and an MHC also may receive approval to provide certain required primary health care services during certain periods of the year only. An MHC may provide health services other than primary care services due to the health needs of the population it serves. These services may include environmental health services, screening for and control of infectious diseases, and injury prevention programs.

The objective of the program for new and expanded services (CFDA 93.527) under the health centers program, authorized by the Affordable Care Act, is to provide for expanded and sustained national investment in community health. This program also is referred to as “new access points” or NAP.

II. PROGRAM PROCEDURES

Planning Grants

The purpose of these grants is to assess the health care needs of the population to be served and to plan and develop a health center program that will serve medically underserved populations. This includes efforts to obtain financial and professional support, develop linkages with other health-care providers, and involve the community. Planning grants also may be awarded to health centers to plan or develop a managed care network.

Operational Grants

The purpose of these grants is to support the costs of operating health centers that serve medically underserved populations. Operational grants also may include the operation of managed care and practice management networks and plans.

Administration and Services

CHCP grants are awarded and administered at the Federal level by the Bureau of Primary Health Care (BPHC), HRSA, HHS. Based on applications submitted to and approved by HRSA, grants are provided to public and private non-profit organizations including tribal, faith-based and community-based organizations. Factors considered include the population to be served and the current availability of services in the geographical area to be served.

Unless the requirement is waived, grantees are required to have a governing board that is composed of individuals, a majority of whom are being served by the center, and, who, as a group, represent the individuals being served by the center (except in the case of an entity operated by and Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or an urban Indian organization under the Indian Health Care Improvement Act). The responsibilities of the governing board include, among other things, selecting the services to be provided, determining the center’s hours of operation, and approving the selection of the center director. Grantees may enter into service and care arrangements with vendors to expand their service networks.

The annual level of HRSA funding for the operation of a health center is determined on the basis of the center's approved scope of services, projected total costs of operation, and expected revenues from program income and funding from non-Federal sources. This includes all State, local, and other operational funding received by or allocated to the approved project, and all premiums, fees, and third-party reimbursements received (adjusted for uncollectible amounts). The Federal dollars awarded are intended to make up the expected difference between the projected costs and revenues.

Source of Governing Requirements

The CHCP and NAP are authorized under Section 330 of the Public Health Service Act, as amended by Section 10503 of The Patient Protection and Affordable Care Act (Pub. L. No. 111-148). The statutory provisions are codified at 42 USC 254b. The implementing program regulations for Community Health Centers (CHC) and MHCs are 42 CFR parts 51c and 56, respectively. The HCH and PHPC components do not have program-specific regulations.

Availability of Other Program Information

Additional program information is available from the BPHC web site at <http://www.bphc.hrsa.gov/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Operational Grants for Other than Managed Care and Practice Management Networks and Plans*
 - a. Required primary health services include:
 - (1) Basic health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and, where appropriate, by physician assistants, nurse practitioners, and nurse midwives (42 USC 254b(b)(1)(A)(i)(I)).
 - (2) Diagnostic laboratory and radiological services (42 USC 254b(b)(1)(A)(i)(II)).
 - (3) Preventive health services, including prenatal and perinatal services; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases and cholesterol; pediatric eye, ear, and dental screenings; voluntary

- family planning services; and preventive dental services (42 USC 254b(b)(1)(A)(i)(III)).
- (4) Emergency medical services (42 USC 254b(b)(1)(A)(i)(IV)).
 - (5) Pharmaceutical services, as may be appropriate for particular centers (42 USC 254b(b)(1)(A)(i)(V)).
 - (6) Referrals to providers of medical services, (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services) (42 USC 254b(b)(1)(A)(ii)).
 - (7) Patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, educational, housing, or other related services (42 USC 254b(b)(1)(A)(iii)).
 - (8) Services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by the center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals) (42 USC 254b(b)(1)(A)(iv)).
 - (9) Education of patients and the general population served by the health center regarding the availability and proper use of health services (42 USC 254b(b)(1)(A)(v)).
- b. Additional health services that may be provided as appropriate to meet the health needs of the population to be served include:
- (1) Behavioral and mental health and substance abuse services 42 USC 254b(2)(A); however, substance abuse services are required under HCH grants (42 USC 254b(h)(2)).
 - (2) Recuperative care services (42 USC 254b(b)(2)(B)).
 - (3) Environmental health services, including the detection and alleviation of unhealthful conditions associated with water supply, chemical and pesticide exposures, air quality, or exposure to lead; sewage treatment; solid waste disposal; rodent and parasitic infestation; field sanitation; housing; and other environmental factors related to health (42 USC 254b(b)(2)(C)).

- (4) For MHCs, special occupation-related health services for migratory and seasonal agricultural workers, including screening for and control of infectious diseases (including parasitic diseases) and injury prevention programs (including prevention of exposure to unsafe levels of agricultural chemicals including pesticides) (42 USC 254b(b)(2)(D)).
- c. Funds may be used for the reimbursement of members of the grantee's governing board, if any, for reasonable expenses incurred by reason of their participation in board activities (42 CFR sections 51c.107(b)(3) and 56.108(b)(3)).
- d. Funds may be used for the cost of insurance for medical emergency and out-of-area coverage (42 CFR section 51c.107(b)(6)).
- e. Funds may be used for the acquisition and lease of buildings and equipment (including the costs of amortizing the principal of, and paying the interest on, loans for equipment) (42 USC 254b(e)(2)).
- f. Funds may be used for the costs of providing training related to the provision of required primary health care services and additional health services and to the management of health center programs (42 USC 254b(e)(2)).

2. *Planning Grants for Health Centers*

Funds may be used for the acquisition and lease of buildings and equipment (including the costs of amortizing the principal of, and paying the interest on, loans) (42 USC 254b(c)(1)(A)).

3. *Planning Grants for Managed Care or Practice Management Networks or Plans*

- a. Funds may be used for the acquisition and lease of buildings and equipment, which may include data and information systems (including the costs of amortizing the principal of, and paying the interest on, loans for equipment) (42 USC 254b(c)(1)(D)).
- b. Funds may be used to provide training and technical assistance related to the provision of health services on a prepaid basis or other managed care arrangement, and for other purposes that promote the development of managed care networks and plans (42 USC 254b(c)(1)(D)).

B. Allowable Costs/Cost Principles

Program income, including, but not limited to, fees, premiums and third-party reimbursements may be used for allowable activities (see III.A.1, "Activities Allowed or Unallowed – Operational Grants for Other Than Managed Care and Practice Management Networks and Plans") and for such other purposes as are not specifically

prohibited if such use furthers the objectives of the project. As such, program income is subject to the unallowable cost provisions of the program rather than the OMB cost principles circulars (42 USC 254b(e)(5)(D)).

E. Eligibility

1. Eligibility for Individuals

Under HCH funding, if a grantee has provided services to a previously homeless individual and the individual is no longer homeless as a result of becoming a resident in permanent housing, the grantee may continue to provide services for not more than 12 months (42 USC 254b(h)(4)).

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable

3. Eligibility for Subrecipients – Not Applicable

J. Program Income

1. Health centers must have a schedule of fees or payments for the provision of their health services consistent with locally prevailing rates or charges and designed to cover their reasonable costs of operation. They are also required to have a corresponding schedule of discounts applied and adjusted based on the patient's ability to pay (42 USC 254b(k)(3)(G)(i)). The patient's ability to pay is determined based on the official poverty guideline, as revised annually by HHS (42 CFR sections 51c.107(b)(5), 56.108(b)(5), and 56.303(f)). The poverty guidelines are issued each year in the *Federal Register* and HHS maintains a page on the Internet that provides the poverty guidelines (<http://aspe.hhs.gov/poverty/>).
2. Health centers are required to collect (or make every reasonable effort to collect) appropriate reimbursement for their costs in providing health services to persons eligible for medical assistance under Title XIX of the Social Security Act (Medicaid), entitled to insurance benefits under Title XVIII of the Social Security Act (Medicare) or entitled to assistance for medical expenses under any other public assistance program or private health insurance program. Reimbursement for health services to such persons should be collected based on the full amount of fees and payments for those services without application of any discount (42 USC 254b(k)(3)(F) and (G)(ii)(II)).
3. Program income, including, but not limited to, fees, premiums and third-party reimbursements may be used for allowable activities (see III.A.1. above) and for such other purposes as are not specifically prohibited if such use furthers the objectives of the project (42 USC 254b(e)(5)(D)).

L. Reporting**1. Financial Reporting**

- a. SF-270, *Request for Advance or Reimbursement* – Applicable, if specified in the terms and conditions of award.
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable**3. Special Reporting** – *Uniform Data System (OMB No. 0915-0193)* – This system is comprised of two separate sets of reports, the Universal Report and Grant Reports. The conditions for their use are:

- Grantees that receive a single grant under the consolidated health centers program or that receive CHC funding only are required to complete the *Universal Report* only.
- Grantees that receive multiple awards (in addition to or other than CHC funding) must complete a *Universal Report* for the combined grants and individual *Grant Reports* for their HCH, MHC, and PHPC funding, if applicable.

Key Line Items – The following line items contain critical information:

- a. Table 5 – Staffing and Utilization
 - (1) Line 8 – *Total Physicians*
 - (2) Line 15 – *Total Medical Care Services*
 - (3) Line 19 – *Total Dental Services*
 - (4) Line 29 – *Total Enabling Services*
 - (5) Line 33 – *Total Administration and Facility*
- b. Table 8 Part A – Financial Costs
 - (1) Line 4(c) – *Total Medical Care Services*
 - (2) Line 10(c) – *Total Other Clinical Services*
 - (3) Line 13(c) – *Total Enabling and Other Services*

- (4) Line 16 – *Total Overhead*
- (5) Line 18 – *Value of Donated Facilities, Services, and Supplies*

c. Table 9 Part D – Patient Related Revenue

- (1) Line 1 – *Medicaid Non-managed Care*
- (2) Line 2a – *Medicaid Managed Care (capitated)*
- (3) Line 2b – *Medicaid Managed Care (fee-for-service)*
- (4) Line 7 – *Other Public including Non-Medicaid CHIP (non-managed care)*
- (5) Line 10 – *Private Non-Managed Care*
- (6) Line 11a – *Private Managed Care (capitated)*
- (7) Line 11b – *Private Managed Care (fee-for-service)*
- (8) Line 13 – *Self Pay*

4. Section 1512 ARRA Reporting – Not Applicable

5. Subaward Reporting under the Transparency Act – Not Applicable

N. Special Tests and Provisions

1. Governing Board

Compliance Requirement – Unless the requirement for a governing board is waived by HRSA or the center is operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or an urban Indian organization under the Indian Health Care Improvement Act, the health center must have a governing board that (1) is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center; (2) meets at least once a month; (3) selects the services to be provided by the center; (4) schedules the hours during which services will be provided by the center; (5) approves the center’s annual budget; (6) approves the selection of a director for the center; and (7) except in the case of a public center, establishes general policies for the center (42 USC 254b(k)(3)(H)).

Audit Objectives – Determine whether (1) the center has adopted and periodically reviews and updates, as necessary, by-laws or other internal policies for governing board selection and operation; (2) the board meets at least monthly and approves the annual budget; and (3) for actions occurring during the audit period that, by statute, require governing board decision or approval, the center complied with the statute and its by-laws/internal operating procedures.

Suggested Audit Procedures

- a. Ascertain if the center has by-laws or other internal policies addressing the required elements of the board and its operation.
- b. Review meeting minutes to ascertain if the board approved the annual budget.
- c. As of the end of the year preceding the audit, determine the board membership, services provided, operating hours, and center director. Ascertain if changes occurred in any of these areas during the audit period and, if so, whether the governing board had the type of involvement required by the statute and acted in compliance with the center's by-laws/internal operating procedures.

2. Section 340B Drug Pricing Program

Section 602 of Public Law 102-585, the "Veterans Health Care Act of 1992," enacted section 340B of the Public Health Service Act ("PHS Act"), "Limitation on Prices of Drugs Purchased by Covered Entities." Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally qualified health center look-alikes and qualified hospitals. Drugs purchased from participating drug manufacturers by covered entities through the 340B Program may not be sold or transferred to anyone other than the patients of the covered entities. In addition, drugs purchased through the 340B Program are not entitled to rebates under the Medicaid program because this would result in duplicate discounts.

While an organization is eligible to participate in the program, it must notify the Health Resources and Services Administration's (HRSA) Office of Pharmacy Affairs (OPA) of its intention to participate by registering for the 340B Program. Participation in the 340B Program normally begins on the first day of a quarter. It is the entity's responsibility to tell its wholesaler or manufacturer that it is registered for 340B discount prices when it places an order.

All organizations receiving 340B prices are required to maintain records of purchases of covered outpatient drugs and of any claims for reimbursement submitted for such drugs under title XIX of the Social Security Act (Medicaid program, CFDA 93.778).

Guidance for the 340B program is found in the following documents available at <http://www.hrsa.gov/opa/federalregister.htm>:

"Guidance Regarding Section 602 of the Veterans Health Care Act of 1992 Limitation on Prices of Drugs Purchased by Covered Entities" 58 FR 27289 (May 7, 1993)

"Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Duplicate Discounts and Rebates on Drug Purchases (58 FR 34058-34059), June 23, 1993.

"Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Entity Guidelines" 59 FR 25110 (May 13, 1994).

Additional information is available at <http://www.hrsa.gov/opa/introduction.htm>.

Compliance Requirements – Organizations participating in the 340B Program must ensure that (1) their organizational information is accurate in the 340B database maintained by OPA; (2) outpatient drugs purchased under the 340 B Program are not being given to individuals who are not eligible patients (diversion); and (3) discounts are not being received from both Medicaid rebates and 340B discounts (duplicate discounts).

Accurate Information

Section 340B of the PHSA requires OPA to maintain accessible data on the identity of participating entities. Covered entities are required to ensure the accuracy of the information in the database by regularly updating (at least annually) their information, including the covered entity's exact name and street address, through submission of change request forms to OPA.

Diversion

Section 340B(a)(5)(B) of the PHSA prohibits covered entities from selling, transferring, or giving covered outpatient drugs to anyone other than patients of the covered entity. The statute does not define the term “patient” in section 340B and in 1996, HRSA issued a guideline regarding the definition of a “patient” under the 340B program. An individual is a “patient” of a covered entity (with the exception of State-operated or funded AIDS drug purchasing assistance programs) only if: (1) the covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual’s health care; (2) the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g. referral for consultation) such that responsibility for the care provided remains with the covered entity; and (3) the individual receives a health care service or range of services from the covered entity which is consistent with the service or range of services for which grant funding is provided. Additional information is available at <ftp://ftp.hrsa.gov/bphc/pdf/opa/FR10241996.pdf>. “Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility.”

Duplicate Discounts

Section 340B(a)(5)(A) of the PHSA required the Secretary of HHS to establish a mechanism to ensure that manufacturers did not pay a “duplicate discount” on a drug claim. A “duplicate discount” would occur if an entity received a **340B discount** and a **Medicaid rebate** were provided on the same drug. The mechanism that the Secretary established to comply with the legislation’s mandate to prohibit duplicate discounts is a part of the OPA database called the Medicaid Exclusion File (58 FR 34058 (June 23, 1993) and 59 Fed. Reg. 25110 (May 13, 1994)). Additional information is available at <http://www.hrsa.gov/opa/medicaidexclusion.htm>. If this program includes a “payer of last resort” provision, a patient’s Medicaid eligibility will require the return of rebate funds to manufacturers so as not to incur double recovery.

Audit Objectives – To determine if (1) a grantee’s records are correct in the 340B database; (2) drugs were diverted to individuals who are not eligible patients; and (3) if the organization received duplicate discounts.

Suggested Audit Procedures

- a. Determine if the grantee is participating in the 340B Program and, if so, continue with the remaining audit procedures.
- b. Review the grantee’s latest change form submitted to OPA and compare it with the organization’s actual physical location and other current information about the entity.
- c. Test a sample of drugs purchased for use under the funding program (CFDA 93.xxx) during the audit period to determine whether 340B drugs were properly identified throughout the procurement process, including (1) payment at the discounted price and (2) proper identification as a 340B drug upon receipt.
- d. Test a sample of records of 340B drugs purchased for use under the funding program and released from inventory during the audit period to determine whether required authorizations were received, to whom the drugs were dispensed, and if the grantee determined that such individuals were eligible patients before dispensing the drugs.
- e. For eligible patients who received 340B drugs, test a sample of Medicaid reimbursement requests to verify that the grantee did not claim, receive, or retain a duplicate rebate for those drugs under the Medicaid program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.268 **IMMUNIZATION GRANTS**
CFDA 93.712 **ARRA – IMMUNIZATION**

I. **PROGRAM OBJECTIVES**

The objective of the immunization grant program is to reduce and ultimately eliminate vaccine preventable diseases (VPDs) by increasing and maintaining high immunization coverage. Emphasis is placed on populations at highest risk for under-immunization and disease, including children eligible under the Vaccines for Children (VFC) program.

II. **PROGRAM PROCEDURES**

The Immunization Grants program consists of two parts: discretionary Section 317 immunization grants and VFC financed with mandatory Medicaid (CFDA 93.778) funding.

The objective of the discretionary Section 317 immunization grant program is to reduce and ultimately eliminate VPDs by increasing and maintaining high immunization coverage. Emphasis is placed on populations at highest risk for under-immunization and disease, which includes VFC-eligible children. The statute refers to development of programs for all individuals for whom vaccines are recommended, including infants, children, adolescents and adults. The intent of the discretionary Section 317 immunization grant program is to supplement, not supplant, each grantee's immunization effort at the State/local level. The Centers for Disease Control and Prevention (CDC), through its grant guidance, has identified the following areas of activity for programmatic emphasis and funding prioritization: reduce the number of indigenous cases of vaccine-preventable diseases; ensure that all children are appropriately vaccinated; improve vaccine safety surveillance; increase routine vaccination coverage levels for adolescents; and increase the proportion of adults who are vaccinated annually against influenza and who have ever been vaccinated against pneumococcal disease.

VFC, which is authorized by and financed through Title XIX of the Social Security Act (Medicaid), is activity-based financial assistance and direct assistance in the form of vaccine-purchase funds and program operations funds to support implementation of the VFC program. VFC is administered by CDC and is funded entirely by the Federal government. VFC funds are provided to eligible grantees to develop and operate programs designed to ensure effective delivery of vaccination services to eligible children through enrolled providers of medical care. Grantees are required to encourage a variety of providers to participate in the VFC program and to administer vaccines in an appropriate cultural context. Grantees also are required to ensure that providers comply with the requirements of the VFC program. Other criteria, detailed in annual grant application guidance documents, may also apply.

Under VFC, children from birth through 18 years of age are eligible for VFC-purchased vaccine if they are Medicaid-eligible, American Indian/Alaskan Native, or without health insurance. Children who are insured but whose insurance does not cover vaccination also are eligible to receive VFC vaccine at Federally Qualified Health Centers or Rural Health Clinics. The intent of the VFC program is to increase vaccination coverage levels by reducing financial barriers to vaccination. The VFC program ensures that all eligible children receive the benefits of all

recommended vaccines, thus strengthening immunity levels in their communities. The program also ensures that access to newly recommended vaccines for children in low-income and uninsured families does not lag behind that for children in middle- and upper-income families. In addition, the program helps to ensure that there is an adequate supply of routinely recommended vaccines when public health emergencies occur, including vaccine supply shortages.

The VFC program authorizes participating immunization providers in all States to receive publicly purchased vaccine for administration to VFC-eligible children. The goal is to ensure that no child contracts a VPD because his or her parent cannot afford to pay for the vaccine or its administration.

VFC and Section 317 financial assistance (FA) is provided/obligated directly to immunization grantees for administrative and operations costs. Similarly, Section 317 FA is obligated to grantees for the purchase of vaccines not available through federal contracts. Funds for direct assistance (DA) vaccines are maintained at CDC, and are periodically obligated to manufacturer contracts. Grantees are given estimated target budgets for their DA vaccine purchase needs. CDC uses these budgets as a control mechanism for vaccine orders.

Vaccines will be maintained by a federally contracted third-party distributor that receives orders from and ships vaccine to providers. Periodically, when the federal distributors' inventory reaches certain minimum thresholds, the distributor makes a request to CDC for replenishment vaccines. CDC reviews these requests and assigns funding sources to them (VFC or 317) based on the aggregate of grantee submitted spend plans. Orders for the vaccines are processed and sent to the appropriate manufacturer(s), referencing funds that were previously obligated to the manufacturer contracts. The manufacturer fulfills the order and ships the vaccines to the federally contracted distributor.

Source of Governing Requirements

These programs are authorized under 42 USC 247b, 42 USC 243, 42 USC 300aa-3, 300aa-25 and 300aa-26, 42 USC 1396s, **and the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (ARRA)**. Regulations specific to discretionary Section 317 grants may be found at 42 CFR part 51b.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Discretionary Section 317 grant funds may be used to establish and maintain a preventive health service program, including:

- a. Research into the prevention and control of diseases that may be prevented through vaccination;
 - b. Demonstration projects for the prevention and control of such diseases;
 - c. Public information and education programs for the prevention and control of such diseases;
 - d. Education, training, and clinical skills improvement activities in the prevention and control of such diseases for health professionals; and
 - e. Operational activities associated with the conduct of a successful immunization program (42 USC 247b(k)(1)).
2. The VFC program is intended primarily as a vaccine purchase and supply program for eligible children. VFC funds may be expended to support costs associated with the following:
 - a. VFC vaccine ordering;
 - b. VFC vaccine distribution for grantees that have not transitioned to a federally contracted vaccine distributor; and
 - c. Direct VFC program operations, such as provider recruitment and enrollment, overall VFC program coordination, vaccine management and accountability, VFC provider accountability and site visit assessments, and VFC program evaluation (42 USC 1396s).

J. Program Income

Grantees providing direct immunization services may generate program income from fees or donations. Vaccine administration fees may be charged under VFC, however, they may not exceed the maximum reimbursement schedule established by the Centers for Medicare and Medicaid Services, the delegated authority. This cap does not apply to discretionary Section 317 grants. However, no one may be denied immunization services due to the inability to pay a fee or donation (42 USC 1396s(c)(2)(C)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. **Special Reporting** – Not Applicable
4. **Section 1512 ARRA Reporting** – Applicable
5. **Subaward Reporting under the Transparency Act** – Not Applicable

N. Special Tests and Provisions

1. Control, Accountability, and Safeguarding of Vaccine

Compliance Requirement – Effective control and accountability must be maintained for all vaccine under the VFC program. Vaccine must be adequately safeguarded and used solely for authorized purposes (42 USC 1396s). This includes administration only to VFC program-eligible children, as defined in 42 USC 1396s(b)(2)(A)(i) through (A)(iv), regardless of the child's parent's ability to pay (42 USC 1396s(c)(2)(C)(iii)).

Audit Objective – Determine whether the grantee provides oversight of program-enrolled providers to ensure that proper control and accountability is maintained for vaccine, vaccine is properly safeguarded (based on guidance provided by CDC), and VFC-eligibility screening is conducted.

Suggested Audit Procedures

- a. Determine if the grantee has a written procedure for overseeing program-enrolled providers that allows for sampling of provider's inventory records and assessment of storage procedures. Grantees are not required to sample the records of all providers.
- b. Determine if the grantee sampled the provider's inventory records to ensure proper recording of receipt, transfer, and usage of vaccine.
- c. Determine if the grantee reviewed the provider's storage of vaccine for proper safeguarding, including risks of loss from theft, expiration, or improper storage temperature.
- d. Determine if the grantee reviewed a sample of provider medical records for documentation of eligibility screening.
- e. Determine if necessary follow-up procedures were followed if any deficiencies were identified.

2. Record of Immunization

Compliance Requirement – A record of vaccine administered shall be made in each person's permanent medical record (or in a permanent office log or file to which a legal representative shall have access upon request) (42 USC 300aa-25) which includes:

- a. Date of administration of the vaccine;

- b. Vaccine manufacturer and lot number of the vaccine; and
- c. Name and address and, if appropriate, the title of the health care provider administering the vaccine.

Audit Objective – Determine whether the grantee provides oversight of vaccinating providers to ensure that the required information has been recorded for vaccine recipients.

Suggested Audit Procedures

- a. Determine if the grantee has a written procedure for ensuring that the required information has been recorded for vaccine recipients.
- b. Determine if the grantee tested a sample of vaccination records to ascertain if the required information was maintained.
- c. Determine if the grantee took any follow-up action if the required records and information were not maintained.

IV. OTHER INFORMATION

After the end of each month and after the end of each Federal fiscal year, CDC advises each grantee of the value of all federally funded vaccine, **including ARRA-funded vaccine**, which was distributed, in lieu of cash, directly to the grantee and/or on behalf of the grantee to vaccinating providers located in the grantee's geographical area. The annual dollar value of federally funded vaccine, **including ARRA-funded vaccine**, should be treated by the grantee as grant expenditure for purposes of determining audit coverage and reporting on the Schedule of Expenditures of Federal Awards. Vaccinating providers and vaccinated individuals are not considered subrecipients; therefore, the value of vaccine received is not grant expenditure for purposes of determining audit coverage and reporting for those entities.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.505 AFFORDABLE CARE ACT – MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM FORMULA, EXPANSION, AND DEVELOPMENT GRANTS TO STATES

I. PROGRAM OBJECTIVES

The goals of the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program are to: (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

The MIECHV program includes grants to States and six jurisdictions (District of Columbia, Puerto Rico, US Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands). The legislation requires that grantees demonstrate improvement in six benchmark areas: improved maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvement in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports.

This program is intended to support and strengthen cooperation and coordination and promote linkages among various programs that serve pregnant women, expectant fathers, young children, and families in tribal communities and result in high-quality, comprehensive early childhood systems in every community.

II. PROGRAM PROCEDURES

The Health Resources and Services Administration (HRSA) administers the MIECHV program in collaboration with the Administration for Children and Families (ACF), with awards made by HRSA. HRSA and ACF are Operating Divisions of the Department of Health and Human Services (HHS).

Grants are awarded to States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, and America Samoa to conduct needs assessments; develop the infrastructure needed for the widespread planning, adopting, implementing, and sustaining of evidence-based maternal, infant, and early childhood home visiting programs; and provide high-quality, evidence-based home visiting services to pregnant women and families with young children from birth to age 5. The formula grants are awarded for a 2-year project and budget period. Expansion grants were awarded for a 4-year project period composed of four 12-month budget periods. Development grants were awarded for a 2-year project period composed of two 12-month budget periods.

Source of Governing Requirements

This program is authorized under the Social Security Act, Title V, Section 511 (42 USC 711), as amended by Section 2951 of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

Availability of Other Program Information

The HRSA Maternal and Child Health Bureau web site provides general information on this program at <http://mchb.hrsa.gov/programs/homevisiting/>.

The funding opportunity announcements (FOAs) for this program are HRSA-10-275 (formula grants), HRSA-11-179 (development and expansion grants), and HRSA-11-187 (formula grants) and may be found online at <https://grants.hrsa.gov/webexternal/fundingOpp.asp>. Enter CFDA 93.505 and in the Search Archive section at the bottom of the page, set the radio button to “yes.” Scroll to the relevant FOA and click on “View Details.” Scroll down to the “Download Information” section, and click on the FOA document link. The FOAs also are available in the archives at Grants.gov through an advanced search using CFDA 93.505.

HHS launched Home Visiting Evidence of Effectiveness (HomVEE) to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting programs models that target families with pregnant women and children from birth to age 5. Information on this process and a list of the nine evidence-based models can be found at: <http://homvee.acf.hhs.gov/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

Funds may be used to—

1. conduct a coordinated needs assessment to identify at-risk communities through a collaborative process that engages all stakeholders (e.g., maternal and child health; early education and child care; child maltreatment; mental health and substance abuse; domestic violence; and health and human service agencies as well as partners from the business community);
2. develop the infrastructure and capacity needed to implement and sustain evidence-based maternal, infant, and early childhood home visiting programs in those communities;

3. provide home visiting services to eligible families (home visiting is defined as an evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women or children birth to age 5 targeting the participant outcomes in the legislation which include improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits, improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports); and
4. carry out research and evaluation activities to build the knowledge base on home visiting among targeted populations (FOAs HRSA 10-275, 11-179, and 11-187).

See III.G.3 below for expenditure limits.

E. Eligibility

1. Eligibility for Individuals

Services must be provided to families residing in at-risk communities as identified by the State. Eligible families include pregnant women; expectant fathers; parents; and primary caregivers of children aged birth through kindergarten entry, including grandparents or other relatives of the child, foster parents who are serving as the child's primary caregiver, and non-custodial parents who have an ongoing relationship with, and at times provide physical care for, the child (Section 511(d)(4) of the Social Security Act, as added by Section 2951 of Pub. L. No. 111-148).

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable

3. Eligibility for Subrecipients – Not Applicable

G. Matching, Level of Effort, Earmarking

1. Matching – Not Applicable

2.1 Level of Effort – *Maintenance of Effort* – Not Applicable

2.2 Level of Effort – *Supplement Not Supplant*

Funds provided to an eligible entity receiving a grant shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives. The grantee must agree to maintain non-federal funding (State General Funds) for grant activities at a level which is not less than expenditures

for such activities as of the entity's most recently completed fiscal year (home visiting is defined as an evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women or children birth to age 5 targeting the participant outcomes in the legislation which include improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits, improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports) (Section 511(f) of the Social Security Act, as added by Section 2951 of Pub. L. No. 111-148; FOAs HRSA 11-179 and HRSA 11-187, Section III.3).

3. Earmarking

- a. At least 75 percent of grant funds must be spent on implementation of evidence-based home visiting models. Currently, nine home visiting models meet the HHS criteria for evidence-based home visiting models and are eligible for the 75 percent of funding (Child FIRST, Early Intervention Program for Adolescent Mothers, Healthy Families America, Home Instruction for Parents of Preschool Youngsters, Nurse-Family Partnership, Parents as Teachers, Family Check-Up, Healthy Steps, and Early Head Start) (FOA HRSA 11-179, Section I and FOA HRSA 11-187, Section IV.1.x, Section 3).
- b. No more than 25 percent of grant funds may be spent on conducting a program using a service delivery model based on a promising and new approach to the benchmark areas. The 25 percent limit pertains to the total funds awarded to the grantee for the fiscal year, i.e., the amount equal to state's formula grant plus the amount of the competitive grant award, if the state's application is successful. ((Section 511(d)(3)(A)(ii) of the Social Security Act, as added by Section 2951 of Pub. L. No. 111-148); FOA HRSA 11-179, Section II.2).
- c. Not more than 10 percent of the award amount may be spent on administrative expenditures. The requirements of Section 504(d) (relating to a limitation on administrative expenditures) apply to these awards. (Section 511(i)(2) of the Social Security Act, as added by Section 2951 of Pub. L. No. 111-148.)

H. Period of Availability of Federal Funds

Funds are available for expenditure by the grantee through the end of the second succeeding fiscal year after award (Section 511(j)(3) of the Social Security Act, as added by Section 2951 of Pub. L. No. 111-148).

L. Reporting**1. Financial Reporting**

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable**3. Special Reporting** – Not Applicable**4. Section 1512 ARRA Reporting** – Not Applicable**5. Subaward Reporting under the Transparency Act** – Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.508 AFFORDABLE CARE ACT – TRIBAL MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING GRANT PROGRAM

I. PROGRAM OBJECTIVES

The goals of the Affordable Care Act Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program include both supporting the development of healthy, happy, successful American Indian and Alaska Native (AIAN) children and families through a coordinated, high-quality, evidence-based home visiting strategy and expanding the evidence base around home visiting programs for American Indian/Alaska Native populations. Home visiting programs are intended to promote outcomes such as improvements in maternal and prenatal health, infant health, and child health and development; reduced child maltreatment; improved parenting practices related to child development outcomes; improved school readiness; improved family socio-economic status; improved coordination of referrals to community resources and supports; and reduced incidence of injuries, crime, and domestic violence. It is envisioned that this program will support and strengthen cooperation and coordination and promote linkages among various programs that serve pregnant women, expectant fathers, young children, and families in tribal communities and result in high-quality, comprehensive early childhood systems in every community.

II. PROGRAM PROCEDURES

Agency Administration and Services

The Administration for Children and Families (ACF) and the Health Resources and Services Administration are jointly funding this program, with awards made by ACF.

Phase 1: Needs Assessment, Planning, and Capacity-Building (Year 1)

- Grantees must (1) conduct a comprehensive community needs assessment and (2) develop a plan and begin to build capacity to respond to identified needs.

Phase 2: Implementation Phase (Years 2-5)

- Grantees will implement the various components of their approved plan to respond to identified needs (submitted at the end of Phase 1 and work closely with ACF and the Health Services and Resources Administration to ensure high-quality, evidence-based home visiting programs in their community.

NOTE: If a grantee completes its needs assessment, submits a plan for responding to identified needs, and receives approval from ACF and HRSA to implement this plan prior to the end of Year 1, it may use the remainder of Year 1 funding to conduct Phase 2 activities, potentially including providing high-quality, evidence-based home visiting services to families.

Cooperative Agreements

Cooperative agreements are awarded to Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to conduct needs assessments; develop the infrastructure needed for the widespread planning, adopting, implementing, and sustaining of evidence-based maternal, infant, and early childhood home visiting programs; and provide high-quality, evidence-based home visiting services to pregnant women and families with young children aged birth to kindergarten entry. The project period for these grants is 5 years.

Source of Governing Requirements

This program is authorized under Section 511(h)(2)(A) of Title V of the Social Security Act, as added by Section 2951 of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. No. 111-148).

This program is meant to support critical maternal, infant, and early childhood home visiting services for AIANs in Tribal communities, including Indian Tribes or Urban Indian Centers (as defined by Section 4 of the Indian Health Care Improvement Act, Pub.L. No. 94-437).

Availability of Other Program Information

A copy of the FY 2010 Funding Opportunity Announcement for the Tribal Maternal, Infant, and Early Childhood Home Visiting Program Grantees is available at the following website:
<http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-OFA-TH-0134>.

The ACF web site provides general information on this program at
<http://www.acf.hhs.gov/earlychildhood/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Activities Allowed*

Funds may be used to—

- a. conduct a coordinated needs assessment to identify at-risk Tribal communities through a collaborative process that engages all stakeholders (e.g., maternal and child health; early education and child care; child maltreatment; mental health and substance abuse; domestic violence; AIAN Head Start, Tribal child care, Tribal child welfare, the Indian Health

Service, and health and human service agencies as well as partners from the business community);

- b. develop the infrastructure and capacity needed to implement and sustain evidence-based maternal, infant, and early childhood home visiting programs in those communities;
- c. provide home visiting services to eligible families; and
- d. participate in research and evaluation activities to build the knowledge base on home visiting among Tribal populations (Funding Opportunity Announcement, Required Grant Activities).

2. *Activities Unallowed*

- a. Pre-award costs may not be paid under this program,
- b. Construction is not an allowable activity, and
- c. Purchase of real property is not an allowable activity (Funding Opportunity Announcement, Section IV.5).

E. Eligibility

1. Eligibility for Individuals – Not Applicable

2. Eligibility for Groups or Area of Service Delivery

- a. Eligible families in at-risk American Indian/Alaska Native communities include pregnant women, expectant fathers, parents, and primary caregivers of children aged birth through kindergarten entry, including grandparents or other relatives of the child, foster parents who are serving as the child's primary caregiver, and non-custodial parents who have an ongoing relationship with, and at times provide physical care for, the child. (Section 2951(k)(2) of Title V of the Social Security Act, as added by Section 2951 of the Affordable Care Act).
- b. Grantees are required to give priority to serving high-risk groups including: eligible families who reside in communities in need of such services, as identified in the needs assessment; low-income eligible families; eligible families who are pregnant women who have not attained age 21; eligible families that have a history of child abuse or neglect or have had interactions with child welfare services; eligible families that have a history of substance abuse or need substance abuse treatment; eligible families that have users of tobacco products in the home; eligible families that are or have children with low student achievement; eligible families with children with developmental delays or disabilities; and

eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States (Section 511(d)(4) of Title V, as added by Section 2951, Affordable Care Act).

- c. For the purposes of this program, in order to reflect the diverse circumstances of Tribal populations, ACF and HRSA take a broad and inclusive view of the definition of “at-risk community.” Grantees may define an at-risk community in the following ways (and each of these possible definitions has implications for the type and quality of data that will be available for the purposes of the needs assessment):
- (1) An entire Tribe within a discrete geographic region (i.e., on a reservation) could be considered an at-risk community;
 - (2) Subgroups of a Tribe within a discrete geographic region (i.e., on a reservation) could be considered at-risk communities; or
 - (3) Members of a Tribe(s) could live scattered throughout a larger, non-Tribal geographic area interspersed with non-Tribal members (i.e., Indians living in an urban environment) and be considered an at-risk community.
- d. The award of home visiting funds to an Indian Tribe, Tribal Organization, or Urban Indian Organization shall not affect the eligibility of any eligible families in at-risk American Indian/Alaska Native communities to receive home visiting services in the State or States in which the grantee is located.

3. Eligibility for Subrecipients – Not Applicable

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Not Applicable

5. Subaward Reporting under the Transparency Act – Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.556 PROMOTING SAFE AND STABLE FAMILIES

I. PROGRAM OBJECTIVES

The Promoting Safe and Stable Families (PSSF) program provides funds to States and federally recognized Indian Tribes (Tribes and Tribal consortia) to prevent the unnecessary separation of children from their families, improve the quality of care and services to children and their families, and ensure permanency for children by reuniting them with their parents, by adoption or by another permanent living arrangement. The program includes: family support, family preservation, time-limited family reunification, and adoption promotion and support services.

II. PROGRAM PROCEDURES

Administration and Services

The Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS), administers the PSSF. To be eligible for funds, each State and Tribe must submit a five-year comprehensive plan, the Child and Family Services Plan (CFSP). This plan encompasses planning and service delivery for the full child welfare services spectrum. This includes: child welfare services under Title IV-B, Subparts 1 and 2; a child welfare staff development and training plan; a diligent recruitment of foster and adoptive families plan that reflects the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed; and child abuse and neglect prevention, foster care, adoption, and foster care independence services, including an education and training voucher program for foster care youth. An Annual Progress and Services Report (APSR) is required that identifies the specific accomplishments and progress made in the past fiscal year toward meeting each goal and objective in the 5-year comprehensive plan and any revisions in the statement of goals and objectives or to the training plan, if necessary, to reflect changed circumstances.

The Associate Commissioner of the ACF Children's Bureau has approval authority for the title IV-B plans. Following ACF approval, allotments are based on the number of children in the States who received food stamps in the previous three years. Grants may also be made to Tribes that qualify under the allotment formula; no Tribe may be funded if its allotment is less than \$10,000. PSSF services are based on several key principles. The welfare and safety of children and of all family members should be maintained while strengthening and preserving the family. It is advantageous for the family as a whole to receive services, which identify and enhance its strengths while meeting individual and family needs. Services should be easily accessible, often delivered in the home or in community-based settings, and they should respect cultural and community differences. In addition, they should be flexible, responsive to real family needs, and linked to other supports and services outside the child welfare system. Services should involve community organizations and residents, including parents, in their design and delivery. They should be intensive enough to keep children safe and meet family needs, varying between preventive and crisis services.

Source of Governing Requirements

PSSF is authorized under Title IV-B, Subpart 2 of the Social Security Act, as amended, and is codified at 42 USC 629a through 629e. Implementing program regulations are published at 45 CFR parts 1355 and 1357.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Community-based Services* – Programs delivered in accessible settings in the community and responsive to the needs of the community and the individuals and families residing therein. These services may be provided under public or private non-profit auspices (45 CFR section 1357.10(c)).
2. *Family Preservation Services* – Services for children and families designed to protect children from harm and help families (including foster, adoptive, and extended families) at risk or in crisis, including (42 USC 629a(a)(1)):
 - a. Pre-placement preventive services programs, such as intensive family preservation programs, designed to help children at risk of foster care placement remain with their families, where possible;
 - b. Service programs designed to help children, where appropriate, return to families from which they have been removed; or be placed for adoption, with a legal guardian, or, if adoption or legal guardianship is determined not to be appropriate for a child, in some other planned, permanent living arrangement;
 - c. Service programs designed to provide follow-up care to families to whom a child has been returned after a foster care placement;
 - d. Respite care of children to provide temporary relief for parents and other caregivers (including foster parents);
 - e. Services designed to improve parenting skills (by reinforcing parents' confidence in their strengths, and helping them to identify where improvement is needed and to obtain assistance in improving those skills) with respect to matters such as child development, family budgeting, coping with stress, health, and nutrition;

- f. Infant safe haven programs to provide a way for a parent to safely relinquish a newborn infant at a safe haven designated pursuant to a State law; and
 - g. Case management services designed to stabilize families in crisis such as transportation, assistance with housing and utility payments, and access to adequate health care.
3. *Family Support Services* – Community-based services to promote the well-being of children and families designed to increase the strength and stability of families (including adoptive, foster, and extended families), to increase parents' confidence and competence in their parenting abilities, to afford children a stable and supportive family environment, to strengthen parental relationships and promote healthy marriages, and otherwise to enhance child development. Family support services may include (42 USC 629a(a)(2); 45 CFR section 1357.10(c)):
- a. Services, including in-home visits, parent support groups, and other programs designed to improve parenting skills (by reinforcing parents' confidence in their strengths, and helping them to identify where improvement is needed and to obtain assistance in improving those skills) with respect to matters such as child development, family budgeting, coping with stress, health, and nutrition;
 - b. Respite care of children to provide temporary relief for parents and other caregivers;
 - c. Structured activities involving parents and children to strengthen the parent-child relationship;
 - d. Drop-in centers to afford families opportunities for informal interaction with other families and with program staff;
 - e. Transportation, information and referral services to afford families access to other community services, including child care, health care, nutrition programs, adult education literacy programs, legal services, and counseling and mentoring services; and
 - f. Early developmental screening of children to assess the needs of such children, and assistance to families in securing specific services to meet these needs.

4. *Time-Limited Family Reunification Services* – Services and activities that are provided to a child who is removed from his/her home and placed in a foster family home or a child care institution and to the parents or primary caregiver of such a child, in order to facilitate the reunification of the child safely and appropriately within a timely fashion. These services are provided only during the 15-month period that begins on the date that the child, pursuant to 42 USC 675(5)(F), is considered to have entered foster care. The services and activities are the following (42 USC 629a(a)(7)):
 - a. Individual, group, and family counseling;
 - b. Inpatient, residential, or outpatient substance abuse treatment services;
 - c. Mental health services;
 - d. Assistance to address domestic violence;
 - e. Services designed to provide temporary child care and therapeutic services for families, including crisis nurseries; and
 - f. Transportation to or from any of the services and activities described above.
5. *Adoption Promotion and Support Service* – Services and activities designed to encourage more adoptions out of the foster care system, when adoption promotes the best interest of the child, including such activities as pre- and post-adoptive services and activities designed to expedite the adoption process and support adoptive families (42 USC 629a(a)(8)).
6. *Administrative Costs*- Administrative costs (defined as costs of auxiliary functions as identified through an agency's accounting system that are allocable, in accordance with the agency's approved cost allocation plan, to the title IV-B, subpart 2 program cost centers; necessary to sustain the direct effort involved in administering the State plan or an activity providing service to the programs: and centralized in the grantee department or in some other agency) are allowable. Administrative costs include, but are not limited to, the following: procurement; payroll; personnel functions; management; maintenance and operation of space and property; data processing and computer services; accounting; budgeting; and auditing (45 CFR sections 1357.32(h)(1) and (2)). See III.G.3 for a limitation on the amount of administrative costs.
7. *Program Costs* – Program costs are costs, other than administrative costs, incurred in connection with developing and implementing the CFSP (e.g., delivery of services, planning, consultation, coordination, training, quality assurance measures, data collection, evaluations, and supervision) (45 CFR section 1357.32(h)(3)).

8. Funds awarded under Title IV-B, Subpart 2, may not be used for the purchase or construction of facilities (45 CFR section 1357.32(e)).

G. Matching, Level of Effort, Earmarking

1. Matching

Funds are federally reimbursed at 75 percent of allowable expenditures. The IV-B agency's contribution may be in cash, donated funds, and non-public third party in-kind contributions (45 CFR section 1357.32(d)).

2.1 Level of Effort – *Maintenance of Effort* – Not Applicable

2.2 Level of Effort – *Supplement Not Supplant*

- a. States and Tribes (42 USC 629c) may not use Federal funds under title IV-B, Subpart 2, to supplant Federal or non-Federal funds for existing services.
 - (1) “Non-Federal” funds are defined at 42 USC 629a(a)(9) as “State funds, or at the option of a State, State and local funds.” Although State matching may be in the form of cash, donated funds, or non-public third party in-kind contributions, the “supplement not supplant” requirement is limited to non-Federal funds as defined in 42 USC 629a(a)(9).
 - (2) The base year for determining compliance with this requirement is the amount of funds that the State expended for services in the State's fiscal year 1992 (42 USC 629b(a)(7); 45 CFR section 1357.32(f)). The regulations have not been updated to reflect the amendments to the Social Security Act made by the Adoption and Safe Families Act (ASFA) that added two new service categories (i.e., time-limited family and reunification services and adoption promotion and support services) to those specified in 45 CFR section 1357.32(f); however, the base year (1992) remains the same for all four service areas under title IV-B, subpart 2 (42 USC 629b(a) and (b)(1); ACYF-CB-PI-99-07).
- b. The State may not use the amount specified in III.G.3.c. below to supplant any Federal funds paid to the State under part E that could be used for monthly caseworker visitation with children who are in foster care and activities designed to improve caseworker retention, recruitment, training, and ability to access the benefits of technology (Pub. L. No. 109-288, section 3(c)(2)(B)).

3. Earmarking

- a. Unless approved by ACF, States must expend a significant portion of their grant, defined as 20 percent, on each of the following: (1) programs of family preservation services, (2) community-based family support services, (3) time-limited family reunification services, and (4) adoption promotion and support services (42 USC 629b(a)(4); 45 CFR section 1357.15(s); ACYF-CB-PI-10-09 (found at http://www.acf.hhs.gov/programs/cb/laws_policies/policy/pi/2010/pi1009.htm)).
- b. States may not expend more than 10 percent of Federal funds for administrative costs (42 USC 629b(a)(4)). There is no limitation on the percentage of administrative costs that may be reported as State match.
- c. A State shall use the special allocation provided pursuant to Pub. L. No. 109-288 to support monthly caseworker visits with children who are in foster care with a primary emphasis on activities designed to improve caseworker retention, recruitment, training, and ability to access the benefits of technology (42 USC 629f(b)(4)).

H. Period of Availability of Federal Funds

Funds must be expended by September 30 of the fiscal year following the fiscal year in which the funds were awarded (45 CFR section 1357.32(g)), with the exception of those FY 2006 funds provided by the special allocation pursuant to Pub. L. No. 109-288. These latter funds must be expended by September 30, 2009 (Pub. L. No. 109-288, section 3(c)(2)(A)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Not Applicable

5. Subaward Reporting under the Transparency Act – Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- CFDA 93.558** **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)**
CFDA 93.714 **ARRA – EMERGENCY CONTINGENCY FUND FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) STATE PROGRAMS**
CFDA 93.716 **ARRA – TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) SUPPLEMENTAL GRANTS**

I. PROGRAM OBJECTIVES

The objectives of the State and Tribal TANF programs are to provide time-limited assistance to needy families with children so that the children can be cared for in their own homes or in the homes of relatives; end dependence of needy parents on government benefits by promoting job preparation, work, and marriage; prevent and reduce out-of-wedlock pregnancies, including establishing prevention and reduction goals; and encourage the formation and maintenance of two-parent families. This program replaced the Aid to Families with Dependent Children (AFDC), Job Opportunities and Basic Skills Training (JOBS), and Emergency Assistance (EA) programs.

II. PROGRAM PROCEDURES

Administration and Services

The Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS), administers the TANF program on behalf of the Federal Government. To be eligible for the TANF block grant, a State (including the District of Columbia, the Commonwealth of Puerto Rico, the United States (U.S.) Virgin Islands, Guam, and American Samoa) must periodically submit a State plan containing specified information and assurances.

Following ACF review of the State Plan and determination that it is complete, ACF awards the basic “State Family Assistance Grant” (SFAG) to the State using a formula allocation derived from funding levels under the superseded programs. The SFAG is a fixed amount to the State subject to reductions based on any penalties assessed. In addition, amounts may be adjusted on the basis of separate Federal funding of counterpart Indian Tribal programs within the State. States meeting the qualifying criteria may also receive supplemental grants and payments from the contingency fund. As long as the minimum requirements are met, States have significant flexibility in designing programs and determining eligibility requirements. While States have flexibility and discretion, there are provisions to ensure accountability for results, including requirements for data about expenditures and individuals receiving benefits under the program, and monetary penalties for failure to meet programmatic requirements such as work participation.

The Federal TANF block grant program also has an annual cost-sharing requirement, known as maintenance-of-effort (MOE). If a State fails to meet the required minimum all-family or two-parent work participation rate for a Federal fiscal year (FY), then the State must spend at least 80 percent of its fiscal year historic State expenditures to provide benefits and services to eligible clientele. If the State meets both minimum work participation rate requirements, then the

required spending level decreases to 75 percent of its FY 1994 historic State expenditures. “Historic State expenditures” means the State’s FY 1994 share of expenditures in the former Aid to Families with Dependent Children (AFDC), AFDC-EA (Emergency Assistance), AFDC-Related Child Care, Transitional Child Care, At-Risk Child Care and Job Opportunities and Basic Skills (JOBS) programs. States may not use more than 15 percent of the total amount of countable expenditures for the fiscal year for administrative activities.

Tribes

Tribal Family Assistance Plans (TFAP) are developed for a 3-year period and submitted to ACF for review and approval. The Tribal Family Assistance Grant (TFAG) is derived from an amount equal to the Federal share of expenditures, other than child care costs, by the State or States under the former AFDC, EA, and JOBS programs for FY 1994 for all American Indian families residing in the service area identified in the TFAP. The TFAG is a fixed amount, subject to reductions based on any penalties assessed. As long as the minimum requirements are met, Indian tribes (Tribes) have significant flexibility in designing programs and determining eligibility requirements and may use grant funds to provide cash or non-cash assistance, including direct services, and for administrative activities.

Tribal TANF grantees may operate the program under a consolidated Pub. L. No. 102-477 demonstration project. Pub. L. No. 102-477 refers to the Indian Employment, Training and Related Services Demonstration Act of 1992, the purpose of which is to provide for the integration of employment, training and related services to improve the effectiveness of those services. Tribes operating a consolidated Pub. L. No. 102-477 project must still submit a TFAP to the Secretary of HHS for review and approval prior to consolidation of the Tribal TANF program into a Pub. L. No. 102-477 plan. Tribal TANF data collection and performance reporting requirements identified or referenced elsewhere in this program supplement apply. However, Tribes that integrate their Tribal TANF program into the Pub. L. No. 102-477 project may submit TANF financial reports annually as an attachment to their Pub. L. No. 102-477 financial report, the Tribal TANF Financial Addendum Report (12g). Under Pub. L. No. 102-477, funds received from a program must be used and spent in accordance with the applicable rules for that program, subject to any waivers granted by the Secretary of HHS; however, during the period covered by this Supplement in which Federal partners and Tribes are participating in a working group process to address a set of issues relating to plans, reporting, and accountability in Pub. L. No. 102-477 projects, this Supplement provides that auditing of funds should be based on determining that the funds were spent in compliance with the applicable approved plan.

Other Considerations

Funding Methods – States

States have different funding options to expend Federal grant funds and State maintenance-of-effort (MOE) funds. This includes the following:

1. *Federal Only* – Under this option, Federal grant funds are segregated from MOE funds that are expended in the TANF program operated by the State.

2. *Commingled Federal/State* – Under this option, States commingle their MOE funds with Federal grant funds expended in the TANF program operated by the State. A commingled funding structure means that all expenditures are subject to all Federal funding restrictions, TANF requirements, and MOE limitations.
3. *Segregated State* – Under this option, MOE funds are segregated from the Federal grant funds and expended in the TANF program operated by the State.
4. *Separate State Program* – Under this option, States spend their MOE funds in separate State programs, operated outside of the TANF program operated by the State.

Federal grant funds and MOE funds must both be used for “expenditures.” A definition of the term “expenditure” is found in 45 CFR section 260.30. In addition, section 260.33 explains the circumstances under which certain State tax relief provisions would count as expenditures.

Funding Methods – Tribes

Tribes have different funding options under which to expend Federal grant funds and, where applicable, State MOE funds as follows.

1. *Federal Only* – Under this option, Federal grant funds are segregated from any State-donated MOE funds or tribal funds that are expended in the TANF program operated by the Tribe.
2. *Commingled Federal/State-donated MOE* – Under this option, Tribes commingle their State-donated MOE funds with Federal grant funds expended in the TANF program operated by the Tribe. A commingled funding structure means that all expenditures are subject to all Federal funding restrictions and MOE limitations.
3. *Segregated Tribal* – Under this option, MOE funds are segregated from the Federal grant funds and expended separately in the TANF program operated by the Tribe. See IV, “Other Information,” for guidance on State MOE expended by Tribes.

American Recovery and Reinvestment Act

Section 2101 of Subtitle B of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. No. 111-5) established the Emergency Contingency Fund (Emergency Fund) for the State TANF (CFDA 93.714) Program at section 403(c) of the Social Security Act. In accordance with section 2101(c)(6) of ARRA, for qualifying States, Tribes, and Territories, Emergency Fund awards may be used for the same types of expenditures as SFAG or TFAG grant funds.

Policy Announcement TANF-ACF-PI-2009-05 provides additional detail regarding eligibility for the Emergency Fund for State TANF; it is available on the Office of Family Assistance (OFA) website at <http://www.acf.hhs.gov/programs/ofa/policy/pa-ofa/2009/pa200901.htm>.

ARRA made additional changes to TANF, such as extending supplemental grants (CFDA 93.716) through FY 2010 (Section 2102 of Subtitle B of Pub. L. No. 111-5), expanding flexibility in the use of TANF funds carried over from one fiscal year to the next (Section 2103 of Subtitle B of Pub. L. No. 111-5), and adding a hold-harmless provision to the caseload reduction credit for States and Territories serving more TANF families.

Source of Governing Requirements

These programs are authorized under Title IV-A of the Social Security Act, as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Pub. L. No. 104-193), and subsequent amendments thereto, and **ARRA**, and are codified at 42 USC 601-619. PRWORA was signed into law on August 22, 1996, and required State implementation no later than July 1, 1997.

On April 12, 1999, ACF published final regulations for the TANF program. These final rules took effect October 1, 1999 (April 12, 1999, *Federal Register* (64 FR 17720 *et seq.*)). ACF also published technical and correcting amendments to the final rule on July 26, 1999, which were also effective on October 1, 1999 (July 26, 1999, *Federal Register* (64 FR 40290 *et seq.*)). Thus, the obligations and expenditures of Federal TANF funds on or after October 1, 1999, and any State actions occurring on or after October 1, 1999, are subject to the provisions in the final rules, as amended (see 45 CFR Parts 260 – 265 for the TANF regulations applicable to States). The Deficit Reduction Act (DRA) of 2005 (Pub. L. No. 109-171), enacted February 8, 2006, included provisions to reauthorize the TANF program. On June 29, 2006, ACF published interim final regulations implementing the changes to the TANF program required by the DRA (June 29, 2006, *Federal Register* (71 FR 37454 *et seq.*)), which is available at <http://www.acf.hhs.gov/programs/ofa/tanfregs/tfinrule.pdf>. On February 5, 2008, ACF published the final regulations implementing the changes to the TANF program required by the DRA of 2005 (February 5, 2008, *Federal Register* (73 FR 6772 *et seq.*)), which is available at <http://www.acf.hhs.gov/programs/ofa/>. The final rule is effective October 1, 2008.

PRWORA also authorized any federally recognized Tribe in the lower 48 states, 13 specified Alaskan Native entities, and consortia of eligible Tribes to apply for funding under section 412 of the Act to administer a Tribal TANF program beginning July 1, 1997. The Foster Care Independence Act of 1999 (Pub. L. No. 106-169, December 14, 1999) also included technical amendments to the Act, which affected program regulations. Implementing regulations for Tribal TANF are in 45 CFR part 286 and were published in the *Federal Register* on February 18, 2000 (65 FR 8477 *et seq.*).

State and *all* Tribal TANF programs (i.e., including Tribal TANF programs in Pub. L. No. 102-477 projects) are subject to the provisions in 45 CFR part 92, the HHS implementation of the A-102 common rule, and OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments [2 CFR part 225]).

Availability of Other Program Information

TANF-ACF-PI-2007-08, dated November 28, 2007 on *Using Federal TANF and State Maintenance-of-Effort (MOE) Funds for Families in Areas Covered by a Federal or State Disaster Declaration* presents items to consider with respect to the current TANF program when addressing the needs of families affected by a Federal or State-declared disaster. TANF-ACF-PI-2007-08 is available at <http://www.acf.hhs.gov/programs/ofa/policy/tanf-pi.htm>.

Other general program information regarding the State and Tribal TANF programs is available from the Office of Family Assistance (OFA) web site at <http://www.acf.hhs.gov/programs/ofa/>. Questions related to the TANF program may be directed to Robert Shelbourne at 202-401-5150 (direct) or by e-mail at robert.shelbourne@acf.dhhs.gov.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

This program makes references to States, however, in some cases, subrecipients of States (e.g., local governments) may be responsible for compliance requirements that are referred to in this Supplement as “State.” The auditor should adjust accordingly for the entity being audited.

A. Activities Allowed or Unallowed

1. Federal Only

- a. Funds may be used for expenditures for activities that are not permissible under 42 USC 601, but for which the State was authorized to use IV-A or IV-F funds under prior law. The previously authorized activities must have been included in a State’s approved State AFDC plan, JOBS plan, or Supportive Services Plan, as in effect on September 30, 1995, or at the State’s option, on August 21, 1996. Examples of such activities are authorized juvenile justice and foster care activities (42 USC 604(a)(2); 45 CFR section 263.11(a)(2)).
- b. A State may transfer up to 30 percent of the combined total of current fiscal year funds (not prior fiscal year funds carried into the current fiscal year) received under the State family assistance grant, and supplemental grant for population increases for a given fiscal year to carry out programs under the Social Services Block Grant (Title XX) (CFDA 93.667) and/or the Child Care and Development Block Grant (CFDA 93.575). However, no more than 10 percent may be transferred to Title XX, and such amounts may be used only for programs or services to children or their families whose income is less than 200 percent of the poverty level. Neither contingency funds under 42 USC 603(b) nor emergency funds under 42 USC 603(c) (Pub. L. No. 111-5) can be transferred under this authority

(Pub. L. No. 109-171, Sec. 7101(a); Pub. L. No. 110-161 (Consolidated Appropriations Act, 2008 (Social Services Block Grant); 42 USC 604(d); 45 CFR section 263.11(b); and 45 CFR section 264.72(e)). The poverty guidelines are issued each year in the *Federal Register* and HHS maintains a web site that provides the poverty guidelines (<http://aspe.hhs.gov/poverty/index.shtml>).

2. *Federal Only and Commingled Federal/State* – Funds may not be used to provide medical services other than pre-pregnancy family planning services (42 USC 608(a)(6)).
3. *Federal Only, Commingled Federal/State, Segregated State, Separate State Program*
 - a. Funds may be used in any manner reasonably calculated to accomplish the purposes of the program, including providing low-income households with assistance in meeting home heating and cooling costs (42 USC 604(a)(1) and 45 CFR section 263.11(a)(1)). As specified in 42 USC 601 and 45 CFR section 260.20, the TANF program has the following purposes:
 - (1) Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
 - (2) End dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
 - (3) Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and
 - (4) Encourage the formation and maintenance of two-parent families.
 - b. A State may use funds for programs to prevent and reduce the number of out-of-wedlock pregnancies, including programs targeted to law enforcement officials, the educational system and counseling services, that provide education and training of women and men on the problem of statutory rape (42 USC 602(a)(1)(A)(v) and (vi)).
 - c. Funds may be used to make payments or provide job placement vouchers to State-approved public and private job placement agencies providing employment placement services to individuals receiving assistance under TANF (42 USC 604(f)).
 - d. Funds may be used to implement an electronic benefits transfer system (42 USC 604(g)).

- e. Funds may be used to carry out a program to fund individual development accounts (42 USC 604(h)(2); 45 CFR sections 263.20 through 263.23) established by individuals eligible to receive assistance under TANF (42 USC 604(h); 45 CFR part 263, subpart C).
 - f. A State may contract with charitable, religious and private organizations to provide administrative and programmatic services and may provide beneficiaries of assistance with certificates, vouchers, or other forms of disbursement which are redeemable with such organization (42 USC 604a(b), 42 USC 604a(k), and 45 CFR section 260.34). However, funds provided directly to participating organizations may not be used for inherently religious activities, such as worship, religious instruction, or proselytization (42 USC 604a(j); 45 CFR section 260.34(c)).
4. *Tribes: Federal Only*
- a. Funds may be used for expenditures for activities that are not permissible under 42 USC 601, but for which the State or Tribe was authorized to use IV-A or IV-F funds under prior law. The previously authorized activities must have been included in a State's approved State AFDC plan, JOBS plan, or Supportive Services Plan, as in effect on September 30, 1995, or at the State's option, on August 21, 1996. Examples of such activities are authorized juvenile justice and foster care activities (42 USC 604(a)(2); 45 CFR section 263.11(a)(2)). Use of such funds in the Tribal TANF program is allowed if the geographic area of the Tribal TANF program is within the State(s) having had an approved AFDC State plan(s) under Title IV-A that included these activities. If the Tribe plans to exercise this option, these activities must be included in the approved Tribal TFAP.
 - b. Tribes may not transfer any Federal TANF funds to the Social Services Block Grant (Title XX) (CFDA 93.667) or the Child Care and Development Block Grant (CFDA 93.575). Funds may not be used to contribute to or subsidize non-TANF programs (42 USC 604(d); 45 CFR section 286.45 (b)). .
5. *Tribes: Federal Only, Commingled Federal/State-donated MOE, Segregated Tribal*
- a. Funds may be used in any manner reasonably calculated to achieve the purposes of the Tribal TANF program, including providing low-income households with assistance in meeting home heating and cooling costs (42 USC 604(a)(1) and 45 CFR section 286.35(a)(1)). As specified in 42 USC 601 and 45 CFR section 286.35, the Tribal TANF program has the following purposes:
 - (1) Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;

- (2) End dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
 - (3) Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and
 - (4) Encourage the formation and maintenance of two-parent families.
- b. A Tribe may use funds for programs to prevent and reduce the number of out-of-wedlock pregnancies, including programs targeted to law enforcement officials, the educational system and counseling services, that provide education and training of women and men on the problem of statutory rape (42 USC 602(a)(1)(A)(v) and (vi)).
 - c. Funds may be used to make payments or provide job placement vouchers to Tribe-approved public and private job placement agencies providing employment placement services to individuals receiving assistance under TANF (42 USC 604(f)).
 - d. Funds may be used to implement an electronic benefits transfer system (42 USC 604(g)).
 - e. Funds may be used to carry out a program to fund individual development accounts (42 USC 604(h)(2)) established by individuals eligible to receive assistance under Tribal TANF (42 USC 604(h); 45 CFR section 286.40).
 - f. A Tribe may contract with charitable, religious and private organizations to provide administrative and programmatic services and may provide beneficiaries of assistance with certificates, vouchers, or other forms of disbursement which are redeemable with such organization (42 USC 604a(b) and 42 USC 604a(k)). However, Tribes that operate their own TANF program under section 412 of the Social Security Act are not required to follow the Charitable Choice rules because the statutory provisions on Charitable Choice apply only to State and local governments (42 USC 604a(j); September 30, 2003, *Federal Register*, (68 FR 56450 and 56463)).
 - g. Tribal TANF grantees that expend Federal funds on economic development activities must adhere to the instructions contained in the TANF Program Instruction, TANF-ACF-PI-2005-02, dated April 19, 2005, pertaining to economic development expenditures. This program instruction is available at <http://www.acf.hhs.gov/programs/ofa/policy/tanf-pi.htm> (45 CFR section 286.35(a)(1)).

- h. Unlike States, Tribes are not prohibited from expending funds for medical expenses, if the expenditure is in the context of removing barriers to employment, training, or job-related education. However, funds cannot be used for general medical expenses for families. The expenditure of TANF funds is not intended to subsidize, contribute to, or supplant other available medical services or funding – i.e., Indian Health Service, Public Health Service, tribal health services, state, county, and local health services, or other services covered by Medicaid, Medicare, or private health insurance (42 USC 608(a)(6), 45 CFR section 286.45(b)).

C. Cash Management

Tribal TANF grantees are not eligible for any cash management provisions applicable to Pub. L. No. 93-638 Indian Self-Determination contracts or Self-Governance compacts, including the interest exemption. As described in Special Tests and Provisions, III.N.6, “Accountability, Deposit, and Investment of Lump-Sum Drawdowns,” special provisions apply to Tribal TANF grantees participating in Pub. L. No. 102-477 demonstration projects.

E. Eligibility

1. Eligibility for Individuals

The State or Tribal Plan provides the specifics on how eligibility is determined in each State or tribal service area. Whenever used in this section, “assistance,” has the meaning in 45 CFR section 260.31(a) of the TANF regulations for States and 45 CFR section 286.10 of the Tribal TANF regulations for federally recognized Tribes operating an approved Tribal TANF program. Plan and eligibility requirements must comply with the following Federal requirements:

- a. *Federal Only, Commingled Federal/State, Segregated State, and Separate State Program*
 - (1) Only a financially needy family that consists of, at a minimum, a minor child living with a parent or other caretaker relative, or a pregnant woman may receive TANF “assistance” or most maintenance-of-effort (MOE)-funded benefits, services, or “assistance” regardless of the TANF purpose that the expenditure is reasonably calculated to accomplish (see III.A.3.a, “Activities Allowed or Unallowed – Federal Only, Commingled Federal/State, Segregated State, Separate State Program”). The child must be less than 18 years old, or, if a full-time student in a secondary school (or the equivalent level of vocational or technical training), less than 19 years old. (With respect to segregated or separate State MOE funds, the State could use the definition for minor child given in section 419(2) of the Act or some other definition applicable in State law provided the State can articulate a rationale

basis for the age it chooses.) Financially “needy” means financially eligible according to the State’s quantified income and resource (if applicable) criteria to receive the benefit (42 USC 602, 602(a)(1)(B)(iii), 42 USC 609(a)(7)(B)(IV), 608(a)(1), 619(2) and 45 CFR section 263.2(b)(2)). See III.G.2.1, “Matching, Level of Effort, Earmarking – Level of Effort” – Maintenance-of-Effort,” for the limited MOE pro-family exception to this requirement.

Note: A State may continue to provide federally funded (*Federal Only*) TANF “assistance” pursuant to 42 USC 604(a)(2) using the financial eligibility criteria contained in the State’s approved AFDC, EA, JOBS, or Supportive Services plan as of September 30, 1995 (or at State option, as of August 21, 1996). A State may also continue this assistance notwithstanding the family composition requirement described above. (See III A.1.a, “Activities Allowed or Unallowed.”)

Only the financially “needy” are eligible for services, benefits, or “assistance” pursuant to TANF purpose 1 or 2 (see III.A.3.a, “Activities Allowed or Unallowed – Federal Only, Commingled Federal/State, Segregated State, Separate State Program”) (42 USC 601(a)(1) and (2); 45 CFR sections 260.20(a) and (b)). Financially “needy” for TANF and MOE purposes means financial deprivation, i.e., lacking adequate income and resources. For example, a needy family or a needy parent is one who is financially eligible according to the State’s quantified financial eligibility criteria (income and resource (if applicable) standards, April 12, 1999, *Federal Register* (64 FR 17825), 45 CFR section 263.2(b)(3)).

States may choose to use Federal only TANF funds to provide benefits that do not constitute “assistance” to the non-needy pursuant to TANF purpose 3 or 4 only (see III.A.3.a, “Activities Allowed or Unallowed – Federal Only, Commingled Federal/State, Segregated State, Separate State Program”) (42 USC 601(a)(3) and (4); 45 CFR sections 260.20(c) and (d)). States may also choose to use MOE funds to provide certain pro-family non-assistance benefits to the non-needy under TANF purpose 3 or 4 (See III.G.2.1, “Matching, Level of Effort, Earmarking – Level of Effort” – Maintenance of Effort,” for the limited MOE pro-family exception to this requirement).

- (2) Qualified aliens, as defined in 8 USC 1641(b), are the only non-citizens who may receive a TANF public benefit, as defined in 8 USC 1611(c)), using Federal TANF or commingled funds. Qualified aliens are lawful permanent residents, asylees, refugees, aliens paroled into the U.S. for at least one year, aliens whose

deportations are being withheld, aliens granted conditional entry, Cuban/Haitian entrants, and certain battered aliens. Victims of severe forms of trafficking and certain family members are also eligible for federally funded or administered public benefits and services to the same extent as refugees.

Qualified aliens, nonimmigrants under the Immigration and Nationality Act, and individuals paroled into the U.S. for less than a year are the only noncitizen groups that are eligible for a non-commingled State or local MOE-funded public benefit, as defined in 8 USC 1621(c). Aliens that are not lawfully present in the U.S. may also be eligible for a State or local MOE-funded public benefit if the State has enacted a law after August 22, 1996 affirmatively providing for such eligibility. (8 USC 1621(d)) All expenditures must meet all MOE requirements at 45 CFR part 263, Subpart A. See III.G.2.1, “Matching, Level of Effort, Earmarking – Level of Effort” – Maintenance of Effort.”

States have the authority to decide whether or not to provide a Federal TANF public benefit or a MOE-funded public benefit to otherwise qualified aliens (including nonimmigrants and individuals paroled in the U.S. for less than a year in the case of a noncommingled State or local MOE-funded public benefit) (8 USC 1612(b)(1) and 8 USC 1622(a)). If a State has decided not to help eligible aliens, then the State may not deny eligibility to refugees, asylees, aliens whose deportation has been withheld, Amerasians, and Cuban/Haitian entrants for a period of 5 years after the date of entry into the U.S. or the date asylum or withholding of deportation was granted. Also, such States may never deny eligibility to legal permanent residents who have worked 40 qualifying quarters after December 31, 1996 and have not received any Federal means-tested public benefit during such period (once the 5-year bar has expired for a qualified alien entering the U.S. on or after August 22, 1996 as described in the next paragraph), or to aliens who are veterans, members of the military on active duty, and their spouses and unmarried dependents (8 USC 1612(b)(2)(A)(ii) 8 USC 1621(2)(B) and (C), 8 USC 1622(b)(1)-(3)) In other words, Congress did not give States the authority to deny eligibility to all eligible aliens. If the State elects to help all otherwise eligible aliens (as described in the preceding two paragraphs), then this paragraph does not apply.

Unless exempt under 8 USC 1613(b), qualified aliens, as defined in 8 USC 1641(b), entering the U.S. on or after August 22, 1996, are not eligible for a Federal means-test public benefit (e.g., federally funded TANF assistance), as defined in 8 USC 1611(c), for a period of 5 years (8 USC 1613(a)). The 5-year bar begins

either on the date of the alien's entry into the U.S. as a qualified alien or on the date the alien residing in the U.S. becomes a qualified alien, whichever is later. If the alien entered the U.S. on or after August 22, 1996, but does not have an immigration status that qualifies (as defined in 8 USC 1641(b)), the individual is not eligible for a Federal public benefit (as defined in 8 USC 1611(c)). The following qualified aliens are exempt from the 5-year bar: refugees, asylees, aliens whose deportation is being withheld, Amerasians, Cuban/Haitian entrants, as well as veterans, members of the military on active duty, and their spouses and unmarried dependent children (8 USC 1613(b)).

If a noncash Federal or State and local public benefit meets the specifications in the Attorney General's Final Order (Order No. 2353-2001 published January 16, 2001 at 66 FR 3613), then the State may provide the benefit regardless of immigration status (8 USC 1611 (b)(1)(D) and 8 USC 1621(b)(4)).

b. *Federal Only and Commingled Federal/State*

- (1) Any family that includes an adult or minor child head of household or a spouse of the head of household who has received assistance under any State program funded by Federal TANF funds for 60 months (whether or not consecutive) is ineligible for additional federally funded TANF assistance. However, the State may extend assistance to a family on the basis of hardship, as defined by the State, or if a family member has been battered or subjected to extreme cruelty. In determining the number of months for which the head of household or the spouse of the head of household has received assistance, the State must not count any month during which the adult received the assistance while living in Indian country or in an Alaskan Native Village and the most reliable data available with respect to that month (or a period including that month) indicate at least 50 percent of the adults living in Indian country or in the village were not employed (42 USC 608(a)(7); 45 CFR sections 264.1(a), (b), and (c)).

(See III.G.3, "Matching, Earmarking, Level of Effort – Earmarking," for testing the limits related to the number of exemptions.)

- (2) A State may not provide assistance to an individual who is under age 18, is unmarried, has a minor child at least 12 weeks old, and has not successfully completed high school or its equivalent unless the individual either participates in education activities directed toward attainment of a high school diploma or its equivalent, or participates in an alternative education or training program

approved by the State (42 USC 608(a)(4); 45 CFR section 263.11(b)).

- (3) A State may not provide assistance to an unmarried individual under 18 caring for a child, if the minor parent and child are not residing with a parent, legal guardian, or other adult relative, unless one of the statutory exceptions applies (42 USC 608(a)(5)).
- (4) A State may not provide assistance for a minor child who has been or is expected to be absent from the home for a period of 45 consecutive days or, at the option of the State, such period of not less than 30 and not more than 180 consecutive days unless the State grants a good cause exception, as provided in its State Plan (42 USC 608(a)(10)).
- (5) A State may not provide assistance for an individual who is a parent (or other caretaker relative) of a minor child who fails to notify the State agency of the absence of the minor child from the home, as in paragraph e. immediately above, within five days of the date that it becomes clear to that individual that the child will be absent for the specified period of time (42 USC 608(a)(10)(C)).
- (6) A State may not use funds to provide cash assistance to an individual during the 10-year period that begins on the date the individual is convicted in Federal or State court of having made a fraudulent statement or representation with respect to place of residence in order to simultaneously receive assistance from two or more States under TANF, Title XIX, or the Food Stamp Act of 1977, or benefits in two or more States under the Supplemental Security Income program under Title XVI of the Social Security Act. If the President of the United States grants a pardon with respect to the conduct that was the subject of the conviction, this prohibition will not apply for any month beginning after the date of the pardon (42 USC 608(a)(8)).
- (7) A State may not provide assistance to any individual who is fleeing to avoid prosecution, or custody or confinement after conviction, for a felony or attempt to commit a felony (or in the State of New Jersey, a high misdemeanor), or who is violating a condition of probation or parole imposed under Federal or State law (42 USC 608(a)(9)(A)).

c. *Federal Only, Commingled Federal/State, Segregated State*

- (1) A State shall require, as a condition of providing assistance, that a member of the family assign to the State the rights the family member may have for support from any other person. This

assignment does not exceed the amount of assistance provided (42 USC 608(a)(3)).

- (2) An individual convicted under Federal or State law of any offense which is classified as a felony and which involves the possession, use, or distribution of a controlled substance (as defined the Controlled Substances Act (21 USC 802(6)) is ineligible for assistance if the conviction was based on conduct occurring after August 22, 1996. A State shall require each individual applying for TANF assistance to state in writing whether the individual or any member of their household has been convicted of such a felony involving a controlled substance. However, a State may by law enacted after August 22, 1996, exempt any or all individuals from this prohibition or limit the time period that this prohibition applies to any or all individuals 21 USC 862a).
- (3) If an individual in a family receiving assistance refuses to engage in required work, a State must reduce assistance to the family, at least pro rata, with respect to any period during the month in which the individual so refuses, or may terminate assistance. Any reduction or termination is subject to good cause or other exceptions as the State may establish (42 USC 607(e)(1); 45 CFR sections 261.13 and 261.14(a) and (b)). However, a State may not reduce or terminate assistance based on a refusal to work if the individual is a single custodial parent caring for a child who is less than 6 years of age if the individual can demonstrate the inability (as determined by the State) to obtain child care for one or more of the following reasons: (a) the unavailability of appropriate care within a reasonable distance of the individual's work or home; (b) unavailability or unsuitability of informal child care; or (c) unavailability of appropriate and affordable formal child care (42 USC 607(e)(2); 45 CFR sections 261.15(a), 261.56, and 261.57).

d. *Tribes: Federal Only, Commingled Federal/State-Donated MOE*

Eligibility for Tribal TANF is defined in the approved TFAP. See IV, "Other Information," for guidance on State MOE expended by Tribes.

The approved TFAP includes the Tribe's proposal for time limits for the receipt of TANF assistance (45 CFR section 286.115), as well as the percentage of the caseload to be exempted from the time limit. These proposed time limits must be approved by ACF (45 CFR section 286.115).

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable

3. Eligibility for Subrecipients – Not Applicable

G. Matching, Level of Effort, Earmarking

1. Matching – Not Applicable

2.1 Level of Effort – *Maintenance of Effort*

See IV, “Other Information,” for guidance on State MOE expended by Tribes.

The following MOE provisions apply to any State funds that are counted towards the maintenance of effort requirements for TANF, whether such State funds are expended under the *Commingled Federal/State, Segregated State, or Separate State Program* funding options.

- a. *State Basic MOE* – Every fiscal year, a State must maintain an amount of “qualified State expenditures” (as defined in 42 USC 609(a)(7)(B) and 45 CFR section 263.2) for eligible families (as defined in 42 USC 609(a)(7)(B)(i)(IV) and 45 CFR section 263.2(b)) at least at the applicable percentage of the State’s historic State expenditures. Therefore, all amounts claimed for or on behalf of eligible families, including amounts that result from State tax provisions, must be the result of expenditure (42 USC 609(a)(7)(A) and (B)(i)(I); 45 CFR sections 260.30 (“expenditure”) and 260.33, 45 CFR section 92.3, and 45 CFR section 92.24). States may claim qualified expenditures for eligible family members who are citizens or aliens. However, the particular aliens for whom a State may claim qualified expenditures will depend on the State funds used to provide the benefit or service (See III.E.1 a.(2), “Eligibility for Individuals, *Federal only, Commingled Federal/State, Segregated State, or Separate State Program*”) and whether the benefit or service is a Federal, State, or local public benefit (8 USC 1611, 1612(b), 1613, 1621-1622, and 1641(b)).

Effective October 1, 2005, for their FY 2006 awards and ending with their FY 2008 awards, States may also claim expenditures on pro-family activities if the expenditure is reasonably calculated to prevent and reduce the incidence of out-of-wedlock births (TANF purpose 3—see III.A.3.a, “Activities Allowed or Unallowed – Federal Only, Commingled Federal/State, Segregated State, Separate State Program”), or encourage the formation and maintenance of two parent families (TANF purpose 4—see III.A.3.a, “Activities Allowed or Unallowed – Federal Only, Commingled Federal/State, Segregated State, Separate State Program”). This new provision allows States to claim for MOE purposes all qualified pro-family expenditures for *non-assistance* benefits and services provided to or on behalf an individual or family, regardless of financial need or family composition, as long as the activity is reasonably calculated to accomplish TANF purpose 3 or TANF purpose 4. Non-assistance benefits

and services refer to activities that do not constitute “assistance,” as defined in 45 CFR section 260.31(a) (45 CFR sections 263.2(a)(4)(ii) and 263.2(b)).

Effective October 1, 2008 (i.e., FY 2009 awards), States may only claim *certain* pro-family non-assistance expenditures that are reasonably calculated to accomplish TANF purpose 3 or TANF purpose 4. These pro-family expenditures consist of the allowable healthy marriage promotion and responsible fatherhood non-assistance activities enumerated in Title IV-A of the Social Security Act, sections 403(a)(2)(A)(iii) and 403(a)(2)(C)(ii), unless a limitation, restriction or prohibition under 45 CFR part 263, Subpart A applies (45 CFR section 263.2(a)(4)(ii); TANF-ACF-PI-2008-10, dated October 23, 2008, available at <http://www.acf.hhs.gov/programs/ofa/policy/tanf-pi.htm>). States may claim for MOE purposes the qualified pro-family healthy marriage and responsible fatherhood expenditures for *non-assistance* benefits and services provided to or on behalf an individual or family, regardless of financial need or family composition. States must limit the provision of all other qualified MOE-funded assistance and non-assistance benefits to eligible families as defined at 45 CFR section 263.2(b), regardless of the TANF purpose that the expenditure is reasonably calculated to accomplish.

The applicable percentage for each fiscal year is 80 percent of the amount of non-Federal funds the State spent in FY 1994 on AFDC or 75 percent if the State meets the Act’s work participation rate requirements (42 USC 607(a)) for the fiscal year. This is termed “basic MOE” and the requirement is based on the Federal fiscal year. Qualified expenditures with respect to eligible families may come from all programs, i.e., the State’s TANF program as well as programs separate from the State’s TANF program. This requirement may be met through allowable State or local cash expenditures for goods and services, expenditures for allowable costs incurred by other non-Federal third parties (e.g., a non-profit organization, corporation, or other private party), cash donations by non-Federal third parties or the value of third party in-kind contributions (42 USC 609(a)(7)(A) and 609(a)(7)(B)(i)(I); 45 CFR sections 263.1 and 263.2(e)).

Section 409(a)(7)(B)(iv)(IV) of the Social Security Act allows States to count expenditures made as a condition of receiving Federal funds under Title IV, part A of the Social Security Act toward their MOE requirement. The DRA of 2005 (Pub. L. No. 109-171), enacted February 8, 2006, added the Healthy Marriage Promotion and Responsible Fatherhood Grants and placed these provisions under Title IV, part A of the Social Security Act. If grantees are required to contribute a matching share of the total approved costs of Health Marriage Promotion and Responsible Fatherhood projects (discretionary grants awarded for 5-year project period beginning

in FFY 2007 under CFDA 93.086) under subsections 403(a)(2)(A)(iii) and 403(a)(2)(C)(ii) of the Social Security Act, then State expenditures made to meet any required non-Federal share may count toward the State's MOE requirement, provided the expenditure also meets all applicable MOE requirements, restrictions, and limitations (45 CFR section 263.2(g)).

If a State does not meet the basic MOE requirement, a penalty results. The penalty consists of a reduction of the State's Federal TANF grant for the following fiscal year in the amount of the difference between the State's qualified expenditures and the State's basic MOE (42 USC 609(a)(7)(A) and 45 CFR section 263.8). If application of a penalty results in a reduction of Federal TANF funding, a State is required in the immediately succeeding fiscal year to spend from State funds an amount equal to the total amount of the reduction, in addition to the otherwise required basic MOE. The additional funds must be spent in the TANF program, not under "separate State programs." Such expenditures may not be claimed toward the basic MOE (42 USC 609(a)(12); 45 CFR sections 263.6(f) and 264.50).

- b. *Limitations on "Qualified State Expenditures"* – Expenditures under pre-existing programs, other than those that would have been previously authorized and allowable under the former AFDC, JOBS, Emergency Assistance, Child Care for AFDC recipients, At-Risk Child Care, or Transitional Child Programs may not count toward the State's MOE requirement for the current year except to the extent that the current year's expenditures with respect to eligible families exceed the expenditures made under the State or local program in FY 1995.

Exception: If the expenditures are for non-assistance pro-family activities as addressed in paragraph a. immediately above for FYs prior to October 1, 2008 and FYs beginning on or after October 1, 2008, then current year expenditures are not limited to those made with respect to eligible families. If total current fiscal year expenditures for allowable pro-family activities within TANF purpose three or TANF purpose 4 exceed total State expenditures in the program during FY 1995, then the State may claim the excess toward the State's MOE requirement. Thus, to be considered as "exceeding" the FY 1995 level, the expenditures must be new or additional expenditures. (42 USC 609(a)(7)(B)(i)(II)(aa) and 45 CFR section 263.5).

In addition, expenditures by the State from amounts that originated from Federal funds may not count toward meeting a MOE requirement even if the expenditures "qualify" (42 USC 609(a)(7)(B)(iv)(I)).

Except for child-care expenditures, double counting of expenditures to meet the basic MOE requirement is prohibited (42 USC

609(a)(7)(B)(iv)(II-IV); 45 CFR section 263.6). States may count State funds expended to meet the requirements of the Child Care Development Fund Matching Fund (CFDA 93.596) as basic MOE expenditures as long as such expenditures meet the requirements of 42 USC 609(a)(7). The maximum amount of child care expenditures that a State may double-count under this provision is the State's Matching Fund MOE amount under CFDA 93.596 (42 USC 609(a)(7)(B)(iv); 45 CFR sections 263.3 and 263.6).

Expenditures for educational services/activities for eligible families to increase self-sufficiency, job training, and work count if the activities or services are not generally available to other State residents without cost and without regard to their income (42 USC 609(a)(7)(B)(i)(I)(cc); 45 CFR section 263.4, TANF-ACF-PI-2005-01, dated April 14, 2005 at <http://www.acf.hhs.gov/programs/ofa/policy/tanf-pi.htm>).

Administrative costs in connection with the activities that correspond to the qualified expenditures may not exceed 15 percent of the total amount of countable expenditures for the fiscal year (42 USC 609(a)(7)(B)(i)(I)(dd); 45 CFR section 263.2(a)(5)).

The basic MOE requirement expressly does not count expenditures for services or activities that only fall under 42 USC 604 (a)(2) (see III.A.1.a, "Activities Allowed or Unallowed"). Such expenditures are not considered "qualified expenditures" (42 USC 609(a)(7)(B)(i)(I); 45 CFR section 263.2(a)(4)).

- c. *Contingency Fund MOE* – A State must spend more than 100 percent of its historic State expenditures for FY 1994 to keep any of the Federal contingency funds it received (42 USC 603(b), and 45 CFR sections 264.72(a)(2) and 264.70 through 77). This is termed "Contingency Fund MOE." The Contingency Fund MOE requirement may be met only through qualified expenditures under the State's TANF program. Qualified expenditures consist of those defined and provided under 42 USC 609(a)(7)(B)(i) and 45 CFR sections 263.2 (a)(1),(a)(3) through (a)(5), and 263.2(b), but excludes those expenditures described in 42 USC 609(a)(7)(B)(i)(I)(bb) and 45 CFR section 263.2(a)(2) (42 USC 603(b)(6)(B)(ii)(I) and 609(a)(10)).
- d. *1108(b) Territorial Matching Fund MOE Requirement* – See IV, "Other Information," for guidance on the spending requirements applicable to the receipt of Matching Grant funds under section 1108(b) of the Social Security Act (section 1108(b)) (42 USC 1308(b)).

2.2 Level of Effort – Supplement Not Supplant – Not Applicable

3. Earmarking

a. *Federal Only and Commingled Federal/State*

A State may not spend more than 15 percent for administrative purposes, excluding expenditures for information technology and computerization needed for required tracking and monitoring, of the total combined amounts available under the State family assistance grant, supplemental grant for population increases, contingency funds, and emergency funds (42 USC 604(b)(1) and (2); 45 CFR sections 263.0 and 263.13).

b. *Federal Only and Commingled Federal/State*

The average monthly number of families that include an adult or minor child head of household, or the spouse of the head of household, who has received assistance under any State program funded by Federal TANF funds for more than 60 countable months (whether or not consecutive) may not exceed 20 percent of the average monthly number of all families to which the State provided assistance during the fiscal year or the immediately preceding fiscal year (but not both), as the State may elect. To make this determination for a fiscal year, the average monthly number of families with a head of household or spouse of a head of household who received assistance for more than 60 months would be divided by the average monthly number of families that received assistance in that fiscal year, or, if the State chooses, in the previous fiscal year (42 USC 608(a)(7)(C)(ii); 45 CFR sections 264.1(c) and (e)).

(See III.E.1, “Eligibility – Eligibility for Individuals,” for related eligibility testing.)

c. *Tribes: Federal Only and Commingled Federal/State-donated MOE*

The approved TFAP includes a negotiated administrative cost rate for that Tribe for that particular year. As approved in the TFAP, no Tribal TANF grantee may expend more than 35 percent of the total combined Federal TANF funds—i.e., TFAG plus any emergency funds received by the Tribe for FY 2009 and FY 2010—for administrative costs during the first year, 30 percent during the second year, and 25 percent for the third and all subsequent grant periods. The approved tribal administrative cost rate may be found in a letter of approval issued by the ACF/Division of Tribal Services and/or in the approved TFAP. The Tribal administrative cost cap is determined by multiplying the TFAG by the negotiated administrative rate for the fiscal year being tested (45 CFR section 286.50).

Indirect costs may be applied to the Federal TANF funds based on the indirect cost rate negotiated by the Bureau of Indian Affairs, the Department of Health and Human Services’ Division of Cost Allocation, or another Federal agency. However, indirect costs applied to TANF

funding are subject to and included within the administrative cap limits (45 CFR section 285.55(d)).

H. Period of Availability of Federal Funds

1. States

Funds, other than contingency funds, are available to the State until expended for the purpose of providing assistance under the TANF program; contingency funds may be used for qualified expenditures only in the fiscal year for which the funding is provided (42 USC 603(b) and 604(e); 45 CFR sections 263.11(b) and 265.3(c)). Current year TANF funds may be expended on assistance or non-assistance activities during the current fiscal year. However until FY 2009, the following restrictions to unobligated balances and current year obligations on non-assistance apply to the TANF program.

- a. *Unobligated Balances Reported on a State Fourth Quarter Financial Report For the Immediately Preceding Fiscal Year* – Pursuant to 42 USC section 604(e), a State may reserve amounts awarded to the State under section 403 (excluding Contingency Funds), without fiscal year limitation, to provide assistance under the State TANF program.

Prior to October 1, 2008, any Federal unobligated balances carried forward into a fiscal year from a prior fiscal year may only be expended on benefits that meet the definition of assistance at 45 CFR section 260.31(a) and related administrative costs associated with providing such assistance. Effective October 1, 2008, States may use any Federal TANF funds carried forward into a fiscal year from a prior fiscal year to provide, without fiscal year limitation, any benefit or service provided under the State's TANF program (42 USC 604(e), as amended by ARRA).

States have several options for claiming administrative costs when providing assistance with prior year unobligated balances. The State may charge administrative costs related to providing the assistance to the prior year grant if the State has not expended 15 percent of the prior year's Adjusted SFAG on administrative costs previously. If the State has an unobligated balance and has expended the maximum 15 percent on administrative cost previously, the State may charge the administrative costs associated with providing the assistance to current year administrative costs. If the State chooses this option the administrative costs associated with providing assistance with prior year unobligated balances will be included within the 15 percent administrative cost cap for the current fiscal year.

The Federal TANF 15 percent administrative cost cap is based on:

- (1) For States, the Adjusted SFAG (reported in Line 4, Column (A) on the ACF-196, *TANF Financial Report*) plus the Federal

Contingency Award (reported in Line 1, Column (D)) for States that receive Federal Contingency funds for the fiscal year, and Line 1, Column (E) if a State received Federal emergency funds for fiscal year 2009 and 2010 *divided* by the total amount entered in Line 6j, Columns (A), (D) and (E); and

- (2) For Territories, the Adjusted SFAG (reported in Line 4, Columns (A) and (G) (if a Territory receives federal emergency TANF funds for fiscal year 2009 and 2010 on the ACF-196-TR, *Territorial Financial Report*) *divided* by the total amount entered in Line 6j, Columns (A) and (G). .

The administrative cost cap is tracked by the fiscal year for which the funds were awarded and not by the total the State expends on administrative costs in a given fiscal year. States may only charge administrative costs to a prior year grant when it is administering assistance with a prior year unobligated balance.

- b. *Current Fiscal Year Federal Expenditures on Non-Assistance* –Prior to October 1, 2008, the State must obligate by September 30 of the current fiscal year any funds for expenditures on non-assistance. Non-assistance expenditures are reported on Line 6 categories on the *ACF-196 TANF Financial Report* and the *ACF-196-TR, Territorial Financial Report*. The State must liquidate these obligations by September 30 of the immediately succeeding Federal fiscal year for which the funds were awarded. If the final liquidation amounts are lower than the original amount obligated, this difference must be included in the Unobligated Balance Line Item for the year in which they were awarded. Unobligated balances from previous fiscal years may only be expended on benefits that meet the definition of assistance at 45 CFR section 260.31(a) and related administrative costs associated with providing such assistance.

Effective October 1, 2008, States may use Federal TANF funds carried forward into a fiscal year from a prior fiscal year to provide, without fiscal year limitation, any benefit or service provided under the State's TANF program (42 USC 604(e), as amended by ARRA).

2. Tribes

Prior to October 1, 2008, a Tribe may reserve amounts awarded to it, without fiscal year limitation, to provide assistance under the Tribal TANF program. However, a Tribe may only expend funds beyond the fiscal year in which awarded on benefits that meet the definition of assistance at 45 CFR section 286.10 or on the administrative costs directly associated with providing that assistance (45 CFR section 286.60). Effective October 1, 2008, Tribes may use Federal TANF funds carried forward into a fiscal year from a prior fiscal year to provide, without fiscal year limitation, any benefit or service provided under the Tribe's TANF program (42 USC 604(e), as amended by ARRA).

- a. *Unobligated Balances Reported on a Tribal Annual SF-269 Financial Report For the Immediately Preceding Fiscal Year* – Pursuant to section 404(e) of the Act (as amended by Pub. L. No. 106-169, the Foster Care Independence Act of 1999), a Tribe may reserve amounts awarded to the Tribe under section 412, without fiscal year limitation, to provide assistance under the Tribal TANF program. Tribes have several options for claiming administrative costs when providing assistance with prior year unobligated balances. The Tribe may charge administrative costs related to providing the assistance to the prior year grant if the Tribe has not exceeded its negotiated administrative cap for that fiscal year, on administrative costs previously. If the Tribe has an unobligated balance and has exceeded the negotiated administrative cap for the previous fiscal year, the Tribe may charge the administrative costs associated with providing the assistance to current year administrative costs. If the Tribe chooses this option, the administrative costs associated with providing assistance with prior year unobligated balances will be included within the negotiated administrative cost cap for the current fiscal year.
- b. *Current Fiscal Year Federal Expenditures on Non-Assistance* – Prior to October 1, 2008, a Tribe must obligate by September 30 of the current fiscal year any funds for expenditures on non-assistance. The Tribe must liquidate these obligations by September 30 of the immediately succeeding Federal fiscal year for which the funds were awarded. If the final liquidation amounts are lower than the original amount obligated, this difference must be included in the Unobligated Balance Line Item for the year in which they were awarded, on the SF-269 report.

Effective October 1, 2008, Tribes may use Federal TANF funds carried forward into a fiscal year from a prior fiscal year to provide, without fiscal year limitation, any benefit or service provided under the Tribe's TANF program (42 USC 604(e), as amended by ARRA).

ARRA Emergency Contingency Funds – Once a jurisdiction receives emergency funds for which it has qualified, the funds are available until expended and may be used in the same manner as Federal TANF funds, except that they may not be transferred to the Social Services Block Grant (Title XX) (CFDA 93.667) or the Child Care and Development Block Grant (CFDA 93.575).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request from Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable to States (cash status only)
- d. ACF-196T, *Tribal TANF Financial Report Form (OMB No. 0970-0345)* – Applicable to Tribes; Not Applicable to States. This form is applicable to Tribes not administering TANF programs under a Pub. L. No. 102-477 demonstration project. Beginning with the FY 2009 Award, Tribes must use this form to report TANF expenditures quarterly. This form must be used for reporting both regular TANF grant funds and ARRA-Emergency Fund for TANF Tribal Programs funds.
- e. Form 12g, *Tribal TANF Financial Addendum Report (OMB Control No. 1076-0135)* – Applicable to Tribal TANF grantees administering TANF programs under a Pub. L. No. 102-477 demonstration project. Not applicable to States. This report must be filed with the Tribe's annual Pub. L. No. 102-477 financial report (*OMB Control No. 1076-0135*). This report is required to be submitted annually and the information must be reported on a FY basis, which runs from October 1 through September 30. The report must cover the entire immediately preceding FY and include all expenditures, obligations, and unliquidated obligations of Federal funds for the period. In addition, the report must be based on and account for the entire Federal Tribal TANF award that was issued for the fiscal year. A separate 12g report is to be submitted for each fiscal year where Federal funds have not been completely expended. For example, Tribes must submit a report regarding the expenditure of FY 2008 funds in FY 2009 separately from the report on the use of FY 2009 funds in FY 2009. Until the Tribe reports that all of the Federal funds awarded for a given fiscal year have been expended, Tribes must continue to submit reports on the use of funds from that fiscal year. Further, a narrative report is to be prepared that describes the activities and services covered under the category "Total Non-Assistance Expenditures" (see line 4 of the report).

- f. Tribal Temporary Assistance for Needy Families (TANF) ACF-196T, *Financial Report For 102-477 Tribes (OMB approval number pending)* – Applicable to Tribes administering TANF programs under a Pub. L. No. 102-477 demonstration project that receive ARRA-Emergency Fund for TANF Tribal Programs funds. This report must be used to report ARRA funds expenditures quarterly. This report is required to be submitted quarterly to the Division of Workforce Development in the Office of Indian Energy and Economic Development, Department of the Interior with a copy to ACF.
- g. ACF-196, *TANF Financial Report (OMB No. 0970-0247)* – States are required to submit this report quarterly in lieu of the SF-425, *Federal Financial Report* (financial status). Each State files quarterly expenditure data on the State’s use of Federal TANF funds, State TANF MOE expenditures, and State expenditures of MOE funds in separate State programs. If a State is expending Federal TANF funds received in prior fiscal years, it must file a separate quarterly TANF Financial Report for each fiscal year that provides information on the expenditures of that year’s TANF funds. This form must be used for reporting both regular TANF grant funds and ARRA-Emergency Fund for TANF State Programs funds.
- h. ACF-196-TR, *Territorial Financial Report* – Territories report their expenditures and other fiscal data in this report (45 CFR section 265.3(c)). The Territories must report quarterly on their use of Federal TANF funds, Territorial TANF MOE expenditures, expenditures of MOE funds in separate “State” programs, expenditures made as a result of receiving matching grant funds under 42 USC 1308(b), and expenditures made under the Federal Adult Assistance Programs (Titles I, X, XIV, and XVI of the Social Security Act) (42 USC subchapters I, X, XIV, and XVI and 42 USC 1308(a)). This form must be used for reporting both regular TANF grant funds and ARRA-Emergency Fund for TANF Territorial Programs funds.

See III.G.2.1, “Matching, Level of Effort, Earmarking – Level of Effort – Maintenance of Effort,” and IV, “Other Information,” for additional guidance on Territories’ spending levels.

2. Performance Reporting

- a. ACF-199, *TANF Data Report (OMB No. 0970-0309)* and ACF-343, *Tribal TANF Data Report (OMB No. 0970-0215)*.

One of the critical areas of this reporting is the work participation data, which serve as the basis for ACF to determine whether States and Tribes have met the required work participation rates. A penalty may apply for failure to meet the required rates.

States Work Participation Rates

State agencies must meet or exceed their minimum annual work participation rates. The minimum work participation rates are 50 percent for the overall rate and 90 percent for the two-parent rate. A State's minimum work participation rate may be reduced by its caseload reduction credit. HHS may penalize the State by an amount of up to 21 percent of the SFAG for violation of this provision (42 USC 609(a)(4); 45 CFR section 262.1(a)(4)).

ACF-199 (TANF Data Report) Key Line Items – The following line items contain critical information for making the preceding determinations and for other program purposes. Compare the data entered on the file for the key line items below to the documentation in the case file for completeness, accuracy, and consistency:

Section One – Family-Level Data

Item 12 *Type of Family for Work Participation*

Item 17 *Receives Subsidized Child Care*

Item 28 *Is the TANF family exempt from the Federal time limit provisions*

Section One – Person-Level Data

Item 30 *Family Affiliation Code*

Item 32 *Date of Birth*

Item 38 *Relationship to Head-of-Household*

Item 39 *Parents with a Minor Child*

Item 44 *Number of months countable toward the Federal time limit*

Item 48 *Work-Eligible Individual Indicator*

Item 49 *Work Participation Status*

Section One – Adult Work Participation Activities

Items 50 – 62 *Work Participation Activities*

Item 63 *Number of Deemed Core Hours for Overall Rate*

Item 64 *Number of Deemed Core Hours for the Two-Parent Rate*

Section Three – Active Cases

Item 8 *Total Number of Families*

Tribal Work Participation Rates

Tribal TANF agencies must meet or exceed their minimum annual work participation rates. The minimum work participation rates are contained in the respective Tribal TANF plans. Tribal TANF agencies have the

option to negotiate and choose from among a number of work participation rates (e.g., separate rates for one- and two-parent families or an “all-families with parents” rate where one- and two-parent families are combined). HHS may penalize the Tribe by a maximum of five percent of the TFAG for the first violation of this provision. The penalty increases by an additional two percent for each subsequent violation up to a maximum of 21 percent (42 USC 612(c) and 612(g)(2); 45 CFR sections 286.195(a)(3) and 286.205).

ACF-343, *Tribal TANF Data Report (OMB No. 0970-0215)* (65 FR 8545, Appendix A, February 18, 2000)

Key Line Items – The following line items contain critical information used in making a determination of a Tribe’s Work Participation Rates.

Review the Tribe’s TANF plan for a fiscal year to identify the type of family required to participate in work activities and the minimum number of hours per week that the adults and minor heads of household in the family must participate in work activities (45 CFR section 286.80). Compare the data entered on the file for the key line items below to the documentation in the case file for completeness, accuracy, and consistency:

Item 30 *Family Affiliation*

Item 48 *Work Participation Status*

Items 49–62 *Adult Work Participation Activities*

- b. ACF 209, *SSP-MOE Data Report (OMB No. 0970-0309)* – This report is submitted quarterly beginning with the first quarter of FFY 2000.

Key Line Items – The following line items contain critical information:

Section One – Family-Level Data

Item 9 *Type of Family for Work Participation*

Item 15 *Receives Subsidized Child Care*

Section One – Person-Level Data

Item 28 *Date of Birth*

Item 34 *Relationship to Head-of-Household*

Item 41 *Work-Eligible Individual Indicator*

Item 42 *Work Participation Status*

Section One – Adult Work Participation Activities

Items 43 – 55 *Work Participation Activities*

Item 56 *Number of Deemed Core Hours for Overall Rate*

Item 57 *Number of Deemed Core Hours for the Two-Parent Rate*

Section Three – Active Cases

Item 3 *Total Number of SSP-MOE Families*

3. Special Reporting

- a. ACF-204, *Annual Report including the Annual Report on State Maintenance-of-Effort Programs (OMB No. 0970-0248)* – Each State must file an annual report containing information on the TANF program and the State’s MOE program(s) for that year, including strategies to implement the Family Violence Option, State diversion programs, and other program characteristics. Each State must complete the ACF-204 for each program for which the State has claimed basic MOE expenditures for the fiscal year. States may submit this report as a freestanding report or as an addendum to the fourth quarter TANF Data Report.

Key Line Items – The following ACF-204 line items contain critical information:

- (1) *Program Name*
- (2) *Description of Major Program Activities*
- (3) *Program Purpose(s)*
- (4) *Program Type*
- (5) *Total State MOE Expenditures*
- (6) *Number of Families Served with MOE Funds*
- (7) *Eligibility Criteria*
- (8) *Prior Program Authorization*
- (9) *Total Program Expenditures in FY 1995*

The total MOE expenditures reported in item 5 of the ACF-204 should equal the total MOE expenditures reported in line 7, columns (B) plus (C) of the 4th quarter ACF-196 *TANF Financial Report*; or line 17, column (B) of the ACF-196-TR, *Territorial Financial Report*.

- b. An OFA-100, *Emergency Fund Request Form (OMB 0970-0366)* is submitted for each quarter for which a State, Territory or Tribe operating a TANF program applied for and received funds under one or more of categories described below.

Grant Related to Caseload Increases: The jurisdiction’s average monthly assistance *caseload* in a quarter is higher than its average monthly assistance caseload for the corresponding quarter in the TANF Emergency Fund base year (FY 2007 or 2008, whichever year has lower average monthly assistance caseloads), and its expenditures for *basic assistance* in a quarter are higher than its expenditures for such assistance in the

corresponding quarter of the TANF Emergency Fund base year. “Basic assistance” is defined at 45 CFR section 260.31(a)(1)-(2) for States and Territories, and at 45 CFR section 286.10(a)(1) for Tribes.

Grant Related to Increased Expenditures for Non-Recurrent Short-Term Benefits: The jurisdiction’s expenditures for *non-recurrent short-term benefits* in a quarter are higher than its expenditures for such benefits in the corresponding quarter of the TANF Emergency Fund base year (FY 2007 or 2008, whichever year has lower non-recurrent short-term benefit expenditures). “Non-recurrent short-term benefits” are defined at 45 CFR section 260.31(b)(1) for States and Territories, and at 45 CFR section 286.10(b)(1) for Tribes.

Grant Related to Increased Expenditures for Subsidized Employment: The jurisdiction’s expenditures for *subsidized employment* in a quarter are higher than such expenditures in the corresponding quarter of the TANF Emergency Fund base year (FY 2007 or 2008, whichever year has lower subsidized employment expenditures). Subsidized employment refers to “work subsidies,” as defined at 45 CFR section 260.31(b)(2) for States and Territories, and at 45 CFR section 286.10(b)(2) for Tribes.

The qualifying expenditures may come from both Federal TANF funds and the jurisdiction’s MOE funds. (See II, “Program Procedures - Other Considerations, Funding Methods – States and Tribes.”)

TANF-ACF-PI-2009-05 and TANF-ACF-PI-2010-01 provide the OFA-100 and the revised OFA-100, as well as instructions for completion (<http://www.acf.hhs.gov/programs/ofa/policy/tanf-pi.htm>).

Key Line Items – The following OFA-100 sections contain critical information:

Part 1, Request Quarter Data

Part 4, Base Years

4. **Section 1512 ARRA Reporting** – Not Applicable
5. **Subaward Reporting under the Transparency Act** –Applicable

N. Special Tests and Provisions

Special Tests and Provisions 1 through 5 apply to a State's TANF program, not to a Tribal TANF program.

1. Child Support Non-Cooperation

Compliance Requirement – If the State agency responsible for administering the State plan approved under Title IV-D of the Social Security Act determines that an individual is not cooperating with the State in establishing paternity, or in establishing, modifying or enforcing a support order with respect to a child of the individual, and reports that information to the State agency responsible for TANF, the State TANF agency must (1) deduct an amount equal to not less than 25 percent from the TANF assistance that would otherwise be provided to the family of the individual, and (2) may deny the family any TANF assistance. HHS may penalize a State for up to five percent of the SFAG for failure to substantially comply with this required State child support program (42 USC 608(a)(2) and 609(a)(8); 45 CFR sections 264.30 and 264.31).

Audit Objective – Determine whether, after notification by the State IV-D agency, the TANF agency has taken necessary action to reduce or deny TANF assistance.

Suggested Audit Procedures

- a. Review the State's TANF policies and operating procedures concerning this requirement.
- b. Test a sample of cases referred by the IV-D agency to the TANF agency to ascertain if benefits were reduced or denied as required.

2. Income Eligibility and Verification System

Compliance Requirements – Each State shall participate in the Income Eligibility and Verification System (IEVS) required by section 1137 of the Social Security Act as amended. Under the State Plan the State is required to coordinate data exchanges with other federally assisted benefit programs, request and use income and benefit information when making eligibility determinations, and adhere to standardized formats and procedures in exchanging information with other programs and agencies. Specifically, the State is required to request and obtain information as follows (42 USC 1320b-7; 45 CFR section 205.55):

- a. Wage information from the State Wage Information Collection Agency (SWICA) should be obtained for all applicants at the first opportunity following receipt of the application, and for all recipients on a quarterly basis.
- b. Unemployment Compensation (UC) information should be obtained for all applicants at the first opportunity, and in each of the first three months in which the individual is receiving aid. This information should also be obtained in each of the first three months following any recipient-reported loss of employment. If

an individual is found to be receiving UC, the information should be requested until benefits are exhausted.

- c. All available information from the Social Security Administration for all applicants at the first opportunity (See *Federal Tax Return Information* below).
- d. Information from the Immigration and Naturalization Service and any other information from other agencies in the State or in other States that might provide income or other useful information.
- e. Unearned income from the Internal Revenue Service (IRS) (See *Federal Tax Return Information* below).

Federal Tax Return Information – Information from the IRS and some information from the Social Security Administration (SSA) is Federal tax return information and subject to use and disclosure restrictions by 26 USC 6103. Individual data received from the SSA's Beneficiary Earnings Exchange Record (BEER), consisting of wage, self-employment, and certain other income information is considered Federal tax return information. However, benefits payments such as Supplemental Security Income (SSI) are SSA data and not Federal tax return information. Under 26 USC 6103, disclosure of Federal tax return information from IEVS is restricted to officers and employees of the receiving agency. Outside (non-agency) personnel (including auditors) are not authorized to access this information either directly or by disclosure from receiving agency personnel.

The State is required to review and compare the information obtained from each data exchange against information contained in the case record to determine whether it affects the individual's eligibility or level of assistance, benefits or services under the TANF program, with the following exceptions:

- a. The State is permitted to exclude categories of information items from follow-up if it has received approval from ACF after having demonstrated that follow-up is not cost effective.
- b. The State is permitted, with ACF approval, to exclude information items from certain data sources without written justification if it followed up previously through another source of information. However, information from these data sources that is not duplicative and provides new leads may not be excluded without written justification.

The State shall verify that the information is accurate and applicable to the case circumstances either through the applicant or recipient, or through a third party, if such determination is appropriate based on agency experience or is required before taking adverse action based on information from a Federal computer matching program subject to the Computer Matching and Privacy Protection Act (45 CFR section 205.56).

For applicants, if the information is received during the application process, the State must use the information, to the extent possible, to determine eligibility. For recipients or individuals for whom a decision could not be made prior to authorization of benefits, the

State must initiate a notice of case action or an entry in the case record that no case action is necessary within 45 days of its receipt of the information. Under certain circumstances, action may be delayed beyond 45 days for no more than 20 percent of the information items targeted for follow-up (45 CFR section 205.56).

HHS may penalize a State for up to two percent of the SFAG for failure to participate in IEVS (42 USC 609(a)(4) and 1320b-7; 45 CFR sections 264.10 and 264.11).

Audit Objective – Determine whether the State has established and implemented the required IEVS system for data matching, and verification and use of such data. (This audit objective does not include Federal tax return information as discussed in the compliance requirements.)

Suggested Audit Procedures

- a. Review State operating manuals and other instructions to gain an understanding of the State's implementation of the IEVS system.
- b. Test a sample of TANF cases subject to IEVS to ascertain if the State:
 - (1) Used the IEVS to determine eligibility in accordance with the State Plan.
 - (2) Requested and obtained the data from the State Wage Information Collection Agency, the State unemployment agency, the Social Security Administration (excluding Federal tax return information as discussed in the compliance requirements), the Immigration and Naturalization Service, and other agencies, as appropriate, and performed the required data matching.
 - (3) Properly considered the information obtained from the data matching in determining eligibility and the amount of TANF benefits.

3. Penalty for Refusal to Work

Compliance Requirement – State agency must reduce or terminate the assistance payable to the family if an individual in a family receiving assistance refuses to work, subject to any good cause or other exemptions established by the State. HHS may penalize the State by an amount not less than one percent and not more than five percent of the SFAG for violation of this provision (42 USC 609(a)(14); 45 CFR sections 261.14, 261.16, and 261.54).

Audit Objective – Determine whether the State agency is reducing or terminating the assistance grant of those individuals who refuse to engage in work and are not subject to good cause or other exceptions established by the State.

Suggested Audit Procedures

- a. Review the State's TANF policies and operating procedures concerning this requirement.
- b. Test a sample of TANF cases where the individual is not working, and ascertain if benefits were reduced or denied to individuals who are not exempt under State rules or do not meet State good cause criteria.

4. Adult Custodial Parent of Child under Six When Child Care Not Available

Compliance Requirement – If an individual is a single custodial parent caring for a child under the age of six, the State may not reduce or terminate assistance for the individual's refusal to engage in required work if the individual demonstrates to the State an inability to obtain needed child care for one or more of the following reasons:

(a) unavailability of appropriate child care within a reasonable distance from the individual's home or work site; (b) unavailability or unsuitability of informal child care by a relative or under other arrangements; or (c) unavailability of appropriate and affordable formal child care arrangements. The determination of inability to find child care is made by the State. HHS may penalize a State for up to five percent of the SFAG for violation of this provision (42 USC 607(e)(2) and 609(a)(11); 45 CFR sections 261.15, 261.56, and 261.57).

Audit Objective – Determine whether the State has improperly reduced or terminated assistance to single custodial parents who refused to work because of inability to obtain child care for a child under the age of six.

Suggested Audit Procedures

- a. Gain an understanding of the criteria established by the State to determine benefits for a single custodial parent who refused to work because of inability to obtain child care for a child who is under the age of six.
- b. Select a sample of single custodial parents caring for a child who is under 6 years of age whose benefits have been reduced or terminated.
- c. Ascertain if the benefits were improperly reduced or terminated because of inability to obtain child care.

5. Penalty for Failure to Comply with Work Verification Plan

Compliance Requirement – The State agency must maintain adequate documentation, verification, and internal control procedures to ensure the accuracy of the data used in calculating work participation rates. In so doing, it must have in place procedures to: determine whether its work activities may count for participation rate purposes; determine how to count and verify reported hours of work; identify who is a work-eligible individual; and control internal data transmission and accuracy. Each State agency must comply with its HHS-approved Work Verification Plan in effect for the

period that is audited. HHS may penalize the State by an amount not less than one percent and not more than five percent of the SFAG for violation of this provision (42 USC 601, 602, 607, and 609); 45 CFR sections 261.60, 261.61, 261.62, 261.63, 261.64, and 261.65).

Audit Objective – Determine whether the State agency is complying with its Work Verification Plan, including adequate documentation, verification, and internal control procedures.

Suggested Audit Procedures

- a. Review the State’s Work Verification Plan and operating procedures concerning this requirement.
- b. Test a sample of TANF cases that have been reported to HHS under 45 CFR sections 265.3(b)(1) and 265.3(d)(1) and ascertain if the work participation rate data have been documented, verified, and reported in accordance with the State’s Work Verification Plan.

6. Accountability, Deposit, and Investment of Lump-Sum Drawdowns

Compliance Requirement - Effective October 1, 2011, once program funds are available, Tribal TANF grantees participating in a Pub. L. No. 102-477 demonstration project may draw down the full amount of available Pub. L. No. 102-477 TANF demonstration project funding. Lump-sum drawdown/payments must be retained in clearly identifiable cash or investment accounts which are readily accessible for payment of allowable expenditures in accordance with the approved Pub. L. No. 102-477 plan from which it was derived and in compliance with applicable requirements and, to the extent practical, earn interest. This does not require a Tribal TANF grantee to open a separate account with a financial institution or an investment manager. All eligible funds deposited in an appropriate account and earmarked as Pub. L. No. 102-477 demonstration funds must be identified as such. Investments of lump-sum payments must comply with 25 USC 450e-3, “Investment of Advance Payments: Restrictions.” All interest earned must be used on allowable expenditures in accordance with the approved Pub. L. No. 102-477 plan from which it was derived and in compliance with applicable requirements. (Tri-Agency 477 Tribal Leader Letter 9-30-11, Tri-Agency Letter to Committee on Appropriations 10-7-11, and Frequently Asked Questions Regarding P.L. 102-477 (Questions 2 through 4) found at <http://www.indianaffairs.gov/WhoWeAre/AS-IA/IEED/DWD/index.htm>)

Tribal TANF grantees receiving lump-sum drawdown/payments under a Pub. L. No. 102-477 demonstration project may invest these payments (some recipients refer to these advance payments as “deferred revenue”) before such funds are expended in accordance with the approved Pub. L. No. 102-477 plan, so long as such funds are (1) invested only in obligations of the United States or in obligations or securities that are guaranteed or insured by the United States, or mutual (or other) funds registered with the Securities and Exchange Commission and which only invest in obligations of the United States or

securities that are guaranteed or insured by the United States, or (2) deposited only in accounts that are insured by an agency or instrumentality of the United States, or are fully collateralized to ensure protection of the advance funds, even in the event of a bank failure (25 USC 450e-3).

Audit Objective - Determine whether the Tribal TANF grantee participating in a Pub. L. No. 102-477 demonstration project has properly accounted for, deposited, and invested lump-sum drawdowns/payments received under a Pub. L. No. 102-477 demonstration project and unexpended funds are identifiable and readily accessible for use to carry out the approved Pub. L. No. 102-477 plan.

Suggested Audit Procedures

- a. Obtain and review the Tribal TANF grantee policies and procedures and verify that those procedures comply with the requirements for lump-sum drawdowns/payments under a Pub. L. No. 102-477 demonstration project.
- b. Test lump-sum drawdowns/payments and ascertain if they were properly accounted for, deposited, and invested throughout the audit period.
- c. Review unused/unexpended TANF lump-sum drawdowns/payments at year-end, and verify that they are properly invested/deposited and are identifiable and readily accessible to carry out the work outlined in the approved Pub. L. No. 102-477 plan.

IV. OTHER INFORMATION

Transfers out of TANF

As described in III.A.1.b, “Activities Allowed or Unallowed,” States (not Tribes) may transfer a limited amount of Federal TANF funds into the Social Services Block Grant (Title XX) (CFDA 93.667) and the Child Care and Development Block Grant (CFDA 93.575). These transfers are reflected in lines 2 and 3 of both the quarterly *TANF Financial Report* ACF-196, and the quarterly *Territorial Financial Report* ACF-196-TR. The amounts transferred out of TANF are subject to the requirements of the program into which they are transferred and should not be included in the audit universe and total expenditures of TANF when determining Type A programs. The amount transferred out should not be shown as TANF expenditures on the Schedule of Expenditures of Federal Awards, but should be shown as expenditures for the program into which they are transferred. ARRA TANF funds may not be transferred out of TANF.

State MOE Expended by Tribes

A State may provide a Tribe State-donated MOE funds that are expended by the Tribe. For the Tribe, State-donated MOE funds are not Federal awards expended, shall not be considered in determining Type A programs, and shall not be shown as expenditures on the Schedule of Expenditures of Federal Awards. However, State-donated MOE funds expended by a Tribe shall

be included by the auditor of the State when testing III.G.2.1, “Matching, Level of Effort, Earmarking – Level of Effort – Maintenance of Effort.”

Under the Commingled Federal/State-donated MOE option, Tribes may commingle their State-donated MOE funds with Federal grant funds. Because of the commingling, the audit of the Tribe will include testing of the State-donated MOE and the auditor of the State should consider relying on this testing in accordance with auditing standards and OMB Circular A-133. However, the State-donated MOE is not considered Federal awards expended by the Tribe.

Tribal TANF Grantees under a Pub. L. No. 102-477 Demonstration Project

Effective October 1, 2011, the requirements contained in the 2009, 2010, and 2011 Compliance Supplements in the BIA Cross-Cutting Section page 4-15.000-4, IV, “Other Information,” were suspended. The auditor is not required to consider audit findings or modifications of audit opinions for completed audits which were based solely on the page suspended when the auditor is performing the risk based approach under OMB Circular A-133 in the two subsequent year audits. Tribal TANF grantees are not required to take corrective action and the respective Federal agencies will not follow-up on audit findings based solely on the page suspended. For example, a material non-compliance or material weakness in internal control over compliance based solely on the page suspended would not preclude a program from being low risk or an entity from qualifying as a low risk auditee in the two subsequent year audits.

For Tribal TANF grantees participating in Pub. L. No. 102-477 demonstration projects during the period covered by this Supplement:

- (1) the auditor should use the approved Pub. L. No. 102-477 plan in determining compliance requirements to be tested;
- (2) the auditor is permitted to audit the Pub. L. No. 102-477 demonstration project as a cluster of programs;
- (3) the Tribal TANF grantee may present demonstration project expenditures in its Schedule of Expenditures of Federal Awards (SEFA) in the same manner in which it had been presenting these expenditures in the period immediately prior to this Supplement or in the same manner in which it had been presenting these expenditures in the period immediately prior to the 2009 Compliance Supplement.

(Tri-Agency 477 Tribal Leader Letter 9-30-11, Tri-Agency Letter to Committee on Appropriations 10-7-11, and Frequently Asked Questions Regarding P. L. 102-477 (Questions 5 through 9) found at <http://www.indianaffairs.gov/WhoWeAre/AS-IA/IEED/DWD/index.htm>.)

Spending Levels of the Territories

A funding ceiling applies to Guam, the Virgin Islands, American Samoa and Puerto Rico. The programs subject to the funding ceiling are the Adult Assistance programs under Titles I, X, XIV, and XVI of the Social Security Act; TANF; Foster Care (CFDA 93.658); Adoption Assistance (CFDA 93.659) and Independent Living (CFDA 93.674) programs under Title IV-E of the Social Security Act; and the matching grant under section 1108(b). Total payments to each territory may not exceed the following: Guam – \$4,686,000; Virgin Islands – \$3,554,000; Puerto Rico – \$107,255,000; and American Samoa – \$1,000,000. However, the TANF Family Assistance Grant cannot exceed the territory’s fixed annual amount (42 USC 1308(a) and (c)).

Territorial Matching Grant Funding Stream

The Matching Grant under section 1108(b) of the Social Security Act (42 USC 1308(b)) is an optional funding stream for the Territories. Each fiscal year, Puerto Rico, the Virgin Islands, and Guam may receive a Matching Grant in an amount that equals 75 percent of the amount, if any, by which the territory’s total expenditures during the fiscal year under the TANF program (including transfers to the CCDF (CFDA 93.575 and 93.596) and SSBG (CFDA 93.667) programs) and the Foster Care program exceed the total of: (1) the amount that equals the territory’s Federal TANF grant payable (without regard to any applicable penalties; and (2) the amount that equals the sum expended by the territory during fiscal year 1995 in the AFDC and JOBS programs (other than for child care).

Thus, each territory receiving a Matching Grant has two expenditure requirements: (1) expend an amount that equals the territory’s Federal TANF block grant amount; and (2) expend an amount that equals the territory’s share of expenditures in the AFDC and JOBS programs (other than for child care) during FY 1995. This latter requirement is the territory’s Matching Grant MOE expenditure requirement. Territorial expenditures used to receive section 1108(b) Federal Matching Grant funds are expenditures that exceed the sum of these two expenditure requirements. Territorial expenditures in the TANF program in excess of the total spending requirement that are used to receive section 1108(b) Federal Matching Grant funds may be reported in either column (C) or column (D) of the ACF-196-TR, but not in both (45 CFR section 264.80(a)(1)).

The amounts of the two expenditure requirements are as follows:

Territory	Federal TANF Block Grant Spending Amount (FGA)²	Matching Grant MOE Spending Amount³	Total Spending Requirement
Puerto Rico	\$71,562,501	\$28,182,864	\$99,745,365
Guam	\$3,465,478	\$974,517	\$4,439,995
Virgin Islands	\$2,846,564	\$820,380	\$3,666,944
American Samoa	\$0	\$0	\$0

² Amount reported in Column (C) of the ACF-196-TR.

³ Amount reported in Column (D) of the ACF-196-TR.

See 45 CFR section 264.82 for the types of expenditures using Federal and Territorial funds that may count toward meeting the required block grant spending amount. 45 CFR section 264.81 specifies the types of expenditures that may count toward meeting the Matching Grant MOE requirement. Territorial expenditures may count only once, i.e., to meet either expenditure requirement *or* as an excess expenditure to receive Federal Matching Grant funds under 1108(b). (45 CFR sections 264.80 through 264.85 include the requirements pertinent to receipt of matching funds under section 1108(b)).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.563 CHILD SUPPORT ENFORCEMENT

I. PROGRAM OBJECTIVES

The objectives of the Child Support Enforcement programs are to: (1) enforce support obligations owed by non-custodial parents, (2) locate absent parents, (3) establish paternity, and (4) obtain child and spousal support.

II. PROGRAM PROCEDURES

Administration and Services

The Child Support Enforcement programs are administered at the Federal level by the Office of Child Support Enforcement (OCSE), Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS). Under the State Child Support Enforcement program (State program), funding is provided to the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam, based on a State plan and amendments, as required by changes in statutes, rules, regulations, interpretations, and court decisions, submitted to and approved by OCSE. Under the Tribal Child Support Enforcement program (tribal program), funding is provided to federally recognized tribes and tribal organizations based on applications, plans, and amendments, as required by changes in statutes, rules, regulations, and interpretations, submitted to and approved by the ACF Central Office.

The State program is an open-ended entitlement program that allows the State to be funded at a specified percentage, Federal financial participation (FFP), for eligible program costs. Under the tribal program, tribes receive funding for a specified percentage of program costs.

State child support agencies are required to conduct self-reviews of their programs. The first round of self-assessments was required to be completed by March 31, 1999 (42 USC 654(15) and 45 CFR part 308).

Source of Governing Requirements

The Child Support Enforcement programs are authorized under title IV-D of the Social Security Act, as amended. This includes amendments as the result of the Deficit Reduction Act of 2005 (DRA) (Pub. L. No. 109-171) **and the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. No. 111-5, Section 2104, 123 Stat 449)**. The State program is codified at 42 USC 651 through 669. Implementing program regulations for the State program are published at 45 CFR parts 301 through 308. In addition, with regard to eligibility and other provisions, these programs are closely related to programs authorized under other titles of the Social Security Act, including the Temporary Assistance for Needy Families (TANF) program (CFDA 93.558), the Medicaid program (CFDA 93.778), and the Foster Care (title IV-E) program (CFDA 93.658).

The tribal program is authorized under title IV-D of the Social Security Act, as amended, at 42 USC 655. Implementing program regulations are published at 45 CFR part 309 (*Federal Register*, March 30, 2004, 69 FR 16639). These regulations are available at <http://www.acf.hhs.gov/programs/cse/pol/AT/2004/at-04-01a.pdf>.

Awards made under the State program with funding periods beginning on or after October 1, 2003, are subject to the HHS implementation of the A-102 Common Rule, 45 CFR part 92 (*Federal Register*, September 8, 2003, 68 FR 52843-52844). The State program also is subject to 45 CFR part 95. The tribal program is subject to the administrative requirements of 45 CFR part 92 (45 CFR part 309). Both programs are subject to the cost principles under 2 CFR PART 225 – Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A-87,) as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, HHS Publication ASMB C-10, available on the Internet at <http://rates.psc.gov/fms/dca/asmb%20c-10.pdf>.

States and tribes are required to adopt and adhere to their own statutes and regulations for program implementation, consistent with the requirements of title IV-D and the approved State plan/tribal plan and application.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look first to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Activities Allowed*

Consistent with the approved title IV-D plan, allowable activities include the following. A more complete listing of allowable types of activities, with examples, as appropriate, is included at 45 CFR sections 304.20 through 304.22 for the State program and 45 CFR sections 309.145(a) through (o) for the tribal program.

a. *State and tribal programs*

- (1) Parent locator services for eligible individuals (45 CFR sections 304.20(a)(2), 304.20(b), and 302.35(c); 45 CFR section 309.145).
- (2) Paternity and support services for eligible individuals (45 CFR section 304.20(a)(3); 45 CFR sections 309.145(b) and (c)).

- (3) Program administration, including establishment and administration of the State plan/tribal plan, purchase of equipment, and development of a cost allocation system and other systems necessary for fiscal and program accountability (45 CFR sections 304.20(b)(1) and 304.24; 45 CFR sections 309.145(a)(1) and (a)(2), 309.145(h), 309.145(i), and 309.145(o)).
- (4) Establishment of agreements with other State, tribal, and local agencies and private providers, including the costs of cooperative arrangements with appropriate courts and law enforcement officials in accordance with the requirements of 45 CFR section 302.34 , including associated administration and short-term training of staff (45 CFR section 304.21(a); 45 CFR sections 309.145(a)(3)(iii) and 309.145(m)).

b. *State programs only*

Necessary expenditures for support enforcement services and activities provided to individuals from whom an assignment of support rights (as defined in 45 CFR section 301.1) is obtained (45 CFR sections 304.20, 304.21, and 304.22).

c. *Tribal programs*

- (1) The portion of salaries and expenses of a tribe's chief executive and staff that is directly attributable to managing and operating a tribal IV-D program (45 CFR section 309.145(j)).
- (2) The portion of salaries and expenses of tribunals and staff that is directly related to required Tribal IV-D program activities (45 CFR section 309.145(k)).
- (3) Service of process (45 CFR section 309.145(l)).
- (4) Costs associated with obtaining technical assistance from non-Federal third-party sources, including other Tribes, Tribal organizations, State agencies, and private organizations, that are directly related to operating a IV-D program, and costs associated with providing such technical assistance to public entities (45 CFR section 309.145(n)).

2. *Activities Unallowed*

a. *State and tribal programs*

The following costs and activities are unallowable pursuant to 45 CFR sections 304.23 and 309.155:

- (1) Activities related to administering other titles of the Social Security Act.
- (2) Construction and major renovations.
- (3) Any expenditures that have been reimbursed by fees or costs collected.
- (4) Any expenditures for jailing of parents in child support enforcement cases.
- (5) Costs of counsel for indigent defendants in IV-D actions.
- (6) Costs of guardians *ad litem* in IV-D actions.

b. *State programs*

The following costs and activities are unallowable pursuant to 45 CFR section 304.23:

- (1) Education and training programs other than those for title IV-D agency staff or as described in 45 CFR section 304.20(b)(2)(viii).
- (2) Any expenditures related to carrying out an agreement under 45 CFR section 303.15.
- (3) Any costs of caseworkers (45 CFR section 303.20(e)).
- (4) Medical support enforcement activities performed under cooperative arrangements/agreements (45 CFR sections 303.30 and 303.31).
- (5) The following costs associated with cooperative arrangements with courts and law enforcement officials are unallowable: service of process and court filing fees unless the court or law enforcement agency would normally be required to pay the costs of such fees; costs of compensation (salary and fringe benefits) of judges; costs of training and travel related to the judicial determination process incurred by judges; office-related costs, such as space, equipment, furnishings and supplies incurred by judges; compensation (salary and fringe benefits), travel and training, and office-related costs

incurred by administrative and support staffs of judges; and costs of cooperative agreements that do not meet the requirements of 45 CFR section 303.107 (45 CFR section 304.21(b)).

F. Equipment and Real Property Management

Under State programs, equipment that is capitalized or depreciated or is claimed in the period acquired and charged to more than one program is subject to 45 CFR section 95.707(b) in lieu of the requirements of the A-102 Common Rule (45 CFR section 95.707(b)).

G. Matching, Level of Effort, Earmarking

1. Matching

State programs

The Federal share of program costs related to determining paternity, including those related to the planning, design, development, installation and enhancement of the statewide computerized support enforcement system is 66 percent. For costs incurred on or before September 30, 2006, the Federal share of laboratory costs for determining paternity was 90 percent (42 USC 655(a)(1)(C) and (a)(2)(C); 45 CFR sections 304.20(c) and 304.30). Effective October 1, 2006, the Federal share of laboratory costs for determining paternity is 66 percent (DRA, Section 7308).

A Federal match of 66 percent is available for State administrative costs of carrying out child support enforcement program activities under title IV-D of the Social Security Act. ARRA temporarily changed the child support authorization language to allow States to use Federal incentive payments provided to States in accordance with Section 458 of the Social Security Act as their State share of expenditures eligible for Federal match. This change is effective October 1, 2008 through September 30, 2010. This change is in effect for any incentive funds expended during FY 2009 and FY 2010, including incentives earned and not expended in prior years (i.e., prior to October 1, 2008). Incentive payments expended during FY 2008 (October 1, 2007-September 30, 2008) are not eligible for additional Federal funds. The requirements of Section 458(f) of the Social Security Act and 45 CFR section 305.35 regarding “reinvestment” of incentive funds remain in effect.

Tribal programs

The Federal share of program costs is 90 percent for the first 3 years and 80 percent thereafter. Unless waived by the Secretary, the tribe or tribal organization must provide the 10 percent and 20 percent share, respectively (45 CFR sections 309.130(c), (d), and (e)).

2. Level of Effort – Not Applicable

3. Earmarking – Not Applicable

H. Period of Availability of Federal Funds

1. *State programs* – This program operates on a cash accounting basis and each year’s funding and accounting is discrete; i.e., there is no carry-forward of unobligated funds. To be eligible for Federal funding, claims must be submitted to ACF within two years after the calendar quarter in which the State made the expenditure. This limitation does not apply to any claim for an adjustment to prior year costs or resulting from a court-ordered retroactive adjustment (45 CFR sections 95.7, 95.13, and 95.19).
2. *Tribal programs* – A tribe or tribal organization must obligate its Federal title IV-D grant funds no later than the last day of the funding period (equivalent to the Federal fiscal year) for which they were awarded (“obligation period”) or the funds must be returned to ACF. Unless an extension is granted by ACF, valid obligations must be liquidated no later than the last day of the 12-month period immediately following the obligation period or the funds must be returned to ACF (45 CFR sections 309.135(b), (c), and (e)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Applicable for tribal programs; Not Applicable for State programs
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable for tribal programs; Not Applicable for State programs
- d. OCSE 34A, *Child Support Enforcement Program Quarterly Report of Collections (State programs – OMB No. 0970-0181; tribal programs – OMB No. 0970-0218)*.
- e. OCSE 396A, *Child Support Enforcement Program Expenditure Report (OMB No. 0970-0181)* – Applicable for State programs only.

Action Transmittal AT-09-02, “Revisions to expenditure reporting instructions for Fiscal Years (FY) 2009 and 2010 to accommodate Public Law 111-5, the American Recovery and Reinvestment Act of 2009 (ARRA),” was issued on March 26, 2009. Under AT-09-02, the reporting instructions for the OCSE-396A report, “Child Support Enforcement Program Expenditure Report,” were revised to reflect the change in ARRA which temporarily allows States to use Federal incentive payments provided to States in accordance with Section 458 of the Act as their State

share of expenditures eligible for Federal match. This temporary change is effective October 1, 2008 through September 30, 2010. See also III.L.4 below.)

2. **Performance Reporting** – Not Applicable
3. **Special Reporting** – Not Applicable
4. **Section 1512 ARRA Reporting** – Not Applicable

There have been no substantive changes in the expenditure reporting burden for States (or Territories) and subrecipients (e.g., counties) as a result of ARRA. As before, State expenditures are reported quarterly to the Federal government on the OCSE-396A form. Also consistent with existing requirements, claims for administrative expenditures, including administrative expenditures using incentive payments, must be adequately documented for regular audit purposes. Procedures involving subrecipient expenditure reporting within each State or Territory are unaffected by ARRA. Subrecipient reporting practices remain under the jurisdiction of the State or Territory and are subject to that State or Territory's rules and regulations.

5. **Subaward Reporting Under the Transparency Act** – Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES**CFDA 93.566 REFUGEE AND ENTRANT ASSISTANCE—STATE-ADMINISTERED PROGRAMS****I. PROGRAM OBJECTIVES**

The objective of the Refugee and Entrant Assistance Program is to provide States with funds to assist refugees and Cuban/Haitian entrants in attaining economic and social self-sufficiency as soon as possible after their initial placement in U.S. communities. (The term “refugee” is used to mean an individual who meets the immigration status requirements under 45 CFR section 400.43.)

II. PROGRAM PROCEDURES**Administration and Services**

The Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Refugee Resettlement (ORR), administers the Refugee and Entrant Assistance Program on behalf of the Federal Government. ORR provides funds to States through two grant programs: (1) Cash/Medical/Administration (CMA) and (2) Refugee Social Services (RSS).

CMA Grants

CMA grants are made to States upon submittal of an approved State plan and Annual State estimate. CMA grants reimburse States for the costs of providing:

1. *Refugee Cash Assistance (RCA)* – monthly cash benefits for refugees who do not meet the eligibility requirements of the Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) programs;
2. *Refugee Medical Assistance (RMA)* – medical assistance to refugees who do not meet all eligibility requirements for Medicaid and the Children’s Health Insurance Program (CHIP) and medical screening to all refugees if done within the refugees’ first 90 days upon arrival to the U.S.;
3. *Refugee Unaccompanied Minor (RUM) Assistance* – Child welfare services and foster care to unaccompanied refugee minors (until age 18 or higher age as the State’s Title IV-B plan prescribes); and
4. Administrative costs associated with providing RCA, RMA, and RUM, and costs incurred for the overall management of the State’s refugee program.

Refugee Social Service Grants

Refugee Social Services grants are made to States upon submittal of an approved State plan and an Annual Services Plan. RSS grants are allocated to States by formula according to each State's percentage of the national refugee and entrant population for the most recent three years. States are required to use these funds to help refugees become economically self-sufficient as quickly as possible, primarily through the provision of employment services.

A State may administer the program as a publicly State-administered program, or may form a public/private partnership by engaging non-profit organizations to deliver program services and benefits. A State administered program must follow the TANF rules on financial eligibility and payment levels unless the State receives an approved waiver under 45 CFR section 400.300 to continue administering RCA according to the rules of the former Aid to Families With Dependent Children (AFDC) Program. Subject to certain limitations, a public/private program may operate according to its own rules.

Source of Governing Requirements

The Refugee and Entrant Assistance Program is governed under the following authority:

The Refugee Act of 1980 (Pub. L. No. 96-212); Refugee Education Assistance Act of 1980 (Pub. L. No. 96-422); Refugee Assistance Amendments of 1982 (Pub. L. No. 97-363); Refugee Assistance Extension Act of 1986 (Pub. L. No. 99-605); Section 584(c) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act (as included in the fiscal year (FY) 1988 Continuing Resolution (Pub. L. No. 100-202)), insofar as it incorporates by reference with respect to certain Amerasians from Viet Nam the authorities pertaining to assistance for refugees established by section 412(c)(2) of the Immigration and Nationality Act, as amended, including certain Amerasians from Viet Nam who are United States citizens; and, as provided under Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1989 (Pub. L. No. 100-461), 1990 (Pub. L. No. 101-167), and 1991 (Pub. L. No. 101-513); section 107(b)(1)(A) of the Trafficking Victims Protection Act of 2000 (Pub. L. No. 106-386), as amended by the Trafficking Victims Protection Reauthorization Act of 2003 (Pub. L. No. 108-193) and 2005 (Pub. L. No. 109-164), insofar as it states that a victim of a severe form of trafficking and certain other specified family members shall be eligible for federally funded or administered benefits and services to the same extent as a refugee. A "victim of a severe form of trafficking" is defined as a person who is induced by force, fraud or coercion to perform commercial sex acts, or a person who is subjected to involuntary servitude, peonage, debt bondage or slavery through the use of force, fraud or coercion.

Program regulations are at 45 CFR part 400.

Awards under the Refugee and Entrant Assistance Program are subject to the HHS implementation of the A-102 Common Rule. This program also is subject to (1) 45 CFR part 95, subparts E (Cost Allocation Plans) and F (Automatic Data Processing Equipment and Services Conditions for Federal Financial Participation (FFP)), and (2) the cost principles under Office of Management and Budget Circular A-87 (as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal*

Government, HHS Publication ASMB C-10, available on the Internet at <http://rates.psc.gov/fms/dca/asmb%20c-10.pdf>).

Availability of Other Program Information

Additional information is available on the ORR web site at <http://www.acf.dhhs.gov/programs/orr>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

Program funds are to be used to pay for:

1. *Refugee Cash Assistance* (45 CFR section 400.53) (see III.E.1, “Eligibility – Eligibility for Individuals”).
2. *Refugee Medical Assistance* (45 CFR section 400.100) (see III.E.1, “Eligibility – Eligibility for Individuals”).
3. *Refugee Unaccompanied Minor Assistance* (45 CFR section 400.116) (see III.E.1, “Eligibility – Eligibility for Individuals”).
4. *Refugee Medical Screening*

A State may charge refugee medical screening costs to RMA upon submission of a medical screening plan which the State Director or designee and the Director of ORR have approved in writing 45 CFR section 400.107. If such screening is done during the first 90 days after a refugee's initial date of entry into the United States, it may be provided without prior determination of the refugee's eligibility under 45 CFR sections 400.94 or 400.100 and may be charged to RMA with the written approval of the Director of ORR. States may charge to RMA the cost of medical screenings done later than 90 days after the refugees' arrival only if the refugees had been determined ineligible for Medicaid or CHIP (CFDA 93.767) under 45 CFR sections 400.94 and 400.100 (45 CFR section 400.107).

5. *Program Administration* – A State may claim against its CMA grant the reasonable and necessary identifiable administrative costs:
 - a. Associated with providing RCA, RMA, and assistance and services to unaccompanied refugee minors (45 CFR section 400.207).

- b. Incurred by the local resettlement agencies for providing cash assistance under the public/private RCA program (45 CFR section 400.13(e)).
 - c. Incurred for the overall management of the State's refugee program. Such costs may include: development of the State Plan, overall program coordination, and salary and the travel costs of the State Refugee Coordinator (45 section CFR 400.13(c)).
6. *Employability Services* – A State may provide the following employability services:
- a. Employment services, including development of a family self-sufficiency plan and individual employment plan, job development, job search, and job placement (45 CFR section 400.154(a));
 - b. Aptitude and skills testing, employability assessment (45 CFR section 400.154(b));
 - c. On-the job training at the employment site (45 CFR section 400.154(c));
 - d. English language training with emphasis on job-related language skills (45 CFR section 400.154(d));
 - e. Vocational training when part of an employability plan (45 CFR section 400.154(e));
 - f. Skills recertification (45 CFR section 400.154(f));
 - g. Child care when necessary for job retention/acceptance or participation in an employability service (45 CFR section 400.154(g));
 - h. Transportation when necessary for job retention/acceptance or participation in an employability service (45 CFR section 400.154(h));
 - i. Translation and interpreter services when necessary for job retention/acceptance or participation in an employability service (45 CFR section 400.154(i));
 - j. Case management services directed toward a refugee's attainment of employment as soon as possible after arrival in the U.S. (45 CFR section 400.154(j)). All case management services must be charged to RSS; and
 - k. Assistance in obtaining employment authorization documents (45 CFR section 400.154(j)).

7. *Non-Employability Social Services* – A State may provide non-employability social services, which may include:
 - a. Information and referral services (45 CFR section 400.155(a));
 - b. Outreach services designed to familiarize refugees with available services and facilitate access to them (45 CFR section 400.155(b));
 - c. Social adjustment services including emergency services, health-related services, and home management services (45 CFR section 400.155(c));
 - d. Child care, transportation, translation and interpreter services, and case management services which are not directly related to employment or an employability service, when necessary for purposes other than employment or participation in employability services (45 CFR sections 400.155d through 155g);
 - e. Any other service approved by the ORR Director which is aimed at helping the refugee attain economic self-sufficiency, family stability, or community integration (45 CFR section 400.155(h)); and
 - f. Citizenship and naturalization preparation services (45 CFR section 400.155(i)).

B. Allowable Costs/Costs Principles

The following costs may be charged to the State's CMA grant: (1) certain administrative costs incurred for the overall management of the State's refugee program (such as development of the State plan, salary and travel costs of the State Refugee Coordinator, etc.); and (2) costs incurred by local resettlement agencies to provide cash assistance under public/private RCA programs. All other costs must be allocated among the State's CMA grant, its RSS grant, and any other Refugee Resettlement Program grants it may have received. However, no portion of the cost of case management services (as defined at 7 CFR section 400.2) may be allocated to the State's CMA grant; and administrative costs of managing the services component of the RCA program must be charged to the RSS grant (45 CFR section 400.13).

E. Eligibility

1. Eligibility for Individuals

a. General Eligibility

- (1) Clients must have either refugee, asylee, entrant, or Amerasian documented status (45 CFR section 400.43) or, if trafficking victims, must have received a certification or eligibility letter from ORR. Those meeting this status will be collectively referred to as "refugees." (See definition of "victim of severe form of

trafficking” under II, “Program Procedures – Source of Governing Requirements.”)

- (2) A client’s eligibility period generally begins on the date he/she arrived in the U.S. (45 CFR sections 400.203(a) and 400.204(a)). On June 15, 2000, however, HHS adopted a policy of setting the eligibility period for asylees (but not refugees) from the date the person receives a final grant of asylum. Additional information on this matter is available on the ORR web site at <http://www.acf.dhhs.gov/programs/orr> (See State Letter 00-12 (June 15, 2000)).

b. *Refugee Cash Assistance*

(1) *Eligibility Criteria*

Eligibility for RCA is limited to newly arrived refugees who meet all the following criteria:

- (a) They have resided in the U.S. less than the RCA eligibility period (currently 8 months) determined by the ORR Director in accordance with 45 CFR section 400.211 (45 CFR section 400.53).
- (b) They have been determined ineligible for other federally funded cash assistance programs, such as the following programs authorized by the Social Security Act: TANF, SSI, Old Age Assistance (OAA)(Title I), Aid to the Blind (AB)(Title X), Aid to the Permanently and Totally Disabled (APTD)(Title XIV), and Aid to the Aged, Blind, and Disabled (AABD)(Title XVI)(45 CFR sections 400.51 and 400.53).
- (c) They meet the financial eligibility requirements of the applicable type of RCA program: AFDC-type (45 CFR section 400.45), public/private (45 CFR section 400.59), or State-administered (45 CFR section 400.66). In all three types, the administering agency may not treat the following as income or resources available to the applicant: resources remaining in the applicant’s country of origin, income earned by the applicant’s sponsor, or cash assistance the applicant may have received under reception and placement programs administered by the Department of State or Justice (45 CFR sections 400.45(f)(2), 400.59(b) through (d), and 400.66(b) through (d)).
- (d) They are not full-time students in institutions of higher education (45 CFR section 400.53).

- (e) If they are mandatory work registrants, they have not, without good cause, failed or refused to meet the work requirements of 45 CFR section 400.75(a), or voluntarily quit a job or refused an offer of appropriate employment within 30 consecutive calendar days immediately prior to the application for assistance. The payment of RCA assistance to an otherwise eligible client must be terminated if the client fails to meet this requirement (45 CFR sections 400.77 and 400.82(a)).
 - (2) *Benefit Level* – Benefit payments in a State-administered AFDC-type RCA program must be based on the AFDC rate (45 CFR section 400.45(f)(2)). Benefit payments in a State-administered TANF-type RCA program must be based on the TANF rate (45 CFR section 400.66(a)). Benefit payments in a public/private RCA program may neither exceed the rate described in 45 CFR section 400.60(a), nor be less than the State’s TANF payment rate (45 CFR section 400.60(b)).
- c. *Refugee Medical Assistance*
- (1) *Eligibility Criteria*

Eligibility for RMA is limited to newly arrived refugees who meet one of the following sets of conditions:

 - (a) They are not eligible for Medicaid or CHIP but currently receive RCA (45 CFR section 400.100(d)); or
 - (b) They meet all of the following criteria:
 - (i) They have met the same time eligibility requirement stated above for RCA (45 CFR section 400.100(b)).
 - (ii) They are determined ineligible for Medicaid or CHIP (45 CFR section 400.100(a)(1)).
 - (iii) They meet one of the following financial eligibility requirements:
 - (A) In a State with a Medicaid medically needy program, they meet the State’s Medicaid medically needy financial eligibility standards or a financial eligibility standard established at 200 percent of the national poverty level (45 CFR section 400.101(a)).

- (B) In a State without a Medicaid medically needy program, they meet the State's AFDC payment standards and methodologies in effect as of July 16, 1996, or a financial eligibility standard established at 200 percent of the national poverty level (45 CFR section 400.101(b)).
 - (C) They did not meet either of these standards, but spent their resources down to the applicable standard using an appropriate method for deducting incurred medical expenses. States must allow applicants for RMA to do this (45 CFR section 400.103).
 - (c) They are not full-time students in institutions of higher education, unless the State has approved their enrollment as part of the refugee's employability plan under 45 CFR section 400.79 or a plan for an unaccompanied minor in accordance with 45 section CFR 400.100(a).
 - (2) Earnings from employment do not affect refugees' eligibility for RMA. They remain eligible for RMA through the remainder of the time eligibility period after receiving earnings from employment. Refugees who become ineligible for Medicaid due to employment earnings and have resided in the U.S. less than the time eligibility period will become eligible for RMA for the remainder of the time eligibility period (45 CFR section 400.104) without an additional eligibility determination.

States may not require that a refugee actually receive or apply for RCA as a condition of eligibility for RMA (45 CFR section 400.100(d)).
 - (3) *Benefit Level* – In providing medical assistance services to eligible refugees, a State must provide at least the same services in the same manner and to the same extent as under the State's Medicaid program (45 CFR section 400.105). A State may provide additional services beyond the scope of the State's Medicaid program to eligible refugees if the State provides these services through public facilities to its indigent residents (45 CFR section 400.106).
- d. *Refugee Unaccompanied Minor (RUM) Assistance*
- (1) A person must meet the definition of an unaccompanied minor listed in 45 CFR section 400.111.

- (2) A RUM remains eligible for assistance until he/she: (1) is reunited with a parent; (2) is united with a non-parental adult to whom legal custody or guardianship has been granted; or (3) has reached the age of 18, or older if the State's Title IV-B plan so prescribes (45 CFR section 400.116).

e. *Refugee Social Services*

- (1) In providing social services, the State must serve refugees in the following order of priority listed under 45 CFR section 400.147:
 - (a) All refugees who have resided in the U.S. less than a year and who apply for services;
 - (b) Refugees receiving cash assistance;
 - (c) Unemployed refugees who are not receiving cash assistance; and
 - (d) Employed refugees in need of services to retain employment.
- (2) A State may limit eligibility for services to refugees who are 16 or older who are not full-time students in secondary school, except that such a student may be provided services in order to obtain part-time or temporary (summer) employment while a student or permanent, full-time employment upon completion of schooling (45 CFR section 400.152 (a)).
- (3) Except for citizenship and naturalization services and referral and interpreter services, a State may not provide refugee social services to refugees who have been in the U.S. for more than 60 months (45 CFR section 400.152(b)).

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable

3. Eligibility for Subrecipients – Not Applicable

H. Period of Availability of Federal Funds

1. *CMA Funds*

A State must obligate its CMA funds awarded for costs attributable to RCA, RMA and administration during the Federal fiscal year (FFY) in which the grant was awarded. Funds awarded for RUM assistance remain available for obligation in the FFY following the FFY in which the grant was awarded. However, all CMA funds, including funds awarded for RUM services, must be expended by the

end of the FFY following the FFY in which the grant was awarded (45 CFR section 400.210(a)).

2. *Social Services Funds*

A State must obligate its Social Services funds within one year after the end of the FFY in which the grant was awarded, and must expend these funds within two years after the end of the FFY in which the grant was awarded (45 CFR 400.210(b)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271 – *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting

ORR-6, *Performance Report (QPR) (OMB No. 0970-0036)* – A State is required to submit a QPR, which contains a narrative and statistical information on program performance for cash assistance, medical assistance, social services, medical screening, and the provision of services to unaccompanied minors, three times a year.

Key Line Items – The following line items contain critical information:

- a. Schedule B, I and II – *Cash and Medical Assistance*
- b. Schedule C – *Services Report*

3. Special Reporting

ORR-11, *State-of-Origin Report (OMB No. 0970-0043)* – A State is required to submit this report to account for refugee in-migration from other States (secondary migrants) during the prior FFY.

4. Section 1512 ARRA Reporting – Not Applicable

5. Subaward Reporting under the Transparency Act – Not Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.568 LOW-INCOME HOME ENERGY ASSISTANCE

I. PROGRAM OBJECTIVES

The Low-Income Home Energy Assistance Program (LIHEAP) is a block grant program in which States (including territories and Indian tribes) design their own programs, within very broad Federal guidelines. There are four components of LIHEAP: (1) block grants, (2) energy emergency contingency funds, (3) leveraging incentive awards, and (4) the Residential Energy Assistance Challenge Program (REACH). The objectives of LIHEAP are to help low-income people meet the costs of home energy (defined as heating and cooling of residences) increase their energy self-sufficiency, and reduce their vulnerability resulting from energy needs. A primary purpose is meeting immediate home energy needs. The target population is low-income households, especially those with the lowest incomes and the highest home energy costs or needs in relation to income, taking into account family size. Additional targets are low-income households with members who are especially vulnerable, including the elderly, persons with disabilities, and young children.

II. PROGRAM PROCEDURES

LIHEAP Block Grants

The Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Community Services, administers the LIHEAP program at the Federal level. LIHEAP block grant funds are distributed by formula to the States, the District of Columbia, and the territories. In addition, federally or State-recognized Indian tribes (including tribal consortia) have the option of requesting direct funding from ACF, rather than being served by the State in which they are located. Tribes that are directly funded by HHS statutorily receive a share of the funds that would otherwise be allotted to the States in which they are located, based on the number of eligible households in the tribal service area as a percentage of the eligible households in the State, or a larger amount agreed upon in a State/tribe agreement. Over half the States agree to give the tribes located within their State a larger amount than required by the statute.

Each grantee is required to submit a plan/application annually in order to receive block grant funding. The plan contains two parts: (1) an application to describe how the grantee's LIHEAP program will be administered and (2) a program integrity supplement in which the grantee must describe the systems in place to detect and deter fraud and abuse in its LIHEAP program.

State grantees are required to hold a public hearing each year. All grantees must allow for public participation in the development of their annual plans. A separate application is required for those LIHEAP grantees that wish to apply for a leveraging incentive award or a REACH grant.

Energy Emergency Contingency Funds

In addition to appropriations for the LIHEAP block grant program, funds may be awarded to meet the additional home energy assistance needs of States for a natural disaster or other emergency. Contingency funds that are awarded generally must be used under the normal statutory and regulatory requirements that apply to the LIHEAP block grants, unless special conditions are placed upon their use at the time of the award.

Leveraging Incentive Awards

Of the funds appropriated for LIHEAP each year, HHS is required to earmark a portion to reward those LIHEAP grantees that have acquired non-Federal resources to help low-income persons meet their home heating and cooling needs, as an incentive to augment the Federal dollars. This could involve the grantee or private organizations putting some of their own funds into LIHEAP or similar State or private programs, buying fuel at reduced or discount prices through bulk purchases or negotiated agreements, obtaining donations of weatherization materials or fuels, waiving utility fees, or any number of other activities. Awards in the current year are based on leveraging activities carried out during the previous year. Leveraging grants are subject to special terms and conditions, which are specified in the grant awards.

Residential Energy Assistance Challenge Program

Up to 25 percent of the funds earmarked for leveraging incentive awards each year may be set aside for the REACH program to make competitive grants to LIHEAP grantees to help LIHEAP-eligible households reduce their energy vulnerability. The purposes of REACH are: (1) to minimize health and safety risks that result from high energy burdens on low-income households; (2) to prevent homelessness as a result of inability to pay energy bills; (3) to increase efficiency of energy usage by low-income families; and (4) to target energy assistance to individuals who are most in need. REACH grants are to be administered through community-based organizations. REACH grants are subject to special terms and conditions, which are specified in the grant awards.

Source of Governing Requirements

The LIHEAP program is authorized under Title XXVI of the Omnibus Budget Reconciliation Act of 1981, as amended (Pub. L. No. 97-35, as amended, also known as OBRA 1981), which is codified at 42 USC 8621-8629. Implementing regulations for this and other HHS block grant programs authorized by OBRA 1981 are published at 45 CFR part 96. Those regulations include general administrative requirements for the covered block grant programs in lieu of CFR part 92 (the HHS implementation of the A-102 Common Rule)). Requirements specific to LIHEAP are in 45 CFR sections 96.80 through 96.89. In addition, grantees are to administer their LIHEAP programs according to the plans that they have submitted to HHS.

Under the block grant philosophy, each State is responsible for designing and implementing its own LIHEAP program, within very broad Federal guidelines. States must administer their LIHEAP programs according to their approved plan and any amendments and in conformance with their own implementing rules and policies. States must establish appropriate systems and

procedures to prevent, detect and correct waste, fraud and abuse, by clients, vendors, and administering agencies.

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, States are to use the fiscal policies that apply to their own funds in administering LIHEAP. Procedures must be adequate to assure the proper disbursement of and accounting for Federal funds paid to the grantee, including procedures for monitoring the assistance provided (42 USC 8624(b)(10); 45 CFR section 96.30).

Availability of Other Program Information

The ACF LIHEAP page on the Internet (<http://www.acf.hhs.gov/programs/liheap>) provides general information about this program.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

The following guidelines apply to LIHEAP block grants and leveraging incentive award funds, unless noted otherwise. Energy emergency contingency funds generally are subject to the LIHEAP block grant requirements, but the contingency grant award letter should be reviewed to see if different requirements apply. REACH grants are subject to special rules described in the award.

1. LIHEAP funds may be used to assist eligible households to meet the costs of home energy, i.e., heating or cooling their residences (42 USC 8621(a) and 8624(b)(1)).
2. LIHEAP funds may be used to intervene in energy-related crisis situations, as defined by the grantee (42 USC 8623(c) and 8624(b)(1)).
3. LIHEAP funds may be used to conduct outreach activities (42 USC 8624(b)(1)).
4. Leveraging incentive awards must be used to increase or maintain heating, cooling, energy crisis, and weatherization benefits for low-income persons (45 CFR section 96.87(j)).
5. Leveraging incentive award funds may not be used for planning, developing, or administering the LIHEAP program (45 CFR section 96.87(j)).
6. LIHEAP funds may be used to provide low-cost residential weatherization and other cost-effective energy-related home repair (42 USC 8624(b)(1)).

7. LIHEAP grantees may use some or all of the rules applicable to the Department of Energy's Weatherization Assistance for Low-Income Persons program (CFDA 81.042) for their LIHEAP funds spent on weatherization (42 USC 8624(c)(1)(D)).
8. LIHEAP funds may be used to provide services that encourage and enable households to reduce their home energy needs and thereby the need for energy assistance, including needs assessments, counseling, and assistance with energy vendors (42 USC 8624 (b)(16)).
9. LIHEAP funds (other than leveraging incentive award funds) may be used to identify, develop, and demonstrate leveraging programs (45 CFR section 96.87(c)).
10. No LIHEAP funds may be used for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than low-cost residential weatherization or other energy-related home repairs) of any building or other facility (42 USC 8628).

B. Allowable Costs/Cost Principles

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, LIHEAP is exempt from the provisions of the OMB cost principles circulars. State cost principles requirements apply to LIHEAP.

E. Eligibility

1. Eligibility for Individuals

Grantees may provide assistance to: (a) households in which one or more individuals are receiving Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), Supplemental Nutrition Assistance Program (SNAP) benefits, or certain needs-tested veterans benefits; or (b) households with incomes which do not exceed the greater of 150 percent of the State's established poverty level, or 60 percent of the State median income. Grantees may establish lower income eligibility criteria, but no household may be excluded solely on the basis of income if the household income is less than 110 percent of the State's poverty level. Grantees may give priority to those households with the highest home energy costs or needs in relation to income (42 USC 8624(b)(2)).

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable

3. Eligibility for Subrecipients

To the extent it is necessary to designate local administrative agencies, the grantee is to give special consideration to local public or private non-profit agencies (or their successor agencies) which were receiving energy assistance or weatherization funds under the Economic Opportunity Act of 1964 or other laws,

provided that the grantee finds that they meet program and fiscal requirements set by the grantee (42 USC 8624(b)(6)).

G. Matching, Level of Effort, Earmarking

- 1. Matching** – Not Applicable
- 2. Level of Effort** – Not Applicable
- 3. Earmarking**

The following limitations apply to LIHEAP block grants and leveraging incentive award funds, as noted. Energy emergency contingency funds generally are subject to the requirements applicable to LIHEAP block grant funds, but the contingency grant award letter should be reviewed to see if different requirements were applied. REACH grants are subject to special rules described in the award.

a. *Planning and Administrative Costs*

- (1) No more than 10 percent of the LIHEAP funds payable to the State for a Federal fiscal year may be used for planning and administrative costs, including both direct and indirect costs. This limitation applies, in the aggregate, to planning and administrative costs at both the State and subrecipient levels (42 USC 8624(b)(9)(A); 45 CFR section 96.88(a)).
- (2) A tribal or territorial grantee may spend up to 20 percent of the first \$20,000 and 10 percent of the amount above \$20,000 for administration and planning (45 CFR section 96.88(b)).
- (3) Leveraging incentive award funds may not be used for planning and administrative costs. However, either in the award year or the following fiscal year, they may be added to the base on which the maximum amount allowed for planning and administration is calculated (45 CFR section 96.87(j)).

b. *Weatherization*

- (1) No more than 15 percent of the greater of the funds allotted or the funds available to the grantee for a Federal fiscal year may be used for low-cost residential weatherization or other energy-related home repairs. The Secretary may grant a waiver, and the grantee may then spend up to 25 percent for residential weatherization or energy-related home repairs (42 USC 8624(k)).

- (2) Leveraging incentive award funds may be used for weatherization without regard to the weatherization maximum in the statute. However, they cannot be added to the base on which the weatherization maximum is calculated (45 CFR section 96.87(j)).
- c. *Energy Need Reduction Services* – No more than five percent of the LIHEAP funds payable to the grantee may be used to provide services that encourage and enable households to reduce their home energy needs and thereby the need for energy assistance. Such services may include needs assessments, counseling, and assistance with energy vendors (42 USC 8624(b)(16)).
- d. *Identifying and Developing Leveraging Programs*
 - (1) The greater of 0.08 percent of a State’s LIHEAP funds (other than leveraging incentive award funds) or \$35,000 may be spent to identify, develop, and demonstrate leveraging programs, without regard to the limit on planning and administering LIHEAP (42 USC 8626a(c)(2); 45 CFR section 96.87(c)(2)).
 - (2) Indian tribes/tribal organizations and territories may spend up to the greater of two percent or \$100 on such activities (45 CFR section 96.87(c)(1)).

H. Period of Availability of Federal Funds

At least 90 percent of the LIHEAP block grant funds payable to the grantee must be obligated in the fiscal year in which they are appropriated. Up to 10 percent of the funds payable may be held available (or “carried over”) for obligation no later than the end of the following fiscal year. Funds not obligated by the end of the following fiscal year must be returned to ACF. There are no limits on the time period for expenditure of funds (42 USC 8626).

Leveraging incentive award funds and REACH funds must be obligated in the year in which they are awarded or the following fiscal year, without regard to the carryover limit. However, they may not be added to the base on which the carryover limit is calculated (45 CFR sections 96.87(j)(1) and (k)). Funds not obligated within these time periods must be returned to ACF (45 CFR section 96.87(k)).

LIHEAP emergency contingency funds are generally subject to the same obligation and expenditure requirements applicable to the LIHEAP block grant funds, but the contingency award letter should be reviewed to see if different requirements were imposed.

L. Reporting**1. Financial Reporting**

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable**3. Special Reporting**

- a. *LIHEAP Carryover and Reallotment Report (OMB No. 0970-0106)* – Grantees must submit a report no later than August 1 indicating the amount expected to be carried forward for obligation in the following fiscal year and the planned use of those funds. Funds in excess of the maximum carryover limit are subject to reallotment to other LIHEAP grantees in the following fiscal year, and must also be reported (42 USC 8626)

Key Line Items (not numbered):

- (1) “*Carryover amount*”
- (2) “*Reallotment amount*”

- b. *Annual Report on Households Assisted by LIHEAP (OMB No. 0970-0060)*
As part of the application for block grant funds each year, a report is required for the preceding fiscal year of (1) the number and income levels of the households assisted for each component (heating, cooling, crisis, and weatherization), and (2) the number of households served that contained young children, elderly, or persons with disabilities. Territories with annual allotments of less than \$200,000 and Indian tribes are required to report only on the number of households served for each component (42 USC 8629; 45 CFR section 96.82)

Key Line Items –

- (1) Section 1 – LIHEAP Assisted Households
- (2) Section 2 – LIHEAP Applicant Households.

4. Section 1512 ARRA Reporting – Not Applicable**5. Subaward Reporting under the Transparency Act** – Applicable

IV. OTHER INFORMATION

As described in Part 4, Social Services Block Grant (SSBG) program (CFDA 93.667), III.A, “Activities Allowed or Unallowed,” a State may transfer up to 10 percent of its annual allotment under SSBG to this and six other block grant programs.

Amounts transferred into this program are subject to the requirements of this 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.569 COMMUNITY SERVICES BLOCK GRANT CFDA 93.710 ARRA – COMMUNITY SERVICES BLOCK GRANT

I. PROGRAM OBJECTIVES

The objective of the Community Services Block Grant (CSBG) program is to provide assistance to a network of community-based organizations for programs and services to ameliorate the causes and consequences of poverty and to revitalize low-income communities. CSBG can be used to fund programs and other activities that assist low-income individuals and families attain self-sufficiency; provide emergency assistance; support positive youth development; promote civic engagement; and improve the organization infrastructure for planning and coordination among multiple resources that address poverty conditions in the community.

II. PROGRAM PROCEDURES

Administration and Services

The CSBG program is administered at the Federal level by the Office of Community Services (OCS), Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS). CSBG funds are awarded to States, territories, and federally and State-recognized Indian tribes and tribal organizations. Funds are distributed in accordance with a pre-established formula after submission of an application to OCS and acceptance of that application as complete in accordance with statutory requirements. In turn, States subgrant the CSBG funds according to statewide formulae to designated community-based non-profit organizations (and, in special circumstances, public organizations) that plan, develop and implement, and evaluate local programs.

Source of Governing Requirements

The CSBG program was reauthorized under the Community Services Block Grant Act of 1998 (Pub. L. 105-285), and is codified at 42 USC 9901-9920. The implementing regulations for this and other block grant programs are published at 45 CFR part 96. Those regulations include both specific requirements and general administrative requirements for the covered block grant programs in lieu of 45 CFR part 92 (the HHS implementation of the A-102 Common Rule). Requirements specific to CSBG are in 45 CFR sections 96.90 through 96.92. Separate regulations governing religious organizations as nongovernmental providers of service (Charitable Choice) are codified at 45 CFR part 1050.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look first to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed1. *Activities Allowed*

- a. Subgrantees may use CSBG funds for any programs, services or other activities related to achieving the broad goals of the CSBG programs, such as reducing poverty, revitalizing low-income communities, and assisting low-income individuals and families. Funds may be used to:
 - (1) Promote economic self-sufficiency, employment, education and literacy, housing and civic participation.
 - (2) Support community youth development programs.
 - (3) Fill gaps in services through information dissemination, referrals, and case management.
 - (4) Provide emergency assistance through grants and loans, and provision of supplies, services and food stuffs.
 - (5) Secure more active involvement of the private sector, faith-based institutions, neighborhood-based organizations, and charitable groups.
 - (6) Plan, coordinate, and develop linkages among public (Federal, States and local), private, and non-profit resources, including religious organizations, to improve their combined effectiveness in ameliorating poverty (42 USC 9901, 42 USC 9908(b), and 42 USC 9920(a); 45 CFR section 1050.3(a)(1)).
- b. States may use retained funds to achieve CSBG program goals through activities, including, but not limited to:
 - (1) Training and technical assistance.
 - (2) Statewide coordination and communication among eligible entities.
 - (3) Analysis to better target the distribution of funds to the areas of greatest need.
 - (4) Individual development accounts and other asset-building programs for low-income individuals.
 - (5) Coordinating State-operated programs and services targeted to low-income children and families.
 - (6) State charity tax credits.

- (7) Supporting innovative programs and activities conducted by community-based organizations to address the goals of the program.
- (8) Administrative functions (42 USC 9901 and 9907(b)).

2. *Activities Unallowed*

- a. Funds may not be used to purchase or improve land or to purchase, construct, or permanently improve buildings or facilities, other than low-cost residential weatherization or other energy-related home repairs (this limitation may be waived by ACF) (42 USC 9918(a)).
- b. Funds may not be used to support any partisan or non-partisan political activity or to provide voters or prospective voters with transportation to the polls or provide similar assistance in connection with an election or any voter registration (42 USC 9918(b)).
- c. No CSBG program funding provided directly to a religious organization may be used for inherently religious activities, such as worship, religious instruction, or proselytization (42 USC 9920(c); 45 CFR section 1050.3(b)).

B. Allowable Costs/Cost Principles

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, the CSBG program is exempt from the provisions of OMB cost principles circulars at the State level. As a block grant, State cost principles requirements apply to CSBG at the State level. However, OMB administrative requirements and cost principles circulars do apply to subgrantees receiving CSBG funds (42 USC 9916(a)(1)(B)).

E. Eligibility

1. Eligibility for Individuals

The official poverty guideline as revised annually by HHS shall be used to determine eligibility. The poverty guidelines are issued each year in the *Federal Register* and on the HHS web site (<http://aspe.hhs.gov/poverty/>). A State may adopt a revised poverty guideline but it may not exceed 125 percent of the HHS-determined poverty guidelines (42 USC 9902(2)).

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable

3. Eligibility for Subrecipients

Subgrants may be made to the following entities, based on receipt of a community plan (42 USC 9908(b)(11):

- a. A private non-profit organization (including migrant farm worker organization) with a pre-existing designation as an “eligible entity” immediately prior to enactment of the new CSBG Act on October 27, 1999, and with a governance mechanism meeting the tripartite governing board requirement specified in 42 USC 9910(a).
- b. A subdivision of State government with a pre-existing designation as an “eligible entity” immediately prior to enactment of the new CSBG Act, with a governance mechanism meeting either the “tripartite” board requirements or otherwise assuring decision-making and participation by low-income individuals in the development, planning, implementation, and evaluation of CSBG-funded programs (42 USC 9910(b))
- c. A private non-profit organization or subdivision of State government newly designated by the State after October 27, 1999 as an “eligible entity” to provide services in an unserved area, in accordance with the criteria, requirements, and procedures specified by 42 USC 9909.

G. Matching, Level of Effort, Earmarking

1. Matching – Not Applicable

2. Level of Effort – Not Applicable

3. Earmarking

- a. States must use at least 90 percent of the allotted funds for subgrants to eligible entities (42 USC 9907(a)(1)). See III.H.2, “Period of Availability of Federal Funds,” for period of availability of funds to subgrantees.
- b. State administrative expenses, including monitoring activities, may not exceed the greater of \$55,000 or 5 percent of CSBG funds. Such expenditures must be made from the portion of funds remaining to a State after subgranting at least 90 percent of funds to eligible entities (42 USC 9907(b)(2)).

H. Period of Availability of Federal Funds

1. Amounts unobligated by the State at the end of the fiscal year in which they were first allotted shall remain available for obligation during the succeeding fiscal year (45 CFR section 96.14(a)).

2. CSBG funds granted by the State to subgrantees are available to the subgrantee for obligation during the Federal fiscal year that the grant was made and in the following Federal fiscal year (42 USC 9907(a)(2)).

However, beginning on October 1, 2000, if more than 20 percent of the funds granted by the State to a subgrantee in one fiscal year remain unobligated at the end of that fiscal year, a State may recapture and redistribute those funds. A State must either (a) redistribute the recaptured funds to an eligible entity located within the community served by the original subgrantee, or (b) require the original subgrantee to distribute the funds to a private non-profit organization within that community. Activities undertaken with redistributed funds must conform with the activities allowed under the CSBG Act (42 USC 9907(a)(3)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable for financial status; Not Applicable for cash status

2. Performance Reports – Not Applicable

3. Special Reports – Not Applicable

4. Section 1512 ARRA Reporting – Applicable

5. Subaward Reporting under the Transparency Act – Applicable for non-ARRA funds

M. Subrecipient Monitoring

States must conduct full on-site reviews of each eligible subgrantee once every 3 years to check conformity with performance goals, administrative standards, financial management rules, and other requirements. States must conduct an onsite review of each newly designated entity immediately after the completion of the first year in which such entity receives CSBG funding. Follow-up reviews, including prompt return visits to eligible entities and their programs, are required for entities that fail to meet the goals, standards, and requirements established by the State (42 USC 9914(a)).

If a State finds a need for corrective action, the State must (1) inform the subgrantee of the deficiency and require correction; (2) offer training and technical assistance and report to OCS on that assistance, or explain why providing such assistance was not appropriate; (3) and receive an improvement plan from the subgrantee within 60 days,

and approve (42 USC 9915). If the subgrantee fails to remedy the deficiency, the State may initiate proceedings to terminate the subgrantees eligibility or reduce its funding (42 USC 9908(b)(8) and 42 USC 9915(a)(5)).

N. Special Tests and Provisions

Subgrant Award and Administration

Compliance Requirements – States must (1) use at least 90 percent of their allotted funds under this program for subgrants to eligible entities, (2) subgrant funds in a timely manner to allow subgrantees a sufficient opportunity to obligate the funds to accomplish program purposes, and (3) adhere to expense limits for administrative activities performed (42 USC 9907(a)(1), (a)(2), (a)(3), and (b)(2)). There is a concern that some States are (1) not allotting the funds to subgrantees, either to the required level or early enough to allow a full period of performance by subgrantees without the possibility of recapture, resulting in unobligated balances of funds, and (2) inappropriately claiming administrative expenses for subgrant award and monitoring.

Audit Objectives – To determine if the State (1) complied with the requirement to subgrant 90 percent of its allotted funds in a timely manner and (2) claimed appropriate administrative expenses.

- a. Determine the State’s procedures, including any standards for administrative lead time, for issuance of subgrant awards.
- b. Determine if the subgrants were made in a timely manner, consistent with CSBG requirements and the State’s own procedures.
- c. Determine if the State tracks, by each individual subgrant, the issuance date, expenditure by the subgrantee, and the associated administrative costs.
- d. Determine if the State is appropriately claiming administrative costs in relation to its award and administration of subgrants.
- e. Select a sample of subgrantees and match State-maintained records of disbursement of funds with subgrantee records of receipt of funds from the State.

IV. OTHER INFORMATION

As described in Part 4, Social Services Block Grant (SSBG) program (CFDA 93.667), III.A. “Activities Allowed or Unallowed,” a State may transfer up to 10 percent of its annual allotment under SSBG to CSBG and other specified block grant programs for support of health services, health promotion and disease prevention activities, low-income home energy assistance, or any combination of these activities. Amounts transferred into the CSBG program are subject to the requirements of the CSBG 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.575 CHILD CARE AND DEVELOPMENT BLOCK GRANT **CFDA 93.596 CHILD CARE MANDATORY AND MATCHING FUNDS OF THE** **CHILD CARE AND DEVELOPMENT FUND**

I. PROGRAM OBJECTIVES

The Child Care and Development Fund (CCDF) provides funds to States Territories, and Indian Tribes (Tribe).to increase the availability, affordability, and quality of child care services. Funds are used to subsidize child care for low-income families where the parents are working or attending training or educational programs, as well as for activities to promote overall child care quality for all children, regardless of subsidy receipt. The CCDF consolidates the Child Care and Development Block Grant (CCDBG) and funding formerly provided to States through the child care programs under Title IV-A of the Social Security Act.

II. PROGRAM PROCEDURES

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) repealed the child care programs under Title IV-A of the Social Security Act, i.e., Aid to Families with Dependent Children Child Care, Transitional Child Care and At-Risk Child Care, and required that all Federal child care funds be spent in accordance with the provisions of the amended Child Care and Development Block Grant program. While these Federal child care programs have been consolidated under a single set of eligibility requirements, there are three distinct funding sources. The three sources are the Discretionary Fund (CFDA 93.575), Mandatory Fund (CFDA 93.596), and the Matching Fund (CFDA 93.596). Additionally, under the Temporary Assistance for Needy Families (TANF) program (CFDA 93.558), a State may transfer TANF funds to CCDF and, if so, the funds transferred in are treated as Discretionary Funds (42 USC 606(d); 45 CFR section 98.54(a)).

Administration and Services

The Office of Child Care (OCC) (formerly the Child Care Bureau), Administration for Children and Families (ACF), Department of Health and Human Services (HHS), administers the CCDF. To receive funds a State, Territory, or Tribe must submit a plan containing specific information and assurances. The plan serves as the application for funding for States and Territories and is effective for a two-year period. Tribes, in contrast, must submit a yearly application indicating child counts as well as a tribal plan. A Tribe's plan is also effective for two years. Tribes are generally subject to the same program requirements as States and Territories, except as specifically noted below.

Following ACF approval of the plan (and application, in the case of Tribes), funds are awarded to the designated State, territorial or tribal entity (generally referred to as the lead agency) based on statutory/regulatory formulas. State awards are not adjusted by separate direct Federal funding of counterpart tribal programs within the State. As long as statutory and regulatory requirements are met (e.g., that the States, Territories, and those Tribes receiving grants over \$500,000 offer parents certificates for the purchase of child care services), grantees have broad

flexibility in designing programs and offering services. For example, CCDF funds may be used in collaborative efforts with Head Start (CFDA 93.600) programs to provide comprehensive child care and development services for children who are eligible for both programs. In fact, the coordination and collaboration between Head Start and the CCDF is mandated by sections 640(g)(2)(D) and (E), and 642(c) of the Head Start Act (42 USC 9835(g)(2)(D) and (E); 42 USC 9837(c)) in the provision of full working day, full calendar year comprehensive services (42 USC 9835(a)(5)(v)). In order to implement such collaborative programs, which share, for example, space, equipment or materials, grantees may blend several funding streams so that seamless services are provided.

Tribes may operate the CCDF program under a consolidated Pub. L. No. 102-477 demonstration project. Pub. L. No. 102-477 refers to the Indian Employment, Training, and Related Services Demonstration Act of 1992, the purpose of which is to provide for the integration of employment, training, and related services to improve the effectiveness of those services. Under Pub. L. No. 102-477, funds received from a program must be used and spent in accordance with the applicable rules for that program, subject to any waivers granted by the Secretary of HHS; however, during the period covered by this Supplement in which Federal partners and Tribes are participating in a working group process to address a set of issues relating to plans, reporting, and accountability in Pub. L. No. 102-477 projects, this Supplement provides that auditing of funds should be based on determining that the funds were spent in compliance with the applicable approved plan. Tribes participating under a Pub. L. No. 102-477 project submit alternative plans and reports to the Department of the Interior, which serves as the lead Federal agency for Pub. L. No. 102-477

Source of Governing Requirements

The Discretionary Fund (CFDA 93.575) is authorized by the Child Care and Development Block Grant Act of 1990, as amended by Title VI of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Pub. L. No. 104-193), and subsequent amendments thereto, and codified at 42 USC 9858-9858q. The Mandatory and Matching Funds (CFDA 93.596) are authorized under section 418 of Title IV-A of the Social Security Act as amended by PRWORA and the Deficit Reduction Act of 2005 (Pub. L. No. 109-171), and codified at 42 USC 618. The CCDF (i.e., CFDA 93.575 and 93.596) is subject to the implementing regulations at 45 CFR parts 98 and 99.

CCDF is not subject to 45 CFR part 92, the HHS implementation of the A-102 Common Rule, or to 2 CFR part 225 (formerly OMB Circular A-87).

Availability of Other Program Information

OCC's web site (<http://www.acf.hhs.gov/programs/occ/>) provides general information on this program.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to

identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Funds may be used for child care services in the form of certificates, grants, or contracts (42 USC 9858c(c)(2)(A)).
2. Funds may be used for activities that improve the quality or availability of child care services, consumer education, and parental choice (42 USC 9858e).
3. Funds may be used for any other activity that the State deems appropriate to promoting parental choice, providing comprehensive consumer education information to help parents and the public make informed choices about child care, providing child care to parents trying to achieve independence from public assistance, and implementing the health, safety, licensing, and registration standards established in State regulations (42 USC 9858c(c)(3)(B)).
4. No funds may be expended through any grant or contract for child care services for any sectarian purpose or activity, including sectarian worship or instruction (42 USC 9858k(a)).
5. With regard to services to students enrolled in grades 1 through 12, no funds may be used for services provided during the regular school day, for any services for which the students receive academic credit toward graduation, or for any instructional services that supplant or duplicate the academic program of any public or private school (42 USC 9858k(b)).
6. Except for Tribes, no funds can be used for the purchase or improvement of land, or for the purchase, construction, or permanent improvement (other than minor remodeling) of any building or facility (42 USC 9858d(b)).

Tribes may use funds for the construction and major renovation of child care facilities with ACF approval (42 USC 9858m(c)(6); 45 CFR section 98.84).

“Construction” is defined as the erection of a facility that does not currently exist. “Major renovation” is considered permanent improvement and is defined as: (1) structural changes to the foundation, roof, floor, exterior or load-bearing walls of a facility, or the extension of a facility to increase its floor area; or (2) extensive alteration of a facility such as to significantly change its function and purpose, even if such renovation does not include any structural change (45 CFR section 98.2). Improvements or upgrades to a facility which are not specified under the definitions of construction or major renovation may be considered minor remodeling and are, therefore, allowable.

7. Except for sectarian organizations, funds may be used for the minor remodeling of child care facilities. For sectarian organizations, funds may be used for the renovation or repair of facilities only to the extent that it is necessary to bring the

facility into compliance with the health and safety standards required by 42 USC 9858c(c)(2)(F) (42 USC 9858d(b)).

B. Allowable Costs/Cost Principles

As indicated in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, grantees (lead agencies) shall expend and account for CCDF funds in accordance with the laws and procedures they use for expending and accounting for their own funds (45 CFR section 98.67).

C. Cash Management

For the Matching Fund's (CFDA 93.596) requirement, the drawdown of Federal cash should not exceed the federally funded portion of the State's Matching Funds, taking into account the State matching requirements. For example, the total Matching Fund expenditures for a year—both State and Federal shares—for a fiscal year are \$100. Of this \$100, the State share of the Matching Fund is \$40. For any period, the amount of Federal funds drawn down should not exceed 60 percent of the total expenditures for that period (31 CFR section 205.15(d)).

As described in Special Tests and Provisions, III.N.3., "Accountability, Deposit, and Investment of Lump-Sum Drawdowns," special provisions apply to Tribal CCDF grantees participating in Pub. L. No. 102-477 demonstration projects.

E. Eligibility

1. Eligibility for Individuals

Lead Agencies must have in place procedures for documenting and verifying eligibility in accordance with the following Federal requirements, as well as the specific eligibility requirements selected by each State/Territory/Tribe in its approved Plan.

- a. Children must be under age 13 (or up to age 19, if incapable of self care or under court supervision), who reside with a family whose income does not exceed 85 percent of State/territorial/tribal median income for a family of the same size, and reside with a parent (or parents) who is working or attending a job-training or education program; or are in need of, or are receiving, protective services. Tribes may elect to use State or tribal median income (42 USC 9858n(4); 45 CFR sections 98.20(a) and 98.80(f)).
- b. Lead Agencies shall establish a sliding fee scale, based on family size, income, and other appropriate factors, that provides for cost sharing by families that receive CCDF child care services (45 CFR section 98.42). Lead Agencies may exempt families below the poverty line from making copayments and shall establish a payment rate schedule for child care providers caring for subsidized children (45 CFR section 98.43).

2. Eligibility for Group of Individuals or Area of Service Delivery

The award of CCDF funds to an Indian Tribe shall not affect the eligibility of any Indian child to receive CCDF services in the State or States in which the Tribe is located (45 CFR section 98.80(d)).

3. Eligibility for Subrecipients – Not Applicable

G. Matching, Level of Effort, Earmarking

The matching and MOE requirements apply only to the Matching Fund (CFDA 93.596). The State's matching and MOE expenditures are closely related. For a State to receive the allotted share of the Matching Fund, the State must meet the MOE requirement and obligate the Mandatory Fund by year end (see III.H, "Period of Availability of Federal Funds"). The matching and MOE amounts are reported on the CCDF Financial Report (ACF-696) (see III.L.1, "Reporting – Financial Reporting").

1. Matching

- a. A State is eligible for Federal matching funds (limit specified in 42 USC 618 and 45 CFR section 98.63) only for those allowable State expenditures that exceed the State's MOE requirement, provided all of the Mandatory Funds (CFDA 93.596) allocated to the State are also obligated by the end of the fiscal year (45 CFR section 98.53).
- b. State expenditures will be matched at the Federal Medical Assistance Percentage (FMAP) rate for the applicable fiscal year. This percentage varies by State and is available on the Internet at <http://www.aspe.hhs.gov/health/fmap.htm>. To be eligible an activity must be allowable and be described in the approved State plan (45 CFR section 98.53).
- c. Private or public donated funds may be counted as State expenditures for this purpose subject to the limitations in 45 CFR section 98.53.
- d. No more than 30 percent of State matching claims may be for pre-kindergarten services (45 CFR section 98.53(h)(3)). The same expenditure may not be used for both MOE and matching purposes (45 CFR sections 98.53(d) and 98.53(h)).

2.1 Level of Effort – *Maintenance of Effort*

If a State requests Matching Funds (CFDA 93.596), State MOE (non-Federal) funds for child care activities must be expended in the year for which Matching Funds are claimed in an amount that is at least equal to the State's share of expenditures for FY 1994 or 1995 (whichever is greater) under former Sections 402(g) and (i) of the Social Security Act (42 USC 618). Private or public donated

funds may be counted as State expenditures for this purpose (45 CFR section 98.53).

No more than 20 percent of the MOE requirement may be met with State expenditures for pre-kindergarten services. The same expenditure may not be used for both MOE and matching purposes (45 CFR sections 98.53(d) and 98.53(h)).

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable

3. Earmarking

- a. *Administrative Earmark* – A State/Territory may not spend on administrative costs more than five percent of total CCDF awards expended (i.e., the total of CFDA 93.575 and 93.596) and any State expenditures for which Matching Funds (CFDA 93.596) are claimed (42 USC 9858c(c)(3)(C); 45 CFR section 98.52).

Tribes are allowed 15 percent of the amount expended under CFDA 93.575 and 93.596 for administrative costs. Tribes with at least 50 children under age 13 are provided a base amount of \$20,000, which may be expended for any purpose consistent with the purpose and requirements of the CCDF. Tribes with fewer than 50 children who are members of a consortium receive a pro rata amount of the \$20,000 in proportion to the number of children under age 13 in relation to 50. The base amount is not included in the amount against which the administrative earmark is calculated (45 CFR sections 98.61(c), 98.83(e), and 98.83(g)).

As explained in the preamble to 45 CFR part 98 and the Conference Agreement for [PRWORA](#) (H.R. Rep. 104-725 at 411) <http://www.acf.hhs.gov/programs/occ/law/finalrul/fr072498.pdf>, the following activities are not considered administrative costs (63 FR 39962):

- (1) Eligibility determination and redetermination.
- (2) Preparation and participation in judicial hearings.
- (3) Child care placement.
- (4) Recruitment, licensing, inspection, review and supervision of child care placements.
- (5) Rate-setting.
- (6) Resource and referral services.
- (7) Training of child care staff.

- (8) Establishment and maintenance of computerized child care information systems.
- (9) Establishment and operation of a certificate program.
- b. *Quality Earmark* – States and Territories must spend on quality and availability activities, as provided in the State/territorial plan, not less than 4 percent of CCDF funds expended (i.e., the total of CFDA 93.575 and 93.596 funds) and any State expenditures for which Matching Funds (CFDA 93.596) are claimed (45 CFR section 98.51).

Only those Tribes receiving grants over \$500,000 must spend at least four percent of CCDF funds expended on quality activities as described in the tribal plan/application. The \$20,000 base amount is not included in the amount against which the quality earmark is calculated (45 CFR sections 98.51(a), 98.83(e), and 98.83(f)).

- c. *Targeted Funds* – Congress may also specifically target funds for certain purposes. For example, in the FY 2011 HHS appropriation, Congress specified three types of targeted funds:
 - (1) resource and referral and school-aged activities (States, Territories, and Tribes);
 - (2) activities to increase the quality of child care for infants and toddlers (States and Territories); and
 - (3) quality improvement activities (States and Territories).

H. Period of Availability of Federal Funds

1. Discretionary Funds (CFDA 93.575) must be obligated by the end of the succeeding fiscal year after award, and expended by the end of the third fiscal year after award (42 USC 9858h(c); 45 CFR section 98.60).
2. Mandatory Funds (CFDA 93.596) for States must be obligated by the end of the fiscal year in which they are awarded if the State also requests Matching Funds (CFDA 93.596). If no Matching Funds are requested for the fiscal year, then the Mandatory Funds (CFDA 93.596) are available until liquidated (45 CFR section 98.60(d)).
3. Mandatory Funds (CFDA 93.596) for Tribes must be obligated by the end of the succeeding fiscal year after award, and liquidated by the end of the third fiscal year after award (45 CFR section 98.60(e)).
4. Matching Funds (CFDA 93.596) must be obligated by the end of the fiscal year in which they are awarded, and liquidated by the end of the succeeding fiscal year after award (45 CFR section 98.60(d)).

For example, availability periods for FY 2011 funds awarded on any date in FY 2011 (October 1, 2010 through September 30, 2011):

If Source of Obligation Is --	Obligation must Be Made by End of --	Obligation must Be Liquidated by End of --
FY 2011 Discretionary ^{1,2} (CFDA 93.575)	FY 2012 (i.e., by 9/30/12)	FY 2013 (i.e., by 9/30/13)
FY 2011 Mandatory (State) (CFDA 93.596)	FY 2011 (i.e., by 9/30/11 but ONLY if Matching Funds are used)	No requirement for liquidation by a specific date
FY 2011 Mandatory (Tribes) ² (CFDA 93.596)	FY 2012 (i.e., by 9/30/12)	FY 2013 (i.e., by 9/30/13)
FY 2011 Matching (CFDA 93.596)	FY 2011 (i.e., by 9/30/11)	FY 2012 (i.e., by 9/30/12)

¹ TANF funds (CFDA 93.558) transferred to the CCDF during a fiscal year are treated as Discretionary Funds of the year they are transferred for purposes of the period of availability (45 CFR section 98.54(a)(1)).

² In lieu of the obligation and liquidation requirements cited above, Tribes are required to liquidate CCDF funds used for construction or major renovation by the end of the second fiscal year following the fiscal year for which the grant is awarded (45 CFR section 98.84(e)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request from Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Not applicable for financial status; Applicable for cash status
- d. ACF-696, *Child Care and Development Fund Financial Report (OMB No 0970-0163)* is due quarterly from States and Territories. The ACF-696T, *Child Care and Development Fund Financial Report for Tribes (OMB No. 0970-0195)* is due annually from Tribes except for Tribes operating their CCDF program under a Pub. L. No.102-477 project. These reports are in lieu of the SF-269, *Financial Status Report/SF-425, Federal Financial Report* (financial status). Each fiscal year's expenditure report must be separate, therefore, multiple reports may be required if awards from more than one fiscal year are expended in a given quarter. Any funds transferred from TANF are treated as Discretionary Funds for reporting on the ACF-696 (42 USC 604(d); 45 CFR section 98.54(a)).

2. **Performance Reporting** – Not Applicable
3. **Special Reporting** – Not Applicable
4. **Section 1512 ARRA Reporting** – Not Applicable (except for FY 2009 ARRA awards)
5. **Subaward Reporting under the Transparency Act** – Applicable

M. Subrecipient Monitoring

Lead Agencies that use other governmental or non-governmental subrecipients to administer the program must have written agreements in place outlining roles and responsibilities for meeting CCDF requirements. Lead Agencies shall oversee the expenditure of funds by sub-grantees, monitor programs and services, and ensure that sub-grantees that determine individual eligibility operate according to rules established by the program (45 CFR section 98.11).

N. Special Tests and Provisions

1. Health and Safety Requirements

Compliance Requirement – Lead Agencies must verify that child care providers (unless they meet an exception, e.g., family members who are caregivers or individuals who object to immunization on certain grounds) serving children who receive subsidies meet requirements pertaining to prevention and control of infectious diseases, building and physical premises safety, and basic health and safety training for providers (45 CFR section 98.41).

Audit Objective – Determine whether Lead Agencies ensure that child care providers serving children who receive subsidies meet applicable health and safety requirements.

Suggested Audit Procedures

- a. Request that the Lead Agency identify State health and safety requirements for child care providers serving children who receive subsidies.
- b. Review the Lead Agency's procedures for documenting and verifying child care provider compliance with relevant health and safety requirements for those providers serving children who receive subsidies.
- c. Review a sample of Lead Agency payments to child care providers serving children who receive subsidies to verify that the Lead Agency's procedures were followed to determine compliance with State health and safety requirements before payment was made.

2. Fraud Detection and Repayment

Compliance Requirement – Lead Agencies shall recover child care payments that are the result of fraud. These payments shall be recovered from the party responsible for committing the fraud (45 CFR section 98.60).

Audit Objective – Determine if the Lead Agency correctly identified and reported fraud and took steps to recover payment.

Suggested Audit Procedures

- a. Review the Lead Agency’s procedures for identifying and recovering payments resulting from fraud, including the lead agency’s definition of fraudulent child care payments.
- b. Request documentation of any fraudulent payments that have been identified by the Lead Agency. If fraudulent payments occurred, review a sample of those payments to verify that proper procedures were followed to authenticate that a payment was actually fraudulent and, as applicable, recover payment.

3. Accountability, Deposit, and Investment of Lump-Sum Drawdowns

Compliance Requirement - Effective October 1, 2011, once program funds are available, Tribal CCDF grantees participating in a Pub. L. No. 102-477 demonstration project may draw down the full amount of available Pub. L. No. 102-477 CCDF demonstration project funding. Lump-sum drawdown/payments must be retained in clearly identifiable cash or investment accounts which are readily accessible for payment of allowable expenditures in accordance with the approved Pub. L. No. 102-477 plan from which it was derived and in compliance with applicable requirements and, to the extent practical, earn interest. This does not require a Tribal CCDF grantee to open a separate account with a financial institution or an investment manager. All eligible funds deposited in an appropriate account and earmarked as Pub. L. No. 102-477 demonstration funds must be identified as such. Investments of lump-sum payments must comply with 25 USC 450e-3, “Investment of Advance Payments: Restrictions.” All interest earned must be used on allowable expenditures in accordance with the approved Pub. L. No. 102-477 plan from which it was derived and in compliance with applicable requirements. (Tri-Agency 477 Tribal Leader Letter 9-30-11, Tri-Agency Letter to Committee on Appropriations 10-7-11, and Frequently Asked Questions Regarding P.L. 102-477 (Questions 2 through 4) found at <http://www.indianaffairs.gov/WhoWeAre/AS-IA/IEED/DWD/index.htm>).

Tribal CCDF grantees receiving lump-sum drawdown/payments under a Pub. L. No. 102-477 demonstration project may invest these payments (some recipients refer to these advance payments as “deferred revenue”) before such funds are expended in accordance with the approved Pub. L. No. 102-477 plan, as long as such funds are (1) invested only in obligations of the United States or in obligations or securities that are guaranteed or insured by the United States, or mutual (or other) funds registered with the Securities and Exchange Commission and which only invest in obligations of the United States or

securities that are guaranteed or insured by the United States or (2) deposited only in accounts that are insured by an agency or instrumentality of the United States, or are fully collateralized to ensure protection of the advance funds, even in the event of a bank failure (25 USC 450e-3).

Audit Objective – Determine whether the Tribal CCDF grantee participating in a Pub. L. No. 102-477 demonstration project has properly accounted for, deposited, and invested lump-sum drawdowns/payments received under a Pub. L. No. 102-477 demonstration project and unexpended funds are identifiable and readily accessible for use to carry out the approved Pub. L. No. 102-477 plan.

Suggested Audit Procedures

- a. Obtain and review the Tribal CCDF grantee policies and procedures and verify that those procedures comply with the requirements for lump-sum drawdowns/payments under a Pub. L. No. 102-477 demonstration project.
- b. Test lump-sum drawdowns/payments and ascertain if they were properly accounted for, deposited, and invested throughout the audit period.
- c. Review unused/unexpended CCDF lump-sum drawdowns/payments at year-end, and verify that they are properly invested/deposited and are identifiable and readily accessible for use to carry out the work outlined in the approved Pub. L. No. 102-477 plan.

IV. OTHER INFORMATION

Under the TANF program (CFDA 93.558), a State may transfer TANF funds to CCDF and the funds transferred are treated as Discretionary Funds under CCDF (42 USC 604(d); 45 CFR section 98.54(a)). The amounts transferred into CCDF should be included in the audit universe and in total expenditures of CCDF when determining Type A programs. On the Schedule of Expenditures of Federal Awards (SEFA), the amount transferred in should be shown as CCDF expenditures when expended.

Tribal CCDF Grantees under a Pub. L. No. 102-477 Demonstration Project

Effective October 1, 2011, the requirements contained in the 2009, 2010, and 2011 Compliance Supplements in the BIA Cross-Cutting Section page 4-15.000-4, IV, “Other Information,” were suspended. The auditor is not required to consider audit findings or modifications of audit opinions for completed audits which were based solely on the page suspended when the auditor is performing the risk based approach under OMB Circular A-133 in the two subsequent year audits. Tribal CCDF grantees are not required to take corrective action and the respective Federal agencies will not follow-up on audit findings based solely on the page suspended. For example, a material non-compliance or material weakness in internal control over compliance based solely on the page suspended would not preclude a program from being low risk or an entity from qualifying as a low risk auditee in the two subsequent year audits.

For Tribal CCDF grantees participating in Pub. L. No. 102-477 demonstration projects during the period covered by this Supplement:

- (1) the auditor should use the approved Pub. L. No. 102-477 plan in determining compliance requirements to be tested;
- (2) the auditor is permitted to audit the Pub. L. No. 102-477 demonstration project as a cluster of programs; and
- (3) the Tribal CCDF grantee may present demonstration project expenditures in its Schedule of Expenditures of Federal Awards (SEFA) in the same manner in which it had been presenting these expenditures in the period immediately prior to this Supplement or in the same manner in which it had been presenting these expenditures in the period immediately prior to the 2009 Compliance Supplement.

(Tri-Agency 477 Tribal Leader Letter 9-30-11, Tri-Agency Letter to Committee on Appropriations 10-7-11, and Frequently Asked Questions Regarding P. L. 102-477 (Questions 5 through 9) found at <http://www.indianaffairs.gov/WhoWeAre/AS-IA/IEED/DWD/index.htm>.)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.600 HEAD START
CFDA 93.708 ARRA – HEAD START
CFDA 93.709 ARRA – EARLY HEAD START

I. PROGRAM OBJECTIVES

The objectives of the Head Start and Early Head Start programs are to promote the school readiness of low-income preschool children (ages 3 to 5), including children of federally recognized Indian tribes, Alaska Natives, and migratory seasonal and farm workers, and infants and toddlers (birth through age 3) by enhancing their cognitive social and emotional development in learning environments that support their growth in language, literacy, mathematics, science, social and emotional functioning, creative art, physical skills, and approaches to learning. Parents receive social services and participate in various decision-making processes related to the operation of the program.

II. PROGRAM PROCEDURES

Administration and Services

The Office of Head Start (OHS), Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS), administers the Head Start program. OHS provides financial assistance to organizations that are eligible for designation as a Head Start agency for a period not-to-exceed 5 years for the planning, administration, and evaluation of a Head Start program.

Head Start/Early Head Start programs operate in all 50 States, the District of Columbia, Puerto Rico, the U.S. territories, and the Republic of Palau. Grants are awarded to public, non-profit, and for-profit organizations directly by ACF's 10 Regional Offices and, for awards to Tribes, Alaska Native organizations, and organizations serving migrant and seasonal workers, as well as replacement grants, by the OHS Headquarters office in Washington, DC.

Under the Early Head Start program, grants for services to eligible infants, toddlers, and pregnant women are made to Head Start grantees, school systems, universities, colleges, and other public and private entities. Early Head Start grants are subject to most of the same program performance standards and compliance requirements as Head Start grants; therefore, references to Head Start apply to both. For Early Head Start grantees that are also Head Start grantees, the Early Head Start program is not a separate grant; instead, Early Head Start is a separate program account under the same grant award.

A Head Start agency may subgrant operational responsibilities to one or more “delegate agency,” but the Head Start agency governing body retains legal and fiscal responsibility for the grant. Delegate agencies may be public, non-profit, or for-profit organizations.

Head Start agencies must collaborate with other entities carrying out early childhood education and child-care programs in the community, including those funded by the Child Care and Development Fund (CCDF) (CFDA 93.575 and CFDA 93.596) and Temporary Assistance to

Needy Families (CFDA 93.558). The coordination and collaboration between Head Start and the CCDF entity is mandated by sections 640(a)(5)(E), 640(g)(2)(D) and (E) and 642(c) of the Head Start Act (42 USC 9837(c)) in the provision of full-working day, full calendar-year comprehensive services (42 USC 9835(a)(5)(C)(v)).

In serving families and local communities, Head Start agencies must provide for the regular and direct participation of parents and community residents in the implementation of the Head Start program including decisions that influence the character of such program. As long as the statutory and regulatory performance requirements are met, including requirements for reporting data about expenditures and children and families receiving services, Head Start agencies have significant flexibility and discretion in designing programs to meet local community and family needs.

The Head Start program provides services in the following areas:

Early Childhood Development and Health – Head Start’s educational program is designed to meet the needs of each child and family, including those children who are dual-language learners and families who have limited English proficiency, and the local community served, taking into account its ethnic and cultural characteristics. Every child receives a variety of learning experiences to foster intellectual, social, and emotional growth. Head Start also emphasizes the importance of the early identification of health problems. Every child, including children with disabilities, is involved in a comprehensive health program in collaboration with parents, which includes immunizations, medical, dental, mental health, and nutritional services.

Head Start agencies are responsible for ensuring that they have qualified staff to implement educational programs that support classroom instructional practices, are able to identify children with special needs, and institute other practices related to school readiness and children’s later success in school. Head Start emphasizes the importance of the early identification of health problems or potential health concerns. Head Start agencies are required to provide timely referrals to State or local agencies providing services under the Individuals with Disabilities Act to ensure the provision of special education and related services to meet the special needs of children with disabilities.

Head Start agencies assess and prioritize the nutrition status and nutritional needs of enrolled children, work in collaboration with each child’s parents to ensure that children receive needed preventive nutrition and/or treatment services, provide food to help meet children’s daily nutritional needs, provide meals that meet U.S. Department of Agriculture (USDA) dietary guidelines for children in settings that are relaxed and promote learning, demonstrate the connection of nutrition to other Head Start activities and its contribution to the child’s cognitive, social, emotional, and physical development, provide nutrition education to staff, parents, and children, and involve all staff, parents, and other community agencies, as appropriate, in meeting the child’s nutritional needs.

Mental health services must be provided in partnership with families and include on-site consultations with mental health professionals that support the efforts of staff and parents to promote children’s mental health.

Family and Community Partnerships – An essential part of the Head Start program is the involvement of parents in parent education, program planning, and operating activities. Many parents serve as members of policy councils and committees and have a voice in Head Start program operations. Participation in classes and workshops on child development and staff visits assist parents in identifying the needs of their children and about educational activities that can take place at home. Specific services are geared to each family after its needs are determined. They include community outreach; referrals; family need assessments; recruitment and enrollment of children; and emergency assistance or crisis intervention.

Grantees engage in a process of collaborative partnership-building with parents to establish mutual trust and to identify family goals, strengths, and necessary services and other supports. Parents are offered opportunities to develop and implement individualized family partnership agreements that describe family goals, responsibilities, timetables and strategies for achieving these goals as well as progress in achieving them.

Grantees take an active role in community planning to encourage strong communication, cooperation, and the sharing of information among agencies and their community partners and to improve the delivery of community services to children and families. In addition, grantees take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs, and to ensure that Early Head Start and Head Start programs respond to community needs.

Program Design and Management – Upon receiving designation as a Head Start agency, the organization must establish and maintain a formal structure for program governance, oversight of quality services for children and families, and decision-making related to program design and implementation. Such a structure must include a governing body, a policy council, and, if there is a delegate agency, a policy committee for each such subrecipient.

Policy councils are responsible for aspects of program design and operation and long- and short-term planning and goals and objectives. Policy councils are composed of parents of children who are currently enrolled in the Head Start program, as well as members at large of the community served by the Head Start agency.

Policy committees at the delegate agency level are responsible for aspects of the delegate agency's program design and operation and long- and short-term planning and goals and objectives. These committees are composed of parents of children who are currently enrolled in the Head Start program served by the delegate agency, as well as members at large of the community served by the Head Start delegate agency.

Source of Governing Requirements

Head Start began in 1965 under the Office of Economic Opportunity and is now administered by OHS, ACF, HHS. Head Start programs are currently authorized under the Head Start Act (Pub. L. No. 110-134), as amended by the Improving Head Start for School Readiness Act of 2007 (42 USC 9831-9852. **The American Recovery and Reinvestment Act of 2009 (ARRA)**)

(Pub. L. No 111-5, 123 Stat 178) added funding for these programs. The implementing program regulations are 45 CFR parts 1301 through 1310.

Availability of Other Program Information

The OHS web page for the Early Childhood Learning and knowledge Center (<http://eclkc.ohs.acf.hhs.gov/hslc>) provides information about this program.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Funds may be used for the following program services consistent with the Head Start performance standards:
 - a. Providing for the direct participation of parents of children in the development, conduct, and program direction at the local community level (42 USC 9833 and 42 USC 9837(b)(1));
 - b. Training and technical assistance activities which may include the establishment of local or regional agreements with community experts, institutions of higher education, or private consultants, to make program improvements (42 USC 9835(a)(2)(C));
 - c. Improving the compensation (including benefits) of educational personnel, family service workers, and child counselors to—
 - (1) ensure that compensation is adequate to attract and retain qualified staff;
 - (2) improve staff qualifications and assist with the implementation of career development programs for staff that support ongoing improvement of their skills and expertise; and
 - (3) provide educational and professional development to enable teachers to meet professional standards, including providing assistance to complete post-secondary course work, improve the qualifications and skills of educational personnel to become certified and licensed as bilingual education teachers, or as teachers of English as a second language, and improve the qualifications and skills of educational personnel to teach and provide services to children with disabilities (42 USC 9835(a)(5)(A) and 42 USC 9835(j)).

- d. Supporting staff training, child counseling, and other services necessary to address the challenges of children from immigrant, refugee, and asylee families, homeless children, children in foster care, limited English proficient children, children of migrant or seasonal farmworker families, children from families in crisis, children referred to Head Start programs by child welfare agencies and children who are exposed to chronic violence or substance abuse (42 USC 9835(a)(5)(B)(i));
- e. Ensuring the physical environment is conducive to providing effective program services to children and families and are accessible to children and others with disabilities (42 USC 9835(a)(5)(B)(ii));
- f. Employing additional qualified classroom staff to reduce the child-to-teacher ratio in the classroom and additional qualified family service workers to reduce the family-to-staff ratio for those workers (42 USC 9835(a)(5)(B)(iii));
- g. Increasing hours of program operation, including the conversion of part-day programs to full-working day programs and increasing the number of weeks of operation in a calendar year (42 USC 9835(a)(5)(B)(v));
- h. Improving community wide strategic planning and needs assessments and collaboration efforts, including outreach (42 USC 9835(a)(5)(B)(vi));
- i. At the Head Start agency's option, transporting children to and from Head Start programs and program activities. When transportation services are provided, they must be provided in accordance with Head Start performance standards. Transportation costs may be paid with quality improvement funds, but, if so, are subject to a 10 percent cap; in any other case, allowable transportation costs are not subject to a cap (42 USC 9835(a)(5)(B)(vii) and 45 CFR part 1310);
- j. Establishing and implementing procedures to evaluate the performance of delegate agencies and ensure corrective action for deficiencies identified through such evaluations (42 USC 9836A(d));
- k. Correcting areas of noncompliance or deficiencies and developing quality improvement plans (42 USC 9836A(e));
- l. Carrying out activities related to operation of the governing body. This includes activities related to administering and overseeing the Head Start grant; developing or implementing practices that ensure, active, independent, and informed governance of the Head Start agency; ensuring the necessary membership on the governing body (i.e., at least one individual with background and expertise in each of the following: fiscal management or accounting and early childhood education and development, and at least one licensed attorney familiar with issues that

- come before governing bodies); or, as required, employing consultant services to obtain such expertise (42 USC 9837(c)(1)).
- m. With the consultation and participation of policy councils, and as appropriate, policy committees and community members, the conduct of an annual self-assessment of the Head Start agency's effectiveness and progress in meeting program goals and objectives as well as in implementing and complying with Head Start performance standards (42 USC 9836A(g));
 - n. Offering directly, or through referral to local entities, family literacy services, parenting skills training, substance abuse counseling, including information on the effect of drug exposure on infants and fetal alcohol syndrome (42 USC 9837(b)(4) and 42 USC 9837(b)(5));
 - o. Provision of family needs assessments that include consultation with parents (including foster parents, grandparents, and kinship caregivers) (42 USC 9837(b)(7));
 - p. Outreach and information to parents of limited English proficient children in an understandable and uniform format (42 USC 9837(b)(11));
 - q. Collaboration and coordination with public and private entities to improve the availability and quality of services to Head Start children and families, including outreach to the schools in which children participating in Head Start programs will enroll (42 USC 9837(e) and 42 USC 9837A(a));
 - r. Implementation of a research-based early childhood curriculum (42 USC 9837(f)(3)); and
 - s. In the case of a Early Head Start program or program component, provision, either directly or through referral, of early continuous, intensive, and comprehensive child development and family support services that enhance the physical, social, emotional, and intellectual development of children under the age of 3 (42 USC 9840A(b)).
2. Funds may be used for development and administrative costs, subject to the limitation in III.G.3, "Matching, Level of Effort, Earmarking – Earmarking." The term "development and administrative costs" means costs incurred in accordance with an approved Head Start budget which do not directly relate to the provision of program component services as described under paragraph 1 of this section (42 USC 9839(b) and 45 CFR section 1301.32 (a)).
 3. With specific ACF prior approval only, funds may be used for capital expenditures (including paying the cost of amortizing the principal, and paying interest on, loans) such as construction of new facilities, purchase of new or existing facilities, major renovations on existing facilities, and purchase of

vehicles used for programs conducted at the Head Start facilities (42 USC 9839(f) and (g)).

4. Funds may not be used by Head Start agencies to engage in any partisan or nonpartisan political activity associated with a candidate, or contending faction or group, in an election for public or party office or any activity to provide voters or prospective voters with transportation to the polls or similar assistance in connection with any such election (42 USC 9851(b)(1)). These prohibitions do not apply to the use of Head Start facilities during hours of operation for any nonpartisan organization to increase the number of eligible citizens who register to vote in elections for Federal office (42 USC 9851(b)(2)).
5. Funds from USDA's Child and Adult Care Food Program (CFDA 10.558) must be used as the primary source of payment for children's nutritional services (meals and snacks). Head Start funds may be used to cover those allowable costs not covered by USDA (45 CFR section 1304.23(b)(i)).
6. Funds may be used for professional and dental services as a payer of last resort (45 CFR section 1304.20(c)(5)). (See also III.N.3, "Special Tests and Provisions – Medical and Dental Services.")

B. Allowable Costs/Cost Principles

Indirect costs attributable to common or joint use of facilities or services by Head Start programs and other programs must be fairly allocated among the various programs that utilize such services (42 USC 9839(c)).

D. Davis-Bacon Act

The Davis-Bacon Act applies to construction or major renovation of facilities under the Head start program. 'Major renovation' means the extensive alteration of an existing facility, such as to significantly change its function and purpose, even if such renovation does not include any structural change to the facility. Major renovation also includes a renovation of any kind which has a cost exceeding the lesser of \$200,000, adjusted annually to reflect the percentage change in the Consumer Price Index for All Urban Consumers (issued by the Bureau of Labor Statistics) beginning one year after June 2, 2003, or 25 percent of the total annual direct costs approved for the grantee by ACF for the budget period in which the application is made (42 USC 9839(g)(3); 45 CFR sections 1309.3 and 1309.54).

E. Eligibility

1. Eligibility for Individuals

- a. The general rule is that for Head Start agencies other than Indian tribes/tribal organizations, the enrollees must come from families whose income is below the official Federal poverty guidelines or who are receiving public assistance (income-eligible) (45 CFR section 1305.4

(b)(1)). In addition to the general income eligibility rule, homeless children and children in foster care are categorically eligible to enroll in Head Start programs. Once the needs of these groups are met, then (up to 10 percent of the children who are enrolled may be from families that are not income-eligible (45 CFR section 1305.4 (b)(2)) (45 CFR section 1305.2(l), 42 USC 9840(a)(1)(B)(ii), and 42 USC 9840(a)(1)(B)(iii)(II)).

- b. For tribal grantees, the income-eligible percentage that may be enrolled in the programs may be as low as 51 percent, providing certain conditions are met (45 CFR section 1305.4(b)(3)).
- c. The family income must be verified by the Head Start grantee before determining that a child is income-eligible (45 CFR section 1305.4(c)). Homeless children may be enrolled while required documentation is obtained within a reasonable amount of time. Verification must include examination of any of the following: Individual Income Tax Form 1040, W-2 forms, pay stubs, pay envelopes, written statements from employers, or documentation showing current status as recipients of public assistance (45 CFR section 1305.4(d)). Although copies of income verification documents need not be retained by grantees, the child or family record must include a statement, signed by an employee of the grantee (Head Start program), identifying which income verification document was examined and stating that the child is income-eligible (45 CFR section 1305.4(e)).

The poverty guidelines are issued each year in the *Federal Register* and HHS maintains a web page that provides the poverty guidelines (<http://aspe.hhs.gov/poverty/>).

2. **Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable**
3. **Eligibility for Subrecipients**

Delegate agencies may be public, non-profit, or for-profit organizations (45 CFR section 1301.33).

F. Equipment and Real Property Management

1. Head Start grantees are required to operate and maintain facilities, real property, and related assets to ensure their use for the funded project purpose(s) and to adequately protect such facilities, real property, and related assets.
2. The Federal interest in real property acquired with Head Start funds or which has undergone major renovation with Head Start funds may not be conveyed, transferred, assigned, mortgaged, leased, or otherwise be encumbered or subordinated by a grantee unless approved by ACF (45 CFR section 1309.21(b)).

3. The grantee must file a Notice of Federal Interest when construction or major renovation begins or when an existing facility or land is acquired on which a facility will be built. The Notice of Federal Interest, meeting the requirements of 45 CFR section 1309.21(d)(2), must be filed in the appropriate public records of the jurisdiction in which the property is located (45 CFR section 1309.21(d)(2)).

G. Matching, Level of Effort, Earmarking

1. Matching

Grantees are required to contribute at least 20 percent of the costs of the program through cash or in-kind contributions, unless a lesser amount has been approved by ACF (42 USC 9835(b); 45 CFR sections 1301.20 and 1301.21).

2. Level of Effort – Not Applicable

3. Earmarking

- a. *Administrative earmark.* The costs of developing and administering a Head Start program shall not exceed 15 percent of the annual total program costs, including the required non-Federal contribution to such costs (i.e., matching), unless a waiver has been granted by ACF. Development and administrative costs include, but are not limited to, the cost of organization-wide planning, coordination and general purpose direction, accounting and auditing, purchasing and personnel functions, and the cost of operating and maintaining space for these purposes (42 USC 9839(b)(2); 45 CFR section 1301.32).
- b. *Targeted earmark.* Each Head Start agency must enroll 100 percent of its funded enrollment (42 USC 9387(g)). For Fiscal Year 2009 and thereafter, not less than 10 percent of the total number of children actually enrolled by each Head Start Agency and each delegate agency must be children with disabilities determined to be eligible for special education and related services unless a waiver has been approved by ACF (42 USC 9835(d)).
- c. *Required percentage of income eligibles*
 - (1) For grantees other than Indian tribes/tribal organizations, at least 90 percent of the enrollees must come from families whose income is below the official Federal poverty guidelines or who are receiving public assistance (income-eligible). Up to 10 percent of the children who are enrolled may be from families that are not income-eligible (45 CFR section 1305.4). The Head Start agency may also enroll up to 35 percent of children from families with income 130 percent below the poverty line as specified in III.E.1.a, Eligibility – Eligibility for Individuals, above.

- (2) For tribal grantees, the income-eligible percentage may be as low as 51 percent, providing certain conditions are met (45 CFR section 1305.4(b)(3)).
- (3) The family income must be verified by the Head Start grantee before determining that a child is income-eligible (45 CFR section 1305.4(c)).
- (4) Verification must include examination of any of the following: Individual Income Tax Form 1040, W-2 forms, pay stubs, pay envelopes, written statements from employers, or documentation showing current status as recipients of public assistance (45 CFR section 1305.4(d)).
- (5) Although copies of income verification documents need not be retained by grantees, the child or family record must include a statement, signed by an employee of the grantee (Head Start program), identifying which income verification document was examined and stating that the child is income-eligible (45 CFR section 1305.4(e)).

The poverty guidelines are issued each year in the *Federal Register* and HHS maintains a web page that provides the poverty guidelines (<http://aspe.hhs.gov/poverty/>).

J. Program Income

Head Start programs may not charge fees for participation in the program nor solicit, encourage, or in any way condition a child's enrollment or participation upon the payment of a fee. If the family of an eligible child volunteers to pay part or all of the costs of the child's participation, the Head Start agency may accept the voluntary payments and record the payments as program income. Such program income must be used for purposes related to the Head Start grant (45 CFR section 1305.9).

A Head Start agency that provides full-working-day services in collaboration with other agencies or entities may collect a family co-payment to support extended day services if a co-payment is required in conjunction with the collaborating agency or entity. The co-payment charged to families receiving services through the Head Start program shall not exceed the co-payment charged to families with similar incomes and circumstances who are receiving the services through participation in a program carried out by another agency or entity (42 USC 9840(b)).

L. Reporting

1. Financial Reporting

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

- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
 - c. SF-425, *Federal Financial Report* – Applicable
2. **Performance Reporting** – Not Applicable
 3. **Special Reporting** – Not Applicable
 4. **Section 1512 ARRA Reporting** – Applicable
 5. **Subaward Reporting under the Transparency Act** – Applicable to non-ARRA funds

M. Subrecipient Monitoring

Grantees must establish and implement procedures for the ongoing monitoring of their own Head Start and Early Head Start operations, as well as those of their delegate agencies, to ensure that these operations effectively implement Federal regulations, including procedures for evaluating delegate agencies and procedures for defunding them. Grantees must inform delegate agency governing bodies of any identified deficiencies in delegate agency operations identified in the monitoring review and assist them in developing plans, including timetables, for addressing identified problems (42 USC 9836A(d) and 45 CFR sections 1304.51(i)(2) and (3)).

DEPARTMENT OF HEALTH AND HUMAN SERVICES**CFDA 93.645 STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM****I. PROGRAM OBJECTIVES**

The purpose of the Stephanie Tubbs Jones Child Welfare Services (CWS) program is to promote State and Tribe flexibility in the development and expansion of a coordinated child and family services program that utilizes community-based agencies and ensures all children are raised in safe, loving families.

II. PROGRAM PROCEDURES

The Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Administration on Children, Youth and Families, Children's Bureau, administers the CWS program on the Federal level. Funds are awarded directly to States and tribes. State agencies can have agreements and contracts with other public agencies and with private agencies for provision of appropriate services. Each State receives a base amount of \$70,000. Additional funds are distributed in proportion to the State's population of children under age 21 multiplied by the complement of the State's average per capita income. The funds must go to, and be administered only by, the State child welfare agency, federally recognized Tribes, Tribal Organizations, or Tribal Consortia (hereafter "Tribe").

To be eligible for funds, each State and Tribe must submit a five-year comprehensive plan, the Child and Family Services Plan (CFSP). This plan encompasses planning and service delivery for the full child welfare services spectrum. This includes: Child Welfare Services, services promoting safe and stable families under title IV-B, Subpart 2; a child welfare staff development and training plan; a diligent recruitment of foster and adoptive families plan that reflects the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed; and child abuse and neglect prevention, foster care, adoption, and foster care independence services. The plan must include how the State or Tribe intends to meet specific goals, provide services, and coordinate services. The Children's Bureau has approval authority for the CFSP. An Annual Progress and Services Report (APSR) is required that identifies the specific accomplishments and progress made in the past fiscal year (FY) toward meeting each goal and objective in the 5-year comprehensive plan and any revisions in the statement of goals and objectives or to the training plan, if necessary, to reflect changed circumstances. The Associate Commissioner of the ACF Children's Bureau has approval authority for the title IV-B plans.

As required by the Child and Family Service Improvement Act of 2006 (Pub. L. No. 109-288), which amended Part B of title IV of the Social Security Act, States, in consultation with HHS, were required to establish by June 30, 2008, an outline of steps to be taken to ensure that 90 percent of children in foster care are visited by their caseworkers on a monthly basis by October 1, 2011, and that the majority of the visits occur in the residence of the child (Pub. L. No. 109-288, Section 6(c) (42 USC 622 (b)(17))). HHS must reduce the Federal share of participation in expenditures under the State's title IV-B, subpart 1, program by a certain statutory percentage if

the State does not meet its annual progress toward the 90 percent caseworker visit standard. The law requires the State to submit FY 2007 data, which will be used as a baseline in determining annual progress toward the 90 percent standard (Pub. L. No. 109-288, Section 6(b)(2) (42 USC 623(e)(1) and (2))). The law also requires that States establish target percentages for the children in foster care who will be visited during each and every calendar month for FY 2008 through 2011. If these target percentages are not achieved for a FY, the Federal match rate for title IV-B, subpart 1 funds will be reduced in the subsequent FY in proportion to the amount that the State failed to reach its target (section 424(e)(2)(B) of the Act).

Source of Governing Requirements

The CWS program is authorized under title IV-B, Subpart 1 (sections 421 – 428) of the Social Security Act as amended, and is codified at 42 USC 620-628a. Implementing program regulations are published at 45 CFR parts 1355 and 1357.

III. Compliance Requirements

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Prior to fiscal year (FY) 2007, funds for CWS could be used to accomplish the following purposes:
 - a. Protecting and promoting the welfare and safety of all children, including individuals with disabilities, homeless, dependent, or neglected children (45 CFR section 1357.10(c)(1));
 - b. Preventing or remedying, or assisting in the solution of problems that may result in the neglect, abuse, exploitation, or delinquency of children (45 CFR section 1357.10(c)(2));
 - c. Preventing the unnecessary separation of children from their families by identifying family problems and assisting families in resolving their problems and preventing the breakup of the family where the prevention of child removal is desirable and possible (45 CFR section 1357.10(c)(3));
 - d. Restoring children who have been removed and may be safely returned to their families, by the provision of services to the child and the family (45 CFR section 1357.10(c)(4));
 - e. Assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption (45 CFR section 1357.10(c)(5)); and

- f. Placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate (45 CFR section 1357.10(c)(6)).
2. Beginning in FY 2007, funds may be used for the following purposes:
 - a. Protecting and promoting the welfare of all children (Pub. L. No. 109-288, Section 421(1));
 - b. Preventing the abuse, neglect, or exploitation of children (Pub. L. No. 109-288, Section 421(2));
 - c. Supporting at-risk families through services that allow children to remain with their families or return to their families in a timely manner (Pub. L. No. 109-288, Section 421(3));
 - d. Promoting the safety, permanence, and well-being of children in foster care and adoptive families (Pub. L. No. 109-288, Section 421(4));
 - e. Providing training, professional development, and support to ensure a well-qualified workforce (Pub. L. No. 109-288, Section 421(5))
3. Funds may be used for administrative costs, subject to the limitation in III.G.3 Matching, Level of Effort, Earmarking – Earmarking) below. The term “administrative costs” means costs for the following but only to the extent incurred in administering the State plan for this program: procurement; payroll management; personnel functions (other than the portion of the salaries of supervisors attributable to time spent directly supervising the provision of services by caseworkers); management; maintenance and operation of space and property; data processing and computer services; accounting; budgeting; auditing; and travel expenses (except those related to the provision of services by caseworkers or oversight of the program). (Pub. L. No. 109-288, Sections 422(b)(14) and (c) and 424(e) (42 USC 622(b)(14) and (c) and 623(e))).
4. Funds may not be used for the purchase or construction of facilities (45 CFR section 1357.30(f)).

G. Matching, Level of Effort, Earmarking

1. Matching

- a. The State and Tribal match requirement is 25 percent of the Federal funds expended (42 USC 623 and 629d(a)(1)(A)). The IV-B agency’s contribution may be in cash, donated funds, and non-public third party in-kind contributions (45 CFR section 1357.30(e)(1)).
- b. Beginning in FY 2008, the State cannot use more than the amount it spent in FY 2005 using non-Federal funds on foster care maintenance payments

as match for the title IV-B, subpart 1, program (Pub. L. No. 109-288, Section 424(d) (42 USC 623(d))).

2.1 Level of Effort – Maintenance of Effort

Beginning in FY 2008, a State may not receive an amount of Federal funds under title IV-B for child care, foster care maintenance or adoption assistance payments in excess of the amount of title IV-B, subpart 1, funds they spent on these activities in FY 2005 (Pub. L. No. 109-288, Section 424(c) (42 USC 623(c))).

2.2 Level of Effort – Supplement Not Supplant – Not Applicable

3. Earmarking

Beginning in FY 2008, no more than 10 percent of the expenditures of the State or Tribe with respect to activities funded from amounts provided under title IV-B, subpart 1 may be used for administrative costs (Pub. L. No. 109-288, Sections 422(b)(14) and (c) and 424(e) (42 USC 622(b)(14) and (c) and 623(e))).

H. Period of Availability of Federal Funds

Funds under title IV-B, subpart 1, must be expended by September 30 of the fiscal year following the fiscal year in which the funds were awarded (45 CFR section 1357.30(i)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable.
- c. SF-425, *Federal Financial Report* – Applicable (expenditure reporting only)

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Not Applicable

5. Subaward Reporting under the Transparency Act – Not Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.658 FOSTER CARE—TITLE IV-E

I. PROGRAM OBJECTIVES

The objective of the Foster Care program is to help agencies authorized to administer title IV-E programs to provide safe, appropriate, 24-hour, substitute care for children who are under the jurisdiction of the administering IV-E agency and need temporary placement and care outside their homes.

II. PROGRAM PROCEDURES

Administration and Services

The Foster Care program is administered at the Federal level by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS). Funding is provided to the 50 States, the District of Columbia, Puerto Rico and federally recognized Indian Tribes, Indian tribal organizations and tribal consortia with approved title IV-E plans, based on a IV-E plan and amendments, as required by changes in statutes, rules, and regulations submitted to and approved by the ACF Children's Bureau Associate Commissioner. This program is considered an open-ended entitlement program and allows the State or Tribe to be funded at a specified percentage (Federal financial participation) for program costs for eligible children.

The designated State or tribal agency for this program, which is authorized under title IV-E of the Social Security Act, as amended, also administers ACF funding provided for other title IV-E programs, e.g., Adoption Assistance (CFDA 93.659); Guardianship Assistance (CFDA 93.090) at agency option and Independent Living Services (CFDA 93.674), as well as Child Welfare Services (CFDA 93.645) and Promoting Safe and Stable Families (CFDA 93.556) programs (title IV-B of the Social Security Act, as amended); and (States only) the Social Services Block Grant program (CFDA 93.667) (title XX of the Social Security Act, as amended). The IV-E agency may either directly administer the Foster Care program or supervise its administration by local level agencies. Where the program is administered by a State, in accordance with the approved IV-E plan, it must be in effect in all political subdivisions of the State, and, if administered by them, program requirements must be mandatory upon them. Where the program is administered by a Tribe, it must be in effect in all political subdivisions within the Tribal service area(s) and for all populations to be served under the plan. If the program is administered by a political subdivision of a Tribe, program requirements must be mandatory upon them. (42 USC 671(a)(1-4) and 42 USC 679B(c)(1)(B))

Source of Governing Requirements

The Foster Care program is authorized by title IV-E of the Social Security Act, as amended (42 USC 670 *et seq.*). This includes those amendments made by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Pub. L. No. 110-351). Implementing regulations are at 45 CFR parts 1355, 1356, and 1357. **Section 5001 of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. No. 111-5, 123 Stat 496) as amended by section**

201 of Pub. L No. 111-226 provided for temporary increases in the Federal Medical Assistance Percentage (FMAP) rates for expenditure periods between October 1, 2008 and June 30, 2011 to provide additional funding to IV-E agencies (see paragraph III.G.1.b of this program supplement).

Awards under the Foster Care program with funding periods beginning on or after October 1, 2003, are subject to the HHS implementation of the A-102 Common Rule, 45 CFR part 92 (*Federal Register*, September 8, 2003, 68 FR 52843-52844). Previously, this program and other HHS entitlement programs described in the Supplement (as noted under the applicable program description) were excluded from this coverage. This program also is subject to 45 CFR part 95 (Subpart E Cost Allocation Plans is applicable to States) and the cost principles under Office of Management and Budget Circular A-87 (as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, HHS Publication ASMB C-10, available on the Internet at <http://rates.psc.gov/fms/dca/asmb%20c-10.pdf>).

States and Tribes are required to adopt and adhere to their own statutes and regulations for program implementation, consistent with the requirements of title IV-E and the approved IV-E plan.

Availability of Other Program Information

The Children's Bureau manages a policy issuance system that provides further clarification of the law and guides States and Tribes in implementing the Foster Care program. This information may be accessed on the Internet at http://www.acf.hhs.gov/programs/cb/laws_policies/index.htm.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look first to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Activities Allowed

- a. Funds may be expended for Foster Care maintenance payments on behalf of eligible children, in accordance with the IV-E agency's Foster Care maintenance payment rate schedule and in accordance with 45 CFR section 1356.21, to individuals serving as foster family homes, to child-care institutions, or to public or private child-placement or child-care agencies. Such payments may include the cost of (and the cost of providing, including certain associated administrative and operating costs of an institution) food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation, as well as reasonable

travel for the child to remain in the same school he or she was attending prior to placement in foster care (42 USC 672(b)(1) and (2), (c)(2), and 675(4)).

- b. Funds may be expended for training (including both short and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the agency administering the plan (42 USC 674(a)(3)(A)). All training activities and costs funded under title IV-E shall be included in the Title IV-E agency's training plan for title IV-B (45 CFR section 1356.60(b)(2)).
- c. Funds may be expended for short-term training of: relative guardians; State/Tribe-licensed or State/Tribe-approved child welfare agencies providing services to children receiving title IV-E assistance; child abuse and neglect court personnel; agency, child or parent attorneys; guardians ad litem; and, court appointed special advocates (42 USC 674(a)(3)(B), as amended by section 203 of Pub. L. No. 111-351).
- d. Funds may be expended for short-term training, including associated travel and per diem, of current or prospective foster parents and staff of licensed or approved child-care institutions at the initiation of or during their period of care (45 CFR section 1356.60(b)(1)(ii)).
- e. Funds may be expended for costs directly related to the administration of the program that are necessary for the proper and efficient administration of the title IV-E plan. The approved public assistance cost allocation plan (States) or approved cost allocation methodology (Tribes) shall identify which costs are allocated and claimed under this program. Examples of allowable administrative costs for the administration of the Foster Care program include those associated with eligibility determination and redetermination; referral to services; preparation for and participation in judicial determinations; hearings and appeals; rate setting; placement of the child; development of the case plan; case reviews; case management and supervision; recruitment and licensing of foster homes and institutions; costs related to data collection and reporting; and a proportionate share of related agency overhead (45 CFR section 1356.60(c)).
- f. With any required ACF approval, funds may be expended for costs related to design, implementation and operation of a statewide or tribal service area-wide data collection system (45 CFR sections 1356.60(d) and 95.611).

2. *Activities Unallowed*

- a. Costs of social services provided to a child, the child's family, or the child's foster family which provide counseling or treatment to ameliorate or remedy personal problems, behaviors, or home conditions are unallowable (45 CFR section 1356.60(c)(3)).
- b. Costs claimed as foster care maintenance payments that include medical, educational or other expenses not outlined in 42 USC 675(4)(A).

B. Allowable Costs/Cost Principles

Both States and Tribes are subject to the requirements of OMB Circular A-87 (2 CFR part 225). States also are subject to the cost allocation provisions and rules governing allowable costs of equipment of 45 CFR part 95, which references OMB Circular A-87 at 45 CFR section 95.507(a)(2) (45 CFR sections 1355.57, 95.503, and 95.705).

E. Eligibility

1. Eligibility for Individuals

Foster Care benefits may be paid on behalf of a child only if all of the following requirements are met:

- a. Foster Care maintenance payments are allowable only if the foster child was removed from the home of a relative specified in section 406(a) of the Social Security Act, as in effect on July 16, 1996, and placed in foster care by means of a judicial determination, as defined in 42 USC 672(a)(2), or pursuant to a voluntary placement agreement, as defined in 42 USC 672(f), (42 USC 672(a)(1) and (2) and 45 CFR section 1356.21).

(1) *Judicial Determination*

- (a) *Contrary to the welfare determination* – A child's removal from the home (unless removal is pursuant to a voluntary placement agreement) must be in accordance with a judicial determination to the effect that continuation in the home would be contrary to the child's welfare, or that placement in foster care would be in the best interest of the child. The judicial determination must be explicitly stated in the court order and made on a case by case basis. The precise language "contrary to the welfare" does not have to be included in the removal court order, but the order must include language to the effect that remaining in the home will be contrary to the child's welfare, safety, or best interest (45 CFR section 1356.21(c)).

- (i) *Prior to March 27, 2000* – For a child who entered foster care before March 27, 2000, the judicial determination of contrary to the welfare must be in a court order that resulted from court proceedings that are initiated no later than 6 months from the date the child is removed from the home, consistent with Departmental Appeals Board (DAB) Decision Number 1508 (DAB 1508). The Departmental Appeals Board, through Decision Number 1508, ruled that a petition to the court stating the reason for the State agency’s request for the child’s removal from home, followed by a court order granting custody to the State agency is sufficient to meet the contrary to the welfare requirement (*Federal Register*, January 25, 2000, Vol. 65, Number 16, pages 4020 and 4088-89).
- (ii) *On or after March 27, 2000* – For a child who enters foster care on or after March 27, 2000, the judicial determination of contrary to the welfare must be in the first court ruling that sanctions the child’s removal from home (45 CFR section 1356.21(c)). Acceptable documentation is a court order containing a judicial determination regarding contrary to the welfare or a transcript of the court proceedings reflecting this determination (45 CFR section 1356.21(d)). For the first 12 months that a Tribe’s title IV-E plan is in effect, the Tribe may use *nunc pro tunc* orders and affidavits to verify reasonable efforts and contrary to the welfare judicial determinations for title IV-E foster care eligibility (42 USC 679c(c)(1)(C)(ii)(I), as added by Section 301, Pub. L. No. 110-351).
- (b) *Reasonable efforts to prevent removal determination* – Within 60 days from the date of the removal from home pursuant to 45 CFR section 1356.21(k)(ii), there must be a judicial determination as to whether reasonable efforts were made or were not required to prevent the removal (e.g., child subjected to aggravated circumstances such as abandonment, torture, chronic abuse, sexual abuse, parent convicted of murder or voluntary manslaughter or aiding or abetting in such activities) (45 CFR sections 1356.21(b)(1) and (k)). The judicial determination must be explicitly documented, i.e., so stated in the court order and made on a case by case basis.

- (i) *Prior to March 27, 2000* – For a child who entered care foster care before March 27, 2000, the judicial determination that reasonable efforts were made to prevent removal or that reasonable efforts were made to reunify the child and family satisfies the reasonable efforts requirement (*Federal Register*: January 25, 2000, Vol. 65, Number 16, pages 4020 and 4088).
 - (ii) *On or after March 27, 2000* – For a child who enters foster care on or after March 27, 2000, the judicial determination that reasonable efforts were made to prevent removal or were not required must be made no later than 60 days from the date of the child’s removal from the home (45 CFR section 1356.21(b)(1)). Acceptable documentation is a court order containing a judicial determination regarding reasonable efforts to prevent removal or a transcript of the court proceedings reflecting this determination (45 CFR section 1356.21(d)). For the first 12 months that a Tribe’s title IV-E plan is in effect, the Tribe may use *nunc pro tunc* orders and affidavits to verify reasonable efforts and contrary to the welfare judicial determinations for title IV-E foster care eligibility (42 USC 679c(c)(1)(C)(ii)(I)), as added by Section 301, Pub. L. No. 110-351).
- (c) *Reasonable efforts to finalize a permanency plan* – A judicial determination regarding reasonable efforts to finalize the permanency plan must be made within 12 months of the date on which the child is considered to have entered foster care and at least once every 12 months thereafter while the child is in foster care. The judicial determination must be explicitly documented and made on a case by case basis. If a judicial determination regarding reasonable efforts to finalize a permanency plan is not made within this timeframe, the child is ineligible at the end of the 12th month from the date the child was considered to have entered foster care or at the end of the month in which the subsequent judicial determination of reasonable efforts was due, and the child remains ineligible until such a judicial determination is made (45 CFR section 1356.21(b)(2)).
 - (i) *Prior to March 27, 2000* – For a child who entered foster care before March 27, 2000, the judicial determination of reasonable efforts to finalize the

permanency plan must be made no later than March 27, 2001, because such child will have been in care for 12 months or longer (January 25, 2000, *Federal Register*, Vol. 65, Num 16, pages 4020 and 4088).

- (ii) *On or after March 27, 2000* – For a child who enters foster care on or after March 27, 2000, the judicial determination of reasonable efforts to finalize the permanency plan must be made no later than 12 months from the date the child is considered to have entered foster care (45 CFR section 1356.21(b)(2)). Acceptable documentation is a court order containing a judicial determination regarding reasonable efforts to finalize a permanency plan or a transcript of the court proceedings reflecting this determination (45 CFR section 1356.21(d)). For the first 12 months that a Tribe’s title IV-E plan is in effect, the Tribe may use *nunc pro tunc* orders and affidavits to verify reasonable efforts and contrary to the welfare judicial determinations for title IV-E foster care eligibility (42 USC 679c(c)(1)(C)(ii)(I), as added by Section 301 Pub. L. No. 110-351).
- (2) If the removal was by a voluntary placement agreement, it must be followed within 180 days by a judicial determination to the effect that such placement is in the best interests of the child (42 USC 672(e); 45 CFR section 1356.22(b)).
- b. The child’s placement and care are the responsibility of either the IV-E agency administering the approved title IV-E plan or any other public agency under a valid agreement with the cognizant IV-E agency (42 USC 672(a)(2)).
 - c. A child must meet the eligibility requirements of the former Aid to Families with Dependent Children (AFDC) program (i.e., meet the State-established standard of need as of July 16, 1996, prior to enactment of the Personal Responsibility and Work Opportunity Reconciliation Act) (42 USC 672(a)). Tribes must use the title IV-A State plan (as in effect as of July 16, 1996) of the State in which the child resided at the time of removal (42 USC 679c(c)(1)(C)(ii)(II)). Program eligibility is limited to an individual defined as a “child.” This classification ordinarily ceases at the child’s 18th birthday (42 USC 672(a)(3), and 42 USC 675(8)(A)). *If, however, the State in which the child was living at removal had as a title IV-A State plan option* (as in effect as of July 16, 1996), a title IV-E agency may provide foster care maintenance payments on behalf of youth who have attained age 18, but are under the age of 19, and who are full-time students expected to complete their secondary schooling or

equivalent vocational or technical training before reaching age 19 (45 CFR section 233.90(b)(3)).

Beginning on October 1, 2010, a title IV-E agency may also amend its title IV-E plan to provide that an individual in foster care who is over age 18 (where an existing eligibility age extension provision for a full-time student expected to complete secondary schooling prior to attaining age 19 is not applicable) and has not attained 19, 20, or 21 years old (as the IV-E agency may elect) remains eligible as a child when the youth meets prescribed conditions for continued maintenance payments. A youth over age 18 must also (as elected by the IV-E agency) be (1) completing secondary school (or equivalent), (2) enrolled in post-secondary or vocational school, (3) participating in a program or activity that promotes or removes barriers to employment, (4) employed 80 hours a month, or (5) incapable of any of these due to a documented medical condition (42 USC 675(8)(B)).

Effective on April 8, 2010, the requirement to conduct annual AFDC redeterminations for purposes of determining continuing title IV-E eligibility has been eliminated to ease an administrative burden. The title IV-E agency must (for periods beginning on or after April 8, 2010) establish AFDC eligibility only at the time the child is removed from home or a voluntary placement agreement is entered (42 USC 672(a)(3)(A) and section 8.4A, QA#24 of the Child Welfare Policy Manual).

- d. The provider, whether a foster family home or a child-care institution must be fully licensed by the proper State or Tribal foster care licensing authority responsible for licensing such homes or child care institutions. The term “child care institution” as defined in 45 CFR section 1355.20 includes a private child care institution, or a public child care institution which accommodates no more than 25 children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing, but does not include detention facilities, forestry camps, training schools, or facilities operated primarily for the purpose of detention of children who are determined to be delinquent (42 USC 671(a)(10) and 672(c)). Effective October 1, 2010, the existing statutory definition of a child care institution includes a supervised setting in which an individual who has attained 18 years of age is living independently, consistent with conditions the Secretary establishes in regulations (42 USC 672(c)(2)).
- e. The foster family home provider must satisfactorily have met a criminal records check, including a fingerprint-based check, with respect to prospective foster and adoptive parents (42 USC 671(a)(20)(A)). This involves a determination that such individual(s) have not committed any

prohibited felonies in accordance with 42 USC 671(a)(20)(A)(i) and (ii). The requirement for a fingerprint-based check took effect on October 1, 2006 unless prior to September 30, 2005 the State has elected to opt out of the criminal records check requirement or State legislation was required to implement the fingerprint-based check, in which case a delayed implementation is permitted until the first quarter of the State's regular legislative session following the close of the first regular session beginning after October 1, 2006. The requirement applies to foster care maintenance payments for calendar quarters beginning on or after the State's effective date for implementation (Pub. L. No. 109-248, section 152(c)(1) and (3)). States that opted out of the criminal records check requirement at section 471(a)(20) of the Social Security Act prior to September 30, 2005 had until October 1, 2008 to implement the fingerprint-based check requirement. Effective October 1, 2008, a State is no longer permitted to opt out of the fingerprint-based check requirement. The opt-out provision does not impact Tribes since they only became eligible to administer a title IV-E plan effective on October 1, 2009. The statutory provisions apply to all prospective foster parents who are newly licensed or approved after the IV-E agency's authorized date for implementation of the fingerprint-based background check provisions (42 USC 671(a)(20)(B); Pub. L. No. 109-248, section 152(c)(2)).

- f. A IV-E agency must check, or request a check of, a State-maintained child abuse and neglect registry in each State the prospective foster and adoptive parents and any other adult(s) living in the home have resided in the preceding 5 years before the State can license or approve a prospective foster or adoptive parent. This requirement became effective on October 1, 2006 unless the State requires legislation to implement the requirement, in which case a delayed implementation is permitted until the first quarter of the State's regular legislative session following the close of the first regular session beginning after October 1, 2006. The requirement applies to foster care maintenance payments for calendar quarters beginning on or after that date. Tribes first became eligible to administer a title IV-E plan effective October 1, 2009 and must, therefore, comply with this requirement (42 USC 671(a)(20)(C); Pub. L. No. 109-248, section 152(c)(2) and (3)).
- g. The licensing file for the child-care institution must contain documentation that verifies that safety considerations with respect to staff of the institution have been addressed (45 CFR section 1356.30(f)).

- h. Foster care administrative costs for the provision of child-placement services generally are allowable only when performed on behalf of a foster child that is eligible to receive title IV-E foster care maintenance payments (42 USC 674(a)(3)(E) and 45 CFR section 1356.60). The following exceptions apply:
- (1) Activities specifically associated with the determination or redetermination of title IV-E eligibility are allowable regardless of the outcome of the eligibility determination (DAB Decision No. 844).
 - (2) Otherwise allowable activities performed on behalf of *title IV-E eligible foster children placed in unallowable facilities and unlicensed relative homes can be allowable under limited circumstances as follows:*
 - (a) For the lesser of 12 months or the average length of time it takes the State or Tribe to issue a license or approval of the home when the child, otherwise title IV-E eligible, is placed in the home of a relative who has an application pending for a foster family home license or approval (42 USC 672(i)(1)(A)).
 - (b) For not more than one calendar month for an otherwise title IV-E eligible child transitioning from an unlicensed or unapproved facility to a licensed or approved foster family home or child care institution (42 USC 672(i)(1)(B)).
 - (3) In the case of any other child not in foster care who is potentially eligible for benefits under a title IV-E plan approved under this part and at imminent risk of removal from the home, only if-
 - (a) Reasonable efforts are being made in accordance with 42 USC 471(a)(15) to prevent the need for, or if necessary to pursue, removal of the child from the home; and
 - (b) The title IV-E agency has made, not less often than every 6 months, a determination (or redetermination) as to whether the child remains at imminent risk of removal from the home (42 USC 672(i)(2)).
- 2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable**
- 3. Eligibility for Subrecipients – Not Applicable**

F. Equipment and Real Property Management

Equipment that is capitalized and depreciated or is claimed in the period acquired and charged to more than one program is subject to 45 CFR section 95.707(b) in lieu of the requirements of the A-102 Common Rule (applies to States only).

G. Matching, Level of Effort, Earmarking

1. Matching

The percentage of required State/Tribe funding and associated Federal funding (“Federal financial participation” (FFP)) varies by type of expenditure as follows:

- a. Third party in-kind contributions cannot be used to meet the State’s cost sharing requirements (Child Welfare Policy Manual 8.1F.Q#2 8/16/02). The non-applicability of the matching and cost sharing provisions of 45 CFR part 74 to this program conveys to the similar provisions of 45 CFR section 92.24 (as a result of the inclusion of HHS’ entitlement programs under 45 CFR part 92) (45 CFR sections 1355.30(c) and 1355.30(n)(1); 45 CFR section 201.5(e)). Tribes receiving title IV-E funds are permitted to use in-kind funds from third-party sources as match for a portion of administrative and training costs. The statute places specific limits on the amount of in-kind expenditures and types of third-party sources (42 USC 679c(c)(1)(D), as added by Section 301, Pub. L. No. 110-351).
- b. The percentage of Federal funding in Foster Care maintenance payments will be the Federal Medical Assistance Program (FMAP) percentage. This percentage varies by State and is available on the Internet (<http://www.aspe.hhs.gov/health/fmap.htm>) (42 USC 674(a)(1); 45 CFR section 1356.60(a)). **ARRA provides for a temporary increase in FMAP rates to provide additional funding to IV-E agencies (ARRA, Section 5001 as amended by Section 201 of the Education, Jobs and Medicaid Assistance Act, Pub. L No. 111-226). These temporary increases will affect rates for FY 2009, FY 2010, and the first three quarters of FY 2011 only (i.e., October 1, 2008 – June 30, 2011). Generally, aside from the possible applicability of a hold-harmless provision, an increase of 6.2 percent will be added to the FMAP percentage rate of every State for quarters from October 1, 2008 through December 31, 2010. In accordance with section 201 of Pub. L. No. 111-226, the ARRA temporary FMAP percentage rate increase is extended for an additional 6 months, but the level of increase is modified as follows: 3.2 percent for the quarter ending March 31, 2011 and 1.2 percent for the quarter ending June 30, 2011.**

Effective October 1, 2009, separate Tribal FMAP rates, which are based upon the Tribe's service area and population, apply to Foster Care program maintenance payments incurred by Tribes that are participating in title IV-E programs through either direct operation of an approved title IV-E plan or through operation of a title IV-E agreement or contract with a State title IV-E agency. The methodology for calculating Tribal FMAP rates was provided through a final notice in the Federal Register that is available on the internet as follows: <http://www.gpo.gov/fdsys/pkg/FR-2011-08-01/pdf/2011-19358.pdf>. The calculated FMAP rate for each Tribe includes any statutory temporary percentage increase applicable to State FMAP rates and applies unless it is exceeded by the FMAP rate for any State in which the Tribe is located (42 USC 679B(d) and 42 USC 679B(e)).

- c. The percentage of Federal funding in expenditures for short- and long-term training at educational institutions of employees or prospective employees, and short-term training of current or prospective foster or adoptive parents and members of staff of State/Tribe-licensed or State/Tribe-approved child-care institutions (including travel and per diem) is 75 percent (42 USC 674(a)(3)(A) and (B); 45 CFR section 1356.60(b)).
- d. The percentage of Federal funding in expenditures for short-term training of: relative guardians; State/Tribe-licensed or State/Tribe-approved child welfare agencies providing services to children receiving title IV-E assistance; child abuse and neglect court personnel; agency, child or parent attorneys; guardians ad litem; and, court appointed special advocates is subject to an increasing FFP rate for these additional trainee groups as follows: 55 percent in FY 2009; 60 percent in FY 2010; 65 percent in FY 2011; 70 percent in FY 2012; 75 percent in FY 2013 and thereafter (42 USC 674(a)(3)(B), as added by Section 203(b), Pub. L. No. 110-351).
- e. The percentage of Federal funding for expenditures for planning, design, development, and installation and operation of a statewide or tribal service area-wide automated child welfare information system meeting specified requirements (and expenditures for hardware components for such systems) is 50 percent (42 USC 674(a)(3)(C) and (D); 45 CFR sections 1355.52 and 1356.60(d)).
- f. The percentage of Federal funding of all other allowable administrative expenditures is 50 percent (42 USC 674 (a)(1)(E); 45 CFR section 1356.60(c)).

2. Level of Effort – Not Applicable

3. Earmarking – Not Applicable

H. Period of Availability of Federal Funds

This program operates on a cash accounting basis and each year's funding and accounting is discrete. To be eligible for Federal funding, claims must be submitted to ACF within 2 years after the calendar quarter in which the IV-E agency made the expenditure. This limitation does not apply to prior period decreasing adjustments and any claim qualifying for a time limits exception in accordance with 45 CFR section 95.19 (42 USC 1320b-2; 45 CFR sections 95.7, 95.13, and 95.19).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Not Applicable
- d. For reporting periods through September 30, 2010: ACF-IV-E-1, *Foster Care and Adoption Assistance Financial Report (OMB No. 0970-0205)* – Title IV-E agencies report current expenditures for the previous quarter, and estimate costs for the next quarter. Prior quarter adjustment (increasing and decreasing) expenditures applicable to earlier quarters must also be separately reported on this form.

Key Line Items – The following line items contain critical information.

Part 1, *Foster Care Expenditures, columns (a) through (d)*

Part 2, *Prior Quarter Adjustments – Foster Care, columns (a) through (d)*

(Part 3, *Semi-Annual Budget Projections* was repealed in January 2009)

Part 4, *Foster Care Demonstration Projects, columns (a) through (e)*

- e. For reporting periods beginning October 1, 2010 or later: CB-496, *Title IV-E Programs Quarterly Financial Report (OMB No. 0970-0205)* – Title IV-E agencies report current expenditures and information on children assisted for the quarter that has just ended and estimates of expenditures and children to be assisted for the next quarter. Prior quarter adjustment (increasing and decreasing) expenditures applicable to earlier quarters must also be separately reported on this form.

Key Line Items – The following line items contain critical information:

Part 1, *Expenditures, Estimates and Caseload Data, columns (a) through (d) (Sections A and D (Foster Care Program))*

Part 2, *Prior Quarter Expenditure Adjustments – Foster Care, columns (a) through (d)*

Part 3, *Foster Care Demonstration Projects, columns (a) through (e)*

2. **Performance Reporting** – Not Applicable
3. **Special Reporting** – Not Applicable
4. **Section 1512 ARRA Reporting** – Not Applicable
5. **Subaward Reporting under the Transparency Act** – Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.659 ADOPTION ASSISTANCE—TITLE IV-E

I. PROGRAM OBJECTIVES

The objective of the Adoption Assistance program is to facilitate the placement of children with special needs in permanent adoptive homes and thus prevent long, inappropriate stays in foster care.

II. PROGRAM PROCEDURES

Administration and Services

The Adoption Assistance program is administered at the Federal level by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS). The Adoption Assistance program provides Federal matching funds to title IV-E agencies with approved title IV-E plans that provide subsidy payments to parents who adopt eligible children with special needs and enter into an adoption assistance agreement. Depending on the circumstances, the child may also need to meet the eligibility requirements of the Aid to Families with Dependent Children (AFDC) program (i.e., meet the State-established standard of need as of July 16, 1996, prior to enactment of the Personal Responsibility and Work Opportunity Reconciliation Act [PRWORA]) or the Supplemental Security Income (SSI) program. In cases where program eligibility requires an assessment of SSI program eligibility, the child will need to meet either all criteria or for an applicable child [defined in III.E.1,a.(1)(a), Eligibility for Individuals, of this program supplement] only the medical and disability criteria. Tribes must use the title IV-A State plan (as in effect as of July 16, 1996) of the State in which the child resided at the time of removal in determining the child's AFDC eligibility (42 USC 679c(c)(1)(C)(ii)(II)).

An adoption assistance agreement is a written agreement between the adoptive parents, the IV-E agency, and other relevant agencies (such as a private adoption agency) specifying the nature and amount of assistance to be given on a monthly basis to parents who adopt eligible special needs children. A child with special needs is defined as a child who the IV-E agency has determined cannot or should not be returned home; has a specific factor or condition, as defined by the State or Tribe, because of which it is reasonable to conclude that the child cannot be adopted without financial or medical assistance; and for whom a reasonable effort has been made to place the child without providing financial or medical assistance (42 USC 673(a)(2)).

Funding is provided to the 50 States, the District of Columbia and Puerto Rico. Federally recognized Indian Tribes, Indian tribal organizations and tribal consortia may also apply for title IV-E funding via the submission of a title IV-E plan. Funding is based on an approved IV-E plan and amendments, as required by changes in statutes, rules, and regulations, submitted to and approved by the ACF Children's Bureau Associate Commissioner. The Adoption Assistance program is an open-ended entitlement program. Federal financial participation in State or tribal expenditures for adoption assistance agreements is provided at the Medicaid match rate for medical assistance payments, which varies among States and Tribes. Monthly payments to families made on behalf of eligible adopted children also vary from IV-E agency to IV-E agency.

Federal financial participation (FFP) is made at an open-ended 50 percent match rate for administrative expenditures and at an open-ended 75 percent for most categories of State/tribal IV-E training expenditures. In addition, the program authorizes Federal matching funds for IV-E agencies that reimburse the non-recurring adoption expenses of adoptive parents of special needs children (regardless of AFDC or SSI eligibility) as administrative expenditures at an open-ended 50 percent FFP rate.

The designated IV-E agency for this program also administers ACF funding provided for other Social Security Act programs (e.g., Foster Care (CFDA 93.658), Guardianship Assistance (CFDA 93.090) at agency option and Independent Living Services (CFDA 93.674) programs (Title IV-E of the Social Security Act); Child Welfare Services (CFDA 93.645) and Promoting Safe and Stable Families (CFDA 93.556) programs (Title IV-B of the Social Security Act, as amended); and (States only) the Social Services Block Grant program (CFDA 93.667) (Title XX of the Social Security Act, as amended)). The IV-E agency may either directly administer the Adoption Assistance program or supervise its administration by local level agencies. Where the program is administered by a State, in accordance with the approved IV-E plan, it must be in effect in all political subdivisions of the State, and, if administered by them, program requirements must be mandatory upon them. Where the program is administered by a Tribe, it must be in effect in all political subdivisions within the Tribal service area(s) and for all populations to be served under the plan. If the program is administered by a political subdivision of a Tribe, program requirements must be mandatory upon them. (42 USC 671(a)(1-4) and 42 USC 679B(c)(1)(B))

Source of Governing Requirements

The Adoption Assistance program is authorized by Title IV-E of the Social Security Act, as amended (42 USC 670 *et seq.*). This includes those amendments made by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Pub. L. No. 110-351). Implementing regulations are published at 45 CFR parts 1355 and 1356. States and Tribes are to implement the program according to their IV-E plan, which is submitted to ACF for approval. **Section 5001 of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. No. 111-5, 123 Stat 496) as amended by Section 201 of Pub. L. No. 111-226, provided for temporary increases in the Federal Medical Assistance Percentage (FMAP) rates for expenditure periods between October 1, 2008 and June 30, 2011 to provide additional funding to IV-E agencies (see paragraph III.G.1.b, Matching, of this program supplement).**

Awards made under the Adoption Assistance program with funding periods beginning on or after October 1, 2003, are subject to the HHS implementation of the A-102 Common Rule, 45 CFR part 92 (*Federal Register*, September 8, 2003, 68 FR 52843-52844). Previously, this program and other HHS entitlement programs described in the Compliance Supplement (as noted under the applicable program description) were excluded from this coverage. This program also is subject to 45 CFR part 95 (Subpart E Cost Allocation Plans is applicable to States) and the cost principles under Office of Management and Budget Circular A-87 (as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, HHS Publication ASMB C-10, available on the Internet at <http://rates.psc.gov/fms/dca/asmb%20c-10.pdf>). States and Tribes are required to

adopt and adhere to their own statutes and regulations for program implementation, consistent with the requirements of Title IV-E and the approved IV-E Plan.

Availability of Other Program Information

The Children's Bureau manages a policy issuance system that provides further clarification of the law and guides States and Tribes in implementing the Adoption Assistance program. This information may be accessed on the Internet at http://www.acf.dhhs.gov/programs/cb/laws_policies/laws/cwpm/index.jsp.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Adoption Assistance Subsidies* – Funds may be expended for adoption assistance agreement subsidy payments, in accordance with the State's or Tribe's foster care maintenance payment rate schedule. Subsidy payments are made to adoptive parents based on the need(s) of the child (i.e. developmental, cognitive, emotional behavioral) and the circumstances of the adopting parents (42 USC 673(a)(2)). Subsidy payment amounts cannot be based on any income eligibility requirements of the prospective adoptive parents (45 CFR section 1356.41(c)). Adoption assistance subsidy payments cannot exceed the foster care maintenance payment the child would have received in a foster family home; however, the amount of the subsidy payments may be up to 100 percent of the foster care maintenance payment rate (42 USC 673(a)(3)).
2. *Administrative Costs*
 - a. *Program Administration* – Funds may be expended for costs directly related to the administration of the program. Approved public assistance cost allocation plans (States) or approved cost allocation methodologies (Tribes) will identify which costs are allocated and claimed under this program (45 CFR section 1356.60(c)).
 - b. *Nonrecurring Costs* – Funds may be expended by a IV-E agency under an adoption assistance agreement for nonrecurring expenses up to \$2,000 (gross amount), for any adoptive placement (45 CFR section 1356.41(f)(1)). Nonrecurring adoption expenses are defined as reasonable and necessary adoption fees, court costs, attorney fees and other expenses that are directly related to the legal adoption of a child with special needs. Other expenses may include those costs of adoption incurred by or on behalf of the adoptive parents, such as, the adoptive home study, health and psychological examination, supervision of the placement prior to

adoption, transportation and the reasonable costs of lodging and food for the child and/or the adoptive parents when necessary to complete the placement or adoptions process (45 CFR section 1356.41(i)).

- c. *Adoption Placement Costs* – Funds expended by the IV-E agency for adoption placements (including nonrecurring costs) are considered an administrative expenditure and are subject to the matching requirements in section III.G.3.c (45 CFR section 1356.41(f)(1)).

3. *Training*

- a. Funds may be expended for short-term training of current or prospective adoptive parents and members of the staff of State/Tribe-licensed or State/Tribe-approved child care institutions (including travel and per diem) at the initiation of or during their period of care (42 USC 674(a)(3)(B) and 45 CFR section 1356.60(b)(1)(ii)).
- b. Funds may be expended for short-term training of: relative guardians; State/Tribe-licensed or State/Tribe-approved child welfare agencies providing services to children receiving title IV-E assistance; child abuse and neglect court personnel; agency, child or parent attorneys; guardians ad litem; and, court appointed special advocates (42 USC 674(a)(3)(B), as amended by section 203 of Pub. L. No. 111-351).
- c. Funds may be expended for training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the agency administering the plan (42 USC 674(a)(3)(A)).

B. Allowable Costs/Cost Principles

Both States and Tribes are subject to the requirements of OMB Circular A-87. States also are subject to the cost allocation provisions and rules governing allowable costs of equipment of 45 CFR part 95, which references OMB Circular A-87 at 45 CFR section 95.507(a)(2) (45 CFR sections 1355.57, 95.503, and 95.705).

E. Eligibility

1. Eligibility for Individuals

- a. Adoption assistance subsidy payments may be paid on behalf of a child only if all of the following requirements are met:
 - (1) *Categorical Eligibility*
 - (a) *Applicable and Non-Applicable Children* – An applicable child is a child for whom an adoption assistance agreement

was entered into in fiscal year (FY) 2010 or later and who meets the applicable age requirement (differs over a 9 fiscal year phase-in period beginning in FY 2010), or a child who has been in foster care under the responsibility of the title IV-E agency for at least 60 consecutive months, or a sibling to either such child if both are to have the same adoption placement (42 USC 673(e)(2) and (e)(3)). The applicable age requirement is met only if the child has attained that age any time before the end of the Federal fiscal year during which the adoption assistance agreement is entered into. The applicable age for FY 2010 agreements includes children who will turn age 16 or older in that FY. In each subsequent FY, the age to apply the revised “applicable child” program rules decreases by 2 years (e.g., children who turn 14 or older in FY 2011 and children who turn 12 or older in FY 2012) until children of any age may be eligible according to the revised criteria in FY 2018 (42 USC 673(e)(1)(B), as amended by Section 402, Pub. L. No. 110-351).

A child who is referred to as “not an applicable child” is one for whom an adoption assistance agreement was entered into in FY 2009 or earlier or in a later FY if the applicable child requirements pertinent to the FY in which the adoption assistance agreement was entered into are not satisfied. In this instance the revised “applicable child” eligibility criteria do not apply and the eligibility requirements in place prior to October 1, 2009 apply (42 USC 673(a)(2)(A)(i)).

- (b) *Adoption agreements entered into prior to the beginning of FY 2010, or agreements entered into during FY 2010 or thereafter for a “non-applicable child”* – The child is categorically eligible if:
- (i) the child was eligible, or would have been eligible, for the former AFDC program (i.e., met the State-established standard of need as of July 16, 1996, prior to enactment of the PRWORA (Tribes must use the title IV-A State plan in effect as of July 16, 1996 of the State in which the child resided at the time of removal in determining the child’s AFDC eligibility (42 USC 679c(c)(1)(C)(ii)(II))) except for his/her removal from the home of a relative pursuant to either a voluntary placement agreement or as a result of a judicial determination to the effect

- that continuation in the home of removal would have been contrary to the welfare of the child; or
- (ii) the child is eligible for SSI; or
 - (iii) the child is a child whose costs in a foster family home or child care institution are covered by the foster care maintenance payments being made with respect to his/her minor parent (42 USC 673(a)(2)(A)(i)(I)).
- (c) *Adoption agreements entered into during FY 2010 or thereafter for an “applicable child”* – The child is categorically eligible if the child:
- (i) at the time of the initiation of adoption proceedings, was in the care of a public or private child placement agency by way of a voluntary placement, voluntary relinquishment or a court-ordered removal with a judicial determination that remaining at home would be contrary to the child’s welfare; or
 - (ii) meets the disability or medical requirements of the SSI program; or
 - (iii) was residing with a minor parent in foster care (who was placed in foster care by way of a voluntary placement, voluntary relinquishment or court-ordered removal); or,
 - (iv) was eligible for adoption assistance in a previous adoption in which the adoptive parents have died or had their parental rights terminated (42 USC 673(a)(2)(A)(ii)(I) and 673(a)(2)(C)(ii)); and
 - (v) does not fit within the following prohibited class for the payment of an adoption assistance payment (including payments of non-recurring expenses under 42 USC 673(a)(1)(B)(i)), i.e., an “applicable child” who is not a citizen or resident of the U.S. and was either adopted outside the U.S. or brought to the U.S. for the purpose of being adopted (42 USC 673(a)(7) as added by Pub. L. No. 110-351).

- (2) The following additional eligibility provisions must be met in addition to the establishment of categorical eligibility:
- (a) The child was determined by the IV-E agency as someone who cannot or should not be returned to the home of his or her parents (42 USC 673(c)(1));
 - (b) The child was determined by the IV-E agency to be a child with special needs. Special needs means that there is a specific factor or condition (such as ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance under title IV-E and medical assistance under title XIX. In the case of an applicable child, the child is also considered to have special needs if that applicable child meets all of the medical or disability requirements for Supplemental Security Income (SSI) and the IV-E agency determines that it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance under title IV-E and medical assistance under title XIX. The criteria for the factor or condition element of the special needs determination will be met if an applicable child meets all the medical or disability requirements for SSI (42 USC 673(c)(1)(B) and 673(c)(2)(B), as amended/added by Pub. L. No. 110-351).
 - (c) The IV-E agency has made reasonable efforts to place the child for adoption without a subsidy. The only exception to this requirement is where it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in the care of the parents as a foster child (42 USC 673(c)(1)(B) and 673(c)(2) as amended/added by Pub. L. No. 110-351).
 - (d) The agreement for the subsidy was signed and was in effect before the final decree of adoption and contains information concerning the nature of services; the amount and duration of the subsidy; the child's eligibility for Title XX services and Title XIX Medicaid; and covers the child should he/she move out of State with the adoptive family (42 USC 675(3)).

- (e) The prospective adoptive parent(s) must satisfactorily have met a criminal records check, including a fingerprint-based check (42 USC 671(a)(20)(A)). This involves a determination that such individual(s) have not committed any prohibited felonies in accordance with 42 USC 671(a)(20)(A)(i) and (ii). The requirement for a fingerprint-based check took effect on October 1, 2006, unless prior to September 30, 2005 the State has elected to opt out of the criminal records check requirement or State legislation was required to implement the fingerprint-based check, in which case a delayed implementation is permitted until the first quarter of the State's regular legislative session following the close of the first regular session beginning after October 1, 2006. The requirement applies to adoption assistance payments for calendar quarters beginning on or after the State's effective date for implementation (Pub. L. No. 109-248, section 152(c)(1) and (3)). States that opted out of the criminal records check requirement at section 471(a)(20) of the Social Security Act prior to September 30, 2005 had until October 1, 2008 to implement the fingerprint-based check requirement. Effective October 1, 2008, a State is no longer permitted to opt out of the fingerprint-based check requirement. The opt out provision does not impact Tribes since they only became eligible to administer a title IV-E plan effective on October 1, 2009 (42 USC 671(a)(20)(B); Pub. L. No. 109-248, section 152(c)(2) and 45 CFR sections 1356.30(b) and (c)).
- (f) The prospective adoptive parent(s) any other adult living in the home who has resided in the provider home in the preceding 5 years must satisfactorily have met a child abuse and neglect registry check. This requirement became effective on October 1, 2006 unless the State requires legislation to implement the requirement, in which case a delayed implementation is permitted until the first quarter of the State's regular legislative session following the close of the first regular session beginning after October 1, 2006. The requirement applies to foster care maintenance payments for calendar quarters beginning on or after that date. Tribes first became eligible to administer a title IV-E plan effective on October 1, 2009 and must, therefore, comply with this requirement (42 USC 671(a)(20)(C); Pub. L. No. 109-248, sections 152(c)(2) and (3)).

- (g) Once a child is determined eligible to receive title IV-E adoption assistance, he or she remains eligible and the subsidy continues until: (i) the age of 18 (or 21 if the IV-E agency determines that the child has a mental or physical disability which warrants the continuation of assistance); (ii) the IV-E agency determines that the parent is no longer legally responsible for the support of the child, or (iii) the IV-E agency determines the child is no longer receiving any support from the parents (42 USC 673(a)(4)(A) and (B)).

Beginning on October 1, 2010, a title IV-E agency may amend its title IV-E plan to provide for a definition of a “child” as an individual who has not attained 19, 20, or 21 years old (as the IV-E agency may elect) (42 USC 675(8)(B)(iii)). This definition of a child will then permit payment of adoption assistance for a child who is over age 18 (where the IV-E agency does not determine that the child has a mental or physical disability which warrants the continuation of assistance up to age 21) if such a youth is part of an adoption assistance agreement that is in effect under section 473 of the Social Security Act and the youth had attained 16 years of age before the agreement became effective. As an additional requirement, a youth over age 18 must also (as elected by the IV-E agency) be (i) completing secondary school (or equivalent), (ii) enrolled in post-secondary or vocational school, (iii) participating in a program or activity that promotes or removes barriers to employment, (iv) employed 80 hours a month, or (v) incapable of any of these due to a documented medical condition (42 USC 675(8)(B)).

- b. Nonrecurring expenses of adoption may be paid on behalf of a child only if all of the following requirements are met:
- (1) The agreement, as a separate document or part of an agreement for State/Tribe or Federal Adoption assistance payment or services, was signed prior to the final decree of adoption (45 CFR section 1356.41(b)).
 - (2) The agreement indicates the nature and amount of the nonrecurring expenses to be paid (45 CFR section 1356.41(a)).
 - (3) The State or Tribe has determined that the child is a child with special needs (45 CFR section 1356.41(d)).

- (4) The child has been placed for adoption in accordance with applicable State and local laws (45 CFR section 1356.41(d)).
 - (5) The costs incurred by or on behalf of adoptive parents are not otherwise reimbursed from other sources (45 CFR section 1356.41(g)).
 - c. There may be no income-eligibility requirement (means test) for the prospective adoptive parent(s) in determining eligibility for adoption assistance subsidy payments or nonrecurring expenses of adoption (45 CFR sections 1356.40(c) and 1356.41(c)).
 - d. In the case of a child adopted after the dissolution of a guardianship where the child was receiving title IV-E guardianship assistance payments, the child's eligibility for adoption assistance is to be determined without consideration of the placement of the child with the relative guardian and any kinship guardianship assistance payments made on behalf of the child. Thus, if such a child is adopted, the title IV-E agency would apply the adoption assistance criteria for the child as if the guardianship had never occurred (42 USC 673(a)(1)(D) as added by Section 101(c) of Pub. L. No. 110-351).
 2. **Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable**
 3. **Eligibility for Subrecipients – Not Applicable**

F. Equipment and Real Property Management

Equipment that is capitalized and depreciated or is claimed in the period acquired and charged to more than one program is subject to 45 CFR section 95.707(b) in lieu of the requirements of the A-102 Common Rule (applies to States only).

G. Matching, Level of Effort, Earmarking

1. Matching

The percentage of required State/tribal funding and associated Federal funding (“Federal financial participation” (FFP)) varies by type of expenditure as follows:

- a. Third party in-kind contributions cannot be used to meet the State's cost sharing requirements (Child Welfare Policy Manual Section 8.1F.Q#2 8/16/02). The non-applicability of the matching and cost sharing provisions of 45 CFR part 74 to this program conveys to the similar provisions of 45 CFR section 92.24 (as a result of the inclusion of HHS' entitlement programs under 45 CFR part 92) (45 CFR sections 1355.30(c) and 1355.30(n)(1); 45 CFR section 201.5(e)). Tribes receiving title IV-E are permitted to use in-kind funds from third-party sources as match for a

portion of administrative and training costs. The statute places specific limits on the amount of in-kind expenditures and types of third-party sources and authorizes the Secretary to set future limits in regulation (42 USC 679c(c)(1)(D), as added by Section 301, Pub. L. No. 110-351).

- b. *Adoption Assistance Subsidy Payments* – The percentage of title IV-E funding in Adoption Assistance subsidy payments will be the Federal Medical Assistance Program (FMAP) percentage. This percentage varies by State and is available on the Internet at <http://www.aspe.hhs.gov/health/fmap.htm> (42 USC 674(a)(1); 45 CFR section 1356.60(a)). **ARRA provides for a temporary increase in FMAP percentages to provide additional funding to IV-E agencies (ARRA, Section 5001 as amended by Section 201 of the Education, Jobs and Medicaid Assistance Act, Pub. L No. 111-226). These temporary increases will affect rates for FYs 2009 and 2010 and the first three quarters of FY 2011 only (i.e., October 1, 2008 – June 30, 2011). Generally, aside from the possible applicability of a hold harmless provision, an increase of 6.2 percent will be added to the FMAP percentage rate of every State for quarters from October 1, 2008 through December 31, 2010. In accordance with Section 201 of Pub. L. No. 111-226, the ARRA temporary FMAP percentage rate increase is extended for an additional 6 months, but the level of increase is modified as follows: 3.2 percent for the quarter ending March 31, 2011 and 1.2 percent for the quarter ending June 30, 2011.**

Effective October 1, 2009, separate Tribal FMAP rates, which are based upon the Tribe's service area and population, apply to Foster Care program maintenance payments incurred by Tribes that are participating in title IV-E programs through either direct operation of an approved title IV-E plan or through operation of a title IV-E agreement or contract with a State title IV-E agency. The methodology for calculating Tribal FMAP rates was provided through a final notice in the *Federal Register* that is available on the internet as follows: <http://www.gpo.gov/fdsys/pkg/FR-2011-08-01/pdf/2011-19358.pdf>. The calculated FMAP rate for each Tribe includes any statutory temporary percentage increase applicable to State FMAP rates and applies unless it is exceeded by the FMAP rate for any State in which the Tribe is located (42 USC 679B(d) and 42 USC 679B(e)).

- c. *Staff and Adoptive Parent Training* – The percentage of Federal funding in expenditures for short- and long-term training at educational institutions of employees or prospective employees, and short-term training of current or prospective foster or adoptive parents and members of staff of State/Tribe-licensed or State/Tribe-approved child care institutions (including travel and per diem) is 75 percent (42 USC 674(a)(3)(A) and (B); 45 CFR section 1356.60(b)).

- d. *Professional Partner Training* – The percentage of Federal funding in expenditures for short-term training of: relative guardians; State/Tribe-licensed or State/Tribe-approved child welfare agencies providing services to children receiving title IV-E assistance; child abuse and neglect court personnel; agency, child or parent attorneys; guardians ad litem; and, court appointed special advocates is subject to an increasing FFP rate for these additional trainee groups as follows: 55 percent in FY 2009; 60 percent in FY 2010; 65 percent in FY 2011; 70 percent in FY 2012; 75 percent in FY 2013 and thereafter (42 USC 674(a)(3)(B), as added by Section 203(b) of Pub .L. No. 110-351).
- e. *Administrative Costs*
- (1) The percentage of Federal funding for expenditures for planning, design, development, and installation and operation of a statewide or tribal service area-wide automated child welfare information system meeting specified requirements (and expenditures for hardware components for such systems) is 50 percent (42 USC 674(a)(3)(C) and (D); 45 CFR sections 1355.52 and 1356.60(d)).
 - (2) The percentage of Federal funding for adoption placement non-recurring cost expenditures is 50 percent for IV-E agency expenditures up to \$2000 for each adoptive placement (45 CFR section 1356.41(f)(1)).
 - (3) The percentage of Federal funding of all other allowable administrative expenditures, is 50 percent (42 USC 674(a)(3)(E); 45 CFR sections 1356.41(f) and 1356.60(c)).

2.1 Level of Effort – Maintenance of Effort

A IV-E agency is required to spend an amount equal to any savings in State or tribal expenditures under title IV-E as a result of applying the differing program eligibility rules to applicable children for a fiscal year to provide any service that is permitted under title IV-B or IV-E (42 USC 673(a)(8)).

2.2 Level of Effort – Supplement Not Supplant– Not Applicable

3. Earmarking – Not Applicable

H. Period of Availability of Federal Funds

This program operates on a cash accounting basis and each year's funding and accounting is discrete. To be eligible for Federal funding, claims must be submitted to ACF within two years after the calendar quarter in which the IV-E agency made the expenditure. This limitation does not apply to prior period decreasing adjustments and

any claim qualifying for a time limits exception in accordance with 45 CFR section 95.19 (42 USC 1320b-2; 45 CFR sections 95.7, 95.13, and 95.19).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Not Applicable
- d. For reporting periods through September 30, 2010: ACF-IV-E-1, *Foster Care and Adoption Assistance Financial Report (OMB No. 0970-0205)* – Title IV-E agencies report current expenditures for the previous quarter, and estimate costs for the next quarter. Prior quarter adjustment (increasing and decreasing) expenditures applicable to earlier quarters must also be separately reported on this form.

Key Line Items – The following items contain critical information:

Part 1, *Adoption Assistance Expenditures, columns (a) through (d)*

Part 2, *Prior Quarter Adjustments – Adoption Assistance, columns (a) through (d)*

Part 4, *Foster Care and Adoption Assistance Demonstration Projects, columns (a) through (d)* (applicable only for States with approved Title IV-E waiver demonstration)

- e. For reporting periods beginning October 1, 2010 or later: CB-496, *Title IV-E Programs Quarterly Financial Report (OMB No. 0970-0205)* – Title IV-E agencies report current expenditures and information on children assisted for the quarter that has just ended and estimates of expenditures and children to be assisted for the next quarter. Prior quarter adjustment (increasing and decreasing) expenditures applicable to earlier quarters must also be separately reported on this form.

Key Line Items – The following line items contain critical information:

Part 1, *Expenditures, Estimates and Caseload Data, columns (a) through (d) (Sections B and D (Adoption Assistance Program))*

Part 2, *Prior Quarter Expenditure Adjustments – Adoption Assistance, columns (a) through (d)*

Part 3, – *Foster Care and Adoption Assistance Demonstration Projects,*
columns (a) through (e)

2. **Performance Reporting** – Not Applicable
3. **Special Reporting** – Not Applicable
4. **Section 1512 ARRA Reporting** – Not Applicable
5. **Subaward Reporting under the Transparency Act** – Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.667 SOCIAL SERVICES BLOCK GRANT

I. PROGRAM OBJECTIVES

The purpose of the Social Services Block Grant (SSBG) program is to provide funds to States (including the District of Columbia and five territories) to provide services for individuals, families, and entire population groups in one or more of the following areas: (1) achieving or maintaining economic self-support and self-sufficiency to prevent, reduce, or eliminate dependency; (2) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests; (3) preserving, rehabilitating, or reuniting families; (4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of intensive care; and (5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

II. PROGRAM PROCEDURES

Administration and Services

The SSBG program is administered by the Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS). Funds are awarded based on the State's population following receipt and review of the State's report on the proposed use of funds for the coming year, which serves as the State's plan. States have the flexibility to determine what services will be provided, consistent with the statutory goals and objectives, who is eligible, and how funds will be distributed among services and entities within the State, including whether to provide services directly or obtain them from other public or private agencies and individuals. The State must also conduct a public hearing on the proposed use and distribution of funds, as included in the report, as a prerequisite to the receipt of SSBG funds.

Source of Governing Requirements

The SSBG program is authorized under Title XX of the Social Security Act, as amended, and is codified at 42 USC 1397 through 1397e. The implementing regulations for this and other block grant programs authorized by Omnibus Budget Reconciliation Act of 1981 are published at 45 CFR part 96. Those regulations include both specific requirements and general administrative requirements in lieu of 45 CFR part 92 (the HHS implementation of the A-102 Common Rule) for the covered block grant programs. Requirements specific to SSBG are in 45 CFR sections 96.70 through 96.74.

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, States are to use the fiscal policies that apply to their own funds in administering SSBG. Procedures must be adequate to assure the proper disbursement of and accounting for Federal funds paid to the grantee, including procedures for monitoring the assistance provided (45 CFR section 96.30).

Under the block grant philosophy, each State is responsible for designing and implementing its own SSBG program, within very broad Federal guidelines. States must administer their SSBG program according to their approved plan and any amendments and in conformance with their own implementing rules and policies.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Services provided with SSBG funds may include, but are not limited to, child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, family planning services, training and related services, employment services, information, referral, counseling services, the preparation and delivery of meals, health support services, and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts (42 USC 1397a(a)). Uniform definitions for these services are included in Appendix A to 45 CFR part 96 – Uniform Definitions of Services.

Expenditures for these services may include expenditures for administration, including planning and evaluation, personnel training and retraining directly related to the provision of those services (including both short- and long-term training at educational institutions), and conferences and workshops, and assistance to individuals participating in such activities (42 USC 1397a(a)).

2. A State may purchase technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, or administering the SSBG program (42 USC 1397a(e)).
3. A State may transfer up to 10 percent of its annual allotment to the following block grants for support of health services, health promotion and disease prevention activities, low-income home energy assistance, or any combination of these activities: Preventive Health and Health Services Block Grant (CFDA 93.991); Block Grants for Prevention and Treatment of Substance Abuse (CFDA 93.959); Maternal and Child Health Services Block Grant to the States (CFDA 93.994); Low-Income Home Energy Assistance (CFDA 93.568); and Community Services Block Grant (93.569) (42 USC 1397a(d); 45 CFR section 96.72).

4. In FY 2009, an additional amount of funding was made available to those States (a) for which the President declared a major disaster during 2008 and (b) previously receiving a declaration for Hurricanes Katrina and Rita. That funding is available to support services as under the regular SSBG program, as well as health and mental health services, and for repair and construction of health care facilities (including mental health facilities), child care centers, and other social service facilities (Pub. L. No 110-329, Chapter 7).
5. Funds may not be used for:
 - a. Except as provided in III.A.4 above, purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any facility (unless the restriction is waived by ACF) (42 USC 1397(d)(a)(1)).
 - b. Cash payments for costs of subsistence or for the provision of room and board (other than costs of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary shelter provided as a protective service) (42 USC 1397(d)(a)(2)).
 - c. Wages of any individual as a social service (other than payment of wages of Temporary Assistance for Needy Families (TANF) (CFDA 93.558) recipients employed in the provision of child day care services) (42 USC 1397(d)(a)(3)).
 - d. Medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug-dependent individual) unless it is an integral but subordinate part of an allowable social service under SSBG (unless the restriction is waived by ACF) (42 USC 1397(d)(a)(4)).
 - e. Social services (except services to an alcoholic or drug-dependent individual or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any individual living in such institution (42 USC 1397(d)(a)(5)).
 - f. The provision of any educational service that the State makes generally available to its residents without cost and without regard to their income (42 USC 1397(d)(a)(6)).
 - g. Any child day care services unless such services meet applicable standards of State and local law (42 USC 1397(d)(a)(7)).
 - h. The provision of cash payments as a service (this limitation does not apply to payments to individuals with respect to training or attendance at conferences or workshops) (42 USC 1397(d)(a)(8)).

- i. Any item or service (other than an emergency item of service) furnished by an entity, physician, or other individual during the period of exclusion from reimbursement by various provisions of Federal regulations (42 USC 1397(d)(a)(9)).

B. Allowable Costs/Cost Principles

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, SSBG is exempt from the provisions of the OMB cost principles circulars. State cost principles requirements apply to SSBG.

G. Matching, Level of Effort, Earmarking

1. Matching – Not Applicable

2. Level of Effort – Not Applicable

3. Earmarking

The State shall use all of the amount transferred in from TANF (CFDA 93.558) only for programs and services to children or their families whose income is less than 200 percent of the official poverty guideline as revised annually by HHS (42 USC 604(d)(3)(A) and 9902(2)). Additional information on this transfer is provided in IV, “Other Information.”

The poverty guidelines are issued each year in the *Federal Register* and HHS maintains a page on the Internet that provides the poverty guidelines (<http://aspe.hhs.gov/poverty/>).

H. Period of Availability of Federal Funds

SSBG funds must be expended by the State in the fiscal year allotted or in the succeeding fiscal year (42 USC 1397a(c)). However, the funds made available under the additional FY 2009 allotment (Pub. L. No. 110-329) expire on September 30, 2011 (Pub. L. No. 111-285).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Not Applicable

2. Performance Reporting – Not Applicable

3. **Special Reporting** – Not Applicable
4. **Section 1512 ARRA Reporting** – Not Applicable
5. **Subaward Reporting under the Transparency Act** – Applicable

IV. OTHER INFORMATION

Transfers out of SSBG

As discussed in III.A, “Activities Allowed or Unallowed,” funds may be transferred out of SSBG to other Federal programs. The amounts transferred out of SSBG are subject to the requirements of the program into which they are transferred and should not be included in the audit universe and total expenditures of SSBG when determining Type A programs. On the Schedule of Expenditures of Federal Awards, the amount transferred out should not be shown as SSBG expenditures but should be shown as expenditures for the program into which they are transferred.

Transfers into SSBG

A State may transfer up to 10 percent of the combined total of the State family assistance grant, supplemental grant for population increases, and bonus funds for high performance and illegitimacy reduction, if any, (all part of TANF) for a given fiscal year to carry out programs under the SSBG. Such amounts may be used only for programs or services to children or their families whose income is less than 200 percent of the poverty level. The amount of the transfers is reflected on the quarterly ACF-196, *Temporary Assistance for Needy Families (TANF) Financial Report*. The amounts transferred into this program are subject to the requirements of this 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**CFDA 93.718 HEALTH INFORMATION TECHNOLOGY REGIONAL EXTENSION CENTERS PROGRAM****I. PROGRAM OBJECTIVES**

The purpose of the Health Information Technology Regional Extension Centers (REC) program is to furnish assistance, defined as education, outreach, and technical assistance, to help providers in their geographic service areas select, successfully implement, and meaningfully use certified electronic health record (EHR) technology to improve the quality and value of health care. Regional centers will also help providers achieve, through appropriate available infrastructures, exchange of health information in compliance with applicable statutory and regulatory requirements, and patient preferences.

II. PROGRAM PROCEDURES

The Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. No. 111-5) authorizes incentive payments for eligible Medicare and Medicaid providers' meaningful use of certified EHR technology. The detailed criteria to qualify for meaningful use incentive payments are established by the Secretary of HHS through the formal rulemaking process with Stage 1 Meaningful Use criteria released July 13, 2010. In 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the meaningful use definition or they will be subject to financial penalties under Medicare (per Sections 4101(b) and 4102(b) of ARRA).

Providers seeking to meaningfully use EHRs face a variety of challenging tasks. Those tasks include assessing needs, selecting and negotiating with a system vendor or reseller, implementing project management, and instituting workflow changes to improve clinical performance and ultimately, outcomes. Past experience has shown that robust local technical assistance can result in effective implementation of EHRs and quality improvement throughout a defined geographic area.

The REC program, administered by the Office of the National Coordinator for Health Information Technology (ONC), within the Office of the Secretary, Department of Health and Human Services, has established 62 regional centers, each serving a defined geographic area. Entities eligible to serve as regional centers are domestic, nonprofit institutions or organizations, or group thereof.

Awards under this program were made as 4-year cooperative agreements with one 4-year budget period. Each regional center will provide federally supported individualized technical assistance to a minimum of 1,000 priority primary-care providers in the 4 years of the cooperative agreement. Funding for years 3 and 4 are contingent upon the Regional Extension Center receiving a positive biennial evaluation at the end of year 2.

Pursuant to requirements of the HITECH Act, priority in providing technical assistance under the REC program must be given to providers that are primary-care providers (physicians and/or other health care professionals with prescriptive privileges, such as physician assistants and nurse practitioners) in any of the following settings:

- individual and small group practices (ten or fewer professionals with prescriptive privileges) primarily focused on primary care;
- public and critical access hospitals;
- community health centers and rural health clinics; and
- other settings that predominantly serve uninsured, underinsured, and medically underserved populations.

The regional centers are expected to leverage and undertake activities that are in synergy with the expertise, capability, and activities of federally supported practice networks, where locally available, including, but not limited to, those supported by the Indian Health Service, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Department of Veterans Affairs, the Department of Defense, and relevant Centers for Medicare & Medicaid Services demonstration projects.

Source of Governing Requirements

This program is authorized by Section 3012 of the Public Health Service Act, as added by ARRA, specifically Title XIII of Division A and Title IV of Division B (the HITECH Act) (42 USC 300jj-32). There are no program regulations for this program. .

Availability of Other Program Information

Additional program information, including the three funding opportunity announcements that resulted in the 62 REC awards, can be found at:

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1335&mode=2&cached=true>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Project funds (cooperative agreement funds and required cost-sharing amounts) may be used in two categories: core support, which includes outreach and educational activities, management activities, local workforce support, and participation peer-learning and knowledge transfer activities, and direct assistance support, for use in providing direct on-site technical assistance to providers.

Consistent with the category funding limitations established in the award for the two categories of support, project funds may be used for the following types of activities:

- a. Planning and implementing outreach, education, and on-site technical assistance programs necessary to assist providers in the REC's geographic service area to meet meaningful use criteria established by the Secretary of HHS. This dissemination of knowledge about the effective strategies and practices to select, implement, and meaningfully use certified EHR technology to improve quality and value of healthcare includes activities such as (1) materials designed to be widely and rapidly disseminated, both for provider self-study and for use by other regional centers; (2) support of regional communities of practice for providers and those who support their health IT implementation; (3) health IT training events for clinical professionals and their support staff; and (4) instruction and assistance on using health IT to enhance the patient-provider relationship and encourage patient self-management. Training events, programs, and communities of practice may be co-sponsored with other local resources, such as (but not necessarily limited to) State and local health services oversight agencies, professional organizations, provider organizations, and consumer organizations.
- b. Participating in activities of the consortium facilitated by the REC and comprised of all of the regional centers, including (1) participating in national meetings and hosting regional network meetings; (2) using the client management, tracking, reporting application (furnished through the Health Information Technology Research Center); and (3) making tools and materials developed using funding provided through the cooperative agreement available for sharing with other regional centers, interested stakeholders, and the public, directly and/or via the REC.
- c. Activities related to assessing the health IT needs of priority primary-care providers and selecting and negotiating contracts with vendors or resellers (of EHR systems, hardware and network infrastructure, and IT services), as well as assisting those providers in holding vendors accountable for adhering to service-level agreements. This includes designing group purchasing plans and helping providers select the highest-value option (defined as that which offers the greatest opportunity to achieve and maintain meaningful use of EHRs and improved quality of care at the most favorable cost of ownership and operation, including both the initial acquisition of the technology, cost of implementation, and ongoing maintenance and predictable needed upgrades over time).
- d. Practice and workflow redesign necessary to achieve meaningful use of EHRs. This includes working with the priority primary-care providers and their EHR vendor(s) to implement and troubleshoot the use of the EHR system for the consistent documentation of essential clinical information

- in structured format; instituting electronic administrative transactions, electronic prescribing, electronic laboratory ordering and resulting, sharing key clinical data across practice settings; providing patient access to their health information; public health reporting; and policies and practices that protect the privacy and security of personal health information.
- e. Assistance to priority primary-care providers in connecting to available health information exchange infrastructure(s), including local health information exchange organizations and state-based shared utilities or directory services, in compliance with applicable statutory and regulatory requirements, patient preferences, and the State Plans for health information exchange (HIE) (developed and HHS-approved under cooperative agreements issued by ONC pursuant to Section 3013 of the PHS Act as added by ARRA (CFDA 93.719).
 - f. Activities that support providers in implementing best practices with respect to the privacy and security of personal health information, including: implementation and maintenance of physical and network security, user-based access controls, disaster recovery, encryption and storage of backup media, human resources training and policies; and identification of state laws and regulatory requirements that impact privacy and security policies for electronic interoperable health information exchange.
 - g. Reviewing the utilization of the EHRs within participating practices, and providing appropriate feedback and support to improve low utilization of features essential for meaningful use (e.g., electronic prescribing).
 - h. Helping priority primary-care providers to understand, and implement technology and process changes needed to attain meaningful use requirements and demonstrate this attainment, as defined by the Secretary through Medicare and Medicaid regulations and guidance.
 - i. Partnering with local resources, such as community colleges, to promote integration of health IT into the initial and ongoing training of health professionals and supporting staff. Regional centers may provide internship opportunities for local training programs, provide instructors for didactic programs, and use local training programs' graduates to fulfill the workforce needs of their extension activities and the implementation, maintenance, and use needs of the centers' participating providers.
2. Project funds may not be used for the following:
- a. Pre-award costs.

- b. Purchase or improvement of land, or purchase, construction, or making permanent improvements to any building except for minor remodeling. (42 USC 300-jj(c) and Funding Opportunity Announcement, sections I. and IV.6).

E. Eligibility

1. Eligibility for Individuals – Not Applicable

2. Eligibility for Group of Individuals or Area of Service Delivery –

Each regional center shall aim to provide assistance and education to all providers in a region, but shall prioritize any direct assistance first to the following:

- a. Public or not-for-profit hospitals or critical access hospitals.
- b. Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act).
- c. Entities that are located in rural and other areas that serve uninsured, underinsured, and medically underserved individuals (regardless of whether such area is urban or rural).
- d. Individual or small group practices (or a consortium thereof) that are primarily focused on primary care.

Note: A practice otherwise meeting the definition of individual or small-group physician practice may participate in shared-services and/or group purchasing agreements, and/or reciprocal agreements for patient coverage, with other physician practices without affecting their status as individual or small-group practices for purposes of the regional centers.

(42 USC 300jj-32(c)(4)(D) and Funding Opportunity Announcement, Appendix E).

3. Eligibility for Subrecipients – Not Applicable

G. Matching, Level of Effort, Maintenance of Effort

1. Matching

Based on an assessment of current national economic conditions, the Secretary of HHS waived the 50 percent limitation on HHS funding for annual capital and operating and maintenance funds needed to establish and maintain a regional center (42 USC 300-jj(c)(5)). In place of these funding requirements, the Secretary has structured the funding partnership between HHS and the regional centers that requires recipients to contribute 10 percent of project costs each year of the cooperative agreement.

2. Level of Effort – Not Applicable

3. Earmarking – Not Applicable

I. Procurement and Suspension and Debarment

Regional centers that choose to offer group purchasing of EHR software, IT support services, and/or hardware must provide a choice of offerings. The selection process for vendors must be open and competitive and the selection committee must include representatives of the priority primary-care providers actively practicing within the regional center's geographic service area (Funding Opportunity Announcement, Section I).

J. Program Income

Program income generated by the REC shall be retained by the REC and first be used to finance the non-federal share of the project. After the cost sharing requirement is met, program income generated shall be added to funds committed to the project by ONC and used to further eligible project or program objectives (Funding Opportunity Announcement, Sections III and IV).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Applicable

5. Subaward Reporting under the Transparency Act – Not Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.719 **ARRA – STATE GRANTS TO PROMOTE HEALTH INFORMATION TECHNOLOGY**

I. PROGRAM OBJECTIVES

The purpose of the State Grants to Promote Health Information Technology (State Health Information Exchange Cooperative Agreements) program is to continuously improve and expand health information exchange (HIE) services over time to reach all health care providers in an effort to improve the quality and efficiency of health care. This program is one of several programs that, collectively, are intended to facilitate the adoption and use of electronic health records (EHRs) and facilitate and expand the secure, electronic movement and use of health information among organizations according to nationally recognized standards. The governance, policy, and technical infrastructure supported through this program will enable standards-based HIE and a high-performance health care system. This program builds on existing efforts to advance regional and State-level HIE while moving towards nationwide interoperability.

II. PROGRAM PROCEDURES

The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. No. 111-5) includes the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) that sets forth a plan for advancing the appropriate use of health information technology (HIT) to improve quality of care and establish a foundation for health care reform. Widespread adoption and meaningful use of HIT is one of the foundational steps in improving the quality and efficiency of health care. The appropriate and secure electronic exchange and consequent use of health information to improve quality and coordination of care is a critical enabler of a high-performance health care system.

The State HIE program is administered by the Office of the National Coordinator for Health Information Technology (ONC), an office within the Office of the Secretary, Department of Health and Human Services. Awards are in the form of cooperative agreements to States (which includes the District of Columbia and the U.S. territories – Puerto Rico, U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) or State-designated non-profit entities (SDEs). ONC will award no more than one cooperative agreement per State; however groups of States may combine their efforts into one project, resulting in an award to a multi-State consortium. Each cooperative agreement award is for both planning and implementation, except for States that have a plan approved by the National Coordinator prior to award, in which case they receive implementation funding only. Funding amounts will be determined as follows: Base Allocation + Equity Adjustments + Needs-Based Adjustments.

These cooperative agreements focus on developing the State-wide policy, governance, technical infrastructure and business practices needed to support the delivery of HIE services. The resulting capabilities for healthcare-providing entities to exchange health information must meet the Medicaid and Medicare meaningful use requirements for health care providers (specifically Medicare and Medicaid Electronic Health Record Incentive Program 42 CFR parts 412, 413, 422, and 495) to achieve financial incentives. Cooperative agreement recipients will evolve and

advance the necessary governance, policies, technical services, business operations and financing mechanisms for HIE over a 4-year performance period.

Source of Governing Requirements

This program is authorized by Section 3013 of the Public Health Service Act (PHSA), as added by ARRA, specifically Title XIII of Division A and Title IV of Division B (the HITECH Act) (42 USC 300jj-33), Subtitle B—Incentives for the Use of Health Information Technology. There are no program regulations for this program. The compliance requirements specified below are found in the statute and/or in the State Health Information Exchange Cooperative Agreement Program Funding Opportunity Announcement (Funding Opportunity Announcement) August 20, 2009.

Availability of Other Program Information

Additional program information can be found at <http://healthit.hhs.gov>. The Funding Opportunity Announcement is available at this site. Program Information Notices (PINs) will be regularly issued to provide cooperative agreement recipients additional guidance to supporting the evolving requirements of meaningful use as they are developed. The first PIN was issued in July, 2010 and these are posted on the ONC website (www.healthit.hhs.gov).

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Project funds (cooperative agreement funds and required matching amounts) may be used for developing or upgrading required plans, i.e., a strategic plan and an operational plan (42 USC 300jj-33(c)).
2. Project funds (cooperative agreement funds and required matching amounts) may be used for the following types of implementation activities:
 - a. Establishing a governance structure to ensure the coordination, integration, and alignment of efforts with Medicaid and public health programs through efforts of the State Health IT Coordinators.
 - b. Establishing mechanisms to provide oversight and accountability of HIE.
 - c. Developing financial policies and implementing procedures to monitor spending and provide appropriate financial controls.

- d. Developing a business plan with feasible public/private financing mechanisms for ongoing information exchange among health care providers and with those offering services for patient engagement and information access.
 - e. Developing or facilitating the creation of a State-wide technical infrastructure that supports State-wide HIE, including (1) electronic eligibility and claims transactions; (2) electronic prescribing and refill requests; (3) electronic clinical laboratory ordering and results delivery; (4) electronic public health reporting (i.e., immunizations, notifiable laboratory results); (5) quality reporting; (6) prescription fill status and/or medication fill history; and (7) clinical summary exchange for care coordination and patient engagement.
 - f. Developing or facilitating the creation and use of shared directories and technical services. Directories may include, but are not limited to: providers (e.g., with practice location(s), specialties, health plan participation, disciplinary actions, etc); laboratory service providers, radiology service providers, health plans (e.g., with contact and claim submission information, required laboratory or diagnostic imaging service providers, etc.). Shared Services may include, but are not limited to, patient matching, provider authentication, consent management, secure routing, advance directives and messaging.
 - g. Providing technical assistance as needed to Health Information Organizations (HIOs) and others developing HIE capacity within the State.
 - h. Establishing a State-wide policy framework.
 - i. Implementing enforcement mechanisms that ensure those implementing and maintaining health information exchange services have appropriate safeguards in place and adhere to legal and policy requirements that protect health information (42 USC 300jj-33(d); Funding Opportunity Announcement, Section I.D.2).
3. Project funds may not be used for the following:
- a. Pre-award costs; and
 - b. Purchase or improvement of land, or purchase, construction, or making permanent improvements to any building except for minor remodeling (Funding Opportunity Announcement, Section IV.F.).

G. Matching, Level of Effort, Maintenance of Effort

1. Matching

The HITECH Act requires a match to federal monies awarded under this program beginning in fiscal year 2011, with an increasing level of match for each year of the program as shown below. Matching requirements can be provided through cash and/or in-kind contributions (42 USC 300jj-33(i)(1) and (2))

Fiscal Year of Funding	Match Required
2010	None
2011 (begins Oct. 1, 2010)	\$1 for each \$10 Federal dollars
2012 (begins Oct 1, 2011)	\$1 for each \$7 Federal dollars
2013 (begins Oct 1, 2012)	\$1 for each \$3 Federal dollars

2. Level of Effort – Not Applicable

3. Earmarking

1. The State HIE program cooperative agreements are funded with monies through three separate funding streams. The recipient is responsible for tracking and reporting expenditures for each funding stream. The specific allocations for each funding category are included on the Notice of Award, which includes, as an attachment, “State Health Information Exchange Cooperative Agreement Program Guidance for Reporting Expenditures.” This guidance provides instruction for allowable program activities within each funding stream.
 - Planning funds (CAN #19999SH): As required in Section 3013, recipients cannot expend funds on implementation until they obtain ONC approval on submitted State plans. To support the State planning activities, ONC allocated funds to each recipient receiving a cooperative agreement that does not have an approved plan. Recipients are allowed 10 percent or a maximum of \$1 million, whichever is the smaller amount, of their total award for planning expenses.
 - Sub-national/Regional (intra-state) HIE (CAN#19999NF): Congress provided not more than and also not less than \$300 million for intra-state HIE development. This activity is interpreted by ONC to be funding for implementation and operational activities that directly enable or benefit HIE activities within the State. Each recipient is given a specific allowance for intra-state HIE capacity development in proportion to its overall

award. The recipient must not spend more and must not spend less than this allowance on intra-state activities.

- Nationwide (inter-state) HIE (CAN#19999SJ): ONC provided an additional amount of funding per recipient for HIE activities that enable State participation in inter-state HIE and the Nationwide Health Information Network activities. Inter-state HIE costs are those in any of the five domains listed above that are expended in order that health information is enabled to be shared across State borders between unaffiliated organizations.
2. Two percent of total project costs must be used for project evaluation (Funding Opportunity Announcement, Section IV.F).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable (to report expenditures within each of the three funding streams that comprise the State HIE program cooperative agreement awards, recipients are instructed to report the funds expended within each CAN in Section 12 “Remarks.”)

2. Performance Reporting – Not Applicable.

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Applicable

5. Subaward Reporting under the Transparency Act – Not Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.767 CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

I. PROGRAM OBJECTIVES

Title XXI of the Social Security Act (Act) authorizes the Children's Health Insurance Program (CHIP) to assist State efforts in initiating and expanding the provision of child health assistance to uninsured, low-income children. Under title XXI, States may provide child health assistance primarily for obtaining health benefits coverage through (1) obtaining coverage under a separate child health program that meets specific requirements; (2) expanding benefits under the State's Medicaid plan under title XIX of the Act; or (3) a combination of both. To be eligible for funds under this program, States must submit a State child health plan (State plan), which must be approved by the Secretary.

II. PROGRAM PROCEDURES

Administration and Services

At the Federal level, CHIP is administered by the Department of Health and Human Services, through the Center for Medicaid, CHIP, Survey, and Certification (CMCS) of the Centers for Medicare and Medicaid Services (CMS).

Title XXI authorizes grants to States that initiate or expand health insurance programs for low-income, uninsured children. Under title XXI, CHIP is jointly financed by the Federal and State governments and is administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligible groups, benefit packages, payment levels for coverage and administrative and operating procedures. CHIP provides a capped amount of funds to States on a matched basis. Federal payments under title XXI to States are based on State expenditures under approved plans that could be effective on or after October 1, 1997.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. No. 110-173) extended CHIP funding through March 31, 2009 to provide adequate funding to States for the purpose of maintaining their current enrollment through that date. Subsequently, the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA 2009) (Pub. L. No. 111-3) reauthorized CHIP through FY 2013.

State Plans

Title XXI State plans and amendments to those plans are approved in CMS's central office. The plans are submitted for review by an intra-Departmental team, which must decide upon approval or disapproval within a 90-day period. This "90-day clock" can be stopped by sending a formal written request for additional information from the State, and can be restarted at the same point when a response is formally received. Copies of State plans are available from the State CHIP administrator and through the CMS website: <http://www.cms.gov/home/chip.asp>.

Waivers

The State may apply for a waiver of CHIP Federal requirements. Waivers are intended to provide 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 enrollees. Waivers allow exceptions to State plan requirements that permit the State to implement innovative programs or activities on a time-limited basis. Such demonstration projects are subject to specific safeguards for the protection of enrollees and the program. The Secretary will approve only demonstration projects that are consistent with key principles of the CHIP statute. States' waiver authority is found at 42 USC 1397gg(e), which extends to CHIP the Medicaid waiver authority at 42 USC 1315.

Source of Governing Requirements

This program is authorized by Section 4901(a) of the Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, as amended by Pub. L. No. 105-100, which added title XXI to the Social Security Act (Act), and subsequent amendments to title XXI. Title XXI authorizes CHIP to assist State efforts to initiate and expand the provision of child health assistance to uninsured, low-income children. Title XXI is codified at 42 USC 1397aa-1397jj. The regulations for this program are found at 42 CFR part 457.

Awards under CHIP are no longer excluded from coverage under the HHS implementation of the A-102 Common Rule, 45 CFR part 92 (*Federal Register*, September 8, 2003, 68 FR 52843-52844). This change is effective for any grant award under this program made after issuance of the initial awards for the second quarter of Federal fiscal year (FY) 2004. 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 (as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, HHS Publication ASMB C-10, available on the Internet at <http://rates.psc.gov/fms/dca/asmb%20c-10.pdf>).

Availability of Other Program Information

States and other interested parties can access information on the Department's policies on this and other issues on the Internet at <http://www.cms.gov/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Activities Allowed* – States have general flexibility in allocating their individual allotments toward activities needed to conduct the CHIP (42 USC 1397ee(a)). In addition to expenditures for child health assistance under the plan for targeted low-income children, other allowable activities, to the extent permitted by 42 USC 1397ee(c), include payment of other child health assistance for targeted low-income children; expenditures for health services initiatives for improving the health of children (targeted and other low income) under the plan; expenditures for outreach activities; and other reasonable costs incurred by the State to administer the plan (42 USC 1397ee).
2. *Activities Unallowed* – Federal funds may not be expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health coverage that includes coverage of abortion, except if necessary to save the life of the mother or if the pregnancy is the result of incest or rape (42 USC 1397ee(c)).

E. Eligibility

1. Eligibility for Individuals

- a. States have flexibility in determining eligibility levels for individuals for whom the State will receive enhanced matching funds within the guidelines established under the Act. Generally, a State may not cover children with higher family income without covering children with a lower family income, nor deny eligibility based on a child having a preexisting medical condition. States are required to include in their State plans a description of the standards used to determine eligibility of targeted low-income children. State plans should be consulted for specific information concerning individual eligibility requirements (42 USC 1397bb(b)).

States have the option to extend eligibility to low-income targeted pregnant women. There is no income eligibility level for pregnant women in CHIP that is lower than the State's Medicaid level, and States must cover pregnant women up to 185 percent of the Federal poverty level before they can elect the option to include pregnant women in the CHIP State plan (Pub. L. No. 111-3, Section 111).

- b. Qualified aliens, as defined at 8 USC 1641, who entered the United States on or after August 22, 1996, are not eligible for a separate child health program under title XXI (CHIP) for a period of five years, beginning on the date the alien became a qualified alien, unless the alien is exempt from this five year bar under the terms of 8 USC 1613. States must provide coverage under a separate child health program under title XXI to all other otherwise eligible qualified aliens who are not barred from coverage under 8 USC 1613 (42 CFR section 457.320(b)(6)).

- c. States may elect to provide medical assistance, notwithstanding section 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to children and pregnant women who are lawfully residing in the United States and who are otherwise eligible for such assistance. This optional coverage in CHIP is only applicable if the State has elected to apply this allowance with respect to such category of children or pregnant women under title XIX Pub. L. No. 111-3, Section 214).

2. **Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable**
3. **Eligibility for Subrecipients – Not Applicable**

G. Matching, Level of Effort, Earmarking

1. Matching

The State matching rate for its CHIP expenditures is determined in accordance with the Federal matching rate for such expenditures, referred to as the enhanced Federal medical assistance percentage (Enhanced FMAP) for a State. That is, the CHIP State matching rate is calculated by subtracting the Medicaid FMAP rate from 100, taking 30 percent of the difference, and then adding it to the Medicaid FMAP rate. The Enhanced FMAP is calculated in accordance with 42 USC 1397ee(b), which provides that the Enhanced FMAP for a State shall never exceed 85 percent. Calculated FMAPs and enhanced FMAPs may be found on the Internet at <http://www.aspe.hhs.gov/health/fmap.htm> (42 USC 1397ee(a) and (b)).

A qualifying State may elect to be paid from the State's allotment for any of FYs 2009 through 2013, an amount equal to the additional amount that would have been paid to the State under title XIX with respect to expenditures if the enhanced FMAP had been substituted for the FMAP (42 USC 1397ee(g)(4)). The qualifying States are Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin (as determined by CMS on the basis of the criteria in Pub. L. No. 108-74, section 1(g)(2) and Pub. L. No. 108-127, section 1).

2.1 Level of Effort – *Maintenance of Effort*

- a. In order to receive Federal matching funds for CHIP expenditures at the enhanced matching rate, each State must continue to maintain its Medicaid eligibility standards and the methodologies that were applied in its Medicaid State plans as of June 1, 1997 (42 USC 1397ee(d)(1) and 1397jj(b)).

- b. Three States, New York, Florida and Pennsylvania, maintain “existing comprehensive State-based programs.” For these three States only, beginning with FY 1999, the amount of the State’s allotment for a fiscal year is reduced by the amount that the “children’s health insurance expenditures” for the previous fiscal year is less than the total of such expenditures for FY 1996. For purposes of this provision, the term “children’s health insurance expenditures” means: the State share of title XXI (CHIP) expenditures; the State share of expenditures under title XIX (Medicaid) attributable to an enhanced FMAP under section 1905(u) of the Act (42 USC 1396d(u)); and State expenditures for health benefits coverage under an existing comprehensive State-based program (42 USC 1397cc(d)(1) and 1397ee(d)(2)).

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable

3. Earmarking

Expenditures not directly related to providing child health insurance assistance under the plan are limited to 10 percent of the State’s total expenditures through CHIP. The following expenditures are subject to the 10 percent limit:

- (a) payment for other child health assistance for targeted low-income children;
 - (b) expenditures for health services initiatives under the State child health assistance plan for improving the health of children;
 - (c) expenditures for outreach activities; and
 - (d) other reasonable costs incurred by the State to administer the State child health assistance plan (42 USC 1397ee(c)).
- States may apply for a waiver, or variance of this 10 percent cap under 42 USC 1397ee(c)(2). If applicable, information regarding such a waiver is in the State plan.

The 10 percent limit is applied on an annual fiscal-year basis and is calculated based on: (a) the total amounts of expenditures and (b) the quarter in which such expenditures are claimed by the State for the fiscal year (42 USC 1397ee).

H. Period of Availability of Federal Funds

The availability of amounts allotted for each of FYs 1998 through 2008 shall remain available for expenditure by the State through the end of the second succeeding fiscal year (i.e., the year of the award and two subsequent fiscal years); and for FY 2009 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the succeeding fiscal year (i.e., the year of award and one subsequent fiscal year) (42 USC 1397dd(e) and (f), as amended by Pub. L. No. 111-3, Section 105),

L. Reporting

1. Financial Reporting

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

- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable for cash status; Not Applicable for expenditure reporting
- d. CMS-64, *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (OMB No. 0938-0067)*
- e. CMS-21, *Quarterly Children’s Health Insurance Program Statement of Expenditures for Title XXI (OMB No. 0938-0731)*

Key Line Items – The following line items contain critical information:

CMS-21 Base – The CMS-21 consists of three parts: CMS-21 Base, CMS-21B, and CMS-21C. Only CMS-21 Base is expected to be tested for compliance.

- 2. **Performance Reporting** – Not Applicable
- 3. **Special Reporting** – Not Applicable
- 4. **Section 1512 ARRA Reporting** – Not Applicable
- 5. **Subaward Reporting under the Transparency Act** – Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- CFDA 93.720** **ARRA - STATE SURVEY AND CERTIFICATION AMBULATORY SURGICAL CENTER HEALTHCARE ASSOCIATED INFECTION (ASC-HAI) PREVENTION INITIATIVE**
- CFDA 93.775** **STATE MEDICAID FRAUD CONTROL UNITS**
- CFDA 93.777** **STATE SURVEY AND CERTIFICATION OF HEALTH CARE PROVIDERS AND SUPPLIERS (TITLE XVIII) MEDICARE**
- CFDA 93.778** **MEDICAL ASSISTANCE PROGRAM (Medicaid; Title XIX)**

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 Medicaid Assistance Program 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) 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.

I. PROGRAM OBJECTIVES**Medical Assistance Program**

The objective of the Medical Assistance Program (Medicaid or Title XIX of the Social Security Act, as amended, (42 USC 1396 *et seq.*)) is to provide payments for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children.

State Medicaid Fraud Control Units

States are required as part of their Medicaid State plans to maintain a State Medicaid Fraud Control Unit (MFCU), unless the Secretary of HHS determines that certain safeguards are met regarding fraud and abuse. 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

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 Medicaid program are in compliance with regulatory health and safety standards and conditions of participation. 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.

State Survey and Certification Ambulatory Surgical Center Healthcare-Associated Infection (ASC-HAI) Prevention Initiative

The objectives of the ASC-HAI Prevention Initiative, which was enacted as part of the Affordable Care Act, are as follows:

- (1) Improve State agency inspection capability and frequency for onsite surveys of Ambulatory Surgical Centers (ASCs) nationwide;
- (2) Use a new infection control survey tool developed by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services (CMS);
- (3) Improve the survey process through the use of a CMS tracer methodology; and

- (4) Use multi-person teams for ASCs over a certain size or complexity.

II. PROGRAM PROCEDURES

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

Administration

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

State Plans

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

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

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

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

Waivers

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

Actions that States may take if waivers are obtained include: (1) implement a primary care case-management system or a specialty physician system; (2) designate an entity to act as a central broker in assisting Medicaid beneficiaries to choose among competing health care plans; (3) share with beneficiaries (through the provision of additional services) cost-savings made possible through the beneficiaries' use of more cost effective medical care; (4) limit 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; (5) include 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; and (6) impose a deduction, cost-sharing or similar charge of up to twice the nominal charge established under the State plan for outpatient services for certain non-emergency services (except that, pursuant to the Deficit Reduction Act of 2005, a State may, at its option and without a waiver, charge higher co-payments for non-emergency services provided in an emergency room). 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 two to five 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

Eligibility for Medicaid is based on categorical (e.g., families and children, aged, blind, and disabled) and financial (e.g., income/resources) status. 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.

Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the cash welfare program known as Aid for Dependent Children (AFDC) was repealed and replaced with block grants to States known as Temporary Assistance for Needy Families (TANF). Under Medicaid, children and parents who received AFDC were automatically enrolled in Medicaid. However, Medicaid for children and parents who would have met the State's old AFDC income and asset standards in place on July 16, 1996, has been preserved whether or not these individuals are eligible for the new TANF system (Pub. L. No. 104-193).

States must provide limited Medicaid coverage for "qualified Medicare beneficiaries." These are aged and disabled persons who are receiving Medicare, whose income is below 100 percent of the Federal poverty level, and whose resources do not exceed twice the allowable amount under SSI (42 CFR section 407.40).

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 are required to have (1) documentation of qualified alien status if the applicant/recipient is not a U.S. citizen, (2) facts in the case record to support the agency's eligibility determination, and (3) a written application on a form prescribed by the agency and signed under a penalty of perjury. The State must require a written application signed under penalty of perjury and include in each applicant's case record facts to support the agency's decision on his/her application. The State must provide notice of its decision concerning eligibility and provide timely and adequate notice of the basis for discontinuing assistance. In cases of persons who are not U.S. citizens, the State must obtain documentation of qualified alien status (42 CFR sections 435.907, 435.912, and 435.913; 42 USC 1320b-7; Section 1137 of the Social Security Act).

Services

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

The Medicare Buy-In Program, also known as QMB (Qualified Medicare Beneficiary) and SLIMB (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 (Qualified Medicare Beneficiary) Program serves individuals with modest assets (up to \$4,000 per individual or \$6,000 per couple) with combined incomes that do not go over 100 percent of the Federal poverty level. The State Medicaid program pays their Medicare Part B premiums and cost-sharing amounts. The SLIMB (Specified Low-Income Medicare Beneficiary) Program pays only the Part B premium for those with incomes between 100 and 120 percent of poverty with assets up to \$4,000 per individual or \$6,000 per couple.

American Recovery and Reinvestment Act

Section 5001 of ARRA provides eligible States with significant increases in their respective Federal medical assistance percentages (FMAPs), which are used for the purpose of determining the amounts of Federal funds available to States for their medical assistance expenditures under the Medicaid program. These increases are effective for a period of 9 calendar quarters between October 1, 2008, and December 31, 2010. Under the ARRA increased FMAP provision, there are a number of requirements and conditions that States must meet in order to continue to be eligible under ARRA for the increase in their FMAPs or for the increase in the FMAPs to be applicable to certain expenditures in their Medicaid programs during this period.

Extension of ARRA. On August 10, 2010, the President signed the extension of ARRA increase in FMAP (Pub. L. No. 111-226) that would continue the additional Federal assistance for 6 months, ending June 30, 2011, but would phase down the level of assistance. Prior to the ARRA extension, the ARRA FMAP increase was scheduled to expire on December 31, 2010. The across the board ARRA increase of 6.2 percent is reduced to 3.2 percent and 1.2 percent for the second and third quarters of FY 2011, respectively. Therefore, the ARRA FMAPs for Quarter 2 of FY 2011 are 3 percentage points less than the Quarter 1 levels (6.2 percent minus 3.2 percent), and the ARRA FMAPs for Quarter 3 of FY 2011 are 2 percentage points less than those for Quarter 2 (3.2 percent minus 1.2 percent). In recognition of these provisions, CMS has provided proxies for Quarters 1 through 3 FY 2011 ARRA FMAPs.

ARRA FMAP Proxies for FY 2011. The Secretary of HHS issues the increased FMAPs for each State, as determined in accordance with section 5001 of ARRA, and consistent with the availability of the necessary data. Because of the timing related to the issuance of the published increased FMAPs under ARRA for each quarter, CMS processed the initial grant awards for the second quarter of FY 2011 using Quarter 2 proxies as provided by CMS since the increased ARRA FMAPs for the second quarter of FY 2011 are not yet available. Under current law, the increased FMAP rates under ARRA are applicable through the end of the third quarter of FY 2011, and therefore, the increased ARRA FMAP proxies for Quarters 1 through 3 should be used for their corresponding quarters of FY 2011 (Note: all three quarters have different ARRA rates).

Maintenance of Effort

ARRA allows States to receive the increased Medicaid funds only if they have not acted since July 1, 2008 to reduce the income limits for Medicaid or otherwise make it more difficult for people to get or keep Medicaid. (The statute gives States until July 1, 2009 to reverse any eligibility cuts that they enacted or implemented after July 1, 2008 and, thus, qualify for the additional funds.)

Section 5001(f)(2) of ARRA provides that the increased FMAP is not available “for any claim received by a State from a practitioner ...for such days during any period in which the State has failed to pay claims in accordance with” the timely processing of claims standards as referenced at Section 1902(a)(37) of the Social Security Act (the Act), and in implementing Federal Medicaid regulations (at 42 CFR section 447.45(d)). Under ARRA, with respect to practitioners the prompt pay provision applies only “to claims made for covered services after the date of enactment.” Since ARRA was enacted on February 17, 2009, the increased FMAP is not available for any practitioner claims received by a State on such day(s), beginning with February 18, 2009, that the State is not in compliance with the prompt pay provision. As described below, in accordance with the applicable timely processing standards, claims received prior to February 18, 2009 will be considered in determining compliance with these standards, beginning on February 18, 2009.

ARRA also requires that, beginning after a grace period ending May 31, 2009, the prompt pay standards as applicable to practitioner claims also will apply to hospital and nursing facility provider claims, insofar as such claims are paid on the basis of submission of claims from these providers.

Under title XIX of the Social Security Act and Federal Medicaid regulations at 42 CFR section 447.45(d) in effect prior to the enactment of ARRA, and which continue to be in effect, there are two prompt pay standards referenced by the ARRA prompt pay provisions which are applicable to claims (as specified in the regulation) that are received from practitioners on or after February 18, 2009:

- 90 percent of clean claims received by the State must be paid within 30 days of receipt.
- 99 percent of clean claims received by the State must be paid within 90 days of receipt.

Note that, under ARRA, the provider claims that are used to determine compliance with the prompt pay standards are separate and distinct from the provider claims that are received on days of non-compliance with the prompt pay standards. The claims received on the days of non-compliance are not eligible for the increased FMAP. These are not the claims that are reviewed to determine compliance.

Indian Care

Although Medicaid allows States to impose enrollment fees, premiums, and cost-sharing charges on Medicaid and Children's Health Insurance Program participants, Section 5006 of ARRA precludes them from imposing these charges on Indian applicants, according to the guidance released by the Centers for Medicare & Medicaid Services.

Specifically, Section 5006(a) of ARRA:

- exempts Indians from paying enrollment fees, premiums or similar charges if they are served by an Indian health care provider;
- exempts Indians from paying a deductible, coinsurance, copayment or similar charges for Medicaid-covered services if they are served by an Indian health care provider; and
- prohibits any reduction in payment due under Medicaid to the Indian health care provider serving an Indian (i.e., a State must pay these providers the full Medicaid payment rate for furnishing the service).

Statutory Changes Affecting the Future Direction of the Medicaid Program

The Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148 (enacted March 23, 2010) and the Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152 (enacted March 30, 2010) include numerous health-related provisions affecting the Medicaid program. A summary of the provisions of these laws is included under IV, Other Information.

The provisions of these two statutes have varying implementation dates. The statutes allow flexibility in (1) in implementing certain provisions and (2) tailoring the individual State program to comply. A summary of the relevant provisions of these statutes is included in IV, "Other Information." Auditors should be aware of the provisions of these laws in designing their audit procedures.

Control Systems

Utilization Control and Program Integrity

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

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

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

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

Inpatient Hospital and Long-Term Care Facility Audits

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

ADP Risk Analyses and System Security Reviews

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

State agencies must establish and maintain a program for conducting periodic risk analyses to ensure appropriate, cost effective safeguards are incorporated into new and existing systems.

State agencies must perform risk analyses whenever significant system changes occur. On a biennial basis State agencies shall review the ADP system security of installations involved in the administration of HHS programs. At a minimum, the reviews shall include an evaluation of physical and data security operating procedures, and personnel practices.

As part of complying with the above requirement, a State may obtain a Statement on Standards for Attestation Engagements 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 and normally includes edits and controls that identify unusual items for follow up by the utilization control and program integrity unit. However, the State may use systems other than MMIS to process medical assistance payments. In many cases the operation of the MMIS is contracted out

to a private contractor. The State plan will describe the administration of each State's claims-processing system.

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.

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

On October 5, 2005, an interim final rule, with an opportunity for comment, was published in the Federal Register setting forth the State requirements to provide information to CMS for the purpose of estimating improper payments in the Medicaid program, as required under the Improper Payments Information Act (IPIA) of 2002. The effective date of these regulations is November 4, 2005.

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 no longer excluded from coverage under the HHS implementation of the A-102 Common Rule, 45 CFR part 92 (Federal Register, September 8, 2003, 68 FR 52843-52844). This change is effective for any grant award under this program made after issuance of the initial awards for the second quarter of Federal fiscal year (FY) 2004. 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) (as provided in Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government, HHS Publication ASMB C-10, available on the Internet at <http://rates.psc.gov/fms/dca/asmb%20c-10.pdf>).

Availability of Other Program Information

The HHS OIG issues fraud alerts, some of which relate to the Medicaid program. These alerts are available on the Internet from the HHS OIG home page, Special Fraud Alerts section (<http://oig.hhs.gov/fraud/fraudalerts.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>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

General Audit Approach for Medicaid Payments

To be allowable, Medicaid costs for medical services must be: (1) covered by the State plan and waivers; (2) for an allowable service rendered (including supported by medical records or other evidence indicating that the service was actually provided and consistent with the medical diagnosis); (3) properly coded; and (4) paid at the rate allowed by the State plan. Additionally, Medicaid costs must be net of applicable credits (e.g., insurance, recoveries from other third parties who are responsible for covering the Medicaid costs, and drug rebates), paid to eligible providers, and only provided on behalf of eligible individuals.

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

- Dependence upon large and complex ADP systems to process the large volume of Medicaid transactions.
- Medical services are provided directly to an eligible beneficiary, normally without prior approval by the State.
- Medical service providers normally determine the scope and medical necessity of the services.
- Notice to the State that service is rendered is after-the-fact when a bill is sent.
- Payments systems do not include a review of original detailed documentation supporting the claim prior to payment.

- Complex billing charge structures and payment rates for medical services, including significance of proper coding of services (e.g., billing by diagnosis related groups (DRG)).
- Different types of Medicaid payments (e.g., inpatient hospital, physicians, prescription drugs and drug rebates).

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

Type of Medicaid Payment	1	2	3	4
Inpatient Hospital	X	X	X	X
Physicians (including dental)	X		X	X
Prescription Drugs (net of rebates)	X		X	X
Institutional Long-Term Care	X	X	X	X

Each of the above Medicaid payment types is tested for compliance with applicable laws and regulations under either III.A, “Activities Allowed or Unallowed;” III.B, “Allowable Costs/Cost Principles;” or III.E.1, “Eligibility – Eligibility for Individuals.” Based upon the assessed level of control risk, the auditor should design appropriate tests of the allowability of Medicaid payments. Testing likely will include tests of medical records, in which case the auditor should consider the need for assistance of specialists. The auditor may consider using the same specialists used by the State.

The auditor should consider the following in planning and performing tests of controls and compliance:

1. III.N, “Special Tests and Provisions” includes required internal controls, which are compliance requirements (i.e., controls (1), (2), and (3) above), and audit objectives and procedures for each. The audit procedures will entail tests of work performed by the State Medicaid agency.
2. Tests of compliance with laws and regulations relating to III.A, B, and E below, and the compliance requirements enumerated in III.N should be coordinated.

A. Activities Allowed or Unallowed

1. Funds can only be used 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 (Pub. L. No. 99-272, Section 9508; 42 CFR part 434).

3. Managed Care – A State may obtain a waiver of statutory requirements in order to develop a system that more effectively addresses the health care needs of its population. For example, a waiver may involve the use of a program of managed care for selected elements of the client population or allow the use of program funds to serve specified populations that would be otherwise ineligible (Section 1115 of the Social Security Act). 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 (Section 1923 of the Social Security Act and 42 USC 1396(r)).
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 on the Internet 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).

B. Allowable Costs/Cost Principles

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 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, 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. Section 1903(w)(1) of the Social Security Act (as amended by Pub. L. No. 102-234) provides that, effective January 1, 1992, before calculating the amount of Federal financial participation, certain revenues received by a State will be deducted from the State's medical assistance expenditures. The revenues to be deducted are (1) donations made by health providers and entities related to providers (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of out-stationed eligibility workers); and (2) impermissible health care-related taxes that exceed a specified limit (42 USC 1396(b)(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)).

The provisions of Pub. L. No. 102-234 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; Federal Register, August 13, 1993, 58 FR 43156-43183).

4. Section 1927 of the Social Security Act 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. 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.

E. Eligibility

1. Eligibility for Individuals

- a. The State Medicaid agency or its designee is required to determine client eligibility in accordance with eligibility requirements defined in the approved State plan (42 CFR section 431.10).
- b. There are specific requirements that must be followed to ensure that individuals meet the financial and categorical requirements for Medicaid. These include that the State or its designee shall:
 - (1) Require a written application signed under penalty of perjury and include in each applicant's case records facts to support the agency's decision on the application (42 USC 1320b-7(d); 42 CFR sections 435.907 and 435.913).
 - (2) Use the income and eligibility verification system (IEVS) to verify eligibility using wage information available from such sources as the agencies administering State unemployment compensation laws, Social Security Administration (SSA), and the Internal Revenue Service to verify income eligibility and the amount of eligible benefits. With approval from HHS, States may use alternative sources for income information. States also: (a) may target the items of information for each data source that are most likely to be most productive in identifying and preventing ineligibility and incorrect payments, and a State is not required to use such information to verify the eligibility of all recipients; (b) with reasonable justification, may exclude categories of information when follow-up is not cost effective; and (c) can exclude unemployment compensation information from the Internal Revenue Service or earnings information from SSA that duplicates information received from another source (42 USC 1320b-7(a); 42 CFR sections 435.948(e) and 435.953).

- (3) Require, as a condition of eligibility objections, refuses to obtain a SSN. In redetermining eligibility, if the case record does not contain the required SSN, the agency must require the recipient to furnish the SSN (42 CFR section 435.920(b)) (42 USC 1320b-7(a)(1); 42 CFR sections 435.910 and 920).
 - (4) Verify each SSN of each applicant and recipient with SSA to insure that each SSN furnished was issued to that individual and to determine whether any others were issued (42 CFR sections 435.910(g) and 42 CFR 435.920).
 - (5) Document qualified alien status if the applicant or recipient is not a U.S. citizen (42 USC 1320b-7d).
 - (6) Redetermine the eligibility of Medicaid recipients with respect to circumstances that may change (e.g., income eligibility), at least every 12 months. The agency may consider blindness and disability as continuing until the review physician or review team determines that the recipient's blindness or disability no longer meets the definition contained in the plan. There must be procedures designed to ensure that recipients make timely and accurate reports of any changes in circumstances that may affect their eligibility. The State must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his or her eligibility (42 CFR section 435.916).
- c. Qualified aliens, as defined at 8 USC 1641, who entered the United States on or after August 22, 1996, are not eligible for Medicaid for a period of five years, beginning on the date the alien became a qualified alien, unless the alien is exempt from this five-year bar under the terms of 8 USC 1613. States must provide Medicaid to certain qualified aliens in accordance with the terms of 8 USC 1612(b)(2), provided that they meet all other eligibility requirements. States may provide Medicaid to all other otherwise eligible qualified aliens who are not barred from coverage under 8 USC 1613 (the five-year bar). All aliens who otherwise meet the Medicaid eligibility requirements are eligible for treatment of an emergency medical condition under Medicaid, as defined in 8 USC 1611(b)(1)(A), regardless of immigration status or date of entry.
- d. As discussed in the General Audit Approach for Medicaid Payments, the auditor will likely combine III.A, "Activities Allowed or Unallowed," III.B, "Allowable Costs/Cost Principles," and III.E, "Eligibility." Therefore, compliance requirements related to amounts provided to or on behalf of eligibles were combined with III.A, "Activities Allowed or Unallowed."

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable

3. Eligibility for Subrecipients – Not Applicable

G. Matching, Level of Effort, Earmarking

1. Matching

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

2. Level of Effort

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

3. Earmarking

A State waiver may contain an earmarking requirement.

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable for expenditure reporting for the administrative costs of the State MFCUs; Not Applicable for expenditure reporting all other components of the cluster
- d. CMS-64, *Quarterly Statement of Expenditures for the Medical Assistance Program (OMB No. 0938-0067)* – Required to be used in lieu of the SF-425, Federal Financial Report (for all components of the cluster other administrative costs of the State MFCUs), prepared quarterly, and submitted electronically to CMS within 30 days after the end of the quarter.

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. **Section 1512 ARRA Reporting** – Not Applicable
5. **Subaward Reporting under the Transparency Act** – Applicable

N. **Special Tests and Provisions**

1. **Utilization Control and Program Integrity**

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.

Audit Objectives – To determine whether the State has established and implemented procedures to: (1) safeguard against unnecessary utilization of care and services, including long term care institutions; (2) identify suspected fraud cases; (3) investigate these cases; and (4) refer those cases with sufficient evidence of suspected fraud cases to law enforcement officials.

Suggested Audit Procedures

- a. Obtain and evaluate the adequacy of the procedures used by the State Medicaid agency to conduct utilization reviews and identifying suspected fraud.
 - (1) Consider the qualifications of the personnel conducting the reviews and identifying suspected fraud. Ascertain that the individuals possess the necessary skill or knowledge by considering the following:
 - (1) professional certification, license, or specialized training;
 - (2) the reputation and standing of licensed medical professionals in the view of peers; and
 - (3) experience in the type of tasks to be performed.
 - (2) Consider if the personnel performing the utilization review and identifying suspected fraud are sufficiently organized outside the control of other Medicaid operations to objectively perform their function.
 - (3) Ascertain if the sampling plan implemented by the State Medicaid agency or the QIO was properly designed and executed.

- b. Test a sample of the cases examined by State Medicaid agency or the QIO and ascertain if such examinations were in accordance with the agency's procedures.
- c. Test a sample of the identified suspected cases of fraud and ascertain if the agency took appropriate steps to investigate and, if appropriate, make a referral.
- d. Based on the above procedures, consider the degree of reliance that can be placed on the utilization review and identification of suspected fraud in performing tests under III.A, "Activities Allowed or Unallowed," III.B, Allowable Costs/Cost Principles," and III.E.1, "Eligibility – Eligibility for Individuals."

2. Inpatient Hospital and Long-Term Care Facility Audits

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).

Audit Objectives – To determine whether the State Medicaid agency performed inpatient hospital and long-term care facility audits as required.

Suggested Audit Procedures

- a. Review the State Plan and State Medicaid agency operating procedures and document the types of audits performed (e.g., desk audits, field audits), the methodology for determining when audits are conducted, and the objectives and procedures of the audits.
- b. Through examination of documentation, ascertain that the sampling plan was carried out as planned.
- c. Select a sample of audits and ascertain if the audits were in compliance with the State Medicaid agency's audit procedures.
- d. Based on the above, consider the degree of reliance that can be placed on the inpatient hospital and long term-care facility audits in performing tests under III.A, "Activities Allowed or Unallowed," III.B, Allowable Costs/Cost Principles," and III.E.1, "Eligibility – Eligibility for Individuals."

3. ADP Risk Analysis and System Security Review

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).

Audit Objective – To determine whether the State Medicaid agency has performed the required ADP risk analyses and system security reviews.

Suggested Audit Procedures

- a. Review the State Medicaid agency's policies and procedures, and document the frequency, timing, and scope of ADP security reviews. This should include any Type II reviews following Statement on Standards for Attestation Engagements No. 16, Reporting on Controls at a Service Organization (SSAE 16) that may have been performed on outside processors (service organizations).
- b. Consider the appropriateness and extent of reliance on such reviews based on the qualifications of the personnel performing the risk analyses and security reviews and their organizational independence from the ADP systems.
- c. Review the work performed during the most recent risk analysis and security review.
- d. Based on the above, consider the degree of reliance that can be placed on the ADP Risk Analysis and System Security Reviews in performing tests under III.A, III.B, and III.E.1.

4. Provider Eligibility

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) and the providers must make certain disclosures to the State (42 CFR part 455, subpart B (sections 455.100 through 455.106)).

Audit Objective – To determine whether providers of medical services are licensed to participate in the Medicaid program in accordance with Federal, State, and local laws and regulations, and whether the providers have made the required disclosures to the State.

Suggested Audit Procedures

- a. Obtain an understanding of the State plan's provisions for licensing and entering into agreements with providers.
- b. Select a sample of providers receiving payments and ascertain if:
 - (1) The provider is licensed in accordance with the State Plan.
 - (2) The agreement with the provider complies with the requirements of the State Plan, including the disclosure requirements of 42 CFR 455 subpart B.

5. Provider Health and Safety Standards

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.

Audit Objective – To determine whether the State ensures that hospitals, nursing facilities, and ICF/MR that serve Medicaid patients meet the prescribed health and safety standards.

Suggested Audit Procedures

- a. Obtain an understanding of the State Plan provisions that ensure that payments are made only to institutions that meet prescribed health and safety standards.
- b. Select a sample of payments for each provider type (i.e., hospitals, nursing facilities, and ICF/MR) and ascertain if the State Medicaid agency has documentation that the provider has met the prescribed health and safety standards.

6. Medicaid Fraud Control Unit

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.

Audit Objective – To determine whether the State ensures suspected criminal violations are referred to an office with authority to prosecute cases of provider fraud.

Suggested Audit Procedures

- a. Obtain an understanding of the States policies and procedures that ensure violations of Medicaid laws and regulations by providers are identified and are referred to an office with authority to prosecute cases of provider fraud.

- b. Select a sample of violations of Medicaid laws and regulations by providers and ascertain if the cases were referred to the State MFCU or, if the State does not have a MFCU, to an office with authority to prosecute cases of provider fraud.

IV. OTHER INFORMATION

Transfers into Medicaid (Title XIX)

As described in Part 4, Children's Health Insurance Program (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 re-determination 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 to the Income Eligibility and Verification System (IEVS), and
- program staff did not have sufficient knowledge of program requirements and policies due to high turnover and lack of training.

2. *Medicaid Claims Processing*

Findings related to Medicaid claims processing found significant weaknesses including:

- inadequate documentation to support the payments claimed in the CMS-64;
- payments reported on the CMS-64 were not readily traceable to the individual claims or information in the sub-system or the financial statements;
- inadequate internal control over utilization, fraud and accuracy of the Medicaid claims;
- lack of understanding of when to report payments in the CMS-64;
- lack of internal control in drawing down ARRA funds;
- inadequate internal control to assure that payments to providers were made in compliance with Federal regulations, e.g. payments for services that were not medically necessary and providers were not eligible Medicaid providers; and
- review of cost report and recoupment of rate adjustments were not timely.

3. *Other areas of weaknesses identified included--*

- inadequate monitoring and oversight of subcontractors;
- inadequate monitoring and oversight to assure provider licensing, agreements or required certification were in effect and up-to-date, and that the related documentation were in file or in the Medicaid Management Information System (MMIS);
- inadequate internal control related to implementation of MMIS replacement system;
- inadequate internal control regarding user access to the MMIS including terminated employees' user access rights; and
- MMIS was not programmed and updated timely and accurately with proper information.

Medicaid EHR Incentive Payment Program

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

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

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

Summary of Statutory Changes Affecting This Cluster Over Time

AFFORDABLE CARE ACT – MEDICAID

(Enacted March 23, 2010) Comprised of the Patient Protection and Affordable Care Act (PPACA), and Pub. L. No. 111-148 and the Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152

Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148

Title II – Role of Public Programs

Subtitle A – Improved Access to Medicaid

Section 2001. Medicaid Coverage for the Lowest Income Populations (as amended by Sections 10201(b)-(c) and Sections 1004(b)(1) and 1201 of HCERA)

- **Eligibility Expansion in 2014:** This provision creates a new mandatory Medicaid eligibility group under the State plan. The new eligibility group consists of individuals whose income is under 133 percent of the FPL, who are under 65, not pregnant and not otherwise covered under Medicaid. In addition, income eligibility for children ages 6 to 18 years of age is expanded from 100 percent of the FPL to 133 percent of the FPL. States also have the option to cover individuals over 133 percent of the FPL and are permitted to phase-in the optional extension of eligibility over 133 percent, so long as the State does not extend eligibility to higher-income individuals before covering lower-income individuals. For both the mandatory expansion to 133 percent and for any optional expansion over 133 percent, this provision requires that parents (or caretaker relatives) may not be enrolled under the Medicaid State plan or waiver of the plan unless their child is enrolled under the State plan or waiver of the plan or under other health insurance coverage. States have the option to provide a period of presumptive eligibility for parents and non-pregnant childless adults in the same manner they provide a period of presumptive eligibility for children and pregnant women.
- **Early Expansion Option:** Effective April 1, 2010, this provision grants States the option to expand coverage early to individuals who will be in the new Medicaid expansion group prior to the mandatory eligibility expansion in 2014.

- **Benefit Requirements:** This provision requires the new Medicaid expansion population to receive benchmark or benchmark-equivalent coverage consistent with Section 1937 of the SSA, regardless of whether the State has elected the option to provide benchmark or benchmark-equivalent coverage. This benchmark benefit requirement applies to individuals covered under the early expansion option as well as individuals who will be covered in 2014. Individuals who are currently exempt from the application of benchmark and benchmark-equivalent coverage will continue to remain exempt from this requirement; this includes mandatory pregnant women, blind and disabled individuals, and dual eligible individuals and other individuals as enumerated in Section 1937(a)(2)(B) of the SSA. This provision also adds mental health services and prescription drug coverage to the list of required basic services in benchmark-equivalent coverage and requires benchmark or benchmark-equivalent plans to comply with mental health parity services requirements. Beginning in 2014, benchmark and benchmark-equivalent plans must provide at least essential health benefits as described in Section 1302(b).
- **Medicaid Maintenance of Effort Requirement:** As a condition of continuing to receive Federal payments under Medicaid, this provision imposes a Medicaid maintenance of effort (MOE) requirement; the MOE requirement prohibits States from imposing eligibility standards, methodologies, or procedures that are more restrictive than those that were in effect as of the date of enactment. For adults, the Medicaid MOE requirement expires when the Exchange in the State is fully operational, but remain in effect for children under age 19 through September 30, 2019. A State is not considered to be in violation of the MOE if it applies the modified adjusted gross income standard (as described in Section 2002) under the early expansion option prior to 2014. States also will not be in violation if they expand eligibility or move waiver populations into coverage under the State plan. However, States must continue comply with the MOE requirements as a condition of receiving increased Federal medical assistance percentage (FMAP) payments as set forth in ARRA. This provision includes an exception to the MOE requirements for non-pregnant, non-disabled adults whose income exceeds 133 percent of the FPL, if during the period between January 1, 2011 and December 31, 2013, a State certifies, with the Secretary, that the State is projected to have a budget deficit.
- **Requirement for Continuation of Political Subdivision Payments:** Effective upon enactment, this provision provides that a State is not eligible for the increased FMAP available for the Medicaid expansion nor the ARRA FMAP increase if a State requires political subdivisions to pay a greater percentage of the non-Federal share of Medicaid expenditures than they were paying on December 31, 2009. Voluntary contributions by a political subdivision are not considered a violation of this provision.
- **Financing the Medicaid Expansion:** This provision establishes that, for the purpose of applying an increased FMAP, the term “newly eligible” includes individuals up to 133 percent of FPL, who are not under 19 years of age and who, as of December 1, 2009, were not eligible under the Medicaid State plan or under a waiver of the plan for full benefits or benchmark or benchmark-equivalent coverage. Individuals who were eligible, but not enrolled, for such benefits under a waiver with an enrollment ceiling are also considered to be “newly eligible.” This provision also establishes a uniform FMAP for all 50 States and the District of Columbia for expenditures related to newly eligible Medicaid beneficiaries.

The Federal government will match the costs of covering “newly eligible” individuals as follows: 2014-2016: 100 percent; 2017: 95 percent; 2018: 94 percent; 2019: 93 percent; and 2020 and years thereafter: 90 percent. These matching rates do not apply to the early expansion option described above. States that opt to expand coverage between April 1, 2010 and January 1, 2014 will receive the regular Medicaid matching rate for such coverage until January 1, 2014.

- **“Expansion State” Policy:** This provision defines “expansion States” as States that currently offer health coverage statewide to parents and non-pregnant childless adults with income that is at least 100 percent of the FPL. To qualify as an expansion State, the coverage offered to parents and non-pregnant childless adults must include inpatient hospital services, coverage that is not dependent on access to employer coverage, an employer contribution for coverage, and coverage that is not limited to premium assistance, hospital-only benefits, a high deductible plan, or alternative benefits under a Health Opportunity Account. For these expansion States, this provision provides an increased FMAP to reduce the State share of costs attributable to previously eligible, non-pregnant, childless adults under 133 percent of the FPL.

For previously eligible childless adults with incomes up to 133 percent of the FPL, each expansion State will receive an increase in its FMAP equal to a specified percentage of the gap between its regular Medicaid matching rate and the enhanced match rate provided to other States. The “transition percentage” changes by year as follows: 2014: 50 percent; 2015: 60 percent; 2016: 70 percent; 2017: 80 percent; 2018: 90 percent; 2019 and years thereafter: 100 percent. In 2019 and thereafter, expansion States will be responsible for the same State share of the costs of covering non-pregnant, childless adults as non-expansion States will be (e.g., 7 percent in 2019, 10 percent thereafter). Also, between January 1, 2014 and December 31, 2015, a State that does not have any “newly eligible” individuals and has not been approved to divert its Medicaid disproportionate share hospital payments to fund coverage expansions will receive a 2.2 percentage point increase in the FMAP for the costs of covering non-newly eligible individuals.

- **Reporting Requirements:** Beginning in January 2015 and annually thereafter, this provision requires each State to submit a report to the Secretary that includes: 1) the total number of enrolled and newly enrolled individuals in the State plan or waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population; 2) a description of outreach and enrollment processes used by the State; and 3) any other data reporting determined necessary by the Secretary to monitor enrollment and retention. Beginning in April 2015 and annually thereafter, the Secretary is required to submit a Report to Congress on the total enrollment and new enrollment in Medicaid on a national and State-by-State basis and shall include recommendations for administrative or legislative changes to improve enrollment in Medicaid.

Section 2002. Income Eligibility for Nonelderly Determined using Modified Gross Income (as amended by Section 1004 of HCERA)

This provision establishes new rules, effective January 1, 2014, for determining eligibility for Medicaid, CHIP, and the Exchanges. These rules will generally replace the use of disregards in Medicaid and CHIP with the application of a modified adjusted gross income (MAGI) standard. States are required, when determining MAGI eligibility, to utilize as the applicable income of an individual an amount equal to the individual's MAGI reduced by the dollar amount that is determined in accordance with Section 1902(e)(14). This requirement effectively raises the upper income eligibility level for the Medicaid expansion from 133 percent of the FPL to 138 percent.

This provision also generally prohibits the use of income disregards and asset tests in Medicaid, with certain exceptions for specific individuals, including the disabled and elderly, and individuals whose income is determined as a result of eligibility for other Federal or State assistance programs (e.g., SSI, foster care). These individuals are also exempt from the MAGI requirements.

This provision requires States to establish income eligibility thresholds for Medicaid populations using MAGI and household income that are not less than the effective income eligibility levels that are applied under the State plan or waiver on the date of enactment. Such eligibility thresholds are to be submitted to the Secretary for approval and the Secretary must ensure that the thresholds proposed by the State will not result in children losing coverage. This provision also requires States to develop an equivalent income test that ensures that individuals eligible for Medicaid on the date of enactment do not lose coverage during the transition to the MAGI standard, and requires that MAGI and household income be determined based on an individual's income as of the point in time at which the application for Medicaid is processed.

Section 2003. Premium Assistance for Employer-Sponsored Insurance (as amended by Section 10203(b))

Effective as if included in Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), this provision aligns the definition of "cost effective" in Sections 1906(e)(2) and 1906A(a) of the SSA to the definition in Section 2105(c)(3)(A) of this Act and applies the definition to adults as well as to children. CHIPRA requires that premium assistance be cost effective relative to either the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide comparable coverage to the child or family involved; or the aggregate amount of expenditures a State would have made under the child health plan, including administrative expenditures, for providing coverage under the plan for the child or their family.

Section 2004. Medicaid Coverage for Former Foster Care Children (as amended by Section 10201(a))

Effective January 1, 2014, this provision creates a new mandatory eligibility category for individuals who have aged-out of the foster care system and had previously received Medicaid while in foster care, so that they can remain eligible for Medicaid until they turn 26.

Presumptive eligibility rules are amended to apply to this new mandatory eligibility category. This provision also specifies that former foster care children remain eligible for the full scope of Medicaid benefits, rather than benchmark or benchmark-equivalent benefits as mandated for individuals receiving coverage under Section 2001.

Section 2005. Payments to territories (as amended by Section 10201(d) and Section 1204 of HCERA)

This provision specifies the terms and conditions for Territories that choose to establish an Exchange and provides \$1 billion to the Territories for this purpose effective for CYs 2014-2019. In addition, it raises the Territories' spending caps by \$6.3 billion, beginning on July 1, 2011, through FY 2019. As of July 1, 2011, this provision permanently raises the Territories' FMAP rate from 50 percent to 55 percent.

Section 2006. Special Adjustment to FMAP Determination for Certain States Recovering from a Major Disaster (as amended by Section 10201(c)(5))

Starting January 1, 2011, this provision reduces projected decreases in the FMAP for States that have experienced major, statewide disasters. The criteria listed for a State to qualify for an FMAP adjustment are: 1) the President has declared for the State a major disaster under the Stafford Disaster Relief and Emergency Assistance Act during the preceding seven fiscal years, and determined as a result of such disaster that every county or parish in the State warranted public assistance under that Act; and 2) the State would have a decrease in its FMAP of at least three percentage points from the previous fiscal year, including a decrease in the base FMAP in any covered fiscal year as established by ARRA. Under this provision, a qualifying State would see an initial 50 percent reduction in the FMAP decrease it would otherwise experience under current law, and a 25 percent reduction in the subsequent years the State qualifies for this adjustment.

Subtitle C – Medicaid and CHIP Enrollment Simplification

Section 2201. Enrollment Simplification and Coordination with State Health Insurance Exchanges

The provision requires States, as a condition of participation in Medicaid and receipt of Federal financial participation for calendar quarters beginning after January 1, 2014, to establish procedures for the following:

- Enabling individuals to apply and renew their Medicaid eligibility through an Internet website;
- Enrolling without any further determination individuals who are identified by an Exchange established by the State as eligible for Medicaid or CHIP;
- Ensuring that individuals who are determined ineligible for Medicaid or CHIP are screened for eligibility for enrollment in qualified health plans offered by an Exchange, including eligibility for any premium credits and cost-sharing reductions;

- Ensuring that the Medicaid agency, CHIP agency, and Exchange utilize a secure electronic interface to allow for Medicaid, CHIP, and premium assistance eligibility determinations;
- Coordinating Medicaid, CHIP, and Exchange coverage including EPSDT services; and
- Conducting outreach to and enrolling vulnerable and underserved populations including children, homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individual with mental health or substance-related disorders, and individuals with HIV/AIDS.

In addition, the provision permits a State Medicaid and State CHIP agency to make eligibility determinations for premium credits and cost-sharing reductions on behalf of the Exchange. By not later than January 1, 2014, the provision requires States to have an Internet website that allows for comparisons of benefits, premiums, and cost-sharing applicable to an individual under Medicaid with those available under a qualified health plan offered through an Exchange. These new requirements are included in a new Section 1943 of the SSA.

Section 2202. Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations

Effective January 1, 2014, this provision allows hospitals and clinics that are participating Medicaid providers to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for Medicaid for purposes of providing medical assistance during a presumptive eligibility period. This provision broadens the populations for which presumptive eligibility decisions may be made. The Secretary of HHS shall establish guidance related to this provision.

Subtitle D – Improvements to Medicaid Services

Section 2301. Coverage for Freestanding Birth Center Services

Effective upon enactment, this provision requires States to cover services provided by freestanding birth centers as a mandatory service. A freestanding birth center service is defined as a service provided in a health facility that is not a hospital, where childbirth is planned to occur away from the pregnant woman's residence, is licensed or otherwise approved by the State, and complies with State requirements. A grace period is granted to provide States an opportunity to pass legislation to amend their Medicaid State plans, if necessary under State law.

Section 2302. Concurrent Care for Children

Effective upon enactment, this provision allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

Section 2303. State Eligibility Option for Family Planning Services

Effective upon enactment, this provision allows State Medicaid programs to cover family planning services and supplies without obtaining a waiver for individuals who are not pregnant and do not exceed the highest eligibility level for pregnant women. This provision also allows for such coverage during a presumptive eligibility period and adds family planning services and supplies as a required element of benchmark or benchmark-equivalent plans.

Section 2304. Clarification of Definition of Medicaid Medical Assistance

Effective upon enactment, this provision amends Section 1905 of the SSA to clarify the original intent of Congress that “medical assistance” encompasses both payment for services provided and the services themselves.

Subtitle E – New Options for States to Provide Long-Term Services and Supports**Section 2401. Community First Choice Option (as amended by Section 1205 of HCERA)**

The provision establishes a new Medicaid State Plan option effective October 1, 2011 to allow States to cover home and community-based attendant services and supports for individuals with incomes not exceeding 150 percent of the FPL or, if greater, who have been determined to require an institutional level of care. It also requires States to make such services and supports available to individuals under a person-centered plan of care for purposes of assisting them in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing. States are provided an additional six percentage point increase in Federal Medicaid matching funds for services and supports provided to such individuals. The provision requires State compliance with certain requirements, an evaluation, and two Reports to Congress, with an interim report due not later than December 31, 2013 and a final report due by December 31, 2015.

Section 2402. Removal of Barriers to Providing Home and Community-Based Services (HCBS)

Amends Section 1915(i) of the SSA effective October 1, 2010 to permit States to cover individuals who are eligible for home and community-based services under a Section 1915(c), (d), or (e) waiver or Section 1115 demonstration and also establishes a 5-year period to phase-in the enrollment of eligible individuals for States that choose to target services to specific populations with 5-year renewal periods, lifts the prohibition on covering other services, and eliminates a State’s option to cap enrollment and disregard statewideness.

Section 2403. Money Follows the Person Rebalancing Demonstration

The provision extends the demonstration, which currently runs through FY 2011, through FY 2017 and, effective April 22, 2010, shortens the length of time from six months to 90 days that an individual is required to reside in a facility prior to transitioning to the community. For purposes of calculating the 90-day period, the provision precludes the counting of any days during which an individual resides in an institution on the basis of receiving short-term rehabilitative services covered by Medicare. Accordingly, \$450 million for each of FYs 2012-

2016 is provided for grants, of which not more than \$1.1 million may be used each year for research on and a national evaluation of the program.

Section 2404. Protection for Recipients of HCBS Against Spousal Impoverishment

For a 5-year period beginning on January 1, 2014, the provision requires States to extend impoverishment protections to spouses of individuals receiving Medicaid HCBS, as they are currently required to do for spouses of individuals residing in an institutional setting.

Subtitle F – Medicaid Prescription Drug Coverage

Section 2501. Prescription Drug Rebates (as amended by Section 1206 of HCERA)

Effective January 1, 2010, this provision increases the minimum rebate for single source and innovator multiple source outpatient prescription drugs from 15.1 percent to 23.1 percent. Under the provision, the minimum rebate for brand name drugs with clotting factors and drugs with pediatric indications is increased from 15.1 percent of average manufacturer's price (AMP) to 17.1 percent of AMP and the rebate percentage for generic drugs is increased from 11 percent to 13 percent of AMP. This provision allows the Federal government to capture savings from these increases in the minimum rebate percentages.

Effective upon enactment, this provision requires drugs dispensed to Medicaid managed care enrollees to be subject to the same rebate amount required under Section 1927 of the SSA. Capitation rates paid to a managed care organization (MCO) must be based on the actual costs related to the rebates and are subject to regulations requiring actuarially sound rates. MCOs are required to report on a timely basis information on the total number of units of each dosage form and strength and package size by National Drug Code (NDC) of each covered outpatient drug dispensed to Medicaid managed care enrollees.

Effective January 1, 2010, this provision specifies the amount of the rebate for reformulated drugs. With respect to a drug that is a line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form, the rebate obligation will be the amount computed under Section 1927 of the SSA or, if greater, the product of the AMP for the line extension drug, the highest additional rebate under Section 1927 for any strength of the original single source drug or innovator multiple source drug, and the total number of units of each dosage form and strength of the line extension product paid for under the State plan in the rebate period. These requirements also apply to orphan drugs. In addition, this provision establishes a limit on the rebate amount for brand name drugs at 100 percent of AMP.

Section 2502. Elimination of Exclusion of Coverage of Certain Drugs

Beginning on January 1, 2014, this provision prohibits States from excluding smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid coverage.

Section 2503. Providing Adequate Pharmacy Reimbursement (as amended by Section 1101(c) of HCERA)

Effective October 1, 2010, this provision revises the Federal Upper Limit (FUL) to be no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly AMP for pharmaceutically and therapeutically equivalent multiple source drugs. This section also clarifies the definition of AMP to include sales by: 1) wholesalers for drugs distributed to retail community pharmacies; and 2) retail community pharmacies that purchase drugs directly from manufacturers. This section also excludes from the definition of AMP prompt payments, discounts provided by manufacturers, and other discounts, and eliminates the requirement that AMP data be disclosed to the public. This provision also adds a requirement that the weighted average of monthly AMPs and the average retail survey prices be disclosed to the public.

Subtitle G – Medicaid Disproportionate Share Hospital (DSH) Payments**Section 2551. Disproportionate Share Hospital (DSH) Payments (as amended by Sections 10201(e)-(f) and Section 1203 of HCERA)**

As amended, this provision reduces States' DSH allotments by an aggregate annual reduction totaling \$18.1 billion for FYs 2014-2020 by applying a methodology that imposes the largest reductions on States with the lowest percentage of uninsured or States that do not target their DSH payments to hospitals with a high volume of Medicaid inpatients and high uncompensated care. A smaller reduction is applied to low DSH States. In addition, this provision extends Hawaii's DSH allotment through FY 2012, establishes Hawaii as a low DSH State beginning in FY 2013, and extends Tennessee's DSH allotment through FY 2013.

Subtitle H – Improved Coordination for Dual Eligible Beneficiaries**Section 2602. Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries**

No later than March 1, 2010, this provision requires the Secretary to establish a Federal Coordinated Health Care Office within CMS, intended to bring together officials and employees of the Medicare and Medicaid programs to more effectively integrate benefits under those programs, and improve the coordination between the Federal and State governments for individuals eligible for both Medicare and Medicaid benefits ("dual eligibles") to ensure that they have full access to the items and services to which they are entitled. It requires the Secretary, as part of the President's budget, to submit an annual Report to Congress containing recommendations for legislation that would improve care coordination and benefits for dual eligibles.

Subtitle I – Improving the Quality of Medicaid for Patients and Providers**Section 2702. Medicaid Health Care-Acquired Conditions**

This provision directs the Secretary to identify State practices that prohibit payment for health care-acquired conditions and incorporate such practices, as appropriate for application to

Medicaid, into regulations in effect as of July 1, 2011. The regulations will prohibit Medicaid payment for services related to health care-acquired conditions specified in the regulation. The Secretary shall apply forthcoming Medicare regulations prohibiting payment for health care-acquired conditions as appropriate to the Medicaid program. Further, the Secretary may *exclude certain payment exclusions identified for Medicare if those conditions are inapplicable to Medicaid beneficiaries.*

Section 2703. State Option to Provide Health Homes for Enrollees with Chronic Conditions

Beginning January 1, 2011, this provision creates a new Medicaid State plan option under which States may provide payment for designated providers or teams of health care professionals for furnishing health home services, including care management, transitional care, patient and family support, referrals to community and social support services, and use of HIT, for individuals with at least two chronic conditions, one chronic condition and at-risk of a second chronic condition, or one serious and persistent mental health condition. It allows States to claim a Federal Medicaid matching rate of 90 percent during the first eight fiscal quarters for such health home services and provides \$25 million in planning grants that the Secretary may award States for purposes of developing its State plan amendment. As a condition of receiving payment for health home services, designated providers must report to the State on quality measures and when appropriate and feasible, use HIT to provide such information.

This provision requires the Secretary to contract for an independent evaluation of States that have exercised this option on the effects of this option on reducing admission rates to hospitals, emergency rooms, and skilled nursing facilities (SNFs). Further, the Secretary shall provide an interim Report to Congress by January 1, 2014 based on State survey data collected by the Secretary, and a final Report to Congress on the results of the independent evaluation by no later than January 1, 2017.

Subtitle K – Protections for American Indians and Alaska Natives

Section 2901. Special Rules Relating to Indians

This provision specifies that Indians with incomes at or below 300 percent of the FPL and enrolled in coverage through a State Exchange are exempt from cost-sharing (as specified in Section 1402(d)). This provision also establishes health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations, or Urban Indian Organizations as the payer of last resort for services provided by those entities to eligible individuals. Finally, this section amends the Express Lane Option added by CHIPRA to specify that the IHS, an Indian tribe, tribal organization, or urban Indian organization can make Express Lane determinations.

Section 2902. Elimination of the Sunset for Medicare Part B Services

Effective January 1, 2010, this provision eliminates the five-year sunset of reimbursement (scheduled to take effect for services performed after December 31, 2009) for Part B services furnished by a hospital or skilled nursing facility of the IHS, whether operated by the IHS or by an Indian tribe or tribal organization.

Subtitle L – Maternal and Child Health Services**Section 2951. Maternal, Infant, and Early Childhood Home Visiting Programs**

This provision establishes a grant program for States, Territories, and Indian Tribes to create maternal, infant, and early childhood home visitation programs. The provision also requires States to conduct an initial needs assessment within six months of the date of enactment to identify populations who could benefit from these programs. The Secretary, with an independent advisory body, shall develop a plan within one year of enactment to establish the grant program, giving priority to programs that target specific high-risk populations. The Secretary is responsible for setting benchmarks, evaluating applications, and developing procedures and requirements for States, tribal organizations, and non-profit organizations to propose and implement a program that demonstrates quantifiable and measurable improvement on several maternal, child, and infant health benchmarks. This provision also requires a Report to Congress by March 31, 2015 on the Secretary's evaluation of the initial State needs assessments, and a Report to Congress by December 31, 2015 on the status of grants authorized under this program.

Section 2954. Restoration of Funding for Abstinence Education

This provision restores funding for Abstinence Education programs (Section 510 of the SSA) through FY 2014.

**Health Care and Education Reconciliation Act (HCERA) of 2010,
Pub. L. No. 111-152**

Subtitle C – Medicaid**Section 1202. Improving Payments for Primary Care Services**

For 2013 and 2014, this provision increases Medicaid fee-for-service and managed care payments for primary care services to equal that of payments under Medicare Part B. The provision defines primary care services as evaluation and management services and services related to immunizations delivered by a physician with a primary care designation of family medicine, general internal medicine, or pediatric medicine. The increase in payment for such services will equal a 100 percent Federal match.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.889 NATIONAL BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM

I. PROGRAM OBJECTIVES

The purpose of the National Bioterrorism Hospital Preparedness Program (commonly known as HPP) is to enable eligible entities to improve surge capacity and capability and enhance community and hospital preparedness for public health emergencies. The primary focus of the HPP is to build medical surge capability through associated planning, personnel, equipment, training and exercise capabilities at the State and local levels. The goal is a collective vision for National preparedness, and establishes National Priorities to guide preparedness efforts at the Federal, State, local and tribal levels.

II. PROGRAM PROCEDURES

The HPP is administered by the Assistant Secretary for Preparedness and Response (ASPR), a Staff Division of the Department of Health and Human Services. The activities under these programs are coordinated with the Centers for Disease Control and Prevention and other Federal entities that assist in State and local public health and medical preparedness efforts.

The HPP makes cooperative agreement awards to the health departments of all 50 States, the District of Columbia, the nation's three largest municipalities (New York City, Chicago, and Los Angeles County), the Commonwealths of Puerto Rico and the Northern Mariana Islands, the territories of American Samoa, Guam and the U.S. Virgin Islands, the Federated States of Micronesia, and the Republics of Palau and the Marshall Islands. The award instrument is a cooperative agreement.

Source of Governing Requirements

This program is authorized by Section 319C-2 of the Public Health Service Act (42 USC 247d-3b), as amended by the Pandemic and All-Hazards Preparedness Act of 2006 (Pub. L. No. 109-417). There are no program regulations for this program.

Availability of Other Program Information

Additional program can be found at
<http://www.phe.gov/Preparedness/planning/hpp/Pages/default.aspx>

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

Funds may be used to achieve the preparedness activities described in Pub. L. No. 109-417, Sections 2802(b)(1), (3)-(6) (42 USC 300hh-1(b)(1), (3)-(6)), which include, but are not limited to:

1. Setting up Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR VHP) systems within the State.
2. Developing statewide plans and community-wide plans for responding to public health and medical emergencies coordinated with the capacities of applicable national, State, and local health agencies and health care providers, including poison control centers.
3. Training or workforce development to enhance the operation of public health laboratories
4. Improving methods to enhance the safety of workers and workplaces in the event of any hazard.
5. Enhanced training and planning to protect the health and safety of personnel, including health care professionals, involved in responding to many different planning scenarios.
6. Training of public health and health care personnel to (1) recognize and treat the mental health consequences of all hazards, and (2) assist in providing appropriate health care for large numbers of individuals.
7. Activities to address the health security needs of children and other vulnerable populations.
8. The purchase or upgrade of equipment (including stationary or mobile communications equipment), supplies, pharmaceuticals or other priority countermeasures to enhance preparedness for and response to all hazards.
9. Conducting exercises to test the capability and timeliness of public health and medical emergency response activities.

G. Matching, Level of Effort, Earmarking**1. Matching**

Starting in FY 2009, the amount of non-federal matching funds is 5 percent of the award amount. In FY 2010 and each year thereafter, the amount of match is 10 percent of the award amount (73 FR 28471, May 16, 2008; subsequent Funding Opportunity Announcements (FOA) (section 3.2 of FY 10 FOA)).

2. Level of Effort**2.1 Level of Effort – *Maintenance of Effort***

Awardees shall maintain expenditures for health care preparedness at a level that is not less than the average level of such expenditures maintained by the entity for the preceding 2-year period. The MOE requirement refers to the awardee's expenditures (i.e., State (or political subdivision) contributions for healthcare preparedness, not Federal dollars) and may include expenditures for surge capacity investments such as (1) beds; (2) isolation; (3) decontamination; (4) personal protective equipment; (5) pharmaceuticals; (6) mobile medical assets; (7) interoperable communications equipment; and (8) laboratory equipment and trainings (Section 319C-2(h), PHS Act, as amended; 73 FR 28472, May 16, 2008; subsequent Funding Opportunity Announcements (FOA) (Section 3.3.1 of FY 10 FOA)).

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable**3. Earmarking – Not Applicable****L. Reporting****1. Financial Reporting**

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable**3. Special Reporting – Not Applicable****4. Section 1512 ARRA Reporting – Not Applicable****5. Subaward Reporting Under the Transparency Act – Applicable**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.914 HIV EMERGENCY RELIEF PROJECT GRANTS

I. PROGRAM OBJECTIVES

The objective of this program is to improve access to a comprehensive continuum of high-quality community-based primary medical care and support services in metropolitan areas that are disproportionately affected by the incidence of Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS). The statute refers to both persons infected with HIV and those who have clinically defined AIDS. These terms are used interchangeably in this compliance supplement but refer to this total universe of eligible individuals.

Emergency financial assistance, in the form of formula-based funding and supplemental project-based funding, is provided to eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) to develop, organize, and operate health and support services programs for infected individuals and their care givers. The supplemental grants are discretionary awards and are awarded, following competition, to EMAs and TGAs that demonstrate need beyond that met through the formula award. They must also demonstrate the ability to use the supplemental amounts quickly and cost-effectively. Other criteria, contained in annual application guidance documents, may also apply. All EMAs and TGAs that are receiving formula assistance are also receiving supplemental assistance.

II. PROGRAM PROCEDURES

Administration

The Health Resources and Services Administration (HRSA), a component of the Department of Health and Human Services, administers the HIV emergency relief programs. HRSA uses data reported to and confirmed by the Centers for Disease Control and Prevention (CDC) to determine eligibility (i.e., any metropolitan area for which there has been reported to and confirmed by the Director of CDC a cumulative total of more than 2,000 cases of AIDS for the most recent 5 calendar-year period for which data are available) and to establish the formula for allocation of funds. A TGA is defined as "... a metropolitan area for which there has been reported to, and confirmed by, the Director of the Centers for Disease Control and Prevention a cumulative total of at least 1000, but fewer than 2000, cases of AIDS during the most recent period of 5 calendar years for which such data is available."

A metropolitan area is not eligible if it does not have an overall population of 50,000 or more. With respect to an EMA that received funding in fiscal year (FY) 2006, the boundaries for determining eligibility are those that were in effect for the area in FY 1994. For areas becoming eligible for funding after FY 2006, the boundaries are those in effect at the time the area first receives funding under this program.

At least two-thirds (66 2/3 percent) of the appropriated amount is made available for the EMAs' and TGA's formula allocation and the remainder is awarded as supplemental project assistance on the basis of demonstrated need and other factors. EMAs and TGAs are funded for the

formula and supplemental allocation and project assistance on the basis of a single application and a combined award.

An extension of TGA status is authorized if it has: (1) a cumulative total between 1,400-1,500 living cases of AIDS as of December 31 of the most recent calendar year for which data is available; and (2) less than 5 percent of an unobligated balance from its total Part A award. Funds previously awarded to TGAs that lose their status due to not meeting the eligibility and continued status requirements will be transferred to the State in which the TGA is located for 3 consecutive years.

Funds are made available to the chief elected official of the EMA or TGA that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals with AIDS in the jurisdiction in accordance with statutory requirements and program guidelines. Day-to-day responsibility for the grant is ordinarily delegated to the jurisdiction's public health department, and some administrative functions may be outsourced to a private entity. The chief elected official of the jurisdiction is also required to establish or designate an HIV health services planning council, which carries out a planning process, coordinating with other State, local and private planning and service organizations, and establishes the priorities for allocating funds. Newly eligible areas designated as TGAs in FY 2007 and beyond may be exempt from the requirement to establish and use an HIV health services planning council.

Consistent with funding and service priorities established through the public planning process, the receiving jurisdiction uses the funds to provide direct assistance to public entities or private non-profit or for-profit entities to deliver or enhance HIV/AIDS-related core and support services; and, within established limits, for associated administrative activities. These administrative activities include EMA or TGA oversight of service provider performance and adherence to their subgrant or contractual obligations. Most of these service providers are non-profit organizations.

Source of Governing Requirements

This program is authorized under the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Pub. L. No. 109-415), as extended and amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Pub. L. No. 111-87). This program is codified at 42 USC 300ff-11 through 300ff-17.

There are no program regulations specific to this program.

Availability of Other Program Information

Additional information about this program is available at <http://hab.hrsa.gov/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed*Activities Allowed*

1. Funds may be used only for core medical services, support services, and administrative expenses (42 USC 300ff-14(a)).
 - a. Core medical services with respect to an individual with HIV/AIDS (including co-occurring conditions, i.e., one or more adverse health conditions of an individual with HIV/AIDS, without regard to whether the individual has AIDS or whether the conditions arise from HIV) means (1) outpatient and ambulatory health services; (2) AIDS Drug Assistance Program treatments; (3) AIDS pharmaceutical assistance; (4) oral health care; (5) early intervention services meeting the requirements of 42 USC 300ff-14(e); (6) health insurance premium and cost sharing assistance for low-income individuals; (7) home health care; (8) medical nutrition therapy; (9) hospice services; (10) home and community-based health services; (11) mental health services; (12) substance abuse outpatient care; and (13) medical case management, including treatment adherence services (42 USC 300ff-14(c)(3)).
 - b. Support services means services that are needed for individuals with HIV/AIDS to achieve their medical outcomes (those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS) (for example, respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, referrals for health care and support services, and such other services specified by HRSA) (42 USC 300ff-14(d)).
 - c. Administrative expenses at the grantee level include activities related to (1) routine grant administration and monitoring (for example, development of applications, receipt and disbursement of program funds, development and establishment of reimbursement and accounting systems, development of a clinical quality management program, preparation of routine programmatic and financial reports, and compliance with grant conditions and audit requirements); (2) contract development, solicitation review, award, monitoring, and reporting; and (3) activities carried out by the HIV health services planning council (42 USC 300ff-14(h)(3)(A) and 300ff-12(b)).
 - d. Subcontractor administrative expenses include usual and recognized overhead activities, management oversight of funded activities, and other types of program support such as quality assurance, quality control, and related activities (42 USC 300ff-14(h)(3)(B)).

Activities Unallowed

1. Funds may not be used to make payment for any item or service if payment has already been made or can reasonably be expected to be made under any State compensation program, under an insurance policy or any Federal or State health benefits program, or by an entity that provides health services on a pre-paid basis except for programs administered by or providing the services of the Indian Health Service (42 USC 300ff-15(a)(6)).
2. Funds may not be used to purchase or improve land or to purchase, construct or make permanent improvement to any building. Minor remodeling is allowed (42 USC 300ff-14(i)).
3. Funds may not be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug (Pub. L. No. 112-74, Section 523).
4. Funds may not be used for AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual (42 USC 300ff-84).

E. Eligibility**1. Eligibility for Individuals**

Eligible beneficiaries are individuals or families of individuals with HIV/AIDS. To the maximum extent practicable, services are to be provided to eligible individuals regardless of their ability to pay for the services and their current or past health condition (42 USC 300ff-15(a)(7)(A));.

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable**3. Eligibility of Subrecipients**

The EMA or TGA may make funds available to public or private non-profit entities or to private for-profit entities if they are the only available providers of quality HIV care in the area (42 USC 300ff-14(b)(2)).

G. Matching, Level of Effort, Earmarking**1. Matching – Not Applicable**

2.1 Level of Effort – *Maintenance of Effort*

Each political subdivision within the metropolitan area is required to maintain its level of expenditures for HIV-related services to individuals with HIV disease (or, effective with FY 2007 awards, core and support services) at a level equal to its level of such expenditures for the preceding fiscal year. Political subdivisions within the EMA or TGA may not use funds received under the HIV grants to maintain the required level of HIV-related services (42 USC 300ff-15(a)(1)(B) and (C)).

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable

3. Earmarking

- a. Unless waived by the Secretary, HHS (or designee), not less than 75 percent of the amount remaining after reserving amounts for EMA or TGA administration and a clinical quality management program shall be used to provide core medical services to eligible individuals in the eligible area (including services regarding the co-occurring conditions of those individuals) (42 USC 300ff-14(c)(1)).
- b. Not more than 10 percent of the amounts awarded to the EMA or TGA may be used for administration at that level (42 USC 300ff-14(h)(1)).

H. Period of Availability of Federal Funds

Funds made available under a grant award for a fiscal year are available for obligation through the end of the one-year period beginning on the date in the fiscal year on which funds first became available, i.e., the beginning date of the budget period shown on the Notice of Grant Award. Funds made available under the formula portion of the award that remain unobligated at the end of this period will be cancelled unless a waiver allowing for carryover of the funds is approved by the Secretary, HHS or designee. If carryover is approved, the funds remain available for a one-year period beginning on the ending date of the budget period under which the funds were awarded. Funds awarded for supplemental grants that remain unobligated at the end of the budget period for which awarded may not be carried over (42 USC 300ff-13(c), as amended by Section 8(b), Pub. L. No. 111-87).

J. Program Income

Providers may impose charges for the provision of services only as follows (42 USC 300ff-15(e)(1) and (2)):

INDIVIDUAL'S INCOME LEVEL	PERMISSIBLE AGGREGATE CHARGES
Less than or equal to 100 percent of official poverty line	No charges may be imposed
Greater than 100 percent of the official poverty line	Charges must be imposed according to a publicly available sliding scale fee schedule, BUT
Greater than 100 percent of the official poverty line and not exceeding 200 percent of that poverty line	A provider may not, for any calendar year, impose aggregate charges in an amount exceeding 5 percent of the annual gross income of the individual involved.
Greater than 200 percent of the official poverty line and not exceeding 300 percent of that poverty line	A provider may not, for any calendar year, impose aggregate charges in an amount exceeding 7 percent of the annual gross income of the individual involved.
Greater than 300 percent of the official poverty line	A provider may not, for any calendar year, impose aggregate charges in an amount exceeding 10 percent of the annual gross income of the individual involved.

The poverty guidelines are available on the Internet at <http://aspe.hhs.gov/poverty/> and are also published each year in the *Federal Register*.

The term “aggregate” applies to the annual charges imposed for all without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges for services (42 USC 300ff-15(e)(3)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

- 4. Section 1512 ARRA Reporting – Not Applicable**
- 5. Subaward Reporting under the Transparency Act – Applicable**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.917 HIV CARE FORMULA GRANTS

I. PROGRAM OBJECTIVES

The objective of this program is to assist States and territories in improving the quality, availability, and organization of health care and support services for individuals with Human Immunodeficiency Virus (HIV) disease /Acquired Immunodeficiency Syndrome (AIDS) and their families. These objectives may be accomplished through provision of services by the State or HIV/AIDS care consortia in a home or community setting, or by paying health insurance premiums that would not otherwise be available to ensure continuity of care.

II. PROGRAM PROCEDURES

Administration and Services

Grants are awarded annually, on a formula basis, to all 50 States, the District of Columbia, Puerto Rico, and territories of the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands following submission of an application to and approval by the HIV/AIDS Bureau, Health Resources and Services Administration (HRSA), a component of the Department of Health and Human Services. The responsible State agency, usually the State health department, is designated by the Governor.

The application addresses how the State plans to address each of the five specified program components: (1) HIV care consortia; (2) home and community-based care; (3) health insurance continuation program; (4) provision of treatments; and (5) State direct services. This includes the State's plans for the AIDS Drug Assistance Program (ADAP). ADAP is earmarked funding provided to the State as a separate amount in addition to the base formula grant amount, which includes supplemental funding.

States may use a variety of service delivery mechanisms. States may provide some or all services directly, or may enter into agreements with local HIV care consortia, associations of public and non-profit health care and support service providers, and community-based organizations that plan, develop, and deliver services for individuals with HIV/AIDS. The State also may delegate some of its authority to monitor provider agreements to a "lead agency" (fiscal agent) within the consortium, with specific responsibilities contained in a formal agreement between the State and that agency.

Source of Governing Requirements

The HIV CARE formula grant program is authorized under Part B of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, which is codified at 42 USC 300ff-21 through 300ff-38, as extended and amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Pub. L. No. 111-87).

There are no regulations specific to this program.

Availability of Other Program Information

Further information about this program is available on the Internet at <http://www.hab.hrsa.gov/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look first to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

Activities Allowed

Funds may be used for core medical services and support services and administrative expenses (42 USC 300ff-22(a); 42 USC 300ff-28(b)(3)).

1. Core medical services with respect to an individual infected with HIV/AIDS (including co-occurring conditions, i.e., one or more adverse health conditions of an individual with HIV/AIDS, without regard to whether the individual has AIDS or whether the conditions arise from HIV) means (1) outpatient and ambulatory health services; (2) AIDS Drug Assistance Program treatments; (3) AIDS pharmaceutical assistance; (4) oral health care; (5) early intervention services meeting the requirements of 42 USC 300ff-22(d); (6) health insurance premium and cost sharing assistance for low-income individuals; (7) home health care; (8) medical nutrition therapy; (9) hospice services; (10) home and community-based health services; (11) mental health services; (12) substance abuse outpatient care; and (13) medical case management, including treatment adherence services (42 USC 300ff-22(b)(3)).
2. Support services means services that are needed for individuals with HIV/AIDS to achieve their medical outcomes (those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS) (for example, respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, referrals for health care and support services, and such other services specified by HRSA). Expenditures for or through consortia are considered support services ((42 USC 300ff-22(c); 42 USC 300ff-23(f)).
3. Administrative expenses at the grantee level include activities related to (1) routine grant administration and monitoring (for example, development of applications, receipt and disbursement of program funds, development and establishment of reimbursement and accounting systems, development of a clinical quality management program, preparation of routine programmatic and financial reports, and compliance with grant conditions and audit requirements); (2) contract development, solicitation review, award, monitoring, and reporting;

and (3) activities carried out by the HIV health services planning council (42 USC 300ff-28(b)(3)(C)).

4. Subcontractor administrative expenses include usual and recognized overhead activities, management oversight of funded activities, and other types of program support such as quality assurance, quality control, and related activities (42 USC 300ff-28(b)(3)(D)).

Activities Unallowed

1. Funds may not be used to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility (42 USC 300ff-28(b)(6)).
2. Funds may not be used to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made for that item or service under any State compensation program, under an insurance policy, or under any Federal or State health benefits program (or by an entity that provides health services on a prepaid basis except for a program administered by or providing the services of the Indian Health Service) (42 USC 300ff-27(b)(7)(F)(ii)).
3. Funds may not be used for inpatient hospital services, or nursing home or other long-term care facilities (42 USC 300ff-24(c)(3)).
4. Funds may not be used to pay any costs associated with creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools) or to pay any amount expended by a State under Title XIX of the Social Security Act (Medicaid) (42 USC 300ff-25(b)).
5. Funds may not be used to develop materials designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual (42 USC 300ff-84).
6. Funds may not be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug (Pub. L. No. 112-74, Section 523).

E. Eligibility

1. Eligibility for Individuals

To be eligible to receive assistance in the form of therapeutics, an individual must have a medical diagnosis of HIV/AIDS and be a low-income individual, as defined by the State (42 USC 300ff-26(b)).

2. Eligibility for Group of Individuals or Area of Service Delivery – Not Applicable

3. Eligibility for Subrecipients

- a. Eligible subrecipients are consortia of one or more public and one or more nonprofit private (or private for-profit providers or organizations if such organizations are the only available providers of quality HIV/AIDS care in the area) health care and support service providers and community-based organizations operating within areas determined by the State to be most affected by HIV/AIDS (42 USC 300ff-23(a)).
- b. To receive funding from the State, consortia must agree to provide, directly or through agreements with other service providers, essential health and support services, and must meet specified application and assurance requirements. These include conducting a needs assessment within the geographic area served and developing a plan (consistent with the State's comprehensive plan required by 42 USC 300ff-27(b)(4)) to meet identified service needs following a consultation process (42 USC 300ff-23(b) and (c)).
- c. For consortia otherwise meeting these requirements, the State shall give priority first to consortia that are receiving assistance from HRSA for adult and pediatric HIV-related care demonstration projects and then to any other existing HIV care consortia (42 USC 300ff-23(e)).

G. Matching, Level of Effort, Earmarking

1. Matching

- a. States and territories (excluding Puerto Rico) with greater than 1 percent of the aggregate number of national cases of HIV/AIDS in the 2-year period preceding the Federal fiscal year in which the State is applying for a grant must, depending on the number of years in which this threshold requirement has been met, provide matching funds as follows (42 USC 300ff-27(d)):

Year(s) in Which Matching Required	Minimum Percentage of Non-Federal Matching	Ratio of Non-Federal to Federal Expenditures
First	16 2/3	\$1 non-Federal/\$5 Federal
Second	20	\$1 non-Federal/\$4 Federal
Third	25	\$1 non-Federal/\$3 Federal
Fourth and subsequent	33 1/3	\$1 non-Federal/\$2 Federal

- b. For entities not subject to the matching requirements in paragraph 1.a. above, non-Federal contributions in an amount equal to \$1 for every \$4 of Federal funds are required for ADAP funds (42 USC 300ff-28(a)(2)(F)(ii)(III)).

2.1 Level of Effort – *Maintenance of Effort*

The State will maintain HIV-related activities at a level that is equal to not less than the level of such expenditures by the State for the 1-year period preceding the fiscal year for which the State is applying for Title II/Part B funds (42 USC 300ff-27(b)(7)(E)).

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable

3. Earmarking

- a. The State may not use more than 10 percent of the amounts received under the grant for planning and evaluation activities (42 USC 300ff-28(b)(2)).
- b. The State may not use more than 10 percent of the funds amounts received under the grant for administration (42 USC 300ff-28(b)(3)).
- c. A State may not use more than a total of 15 percent of the amounts received for the combined costs for administration, planning, and evaluation. States and territories that receive a minimum allotment (between \$200,000 and \$500,000) may expend up to the amount required to support one full-time equivalent employee for any or all of these purposes (42 USC 300ff-28(b)(5)).
- d. The aggregate of expenditures for administrative expenses by entities and subcontractors (including consortia) funded directly by the State from grant funds (“first-line entities”) may not exceed 10 percent of the total allocation of grant funds to the State (without regard to whether particular entities spend more than 10 percent for such purposes) (42 USC 300ff-28(b)(3)(B)).
- e. For the purpose of providing health and support services to women, youth, infants, and children with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, a State shall use for each of these populations not less than the percentage of Title II or Part B funds in a fiscal year constituted by the ratio of the population involved (women, youth, infants, or children) in the State with AIDS to the general population in the State of individuals with AIDS (42 USC 300ff-21(b)). This information is provided to the State by HRSA in the annual application guidance (Appendix II, Estimated Number/Percent of Women, Infants, and Children Living with AIDS in States and Territories).

- f. A State shall use a portion of the funds awarded to establish a program to provide therapeutics to treat HIV/AIDS or prevent the serious deterioration of health arising from HIV/AIDS in eligible individuals, including measures for the prevention and treatment of opportunistic infections. The amount of this specific earmark for ADAP will be provided in the grant agreement. Of the amount earmarked in the grant agreement for this purpose, the State may use not more than 5 percent to encourage, support, and enhance adherence to and compliance with treatment regimens (including related medical monitoring) unless the Secretary (or designee) approves a 10 percent limit (42 USC 300ff-26(c)).
- g. A State shall establish a quality management program to determine whether the services provided under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection and, as applicable, to develop strategies for bringing these services into conformity with the guidelines. Funds used for this purpose may not exceed the lesser of 5 percent of the amount received under the grant or \$3,000,000, and are not considered administrative expenses for purposes of the limitation under paragraph 3.b above (42 USC 300ff-28(b)(3)(E)).
- h. Unless waived by the Secretary, HHS (or designee), not less than 75 percent of the amount remaining after reserving amounts for State administration and a clinical quality management program shall be used to provide core medical services to eligible individuals with HIV/AIDS (including services regarding the co-occurring conditions of those individuals) (42 USC 300ff-22(b)).

H. Period of Availability of Federal Funds

- 1. Not less than 75 percent of the amounts received by a State shall be obligated to specific programs and projects and made available for expenditure not later than 150 days after receipt by the State (budget period beginning date as shown on the Notice of Grant Award issued by HRSA) in the case of the first fiscal year for which amounts are received and, in the case of succeeding fiscal years, 120 days after receipt (42 USC 300ff-28(c)).
- 2. Funds are available for obligation by the State through the end of the one-year period beginning on the date on which funds from the award first became available to the State unless an extension is approved by the Secretary (or designee) for an additional one-year period beginning on the date on which the grant would have expired ((42 USC 300ff-31a(a)).

3. If the State has an unobligated balance at the end of grant year (or extended period, the amount of the balance may be cancelled, requiring the State to return any amounts from such balance that have been disbursed to the State or the amount may be applied to a future-year award, at HRSA's discretion (42 USC 300ff-31a, as amended by Section 8 of Pub. L. No. 111-87). See III.J with respect to use of ADAP rebates.

J. Program Income

1. Providers may impose charges for the provision of services only as follows (42 USC 300ff-27(c)):

INDIVIDUAL'S INCOME LEVEL	PERMISSIBLE AGGREGATE CHARGES
Less than or equal to 100 percent of official poverty line	No charges may be imposed
Greater than 100 percent of the official poverty line	Charges must be imposed according to a publicly available sliding scale fee schedule, BUT
Greater than 100 percent of the official poverty line and not exceeding 200 percent of that poverty line	A provider may not, for any calendar year, impose aggregate charges in an amount exceeding 5 percent of the annual gross income of the individual involved.
Greater than 200 percent of the official poverty line and not exceeding 300 percent of that poverty line	A provider may not, for any calendar year, impose aggregate charges in an amount exceeding 7 percent of the annual gross income of the individual involved.
Greater than 300 percent of the official poverty line	A provider may not, for any calendar year, impose aggregate charges in an amount exceeding 10 percent of the annual gross income of the individual involved.

The poverty guidelines are available on the Internet at <http://aspe.hhs.gov/poverty/> and are also published each year in the *Federal Register*.

The term "aggregate" applies to the annual charges imposed for all without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges for services (42 USC 300ff-27(c)(3)).

These requirements apply to all service providers from which an individual receives Title II/Part B-funded services. The State shall waive this requirement for an individual service provider in those instances when the provider does not impose a charge or accept reimbursement available from any third-party payer, including reimbursement under any insurance policy or any Federal or State health benefits program (42 USC 300ff-27(c)(4)(A)).

2. A State may not use grant funds to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service--
 - a. under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or
 - b. by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Service) (42 USC 300ff-27(b)(7)(F)).
3. Any drug rebates received on drugs purchased from funds provided to establish a program of therapeutics must be used to support the types of activities otherwise eligible for funding under this program, with priority given to activities related to providing therapeutics (42 USC 300ff-26(g)).
4. Beginning in fiscal year, 2010, a State may request that its unobligated balance be reduced by the amount of unused ADAP rebate funds if expenditure of those funds would result in the grantee receiving an unobligated funds penalty (42 USC 300ff-31a(d), as amended by Section 10, Pub. L. No. 111-87).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Not Applicable

5. Subaward Reporting under the Transparency Act – Applicable

N. Special Tests and Provisions

Section 340B Drug Pricing Program

Section 602 of Public Law 102-585, the “Veterans Health Care Act of 1992,” enacted section 340B of the Public Health Service Act (“PHS Act”), “Limitation on Prices of Drugs Purchased by Covered Entities.” Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally qualified health center look-alikes and qualified hospitals. Drugs purchased from participating drug manufacturers by covered entities through the 340B Program may not be sold or transferred to anyone other than the patients of the covered entities. In addition, drugs purchased through the 340B Program are not entitled to rebates under the Medicaid program because this would result in duplicate discounts.

While an organization is eligible to participate in the program, it must notify the Health Resources and Services Administration’s (HRSA) Office of Pharmacy Affairs (OPA) of its intention to participate by registering for the 340B Program. Participation in the 340B Program normally begins on the first day of a quarter. It is the entity's responsibility to tell its wholesaler or manufacturer that it is registered for 340B discount prices when it places an order.

All organizations receiving 340B prices are required to maintain records of purchases of covered outpatient drugs and of any claims for reimbursement submitted for such drugs under title XIX of the Social Security Act (Medicaid program, CFDA 93.778).

Guidance for the 340B program is found in the following documents available at <http://www.hrsa.gov/opa/federalregister.htm>:

“Guidance Regarding Section 602 of the Veterans Health Care Act of 1992 Limitation on Prices of Drugs Purchased by Covered Entities” 58 FR 27289 (May 7, 1993)

“Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Duplicate Discounts and Rebates on Drug Purchases (58 FR 34058-34059), June 23, 1993.

“Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Entity Guidelines” 59 FR 25110 (May 13, 1994).

Additional information is available at <http://www.hrsa.gov/opa/introduction.htm>.

Compliance Requirements – Organizations participating in the 340B Program must ensure that (1) their organizational information is accurate in the 340B database maintained by OPA; (2) outpatient drugs purchased under the 340 B Program are not being given to individuals who are not eligible patients (diversion); and (3) discounts are not being received from both Medicaid rebates and 340B discounts (duplicate discounts).

Accurate Information

Section 340B of the PHS Act requires OPA to maintain accessible data on the identity of participating entities. Covered entities are required to ensure the accuracy of the information in the database by regularly updating (at least annually) their information, including the covered entity's exact name and street address, through submission of change request forms to OPA.

Diversion

Section 340B(a)(5)(B) of the PHS Act prohibits covered entities from selling, transferring, or giving covered outpatient drugs to anyone other than patients of the covered entity. The statute does not define the term "patient" in section 340B and in 1996, HRSA issued a guideline regarding the definition of a "patient" under the 340B program. An individual is a "patient" of a covered entity (with the exception of State-operated or funded AIDS drug purchasing assistance programs) only if: (1) the covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual's health care; (2) the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g. referral for consultation) such that responsibility for the care provided remains with the covered entity; and (3) the individual receives a health care service or range of services from the covered entity which is consistent with the service or range of services for which grant funding is provided. Additional information is available at <ftp://ftp.hrsa.gov/bphc/pdf/opa/FR10241996.pdf>. "Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility."

Duplicate Discounts

Section 340B(a)(5)(A) of the PHS Act required the Secretary of HHS to establish a mechanism to ensure that manufacturers did not pay a "duplicate discount" on a drug claim. A "duplicate discount" would occur if an entity received a **340B discount** and a **Medicaid rebate** were provided on the same drug. The mechanism that the Secretary established to comply with the legislation's mandate to prohibit duplicate discounts is a part of the OPA database called the Medicaid Exclusion File (58 FR 34058 (June 23, 1993) and 59 Fed. Reg. 25110 (May 13, 1994)). Additional information is available at <http://www.hrsa.gov/opa/medicaidexclusion.htm>. If this program includes a "payer of last resort" provision, a patient's Medicaid eligibility will require the return of rebate funds to manufacturers so as not to incur double recovery.

Audit Objectives – To determine if (1) a grantee's records are correct in the 340B database; (2) drugs were diverted to individuals who are not eligible patients; and (3) if the organization received duplicate discounts.

Suggested Audit Procedures

- a. Determine if the grantee is participating in the 340B Program and, if so, continue with the remaining audit procedures.
- b. Review the grantee's latest change form submitted to OPA and compare it with the organization's actual physical location and other current information about the entity.
- c. Test a sample of drugs purchased for use under the funding program (CFDA 93.xxx) during the audit period to determine whether 340B drugs were properly identified throughout the procurement process, including (1) payment at the discounted price and (2) proper identification as a 340B drug upon receipt.
- d. Test a sample of records of 340B drugs purchased for use under the funding program and released from inventory during the audit period to determine whether required authorizations were received, to whom the drugs were dispensed, and if the grantee determined that such individuals were eligible patients before dispensing the drugs.
- e. For eligible patients who received 340B drugs, test a sample of Medicaid reimbursement requests to verify that the grantee did not claim, receive, or retain a duplicate rebate for those drugs under the Medicaid program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.918 GRANTS TO PROVIDE OUTPATIENT EARLY INTERVENTION SERVICES WITH RESPECT TO HIV DISEASE (Ryan White HIV/AIDS Program Part C)

I. PROGRAM OBJECTIVES

The objective of this program is to provide, on an outpatient basis, high-quality, early intervention services and primary care related to the Human Immunodeficiency Virus (HIV). This is accomplished by increasing the present capacity of eligible ambulatory health service providers to provide a continuum of HIV prevention for at-risk individuals, and care for individuals who are HIV-infected, including when applicable, perinatal care.

II. PROGRAM PROCEDURES

Administration and Services

This program is administered at the Federal level by the HIV/Acquired Immunodeficiency Syndrome (AIDS) Bureau, Health Resources and Services Administration (HRSA), a component of the Department of Health and Human Services.

Grants are awarded to public and non-profit private entities, including federally qualified health centers under section 1905(1)(2)(B) of the Social Security Act. Grants are also awarded to non-State family planning organizations, comprehensive hemophilia diagnostic and treatment centers, rural health clinics, health facilities operated by or pursuant to a contract with the Indian Health Service, community-based organizations, clinics, hospitals, and other health facilities that provide early intervention services to those persons infected with HIV/AIDS through intravenous drug use, or to nonprofit private entities that provide comprehensive primary care services to populations at risk of HIV/AIDS, including faith-based and community-based organizations. Those providers must be qualified Medicaid-participating providers unless an exception is granted by HRSA (42 USC 300ff-52(a)(1)(A) through (G) and 42 USC 300ff-52(b)).

The early intervention services (EIS) program enables primary health care providers to include a range of services from risk assessment, and HIV counseling, testing, and referral services to clinical care for people with HIV. Many of these providers receive other Federal funding, e.g., community and migrant health centers, but this categorical funding allows them to provide adequate funding for these services.

Services may be provided directly by the grantee or through contractual agreements with other service providers.

Source of Governing Requirements

The HIV EIS grant program is authorized under Part C of Title XXVI of the PHS Act, as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Program), and is codified at 42 USC 300ff-51 through 300ff-67. The program has no specific program regulations.

Availability of Other Program Information

Further information about this program is available at <http://www.hab.hrsa.gov/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look first to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Activities Allowed*

- a. Funds may be used for counseling (whether or not associated with testing) and testing for HIV (42 USC 300ff-51(e)(1)(A) and (B) and 42 USC 300ff-62(f)).
- b. Funds may be used to provide diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related conditions (including STD, hepatitis C, and tuberculosis). This includes periodic medical evaluations, appropriate treatment of HIV infection, prophylactic, and treatment interventions for complications of HIV infection (including opportunistic infections, opportunistic malignancies, and other AIDS-defining conditions) (42 USC 300ff-51(e)(1)(D) and (E)).
- c. Funds may be used to refer clients to sub-specialty or consultant services, and to related evaluation, diagnostic, and treatment services. This includes, but is not limited to, infectious diseases, oncology, dermatology, ophthalmology, pulmonary and oral health specialists as well as outpatient mental health and substance abuse services and nutrition assessment and counseling related to living with HIV/AIDS (42 USC 300ff-51(e)(2)(A-C)).
- d. Funds may be used for core medical services for an individual with HIV/AIDS, including the co-occurring conditions of the individual, defined as outpatient and ambulatory health services; AIDS Drug Assistance Program treatments defined under 42 USC 300ff-16; AIDS pharmaceutical assistance; oral health care; early intervention services described in 42 USC 300ff-51(e); health insurance premium and cost sharing assistance for low-income individuals in accordance with 42 USC 300ff-15; home health care; medical nutrition therapy; hospice services; home and community-based health services as defined under 42 USC 300ff-14(c); mental health services, substance abuse outpatient care; and medical case management including treatment adherence services (42 USC 300ff-51(c)(3)).

- e. Funds may be used to pay the costs of providing support services that are needed for individuals with HIV/AIDS to achieve their medical outcomes. These services include, but are not limited to, respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, translation, and referrals for health care and support services (42 USC 300ff-51(b)(1)(B)).
- f. Funds may be used for the establishment of a clinical quality management program to assess the extent to which medical services are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infections, to develop strategies for insuring that such services are consistent with the guidelines and to ensure that improvements in the access to and quality of HIV health services are addressed (42 USC 300ff-64(g)(5)).
- g. Funds may be used for administrative expenses. Indirect costs under a federally negotiated indirect cost rate are considered to be administrative expenses (42 USC 300ff-51(b)(1)(C)).

2. *Activities Unallowed*

- a. Funds may not be used to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made for that item or service under any State compensation program, under an insurance policy (except for a program administered by or providing the services of the Indian Health Service), or under any Federal or State health benefits program or by an entity that provides health services on a prepaid basis (42 USC 300ff-64(f)(1)).
- b. Funds may not be awarded to for-profit entities to carry out required early intervention services unless they are the only available providers of quality HIV care in the area (42 USC 300ff-51(e)(3)(A)).
- c. Grant funds may not be used for AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug abuse or sexual activity, homosexual or heterosexual (42 USC 300ff-84).
- d. Funds may not be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug (Pub. L. No. 112-74, Section 523).
- e. Funds received under this grant will not be expended for any purpose other than the purposes for which the grant was awarded (42 USC 300ff-64(g)(1)).

G. Matching, Level of Effort, Earmarking**1. Matching – Not Applicable****2.1 Level of Effort – *Maintenance of Effort***

A grantee must maintain its expenditures for early intervention services at a level equal to not less than the level of expenditures for such services for the fiscal year preceding the fiscal year for which the applicant is applying to receive the grant (42 USC 300ff-64(d)).

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

a. A minimum of 50 percent of the funds awarded must be spent on providing the following early intervention services to individuals with HIV disease: testing, referrals, other clinical and diagnostic services, periodic medical evaluations, and therapeutic measures—directly and on-site or at sites where other primary care services are rendered (42 USC 300ff-51(b)(2), (e)(1) and (2), and (e)(3)(A) and (B)).

b. Unless waived, a minimum of 75 percent of the funds remaining after clinical quality management and administration are deducted must be spent on core medical services for an individual with HIV/AIDS, including the co-occurring conditions of the individual. (42 USC 300ff-51(c)(1)).

(1) Core medical services are defined as outpatient and ambulatory health services; AIDS Drug Assistance Program treatments defined under 42 USC 300ff-16; AIDS pharmaceutical assistance; oral health care; early intervention services described in 42 USC 300ff-51(e); health insurance premium and cost sharing assistance for low-income individuals in accordance with 42 USC 300ff-15; home health care; medical nutrition therapy; hospice services; home and community-based health services as defined under 42 USC 300ff-14(c); mental health services; substance abuse outpatient care; and medical case management including treatment adherence services (42 USC 300ff-51(c)(3)).

(2) A grantee may have applied for and received a waiver of the 75 percent requirement for core medical services if it is determined that, within the service area of the grantee, there are no waiting lists for the AIDS Drug Assistance Program and that core medical services are available to all individuals with HIV/AIDS identified and eligible under the Ryan White HIV/AIDS Program (42 USC 300ff-51(c)(2)).

- c. Not more than 10 percent of the approved Federal grant funds may be used for administrative expenses, including planning and evaluation, except that the costs of a clinical quality management program may not be considered administrative expenses for purposes of such limitation (42 USC 300ff-64(g)(3)).

J. Program Income

Providers may impose charges for the provision of services only as follows (42 USC 300ff-64(e)):

INDIVIDUAL'S INCOME LEVEL	PERMISSIBLE AGGREGATE CHARGES
Less than or equal to 100 percent of official poverty line	No charges may be imposed
Greater than 100 percent of the official poverty line	Charges must be imposed according to a publicly available sliding scale fee schedule, BUT
Greater than 100 percent of the official poverty line and not exceeding 200 percent of that poverty line	A provider may not, for any calendar year, impose aggregate charges in an amount exceeding 5 percent of the annual gross income of the individual involved.
Greater than 200 percent of the official poverty line and not exceeding 300 percent of that poverty line	A provider may not, for any calendar year, impose aggregate charges in an amount exceeding 7 percent of the annual gross income of the individual involved.
Greater than 300 percent of the official poverty line	A provider may not, for any calendar year, impose aggregate charges in an amount exceeding 10 percent of the annual gross income of the individual involved.

The poverty guidelines are published each year in the *Federal Register*. HHS also maintains this information at <http://aspe.hhs.gov/poverty/>.

The term “aggregate charges” applies to the annual charges without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges for services (42 USC 300ff-64 (e)(4)).

The charges shall be made on the basis of a publicly available schedule of charges and may, at the grantee’s discretion, be assessed at an alternate lesser amount (42 USC 300ff-64(e)(1) and (3)).

The requirement for an individual service provider to impose a charge will be waived by HRSA in those instances when the provider does not impose a charge or accept reimbursement available from any third-party payer, including reimbursement under any insurance policy or any Federal or State health benefits program and a waiver has been granted by HRSA under 42 USC 300ff-52(b)(2) (42 USC 300ff-64(e)(5)).

L. Reporting**1. Financial Reporting**

- a. SF-270, *Request for Advance or Reimbursement* – Applicable only for grantees on restricted drawdown as described on the Notice of Grant Award.
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable**3. Special Reporting** – Not Applicable**4. Section 1512 ARRA Reporting** – Not Applicable**5. Subaward Reporting under the Transparency Act** – Not Applicable**N. Special Tests and Provisions****Section 340B Drug Pricing Program**

Section 602 of Public Law 102-585, the “Veterans Health Care Act of 1992,” enacted section 340B of the Public Health Service Act (“PHS Act”), “Limitation on Prices of Drugs Purchased by Covered Entities.” Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally qualified health center look-alikes and qualified hospitals. Drugs purchased from participating drug manufacturers by covered entities through the 340B Program may not be sold or transferred to anyone other than the patients of the covered entities. In addition, drugs purchased through the 340B Program are not entitled to rebates under the Medicaid program because this would result in duplicate discounts.

While an organization is eligible to participate in the program, it must notify the Health Resources and Services Administration’s (HRSA) Office of Pharmacy Affairs (OPA) of its intention to participate by registering for the 340B Program. Participation in the 340B Program normally begins on the first day of a quarter. It is the entity's responsibility to tell its wholesaler or manufacturer that it is registered for 340B discount prices when it places an order.

All organizations receiving 340B prices are required to maintain records of purchases of covered outpatient drugs and of any claims for reimbursement submitted for such drugs under title XIX of the Social Security Act (Medicaid program, CFDA 93.778).

Guidance for the 340B program is found in the following documents available at <http://www.hrsa.gov/opa/federalregister.htm>:

“Guidance Regarding Section 602 of the Veterans Health Care Act of 1992 Limitation on Prices of Drugs Purchased by Covered Entities” 58 FR 27289 (May 7, 1993)

“Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Duplicate Discounts and Rebates on Drug Purchases (58 FR 34058-34059), June 23, 1993.

“Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Entity Guidelines” 59 FR 25110 (May 13, 1994).

Additional information is available at <http://www.hrsa.gov/opa/introduction.htm>.

Compliance Requirements – Organizations participating in the 340B Program must ensure that (1) their organizational information is accurate in the 340B database maintained by OPA; (2) outpatient drugs purchased under the 340 B Program are not being given to individuals who are not eligible patients (diversion); and (3) discounts are not being received from both Medicaid rebates and 340B discounts (duplicate discounts).

Accurate Information

Section 340B of the PHSA requires OPA to maintain accessible data on the identity of participating entities. Covered entities are required to ensure the accuracy of the information in the database by regularly updating (at least annually) their information, including the covered entity's exact name and street address, through submission of change request forms to OPA.

Diversion

Section 340B(a)(5)(B) of the PHSA prohibits covered entities from selling, transferring, or giving covered outpatient drugs to anyone other than patients of the covered entity. The statute does not define the term “patient” in section 340B and in 1996, HRSA issued a guideline regarding the definition of a “patient” under the 340B program. An individual is a “patient” of a covered entity (with the exception of State-operated or funded AIDS drug purchasing assistance programs) only if: (1) the covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual’s health care; (2) the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g. referral for consultation) such that responsibility for the care provided remains with the covered entity; and (3) the individual receives a health care service or range of services from the covered entity which is consistent with the service or range of services for which grant funding is provided. Additional information is available at <ftp://ftp.hrsa.gov/bphc/pdf/opa/FR10241996.pdf>. “Final Notice Regarding Section 602 of the Veterans Health Care Act of 1992 Patient and Entity Eligibility.”

Duplicate Discounts

Section 340B(a)(5)(A) of the PHS Act required the Secretary of HHS to establish a mechanism to ensure that manufacturers did not pay a "duplicate discount" on a drug claim. A "duplicate discount" would occur if an entity received a **340B discount** and a **Medicaid rebate** were provided on the same drug. The mechanism that the Secretary established to comply with the legislation's mandate to prohibit duplicate discounts is a part of the OPA database called the Medicaid Exclusion File (58 FR 34058 (June 23, 1993) and 59 Fed. Reg. 25110 (May 13, 1994)). Additional information is available at <http://www.hrsa.gov/opa/medicaidexclusion.htm>. If this program includes a "payer of last resort" provision, a patient's Medicaid eligibility will require the return of rebate funds to manufacturers so as not to incur double recovery.

Audit Objectives – To determine if (1) a grantee's records are correct in the 340B database; (2) drugs were diverted to individuals who are not eligible patients; and (3) if the organization received duplicate discounts.

Suggested Audit Procedures

- a. Determine if the grantee is participating in the 340B Program and, if so, continue with the remaining audit procedures.
- b. Review the grantee's latest change form submitted to OPA and compare it with the organization's actual physical location and other current information about the entity.
- c. Test a sample of drugs purchased for use under the funding program (CFDA 93.xxx) during the audit period to determine whether 340B drugs were properly identified throughout the procurement process, including (1) payment at the discounted price and (2) proper identification as a 340B drug upon receipt.
- d. Test a sample of records of 340B drugs purchased for use under the funding program and released from inventory during the audit period to determine whether required authorizations were received, to whom the drugs were dispensed, and if the grantee determined that such individuals were eligible patients before dispensing the drugs.
- e. For eligible patients who received 340B drugs, test a sample of Medicaid reimbursement requests to verify that the grantee did not claim, receive, or retain a duplicate rebate for those drugs under the Medicaid program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.958 BLOCK GRANTS FOR COMMUNITY MENTAL HEALTH SERVICES

I. PROGRAM OBJECTIVES

The objective of the Community Mental Health Services (CMHS) Block Grant program is to provide funds to States and territories to enable them to carry out their respective plans for providing comprehensive community-based mental health services for adults with serious mental illness and children with serious emotional disturbances. To insure creative and cost effective delivery of services, States are encouraged to develop solutions to address the specific mental health concerns of their local communities.

II. PROGRAM PROCEDURES

Administration and Services

The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division of the Department of Health and Human Services (HHS), administers the block grant program. Examples of CMHS Block Grant funded activities include: (1) a comprehensive, community-based system of mental health care for adults who have a serious mental illness and children and youth who have a serious emotional disturbances, including case management, treatment, rehabilitation, employment, housing, education, medical, dental, and other support services that enable individuals to function in the community and reduce the rate of psychiatric hospitalization; (2) outreach for homeless individuals who also suffer from serious mental illness and the development of special services for individuals with serious illness living in rural areas; and (3) systemic integration of social, educational, juvenile justice, and substance abuse services with health and mental health services for children with a serious emotional disturbance to ensure that care is appropriate to their multiple needs (including services provided under the Individuals with Disabilities Act).

CMHS funds are allocated to the States according to a formula legislated by Congress. States may then distribute these funds to cities, counties, or service providers within their jurisdictions. Funds may only be used for carrying out the State plan, evaluating programs and services carried out under the plan, or planning, administration, and education activities relating to providing services under the plan.

State Plan

The State must submit to SAMHSA an annual application that includes a plan to meet the community mental health services objectives described above and signed assurances required by the Act. The State plan addresses how the State intends to comply with the various requirements of Title XIX, Part B, Subparts I and III of the Public Health Service Act (42 USC 300x) and its program objectives by addressing the five criteria listed in the statute.

Source of Governing Requirements

This program is authorized under Title XIX, Part B, Subparts I and III of the Public Health Service Act (42 USC 300x *et seq.*). Criteria for the State plan may be found at 42 USC 300x-1. 45 CFR part 96 provides regulations for the general administrative requirements for the covered block grant programs. These regulations are in lieu of 45 CFR part 92 (the HHS implementation of the A-102 Common Rule). In addition, States are to administer the CMHS program according to the plans that they submitted to SAMHSA.

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, States are to use the fiscal policies that apply to their own funds in administering CMHS. Procedures must be adequate to assure the proper disbursement of and accounting for Federal funds paid to the grantee, including procedures for monitoring the assistance provided (45 CFR section 96.30).

Under the block grant philosophy, each State is responsible for designing and implementing its own CMHS program, within very broad Federal guidelines. States must administer their CMHS program according to their approved plan and any amendments and in conformance with their own implementing rules and policies.

Availability of Other Program Information

SAMHSA published a notice in the *Federal Register* on July 6, 2001 (66 FR 35658) that details approval requirements for non-recurring expense exclusions from maintenance-of-effort calculations. A second SAMHSA *Federal Register* notice, published on November 23, 2001 (66 FR 58746-58747) addresses retroactive application of the non-recurring expense exclusion.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Services provided with grant funds shall be provided only through appropriate, qualified community programs (which may include community mental health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer support programs and mental health primary consumer-directed programs). Services under the plan will be provided through community mental health centers only if the services are provided as follows:
 - a. Services principally to individuals residing in a defined geographic area (service area);

- b. Outpatient services, including specialized outpatient services for children, the elderly, individuals with serious mental illness, and residents of the centers who have been discharged from inpatient treatment at a mental health facility;
 - c. 24-hours-a-day emergency care services;
 - d. Day treatment and other partial hospitalization services or psychosocial rehabilitation services; or
 - e. Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission (42 USC 300x-2(b) and (c)).
2. The State shall not use grant funds to:
- a. Provide inpatient hospital services. An inpatient is a person who is formally admitted to the inpatient service of a hospital for observation, care, diagnosis, or treatment;
 - b. Make cash payments to intended recipients of health services;
 - c. Purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility, or purchase major medical equipment;
 - d. Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding; or
 - e. Provide financial assistance to any entity other than a public or non-profit entity. A State is not precluded from entering into a procurement contract for services, since payments under such a contract are not financial assistance to the contractor (42 USC 300x-5(a)).

B. Allowable Costs/Cost Principles

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, CMHS is exempt from the provisions of OMB cost principles circulars. State cost principles requirements apply to CMHS (45 CFR section 96.30).

G. Matching, Level of Effort, Earmarking

1. Matching – Not Applicable

2.1 Level of Effort – *Maintenance of Effort*

- a. The State shall for each fiscal year maintain aggregate State expenditures for community mental health centers at a level that is not less than the average level of such expenditures maintained by the State for the two State fiscal years preceding the fiscal year of the grant. Expenditures for the two previous fiscal years are reported in the State plan. The Secretary may exclude from the aggregate State expenditures funds appropriated to the principal agency for authorized activities which are of a non-recurring nature and for a specific purpose (42 USC 300x-4(b); *Federal Register*, July 6, 2001 (66 FR 35658) and November 23, 2001 (66 FR 58746-58747) as specified in II, “Program Procedures – Availability of Other Program Information”).
- b. The State shall for each fiscal year expend an amount not less than an amount equal to the amount expended in fiscal year 1994 for systems of integrated services for children with serious emotional disturbance (42 USC 300x-2(a)(1)(C)). FY 1994 expenditures are reported in the State plan.

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable

3. Earmarking

The State may not expend more than 5 percent of grant funds for administrative expenses with respect to the grant (42 USC 300x-5(b)).

H. Period of Availability of Federal Funds

Any amounts paid to the State for a fiscal year shall be available for obligation and expenditure until the end of the fiscal year following the fiscal year for which the amounts were paid (42 USC 300x-62).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. **Section 1512 ARRA Reporting** – Not Applicable
5. **Subaward Reporting under the Transparency Act** – Applicable

N. Special Tests and Provisions

Independent Peer Reviews

Compliance Requirement – The State must provide for independent peer reviews that assess the quality, appropriateness, and efficacy of treatment services provided to individuals. At least 5 percent of the entities providing services in the State shall be reviewed annually. The entities reviewed shall be representative of the entities providing the services (42 USC 300x-53(a))

Audit Objectives – Determine whether (1) the required number of entities was peer reviewed, (2) the selection of entities for peer review was representative of entities providing services, and (3) the State ensured that the peer reviewers were independent.

Suggested Audit Procedures

- a. Ascertain the number of entities providing treatment services in the State.
- b. Ascertain if the number of entities reviewed was at least 5 percent of the entities providing treatment services.
- c. Ascertain if the selection of entities for peer review was representative of entities providing services.
- d. From a sample of peer reviews performed, ascertain if the State ensured that the peer reviewers were independent.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.959 BLOCK GRANTS FOR PREVENTION AND TREATMENT OF SUBSTANCE ABUSE

I. PROGRAM OBJECTIVES

The objective of the Substance Abuse Prevention and Treatment (SAPT) Block Grant program is to provide funds to States, territories, and one Indian Tribe for the purpose of planning, carrying out and evaluating activities to prevent and treat Substance Abuse (SA) and other related activities as authorized by the statute.

The SAPT Block Grant is the primary tool the Federal government uses to fund State SA prevention and treatment programs. While the SAPT Block Grant provides Federal support to addiction prevention and treatment services nationally, it empowers the States to design solutions to specific addiction problems that are experienced locally.

II. PROGRAM PROCEDURES

Administration and Services

The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division of the Department of Health and Human Services (HHS), administers the block grant program. For purposes of this guidance, the term “State” includes the 50 States, the District of Columbia, American Samoa, Guam, the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Marianas, Palau, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, and the Red Lake Band of Chippewa Indians. The States generally subaward funds for the provision of services to public and non-profit organizations. Service providers may include for-profit organizations but for-profits may not receive financial assistance.

Examples of SAPT activities are:

- a. *Alcohol Treatment and Rehabilitation* – Direct services to patients experiencing primary problems for alcohol, such as outreach, detoxification, outpatient counseling, residential rehabilitation, hospital based care (not inpatient hospital services), abuse monitoring, vocational counseling, case management, central intake, and program administration.
- b. *Drug Treatment and Rehabilitation* – Direct services to patients experiencing primary problems with illicit and licit drugs, such as outreach, detoxification, methadone maintenance and detoxification, outpatient counseling, residential rehabilitation, including therapeutic communities, hospital based care (not inpatient hospital services), vocational counseling, case management central intake, and program administration.
- c. *Primary Prevention Activities* – Education, counseling, and other activities designed to reduce the risk of substance abuse.

The SAPT funds are allocated to the States according to a formula legislated by Congress. States may then distribute these funds to cities, counties, or service providers within their jurisdictions based on need. Of the SAPT funds dispensed to each State annually, Congress has specified that the State will expend not less than 20 percent for programs for individuals who do not require treatment for substance abuse. The programs should (1) educate and counsel the individuals on such abuse and (2) provide for activities to reduce the risk of such abuse by the individuals. SAPT Block Grant statutory “set asides” were established to fund programs targeting special populations, such as services for women, especially pregnant and postpartum women and their children, and, in certain States, for screening for human immunodeficiency virus (HIV).

State Plan

The State must submit to SAMHSA for approval, an annual application which includes a State plan for SA prevention and treatment services objectives described above and signed assurances required by the Act and implementing regulations. The entire application, including the plan, must be reviewed by SAMHSA to ensure that all of the requirements of the law and regulations are met.

The State plan addresses how the State intends to comply with the various requirements of Title XIX, Part B, Subparts II and III of the Public Health Service Act (42 USC 300x) and its program objectives and specific allocations by: (1) conducting State and local demand and need assessments; (2) establishing statewide prevention and treatment improvement plans with specific multi-year goals for narrowing identified service gaps, implementing training efforts, and fostering coordination among SA treatment, primary health care, and human service agencies; and (3) addressing human resource requirements, clinical standards and identified treatment improvement goals, and ensuring coordination of all health and human services for addicted individuals.

The State shall make the plan public within the State in such a manner as to facilitate comment from any person (including any Federal or other public agency) during development of the plan (including any revisions) and after submission of the plan to SAMHSA.

Source of Governing Requirements

This program is authorized under Title XIX, Part B, Subparts II and III of the Public Health Service Act (42 USC 300x). Implementing regulations are published at 45 CFR part 96. Those regulations include general administrative requirements for the covered block grant programs in lieu of 45 CFR part 92 (the HHS implementation of the A-102 Common Rule)). Requirements specific to SAPT are in 45 CFR sections 96.120 through 96.137. In addition, grantees are to administer their SAPT programs according to the plan that they submitted to SAMHSA.

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, States are to use the fiscal policies that apply to their own funds in administering SAPT. Procedures must be adequate to assure the proper disbursement of and accounting for Federal funds paid to the grantee, including procedures for monitoring the assistance provided (45 CFR section 96.30).

Availability of Other Program Information

SAMHSA published a notice in the *Federal Register* on July 6, 2001 (66 FR 35658) that details approval requirements for non-recurring expense exclusions from maintenance-of-effort calculations. A second SAMHSA *Federal Register* notice, published on November 23, 2001 (66 FR 58746-58747) addresses retroactive application of the non-recurring expense exclusion.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. The State shall not use grant funds to provide inpatient hospital services except when it is determined by a physician that: (a) the primary diagnosis of the individual is SA and the physician certifies this fact; (b) the individual cannot be safely treated in a community based non-hospital, residential treatment program; (c) the service can reasonably be expected to improve an individual's condition or level of functioning; and (d) the hospital based SA program follows national standards of SA professional practice. Additionally, the daily rate of payment provided to the hospital for providing the services to the individual cannot exceed the comparable daily rate provided for community based non-hospital residential programs of treatment for SA and the grant may be expended for such services only to the extent that it is medically necessary (i.e., only for those days that the patient cannot be safely treated in a residential community based program) (42 USC 300x-31(a) and (b); 45 CFR sections 96.135(a)(1) and (c)).
2. Grant funds may be used for loans from a revolving loan fund for provision of housing in which individuals recovering from alcohol and drug abuse may reside in groups. Individual loans may not exceed \$4000 (45 CFR section 96.129).
3. Grant funds shall not be used to make cash payments to intended recipients of health services (42 USC 300x-31(a); 45 CFR section 96.135(a)(2)).
4. Grant funds shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility, or purchase major medical equipment. The Secretary may provide a waiver of the restriction for the construction of a new facility or rehabilitation of an existing facility, but not for land acquisition (42 USC 300x-31(a); 45 CFR sections 96.135(a)(3) and (d)).
5. The State shall not use grant funds to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding (42 USC 300x-31(a); 45 CFR section 96.135(a)(4)).

6. Grant funds may not be used to provide financial assistance (i.e., a subgrant) to any entity other than a public or non-profit entity. A State is not precluded from entering into a procurement contract for services, since payments under such a contract are not financial assistance to the contractor (42 USC 300x-31(a); 45 CFR section 96.135 (a)(5)).
7. The State shall not expend grant funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (42 USC 300ee-5; 45 CFR section 96.135 (a)(6) and Pub. L. 106-113, section 505).
8. Grant funds may not be used to enforce State laws regarding sale of tobacco products to individuals under age of 18, except that grant funds may be expended from the primary prevention set-aside of SAPT under 45 CFR section 96.124(b)(1) for carrying out the administrative aspects of the requirements such as the development of the sample design and the conducting of the inspections (45 CFR section 96.130 (j)).
9. No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization (42 USC 300x-65 and 42 USC 290kk; 42 CFR section 54.4).

B. Allowable Costs/Cost Principles

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, SAPT is exempt from the provisions of OMB cost principles circulars. State cost principles requirements apply to SAPT.

G. Matching, Level of Effort, Earmarking

1. Matching – Not Applicable

2.1 Level of Effort – *Maintenance of Effort*

- a. The State shall for each fiscal year maintain aggregate State expenditures for authorized activities by the principal agency at a level that is not less than the average level of such expenditures maintained by the State for the two State fiscal years preceding the fiscal year for which the State is applying for the grant. The “principal agency” is defined as the single State agency responsible for planning, carrying out and evaluating activities to prevent and treat SA and related activities. The Secretary may exclude from the aggregate State expenditures funds appropriated to the principal agency for authorized activities which are of a non-recurring nature and for a specific purpose (42 USC 300x-30; 45 CFR sections 96.121 and 96.134; and *Federal Register*, July 6, 2001 (66 FR 35658) and November 23, 2001 (66 FR 58746-58747) as specified in II, “Program Procedures – Availability of Other Program Information”).

- b. The State must maintain expenditures at not less than the calculated fiscal year 1994 base amount for SA treatment services for pregnant women and women with dependent children. The fiscal year 1994 base amount was reported in the State's fiscal year 1995 application (42 USC 300x-27; 45 CFR section 96.124(c)).
- c. Designated States shall maintain expenditures of non-Federal amounts for HIV services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the first fiscal year for which the State receives such a grant. A designated State is any State whose rate of cases of HIV is 10 or more such cases per 100,000 individuals (as indicated by the number of such cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the most recent calendar year for which the data are available.) (42 USC 300x-30; 45 CFR sections 96.128 (b) and (f)).
- d. The State shall maintain expenditures of non-Federal amounts for tuberculosis services at a level that is not less than an average of such expenditures maintained by the State for the 2 year period preceding the first fiscal year for which the State receives such a grant (42 USC 300x-24; 45 CFR section 96.127).

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable

3. Earmarking

- a. The State shall expend not less than 20 percent of SAPT for primary prevention programs for individuals who do not require treatment of SA. The programs should educate and counsel the individuals on such abuse and provide for activities to reduce the risk of such abuse by the individuals (42 USC 300x-22; 45 CFR sections 96.124 (b)(1) and 96.125).
- b. Designated States shall expend not less than 2 percent and not more than 5 percent of the award amount to carry out one or more projects to make available to individuals early intervention services for HIV disease at the sites where the individuals are undergoing SA treatment. If the State carries out two or more projects, the State will carry out one such project in a rural area of the State unless the Secretary waives the requirement (42 USC 300x-24; 45 CFR section 96.128(a)(1) and (d)).
- c. The State may not expend more than 5 percent of the grant to pay the costs of administering the grant (42 USC 300x-31; 45 CFR section 96.135 (b)(1)).
- d. The State may not expend grant funds for providing treatment services in penal or correctional institutions in an amount more than that expended for such programs by the State for fiscal year 1991 (42 USC 300x-31; 45 CFR section 96.135(b)(2)).

H. Period of Availability of Federal Funds

Any amounts awarded to the State for a fiscal year shall be available for obligation and expenditure until the end of the fiscal year following the fiscal year for which the amounts were awarded (42 USC 300x-62).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Not Applicable

5. Subaward Reporting under the Transparency Act – Applicable.

N. Special Test and Provisions

Independent Peer Reviews

Compliance Requirement – The State must provide for independent peer reviews which assess the quality, appropriateness, and efficacy of treatment services provided to individuals. At least 5 percent of the entities providing services in the State shall be reviewed. The entities reviewed shall be representative of the entities providing the services. The State shall ensure that the peer reviewers are independent by ensuring that the peer review does not involve reviewers reviewing their own programs and the peer review is not conducted as part of the licensing or certification process (42 USC 300x-53(a); 45 CFR section 96.136).

Audit Objectives – Determine whether (1) the required number of entities was peer reviewed, (2) the selection of entities for peer review was representative of entities providing services, (3) the State ensured that the peer reviewers were independent.

Suggested Audit Procedures

1. Ascertain the number of entities providing treatment services in the State.
2. Ascertain if the number of entities reviewed was at least 5 percent of the entities providing treatment services.

3. Ascertain if the selection of entities for peer review was representative of entities providing services.
4. Select a sample of peer reviews and ascertain if the State ensured that the peer reviewers were independent.

IV. OTHER INFORMATION

As described in Part 4, Social Services Block Grant (SSBG) program (CFDA 93.667), III.A, "Activities Allowed or Unallowed," a State may transfer up to 10 percent of its annual allotment under SSBG to this and other specified block grant programs.

Amounts transferred into this program are subject to the requirements of this 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.991 PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

I. PROGRAM OBJECTIVES

The purpose of the Preventive Health and Health Services Block Grant (PHHSBG) is to provide States with the resources to improve the health status of the population of each grantee through: (1) preventive health services, comprehensive public health services, emergency medical services, etc; (2) activities leading to the accomplishment of the most current Healthy People Objectives for the nation; (3) rodent control and community-school fluoridation activities; (4) specified emergency medical services excluding most equipment purchases; (5) services for sex offense victims including prevention activities; (6) integrated pest management to reduce asthma related illnesses and (7) for related administration, education, monitoring and evaluation activities.

II. PROGRAM PROCEDURES

Administration and Services

The PHHSBG program is administered by the Centers for Disease Control and Prevention (CDC), a component of the Department of Health and Human Services (HHS). After receiving and reviewing a State's grant application, the CDC awards funds to the State according to a two-part formula prescribed at 42 USC 300w-1(a)(1) and 300w-1(b).

Source of Governing Requirements

The PHHSBG is authorized under Title X of the Public Health Service Act, as amended, and is codified as 42 USC 300 et seq. The implementing regulations for this and other block grant programs authorized by Omnibus Budget Reconciliation Act of 1981 are published at 45 CFR part 96. Those regulations include general administrative requirements in lieu of 45 CFR part 92 (the HHS implementation of the A-102 Common Rule) for the covered block grant programs.

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, States are to use the fiscal policies that apply to their own funds in administering PHHSBG. Procedures must be adequate to assure the proper disbursement of and accounting for Federal funds paid to the grantee, including procedures for monitoring the assistance provided (45 CFR section 96.30).

Under the block grant philosophy, each grantee is responsible for designing and implementing its own PHHSBG program, within very broad Federal guidelines. Grantees must administer their PHHSBG program according to their approved plan and any amendments and in conformance with the grantee's own implementing rules and policies.

Availability of Other Program Information

The PHHSBG web page provides general information about this program (<http://www.cdc.gov/nccdphp/blockgrant/index.htm>).

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should first look to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. *Activities Allowed*

- a. Activities consistent with making progress towards achieving the objectives established by the Secretary for the health status of the population of the United States (42 USC 300w-3(a)(1)(A)).
- b. Preventive health service programs for the control of rodents and for community and school-based fluoridation programs (42 USC 300w-3(a)(1)(B)).
- c. Feasibility studies and planning for emergency medical services systems and the establishment, expansion, and improvement of such systems. Amounts for such systems may not be used for the costs of the operation of the systems or the purchase of equipment for the systems, except that such amounts may be used for the payment of not more than 50 percent of the costs of purchasing communications equipment for the systems. Amounts may be expended for feasibility studies or planning for the trauma-care components of such systems only if the studies or planning, respectively, is consistent with the requirements of 42 USC 300d-13(a) ((42 USC 300w-3(a)(1)(C)).
- d. Providing services to victims of sex offenses and for prevention of sex offenses (42 USC 300w-3(a)(1)(D)).
- e. Establishment, operation, and coordination of effective and cost-efficient systems to reduce the prevalence of illness due to asthma and asthma-related illnesses, especially among children, by reducing the level of exposure to cockroach allergen or other known asthma triggers through the use of integrated pest management, as applied to cockroaches or other known allergens (42 USC 300w-3(a)(1)(E)).
- f. Related planning, administration, educational, monitoring, and evaluation activities (42 USC 300w-3(a)(1)(E) and 3(a)(1)(F)).
- g. A State may transfer up to 7 percent of its annual allotment to the following block grants: Block Grants for Community Mental Health Services (CFDA 93.958) and the Maternal and Child Health Services Block Grant to the States (CFDA 93.994). At any time in the first three quarters of the fiscal year a State may transfer not more than 3 percent of

the State's allotment and in the last quarter of a fiscal year a State may transfer the remainder (42 USC 300w-3(c)).

2. *Activities Unallowed*
 - a. Inpatient services (42 USC 300w-3(b)(1)).
 - b. Cash payments to intended recipients of health services (42 USC 300w-3(b)(2)).
 - c. Purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment (42 USC 300w-3(b)(3)).
 - d. Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (42 USC 300w-3(b)(4)).
 - e. Provide financial assistance to any entity other than a public or non-profit entity (42 USC 300w-3(b)(5)).

B. Allowable/Cost Principles

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, PHHSBG is exempt from the provisions of OMB cost principles circulars. State cost principles requirements apply to PHHSBG.

G. Matching, Level of Effort, Earmarking

1. Matching – Not Applicable

2.1 Level of Effort – *Maintenance of Effort*

The State must maintain State expenditures for activities under 42 USC 300w-3 at a level that is not less than the average level of such expenditures maintained by the State for the proceeding 2-year period (42 USC 300w-4(c)(6)).

2.2 Level of Effort – *Supplement Not Supplant* – Not Applicable

3. Earmarking

- a. The State shall not use more than 10 percent paid from each of its allotments for administering the funds. The State will pay from non-Federal sources the remaining cost of administering such funds (42 USC 300w-3(d)).
- b. The notice of Block Grant Awards may provide that specific amounts are earmarked for services to victims of sex offenses (42 USC 300w-3(a)(2)).

H. Period of Availability of Federal Funds

PHHSBG funds must be expended by the State in the fiscal year allotted or in the succeeding fiscal year (42 USC 300w-2(a)(2)).

L. Reporting

1. Financial Reporting

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable
- c. SF-425, *Federal Financial Report* – Applicable

2. Performance Reporting – Not Applicable

3. Special Reporting – Not Applicable

4. Section 1512 ARRA Reporting – Not Applicable

5. Subaward Reporting under the Transparency Act – Applicable

IV. OTHER INFORMATION

Transfers into PHHSBG

A State may transfer up to 10 percent of its annual allotment under SSBG to this and other specified block grant programs for support of health services, health promotion and disease prevention activities, low-income home energy assistance, or any combination of these activities.

Amounts transferred into this program are subject to the requirements of this 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.

Transfers out of PHHSBG

As discussed in III.A, “Activities Allowed or Unallowed,” funds may be transferred out of PHHSBG to other Federal programs. The amounts transferred out of PHHSBG are subject to the requirements of the program into which they are transferred and should not be included in the audit universe and total expenditures of PHHSBG when determining Type A programs. On the Schedule of Expenditures of Federal Awards, the amount transferred out should not be shown as PHHSBG expenditures but should be shown as expenditures for the program into which they are transferred.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CFDA 93.994 MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT TO THE STATES

I. PROGRAM OBJECTIVES

The objective of the program of grants to States under the Maternal and Child Health (MCH) Block Grant program is to provide funds to the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Guam, American Samoa, the Federated States of Micronesia, Palau, the Marshall Islands, and the Northern Marianas (States) for improvement of the health of all mothers and children consistent with applicable health status goals and national health objectives established under the Social Security Act.

Specifically, MCH Block Grants are intended to: (1) provide and assure mothers and children (especially those with low income or limited availability of services) access to quality maternal and child health services; (2) reduce infant mortality and the incidence of preventable diseases and disabling conditions among children; (3) reduce the need for inpatient and long-term care services; (4) increase the number of children appropriately immunized against disease and the number of low-income children receiving health assessments and follow-up diagnostic and treatment services; (5) promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low-income, at-risk pregnant women; (6) promote the health of children by providing preventive and primary care services for low-income children; (7) provide rehabilitation services for blind and disabled individuals under sixteen years of age receiving benefits under Title XVI of the Social Security Act (Supplemental Security Income) to the extent medical assistance for such services is not provided under Title XIX (Medicaid); and (8) provide and promote family-centered, community-based, coordinated care for children with special health care needs and to facilitate the development of community-based systems of services for those children and their families.

II. PROGRAM PROCEDURES

Administration and Services

The MCH Block Grant program was created by the Omnibus Budget Reconciliation Act (OBRA) of 1981. Under that legislation, a number of categorical grants programs were consolidated into the single MCH Block Grant program. These were maternal and child health services for children with special health care needs; supplemental security income for children with disabilities; lead-based paint poisoning prevention programs; genetic disease programs; sudden infant death syndrome programs; and adolescent pregnancy grants. Extensive amendments to the authorizing statute in 1989 increased State programmatic and fiscal accountability under the program. These include requirements for States to define health status measures and to develop measurable objectives for program efforts as well as to report progress on key maternal and child health indicators.

The program is administered by the Division of State and Community Health, Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), a component of the Department of Health and Human Services (HHS). MCH Block Grant funds are awarded to States in accordance with a preestablished formula after submission to and approval of their applications by HRSA. The application addresses how the State plans to implement prioritized tasks based on a statewide needs assessment (required to be conducted every five years) for all mothers and children, including those with special health care needs. The State health agency is responsible for overall program administration according to its approved plan but services may be carried out by the recipient or by local non-profit agencies that are funded in accordance with an allocation methodology determined by the recipient (and approved by HRSA).

Source of Governing Requirements

The MCH Block Grant program is authorized under the 1981 Omnibus Budget Reconciliation Act, as amended, and is codified at 42 USC 701 through 709. The implementing regulations for this and other HHS block grant programs are published at 45 CFR part 96. Those regulations include both specific requirements and general administrative requirements for the covered block grant programs in lieu of 45 CFR part 92 (the HHS implementation of the A-102 Common Rule).

Availability of Other Program Information

Further information about this program is available on the Internet at <http://www.mchb.hrsa.gov/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for a Federal program, the auditor should look first to Part 2, Matrix of Compliance Requirements, to identify which of the 14 types of compliance requirements described in Part 3 are applicable and then look to Parts 3 and 4 for the details of the requirements.

A. Activities Allowed or Unallowed

1. Activities Allowed

- a. Funds may be used to provide health services and related activities, including planning, administration, education, and evaluation (42 USC 704(a)).
- b. Funds may be used to purchase technical assistance from public or private entities if required to develop, implement, or administer the MCH Block Grant (42 USC 704(c)).
- c. Funds may be used for salaries and other related expenses of National Health Service Corps personnel assigned to the State (42 USC 704(a)).

- d. Funds may be used to continue funding of special projects in the State funded under Title V of the Social Security Act prior to the enactment of the MCH Block Grant program on August 31, 1981 (42 USC 705(a)(5)(C)(i)).

2. *Activities Unallowed*

- a. Funds may not be used to purchase or improve land, to purchase, construct, or permanently improve buildings or facilities (other than minor remodeling), or to purchase major medical equipment unless a waiver has been granted by HRSA (42 USC 704(b)(3)).
- b. Funds may not be used to make cash payments to intended recipients of services (42 USC 704(b)(2)).
- c. Funds may not be provided for research or training to any entity other than a public or non-profit private entity (42 USC 704(b)(5)).
- d. Funds may not be used for inpatient services, other than for children with special health care needs or high-risk pregnant women and infants or other inpatient services approved by the Associate Administrator for Maternal and Child Health (42 USC 704(b)(1)). Infants are defined as persons less than one year of age (42 USC 706(a)(2)(E)).
- e. Funds may not be used to make payments for any item or service (other than an emergency item or service) furnished by an individual or entity excluded under Titles V, XVIII (Medicare), XIX (Medicaid), or XX (Social Services Block Grant) of the Social Security Act (42 USC 704(b)(6)).
- f. MCH Block Grant funds may not be transferred to other block grant programs (42 USC 702(a)(3) and 705(a)(5)(B)).

B. Allowable Costs/Cost Principles

As discussed in Appendix I of this Supplement, Federal Programs Excluded from the A-102 Common Rule, the MCH Block Grant program is exempt from the provisions of the OMB cost principles circulars. State cost principles requirements apply to the MCH Block Grant program.

G. Matching, Level of Effort, Earmarking

1. Matching

Federal funds expended for the program must be matched 75 percent by State funds (42 USC 703(a)).

2.1. Level of Effort – Maintenance of Effort

The State must maintain the level of funds provided solely by the State for maternal and child health programs at a level at least equal to the level provided in FY 1989 (42 USC 705(a)(4)).

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

- a. Unless a lesser percentage is established in the State's notice of award for a given fiscal year, the State must use at least 30 percent of payment amounts for preventive and primary care services for children (42 USC 705(a)(3)(A)).
- b. Unless a lesser percentage is established in the State's notice of award for a given fiscal year, the State must use at least 30 percent of payment amounts for services for children with special health care needs (42 USC 705(a)(3)(B)).
- c. A State may not use more than 10 percent of allotted funds for administrative expenses (42 USC 704(d)).

H. Period of Availability of Federal Funds

Funds available to States from their allotment for any fiscal year are available for obligation by the State in that fiscal year or in the succeeding fiscal year. No payment may be made to a State from allotments for a fiscal year for expenditures made after the end of the following fiscal year (42 USC 703(b)).

J. Program Income

Charges imposed by a State for services under this program must be pursuant to a published schedule of charges and adjusted to reflect the income, resources, and family size of the recipients. No charges may be imposed for low-income mothers or children (42 USC 705(a)(5)(D)). The official poverty guideline, as revised annually by HHS, shall be used to determine whether an individual is considered low-income for this purpose. The poverty guidelines are issued each year in the *Federal Register*. HHS maintains a page on the Internet that provides the poverty guidelines (<http://aspe.hhs.gov/poverty/>).

L. Reporting**1. Financial Reporting**

- a. SF-270, *Request for Advance or Reimbursement* – Not Applicable
- b. SF-271, *Outlay Report and Request for Reimbursement for Construction Programs* – Not Applicable

- c. SF-425, *Federal Financial Report* – Applicable
- 2. **Performance Reporting** – Not Applicable
- 3. **Special Reporting**
 - a. *Title V Application/Annual Report (OMB No. 0915-0172)* – The State must submit an annual report by July 15 of each year (at the time it submits the annual application). The reporting forms and instructions are contained in a document entitled “Guidance and Forms for the Title V Application/Annual Report.” Reports are prepared electronically.

Key Line Items – The following line items contain critical information:

Number of Individuals Served and Proportion with Health Coverage:

Form 6 Number and Percentage of Newborns and Others Screened, Confirmed and Treated

Form 7 *Number of Individuals Served (Unduplicated) Under Title V*

Form 8 *Deliveries and Infants Served by Title V and Entitled to Benefits under Title XIX*

Amounts Spent Under Title V on Each Type of Service by Class of Individuals Served for the current year:

Form 3 *State MCH Funding Profile, “Expended” column*

Form 4 *Budget Details by Types of Individuals Served, Items I.a.-g.*

Form 5 *State Title V Program Budget and Expenditures by Types*
- 4. **Section 1512 ARRA Reporting** – Not Applicable
- 5. **Subaward Reporting under the Transparency Act** – Applicable

IV. OTHER INFORMATION

Federal funds from other block grant programs (e.g., Social Services Block Grant (CFDA 93.667), and Preventive Health and Health Services Block Grant (CFDA 93.991)) may be transferred into the MCH Block Grant program. MCH Block Grant funds, however, may not be transferred to other block grant programs (42 USC 702(a)(3) and 705(a)(5)(B)). Funds transferred into the MCH Block Grant are subject to the requirements of this 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.