

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.044 SPECIAL PROGRAMS FOR THE AGING – TITLE III,
PART B—GRANTS FOR SUPPORTIVE SERVICES AND SENIOR CENTERS****ASSISTANCE LISTING 93.045 SPECIAL PROGRAMS FOR THE AGING, TITLE III,
PART C, NUTRITION SERVICES****ASSISTANCE LISTING 93.053 NUTRITION SERVICES INCENTIVE PROGRAM****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—
 - (1) respond to the needs and preferences of older individuals and family caregivers;
 - (2) facilitate the provision, by service providers, of long-term care in home and community-based settings; and
 - (3) 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—
 - (1) the need to plan in advance for long-term care; and
 - (2) 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 nonfederal 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 (NSIP)

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. This program is included as part of this cluster because of its direct relationship to the nutrition services program.

II. PROGRAM PROCEDURES

A. Overview

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 nonprofit 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 management), 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.

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)).

AoA administers NSIP in cooperation with states, sub-state agencies, and other service providers. Under Sections 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 United States Department of Agriculture (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. (See also IV, "Other Information.")

B. 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.

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 reauthorized in 2020 by Pub. L. No. 116-131 is available at the AoA website at <https://acl.gov/about-acl/administration-aging>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	N	N	Y	N	N	Y	Y	Y	N

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)).
- d. Distribution of funding within the State must be allocated as described in the State Plan Attachment C Intrastate Funding Formula (IFF) as approved by the Assistant Secretary for Aging to subrecipients, Area Agencies on Aging (if applicable), (42 USC 3025(a)(2)(C)).

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)).

3. *Service Providers*

Supportive Services and Senior Centers and Nutrition Services

- a. Funds may be used to assist in the operation of multipurpose 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 ten years or more), alter, or renovate existing facilities or to construct new facilities to serve as multipurpose senior centers for not less than ten years after acquisition, or 20 years after completion of construction, unless waived by the assistant secretary for aging (42 USC 3030b).

G. Matching, Level of Effort, Earmarking

1. Matching

a. Title III Supportive Services and Nutrition Services and American Rescue Plan Supportive Services and Nutrition Services Grants

(1) State – State Plan Administration

- (a) 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) State and Area Agencies – Area Plan Administration

State and 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).

(a) *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.

(b) *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.

(3) Service Provision

All services, whether provided by the State Agency, an Area Agency, or other service provider (excluding any ombudsman services provided under the authority of 42 USC 3024 (d)(1)(D)) must be funded with a nonfederal match of at least 15 percent. One third of the required 15 percent match must come from state sources (42 USC 3029 (b)(2)). 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. Nutrition Services Incentive Programs (NSIP) Grants

(1) There is no match requirement.

c. CARES Act Supportive Services and Nutrition Services Grants

(1) State – State Plan Administration

(a) 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) State and Area Agencies - Area Plan Administration

State and 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).

- (a) *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.
- (b) *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.

(3) **Service Provision**

There is no match requirement for services.

2. Level of Effort

State – The State Agency must spend for both services and administration at least the average amount of state funds it reported as spent under the state plan for these activities for the three previous fiscal years. If the State Agency reports as spent 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.3., “Reporting – Financial Reporting,” for the reporting requirement regarding maintenance of effort.

2.1 Level of Effort – *Maintenance of Effort*

Not Applicable

2.2 Level of Effort – *Supplement Not Supplant*

Supportive Services and Senior Centers

- a. Funds expended by a state or unit of general purpose local government (including an Area Agency on aging) to provide services shall supplement, and not supplant, any federal, state, or local funds (42 USC 3030d(d)).

Nutrition Services

- a. Not Applicable

3. Earmarking

- a. *State*

- (1) Overall expenditures for administration are determined by the State agency's status as set forth below, unless a waiver is granted by the assistant secretary for aging (42 USC 3028 (b)):
 - (a) A State agency which serves a State with multiple planning and service areas, not listed in (1)(b) below, shall have available the greater of 5 percent or \$750,000 of the total Title III award (42 USC 3028(b)(2)(A)); or
 - (b) Guam, United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands shall have available the greater of 5 percent or \$100,000 of the total Title III award (42 USC 3028(b)(2)(B)).
- (2) After a state determines the amount to be applied to state plan administration under 42 USC 3028 (b), the state may:
 - (a) Use up to (and including) 10 percent of that amount available for the administration of area plans where the state calculates the 10 percent based 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:
 - a. state plan administration limit; or
 - i. 5 percent of the total amount of the allotments made to a State under sections 3024(a)(1) and 3030s-1(f); or
 - ii. \$750,000
 - b. area plan administration limit of the allotments made to a State under sections 3024(a)(1) and 3030s-1(f). (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)).

J. Program Income

- 1. Service providers are required to provide an opportunity to individuals being served under all parts B and C services program to make voluntary contributions for services received. These voluntary contributions are to be added to the amounts made available for service provision 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

For State Agency-

1. Financial Reporting

- a. *SF-270, Request for Advance or Reimbursement* - Not Applicable.
- b. *SF-271, Outlay Report and Request for Reimbursement for Construction Program* -Not Applicable.
- c. SF-425, Federal Financial Reports- Semi-Annual (OMB No. 4040-0014)- Applicable.
- d. Supplemental Form to the Financial Status Report for all AoA Title III Grantees- (OMB No. 0985-0004).

2. Performance Reporting

Not Applicable

3. Special Reporting

- a. Certification of Maintenance of Effort, OMB No. 0985-0009;(42 USC 3029 (c); 45 CFR section 1321.49) Submitted yearly. A blank copy of the report and reporting instructions can be found at <https://acl.gov/sites/default/files/about-acl/2020-08/0009%20Certification%20of%20Maintenance%20Form%20FINAL.pdf>

1. Key Line Item(s):

- i. State Resources Expended: The State must certify State Resources Expended for the fiscal year in OMB No. 0985-0009. The resources included in this amount must be verifiable and may not include non-State expenditures or non-State in-kind resources, to ensure compliance with 42 USC 3029 (c); 45 CFR section 1321.49.

1. Subsequent submissions may be accepted when there is an identified error in reporting, this is submitted through their fiscal operations specialist and/or ACL regional administrator. Auditors should test most recent submission, resubmissions are a rare occurrence.

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

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).

IV. OTHER INFORMATION

The NSIP program may include both cash payments to states 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 2 CFR section 200.40 definition of “federal financial assistance” and should be valued in accordance with 2 CFR section 200.502(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 2 CFR section 200.510(b).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.090 GUARDIANSHIP ASSISTANCE

I. PROGRAM OBJECTIVES

The objective of the Guardianship Assistance program 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

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 Title 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 Guardianship Assistance program provides federal matching funds to Title IV-E agencies with approved Title IV-E plans that provide ongoing assistance and/or non-recurring payments to relatives who have assumed legal guardianship of eligible children for whom they previously cared for as foster parents and enter into a guardianship assistance agreement. 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 Guardianship Assistance program (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 Title IV-E agency for this program also administers ACF funding provided for other Title IV-E programs, e.g., Adoption Assistance (Assistance Listing 93.659); Foster Care (Assistance Listing 93.658) and John H. Chafee Foster Care Program for Successful Transition to Adulthood (Assistance Listing 93.674), as well as the Child Welfare Services (Assistance Listing 93.645) and Promoting Safe and Stable Families (Assistance Listing 93.556) programs (Title IV-B of the Social Security Act, as amended) (Assistance Listing 93.556) funds available to states and those tribes qualifying for at least a minimum grant of \$10,000), and the Social Services Block Grant program (Assistance Listing 93.667) (Title XX of the Social Security Act, as amended) (states only). The Title IV-E agency may either directly administer the Guardianship Assistance program or supervise its administration by local level agencies. Where the program is administered by a state, in accordance with the approved Title 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 Guardianship Assistance program 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.

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 Title 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 at <https://www.acf.hhs.gov/cb/laws-policies>

.III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an "N." See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment/Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement/Suspension & Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	Y	N	Y	N	N	N	Y	N	N

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, “Eligibility – Eligibility for Individuals”) 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 Title 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. 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. 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. Funds expended by the Title IV-E agency for guardianship placements (including nonrecurring costs) are considered an administrative

expenditure and are subject to the matching requirements in 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)).

4. *Demonstration Projects*

Under Section 1130 of the Social Security Act, Title IV-E agencies may be granted authority to operate a demonstration project as set forth in ACF-approved terms and conditions. Any such terms and conditions identify the specific provisions of the Social Security Act that are waived, the additional activities that are allowable, the scope and duration (which may not exceed a maximum of five total years unless specifically approved for further continuation) of the demonstration project and the methodology for determining cost neutrality (either a matched comparison group or a capped allocation). All approved demonstration projects were required to end no later than September 30, 2019 (42 USC 1320a-9 and Section 201 of Pub. L. No. 112-34).

B. Allowable Costs/Cost Principles

Both states and tribes are subject to the requirements of OMB Circular A-87 (2 CFR part 225)/2 CFR part 200, subpart E, as implemented by HHS at 45 CFR part 75. States also are subject to the cost allocation provisions and rules governing allowable costs of equipment of 45 CFR part 95 (45 CFR sections 1355.57, 95.503, and 95.705).

E. Eligibility

1. Eligibility for Individuals

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

a. *General Eligibility*

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

- (1) 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)).
- (2) The child was eligible for foster care maintenance payments under 42 USC 672 while residing for at least six consecutive months in the home of the prospective relative guardian (42 USC 673(d)(3)(A)(i)(II)).
- (3) The Title 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)).
- (4) The Title 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)).
- (5) 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)).
- (6) 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)).
- (7) 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)).
- (8) Any relative guardian must satisfactorily have met a criminal records check, including a fingerprint-based checks of national crime information databases (as defined in 28 USC 534(e)(3)(A)), 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)).

- (9) 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: (a) attainment of the age of 18 (or attainment of age 21 if the Title IV-E agency determines that the child has a mental or physical disability which warrants the continuation of assistance); (b) the Title IV-E agency determines that the relative guardian(s) is no longer legally responsible for the support of the child; (c) the Title IV-E agency determines the child is no longer receiving any support from the relative guardian(s); or (d) the occurrence of an event described in the kinship guardianship assistance agreement which requires suspension or discontinuation of kinship guardianship assistance payments (42 USC 673(a)(4)(A) and (B); 42 USC 673(d)(1) and Child Welfare Policy Manual section 8.5A Q/A#3).

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 Title 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 Title 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 Title IV-E agency) be (a) completing secondary school (or equivalent); (b) enrolled in post-secondary or vocational school; (c) participating in a program or activity that promotes or removes barriers to employment; (d) employed 80 hours a month; or (e) incapable of any of these due to a documented medical condition (42 USC 675(8)(B)).

b. *Sibling Eligibility*

- (1) The child and any sibling of the eligible child (established under the General Eligibility requirements listed in paragraph E.1.a) 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)).

- (2) Kinship guardianship assistance payments may be paid pursuant to a kinship guardianship assistance agreement (in accordance with requirements in paragraph E.1.a.(6)) on behalf of each sibling so placed. If kinship guardianship assistance payments are paid on behalf of the sibling, the Title 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)).
- (3) Siblings of an eligible child must also individually meet the requirements specified in paragraphs E.1.a.(7) and (9) (42 USC 671(a)(28); 675(7) 42 USC 673(a)(4)(A) and (B); and 42 USC 675(8)(B)).

c. *Title IV-E Guardianship Waiver Post-Demonstration Projects*

- (1) 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)).
- (2) Post-demonstration assistance and services to eligible children assisted in accordance with terminated guardianship related demonstration projects as noted in paragraph E.1.c.(1) is eligible for Title IV-E claiming whether or not the state opts to operate a Guardianship Assistance program 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

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 75.306 is not applicable to this program (45 CFR sections 1355.30(i) 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 any allowable third-party sources to provide up to the full required non-federal share of administrative or training costs (42 USC 679c(c)(1)(D); 45 CFR section 1356.68(c)).

- 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 at <http://www.aspe.hhs.gov/health/fmap.htm> (42 USC 674(a)(1); 45 CFR section 1356.60(a)).

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 at <http://www.gpo.gov/fdsys/pkg/FR-2011-08-01/pdf/2011-19358.pdf>. Information on specific tribal FMAP rates for many tribes applicable for each FY and a table where such rates can be calculated for unlisted tribes is posted on the Children’s Bureau’s website and is available at <https://www.acf.hhs.gov/cb/focus-areas/tribes>. The calculated FMAP rate for each tribe 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 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 Title 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

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. *Form 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 E (Guardianship Assistance Program))

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

Part 3, Foster Care, Adoption Assistance and Guardianship Assistance Demonstration Projects, columns (a) through (e)

2. Performance Reporting

Not Applicable

3. Special Reporting

Not Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.095 HHS PROGRAMS FOR DISASTER RELIEF
APPROPRIATIONS ACT–NON-CONSTRUCTION****ASSISTANCE LISTING 93.096 HHS PROGRAMS FOR DISASTER RELIEF
APPROPRIATIONS ACT–CONSTRUCTION****I. PROGRAM OBJECTIVES**

The objectives of these programs are to assist in disaster response and recovery and other activities directly related to Hurricane Sandy.

II. PROGRAM PROCEDURES**Covered Programs and Eligibility**

As described in the terms and conditions of the award, programs in this cluster may be used for purposes consistent with the following Department of Health and Human Services (HHS) programs:

- a. Head Start
- b. Social Services Block Grant
- c. Health services (including mental health services)
- d. Repair or rebuilding of nonfederal biomedical or behavioral research facilities

HHS may award grants, cooperative agreements, or contracts to eligible organizations in New York and New Jersey and, as applicable, in other states that were declared as major disaster jurisdictions by the Federal Emergency Management Agency (FEMA). These are as follows: the states of Connecticut, Delaware, Maryland, Massachusetts, New Hampshire, Ohio, Pennsylvania, Rhode Island, Virginia, and West Virginia, and the District of Columbia.

Source of Governing Requirements

This funding is authorized by the Disaster Relief Appropriations Act, Division A (Pub. L. No. 113-2), Title VI and Title X, Chapter 8.

Availability of Other Program Information

Additional program information is available from the following websites:

<https://eclkc.ohs.acf.hhs.gov/policy/pi/acf-pi-hs-18-02> (Head Start)

<https://www.acf.hhs.gov/ocs/programs/ssbg/hurricane-sandy-supplemental-funds>
(Social Services Block Grant)

<http://grants.nih.gov/grants/guide/notice-files/NOT-OD-13-106.html> (National Institutes of Health)

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	N	Y	Y	Y	N	N	Y	N	N

A. Activities Allowed or Unallowed

1. The terms and conditions of the award will provide the allowable uses of these funds.
2. Funds provided under Assistance Listings 93.095 and 93.096 may not result in duplication of benefits. If costs are reimbursed by FEMA, under a contract for insurance, or by self-insurance, they cannot be charged to the award (Pub. L. No. 113-2, Division A, 127 Stat. 11, 127 Stat. 34).
3. Funding subject to the Social Services Block Grant (SSBG) requirements may be used for health services, including mental health services, and for costs of renovating, repairing, and rebuilding health care facilities, child care facilities, or other social services facilities (Pub. L. No. 113-2, Division A, 127 Stat. 33).

F. Equipment and Real Property Management

The following specific requirements apply only to awards when the terms and conditions of the award identify funding subject to Head Start requirements found in 45 CFR Part 1309:

1. Head Start grantees are required to operate and maintain facilities, real property, modular units, and related assets to ensure their use for the funded project purpose(s) and to adequately protect the federal interest in such facilities, real property, and related assets (45 CFR Part 1309).
2. Real property acquired or constructed with Head Start funds or which has undergone major renovation with Head Start funds, may not be conveyed, transferred, assigned, mortgaged, leased, or otherwise encumbered or subordinated unless approved by ACF (45 CFR section 1309.21(b)).
3. A Head Start grantee must file a Notice of Federal Interest (also referred to as “reversionary 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)). For modular units, the Notice of Federal Interest must be posted in a conspicuous place on the modular unit (45 CFR section 1309.31).

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

Any matching requirements will be indicated in the terms and conditions of the award.

2. Level of Effort

Not Applicable

3. Earmarking

Any earmarking requirements will be indicated in the terms and conditions of the award.

H. Period of Performance

Unless otherwise provided by statute or a waiver has been granted by the Office of Management and Budget (OMB), funds must be expended within 24 months of the beginning date of the period of performance (Pub. L. No. 113-2, Section 904(c)).

1. Funding subject to the SSBG requirements must be spent by September 30, 2017 (Pub. L. No. 113-2, 127 Stat. 33).
2. OMB granted the National Institutes of Health a waiver for construction and infrastructure projects. See Funding Opportunity Announcement RFA-OD-13-007 at <http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-13-007.html>, Part 2. Full Text of Announcement, Section II. Award Information, Award Project Period: “The total project period may not exceed 5 years. Funds will be provided in a single award with a 60-month budget and project period.”

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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

IV. OTHER INFORMATION

Although funding for programs in this Hurricane Sandy Relief Cluster may be subject to the requirements of the Head Start (Assistance Listing 93.600) or SSBG (Assistance Listing 93.667) programs, they are separate from and, therefore, are not clustered with the Head Start or SSBG programs.

Awards from Assistance Listings 93.095 and 93.096 that are identified in the notice of award as Research and Development (R&D) should be shown on the Schedule of Expenditures of Federal Awards as R&D and should be audited with the R&D cluster rather than this Hurricane Sandy Relief Cluster.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.153 COORDINATED SERVICES AND ACCESS TO RESEARCH FOR WOMEN, INFANTS, CHILDREN, AND YOUTH (RYAN WHITE HIV/AIDS PROGRAM PART D WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY) PROGRAM)****I. PROGRAM OBJECTIVES**

The objective of this program is to provide family-centered care in an outpatient or ambulatory care setting (directly or through contracts or memoranda of understanding) for low income, uninsured, and medically underserved women, infants, children, and youth with HIV.

II. PROGRAM PROCEDURES

The Department of Health and Human Services (HHS) administers the Ryan White HIV/AIDS Program (RWHAP) Part D Coordinated Services for Women, Infants, Children, and Youth (WICY) through the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB). The RWHAP Part D WICY programs provide family-centered outpatient or ambulatory care setting (directly or through contracts or memoranda of understanding) for low income, uninsured, and medically underserved women, infants, children, and youth with HIV. Recipients can also provide additional support services to patients and affected family members.

Grants under the RWHAP Part D WICY are awarded to public and nonprofit 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 recipient or through contractual agreements or memoranda of understanding with other service providers.

Source of Governing Requirements

The RWHAP Part D WICY is authorized under Section 2671 of Title XXVI of the PHS Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Pub. L. No. 111-87) and is codified at 42 USC 300ff-71. The Minority AIDS Initiative (MAI) is authorized under Section 2693(b)(2)(D) of the PHS Act (42 USC 300ff-121(b)(2)(D)).

The RWHAP Part D WICY has no program-specific program regulations.

Availability of Other Program Information

Further information about the RWHAP Part D WICY is available at <https://ryanwhite.hrsa.gov/>.

Additional information on allowable uses of funds under the RWHAP Part D WICY is contained in policy notices and standards found at <https://ryanwhite.hrsa.gov/grants/policy-notice>

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	N	N	Y	Y	Y	N	N

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. 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 the following support services for patients: (1) family-centered care, including case management; (2) referrals for

additional services, including inpatient hospital services, treatment for substance abuse and mental health services, and other social and support services as appropriate; (3) additional services necessary to enable the patient to participate in the RWHAP Part D WICY, including services to recruit and retain youth with HIV; and (4) provision of information and education on opportunities to participate in HIV/AIDS-related clinical research (42 USC 300ff-71(b)). Affected family members (people not identified with HIV) may be eligible for RWHAP support services in limited situations, but these services for affected individuals must always benefit people with HIV. Examples include, but are not limited to, mental health services, and respite care. Services to non-affected family members who meet these criteria may not continue subsequent to the death of the RWHAP client. Refer to HAB Policy Clarification Notice #16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds for further information on circumstances in which affected family members may be eligible to receive RWHAP funded support services.

- c. Funds must be used for the establishment of a clinical quality management program to assess the extent to which HIV health services are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infections, and, as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services (42 USC 300ff-71(f)(2)). Policy Clarification Notice #15-02 <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-02-cqm.pdf>.
- d. Funds may be used for administrative expenses, which are defined as funds used by recipients for grant management and monitoring activities, including costs related to any staff or activity other than provision of services. Indirect costs included in a federally negotiated indirect rate are considered part of administrative costs (see III.G.3, “Matching, Level of Effort, Earmarking – Earmarking,” for a limitation on expenditures for administrative costs) (42 USC 300ff-71(f)(1), (h)(1), and (h)(2)). Funds may be used for administrative expenses; no more than 10 percent on administrative expenses.

2. *Activities Unallowed*

- a. Funds may not be used for AIDS programs or to develop materials, designed to promote or encourage, directly, intravenous drug abuse or sexual activity, whether homosexual or heterosexual (42 USC 300ff-84).
- b. Funds may not be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug (Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113), Division H, Title V, Section 520, and

subsequent appropriations, as applicable). Other elements of syringe services programs may be allowable if in compliance with applicable HHS and HRSA-specific guidance.

- c. Funds may not be used to purchase or improve land or to purchase, construct, or make permanent improvement to any building (Funding Opportunity Announcement, Section IV.6).
- d. Funds may not be used to make cash payments to intended recipients of RWHAP services (Policy Clarification Notice #16-02, Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf>).
- e. Charges that are billable to third party payors (e.g., private health insurance, prepaid health plans, Medicaid, Medicare, HUD, other RWHAP funding including ADAP).
- f. To directly provide housing or health care services (e.g., HIV care, counseling, and testing) that duplicate existing services.
- g. Pre-Exposure Prophylaxis (PrEP) or nonoccupational Post-Exposure Prophylaxis (nPEP) medications or the related medical services. As outlined in the June 22, 2016, RWHAP and PrEP program letter, the RWHAP legislation provides grant funds to be used for the care and treatment of PLWH, thus prohibiting the use of RWHAP funds for PrEP medications or related medical services, such as physician visits and laboratory costs. RWHAP Part D funds can be used toward Psychosocial Support Services, a component of family-centered care, which may include counseling and testing and information on PrEP to eligible clients' partners and affected family members, within the context of a comprehensive PrEP program.
- h. Fundraising expenses.
- i. Lobbying activities and expenses.
- j. International travel.

J. Program Income

The Notice of Award provides guidance on the use of program income. The addition method is used for the Ryan White HIV/AIDS Program Part D. Program income must be used for activities described in III.A.1, "Activities Allowed."

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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 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 American Indian/Alaska Native (AI/AN) Tribes or Tribal Organizations (T/TO), who can request to enter into a Self-Governance (Title V) compact.

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 IHS. A Self-Governance compact is a legally binding and mutually enforceable written agreement, including such terms as the parties intend to 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 Title V compactors who enter into a Self-Governance compact 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 USC5381 et seq.

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 this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	Y	N	N	Y	N	Y	N	N	Y

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 provided under compacts, funding agreements or grants made pursuant to Title V may be used to meet matching or cost participation requirements under any other federal or nonfederal program; when used in this manner, they are considered nonfederal funds (42 CFR section 137.217) and are subject to Single Audit requirements.

B. Allowable Costs/Cost Principles

1. A Self-Governance Tribe must apply the applicable OMB cost principles, except as modified by 25 U.S.C. § 5325, 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. When 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 U.S.C. § 5388(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 the individual is regarded as an Indian by the community in which the individual lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal 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) Services will also be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child during the period of pregnancy through postpartum (generally about six weeks after delivery). In cases when 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. (42 CFR section 136.12(a)).

- (3) The services will also provide medically indicated services to non-Indian members of an eligible Indian's household if a medical officer in charge determines this is necessary to control acute infectious disease or a public health hazard (42 CFR section 136.12(a)).
- (4) In case of an emergency, as an act of humanity, individuals not eligible under 42 CFR 136.12 may be provided temporary care and treatment in Service facilities (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 U.S.C. 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 the individual 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 Performance

1. An FA shall have the term mutually agreed to by the parties. Absent notification from an Indian 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 U.S.C. 5388(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 U.S.C. § 1601 et seq.) provides otherwise for Medicare and Medicaid receipts (25 U.S.C. § 5325 and 25 U.S.C. § 5388(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).

N. Special Tests and Provisions

1. Character Investigations by Indian Tribes and Tribal Organizations

Compliance Requirements the Indian Child Protection and Family Violence Prevention Act (25 USC 3207 requires tribes and tribal organizations that receive funds under the ISDEAA to conduct an investigation of the character of each individual who is employed or is being considered for employment in a position that involves regular contact with, or control over Indian children 25 U.S.C. § 3207(c); 34 U.S.C. § 20351. The Act further states that the tribe or tribal organization can employ only individuals who meet standards of character that are no less stringent than those prescribed by the regulations, which are outlined in 42 CFR section 136.405, and only after an individual has been the subject of a satisfactory background investigation as described in 42 CFR section 136.406. Tribes and tribal organizations may conduct their own background investigations, contract with private firms, or may request that a Federal or State agency conduct investigations., FBI fingerprint checks are required Tribes and tribal organizations can provisionally hire individuals prior to completion of a satisfactory background investigation only if, at all times prior to receipt of the satisfactory background investigation and when Indian children are in the care of the individual, the individual is within sight and under the supervision of someone on staff that has a completed satisfactory background investigation.

Audit Objectives Determine whether tribes and tribal organizations are performing the required background investigations by or being considered for employment at Tribal and IHS health care facilities.

Suggested Audit Procedures

- a. Obtain and review policies and procedures for the performance of background investigations for health care employees.
- b. Perform tests of selected security and personnel files of health care facilities employees occupying positions that have regular contact with or control over Indian children visiting Tribal or IHS health care facilities within the scope of the individual's duties and responsibilities or contact with those Indian children on a recurring and foreseeable basis to verify:
 - (1) A suitability determination was conducted based on the tribe/tribal organizations policy and procedure for adjudicating eligibility for employment (42 CFR section 136.411).
 - (2) The minimum standards of character were met following a satisfactory background investigation that includes a review of (42 CFR section 136.406):
 - (a) Documentation regarding the individual's trustworthiness, through inquiries with the individual's references and places of employment and education;

(b) A criminal history background check, which includes a fingerprint check through the Criminal Justice Information Services Division of the Federal Bureau of Investigation (FBI), under procedures approved by the FBI, and inquiries to State and Tribal law enforcement agencies for the previous five years of residence listed on the individual's application; and

(c) Evidence that a determination has been made as to whether the individual has been found guilty of or entered a plea of nolo contendere or guilty to any felonious offense or any of two or more misdemeanor offenses under Federal, State, or Tribal law involving crimes of violence; sexual assault, molestation, exploitation, contact, or prostitution; crimes against persons; or offenses committed against children.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.217 FAMILY PLANNING – SERVICES

I. PROGRAM OBJECTIVES

The purpose of the Family Planning – Services Project Grant (FPSPG) program is to provide funds for the 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)/Office of the Assistant Secretary for Health (OASH), a component of the Department of Health and Human Services (HHS). Within OS, the Office of Population Affairs is responsible for the program. The program has no statutory funds allocation formula: HHS makes discretionary grant awards the amounts of which are based on estimates of the amounts necessary for successful project performance.

Any public or private nonprofit entity located in a state (which includes one of the 50 United States, District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, , American Samoa, the U.S. Outlying Islands (Midway, Wake, et al.), the Marshall Islands, the Federated State of Micronesia, and the Republic of Palau) is eligible to apply for a grant under this program. Faith-based organizations and American Indian/Alaska Native/Native American organizations are also eligible to apply for Title X family planning services grants. The entity applying for the grant should identify existing as well as non-Title X resources available to address the needs for family planning services within the identified service area to ensure resources and services are not duplicated. In furtherance of maximizing access and best serving individuals in need in the service areas, entities should make reasonable efforts to avoid duplication of effort in the provision of services across the Title X network.

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, Subpart A). In addition, sterilization of clients as part of the Title X project must be consistent with Public Health Service (PHS) sterilization regulations (42 CFR Part 50, Subpart B). Grants administration regulations at 45 CFR Part 75 (“Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards”) and other relevant regulations also apply to Title X awards.

Availability of Other Program Information

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

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	N	N	Y	N	N	Y	Y	Y	N

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 any ancillary services which may be 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 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 similar 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 projects 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 costs may never equal 100 percent nor be less than 90 percent (with certain exceptions). The federal and nonfederal 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

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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.224 HEALTH CENTER PROGRAM (COMMUNITY HEALTH CENTERS, MIGRANT HEALTH CENTERS, HEALTH CARE FOR THE HOMELESS, AND PUBLIC HOUSING PRIMARY CARE)****ASSISTANCE LISTING 93.527 GRANTS FOR NEW AND EXPANDED SERVICES UNDER THE HEALTH CENTER PROGRAM****I. PROGRAM OBJECTIVES**

The purpose of the Health Center Program (HCP) grants under the Health Center Program Cluster is to improve the health of the nation's underserved communities by ensuring continued access to comprehensive, culturally competent, quality primary health care services regardless of ability to pay. HCP grants support a variety of community-based and patient-directed public and private nonprofit organizations that provide primary and preventive health care services to the nation's underserved.

II. PROGRAM PROCEDURES

The purpose of the HCP grants is to support the costs of operating health centers that serve medically underserved populations.

HCP 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 nonprofit organizations, including tribal, faith-based, and community-based organizations. Factors considered include the current availability of services in the geographical area and the population to be served. Grantees may provide services directly or enter into service and care arrangements via contracts or other formal referral arrangement.

The authorizing statute for the HCP requires health centers to annually develop and submit to HRSA a budget that reflects expenses and revenues (including HCP grant(s)) necessary to accomplish the health center project service delivery plan. As such, the total budget must include projections from all revenue sources, including fees, premiums, and third party reimbursements reasonably expected to be received to support operations; and state, local, private, and other operational funding provided to the health center. The amount of the HCP grant funding to be provided by HRSA may not exceed the amount by which the projected cost of operations exceeds the projected non-grant revenue sources (42 USC 254b(e)(5)(A), (k)(3)(D), and (k)(3)(I)(i) and 42 CFR section 51c.106).

Source of Governing Requirements

The HCP is 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 (CHCs) and Migrant Health Centers (MHCs) are codified at 42 CFR parts 51c and 56, respectively. The Health Care for the Homeless (HCH) and Public Housing Primary Care (PHPC) components do not have program-specific regulations.

The Coronavirus Preparedness and Response Supplemental Appropriations Act (CPRSAA), 2020 (Pub. L. No. 116-123) provided one-time funding to current Health Center Program award recipients to support preventing, preparing for, and responding to the novel coronavirus disease 2019 (COVID-19). As with Health Center Program operating awards, unallowable costs include fundraising and the construction of facilities. Other unallowable costs include purchasing or upgrading an electronic health record that is not certified by the Office of the National Coordinator for Health Information Technology (ONCHIT) or for construction-related activities including new construction activities, including additions or expansions; minor alteration or renovation projects; installation of trailers and pre-fabricated modular units; facility or land purchases; or purchase or lease of mobile vans/units, or costs already supported by HCP operational funding.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No. 116-136) provided one-time funding to current Health Center Program award recipients to support the detection of COVID-19 and/or the prevention, diagnosis, and treatment of COVID-19, including maintaining or increasing health center capacity and staffing levels during a coronavirus-related public health emergency. As with Health Center Program operating awards, unallowable costs include fundraising and the construction of facilities. Other unallowable costs include purchasing or upgrading an electronic health record that is not certified by the ONCHIT; new construction activities, including additions or expansions; major alteration and renovation (A/R) projects valued at \$500,000 or greater in total federal and non-federal costs (excluding the cost of allowable moveable equipment); installation of a permanently affixed modular or prefabricated building; facility or land purchases; or significant exterior site work such as new parking lots or storm water structures. Additionally, these funds may not be used for costs already supported by the HCP operational funding or CPRSAA funding.

Paycheck Protection Program and Health Care Enhancement Act (Pub. L. No. 116-139) provided one-time funding to support current Health Center Program award recipients and look-alikes to purchase, administer, and expand capacity for testing to monitor and suppress COVID-19. Health Center Program look-alikes are organizations that HRSA determines meet the requirements of the Health Center Program as well as requirements set forth in sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act. As with Health Center Program operating awards, unallowable costs include fundraising and the construction of facilities. Other unallowable costs include costs already supported with HCP, CPRSAA, or CARES Act funding; those that are reimbursed or compensated by other federal or state programs that provide for such benefits; the purchase or upgrade of an electronic health record that is not certified by the ONCHIT; new construction activities, including additions or expansions; major alteration and renovation projects valued at \$500,000 or greater in total federal and non-federal costs (excluding the cost of allowable moveable equipment); installation of trailers and permanently affixed modular or prefabricated buildings; facility or land purchases; and significant exterior site work such as new parking lots or storm water structures.

American Rescue Plan (ARP) Act (Pub. L. No. 117-2) provided one-time funding to current Health Center Program award recipients and look-alikes to prevent, mitigate, and respond to COVID-19 and to enhance health care services and infrastructure. As with Health Center Program operating awards, unallowable costs include fundraising and the construction of facilities. Other unallowable costs include purchasing or upgrading an electronic health record

that is not certified by the ONCHIT; new construction activities, including additions or expansions; major alteration and renovation (A/R) projects valued at \$500,000 or greater in total federal and non-federal costs (excluding the cost of allowable moveable equipment); installation of a permanently affixed modular or prefabricated building; facility or land purchases; or significant exterior site work such as new parking lots or storm water structures. Additionally, these funds may not be used for costs already paid for by other state or federal programs, HCP operational funding, or CPRSAA, CARES Act, or ARP Act funding.

Availability of Other Program Information

Other program information is available from the HRSA website at <https://bphc.hrsa.gov/>, <https://bphc.hrsa.gov/programrequirements>, and <https://www.hrsa.gov/grants/manage-your-grant/policies-regulations-guidance>.

Information on specific COVID-19 funding resources is available at <https://bphc.hrsa.gov/emergency-response/coronavirus-info>.

COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

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Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	N	Y	Y	N	Y	N	Y

A. Activities Allowed or Unallowed**1. Activities Allowed****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, when 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)).
 - (10) Substance abuse services for grantees with HCH grants (42 USC 254b(h)(2)).
- 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).
 - (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. *Activities Unallowed*

- a. Federal funds awarded under the HCP may not be expended for any abortion. These limitations do not apply to an abortion (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case when a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed (Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260)). See <https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/grants-policy-bulletin-2022-apr.pdf> for further details on legislative mandates.
- b. Federal funds awarded under the HCP may not be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug, provided that this limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant state or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the state or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with state and local law (Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260)).

B. Allowable Costs/Cost Principles

Costs charged to federal funds under the HCP award funds must comply with the cost principles at 45 CFR Part 75, Subpart E, and any other requirements or restrictions on the use of federal funding.

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

Uniform Data System (UDS) (OMB No. 0915-0193) – This system comprises two separate sets of reports that are submitted annually, the Universal Report and Grant Reports. The conditions for their use are:

- a. Grantees that receive a single grant under the HCP or that receive CHC funding only are required to complete the *Universal Report* only.
- b. 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.

The Key Line Items described below indicate which report would be reviewed based on the type of HCP grant award received. See Uniform Data System (UDS) Resources for additional detail available at:

<https://bphc.hrsa.gov/datareporting/reporting/index.html>. The Calendar Year 2021 UDS Reporting Manual is available at:
<https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2021-uds-manual.pdf>.

This information collection is mandatory under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b)

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

Total number of patients (Table 4: Selected Patient Characteristics, Income as a Percent of Poverty Guidelines, Universal Report, Line 6 Column a) reflects the total number of health center patients served during the calendar year. Duplication in the patient count information is of specific concern for this key line item.

[Universal Report and if applicable, Grant Report]

Total Physician Clinic and Virtual Visits (Table 5: Staffing and Utilization, Line 8, Columns b (clinic visits) and b2 (virtual visits)) captures total numbers of patient visits, delivered in-clinic and delivered virtually, attributed to physician personnel. Reported visits must meet the criteria for a countable visit as defined in the UDS Reporting Manual.

[Universal Report and if applicable, Grant Report]

Total NPs, PAs, and CNMs Clinic and Virtual Visits (Table 5: Staffing and Utilization, Line 10a, columns b (clinic visits) and b2 (virtual visits)) captures total numbers of patient visits, delivered in-clinic and delivered virtually, attributed to Nurse Practitioners, Physician Assistants, and Certified Nurse-

Midwives. Reported visits must meet the criteria for a countable visit as defined in the UDS Reporting Manual.

[Universal Report and if applicable, Grant Report]

Total accrued cost before donations and after allocation of overhead (Table 8A: Financial Costs Line 17 Column c) captures data on total financial costs of all in-scope activities provided in the calendar year.

[Universal Report Only]

Total accrued medical staff and other medical cost after allocation of overhead excluding lab and x-ray cost (Table 8A: Financial Costs, Line 1, Column c and Table 8A, Line 3, Column c) captures the total cost After Allocation of Facility and Non-clinical Support Services for Medical Personnel and Medical/Other Direct costs.

[Universal Report Only]

Total BPHC Health Center Program grant(s) drawn-down for the period from January 1 to December 31, of the calendar measurement year (Table 9E: Other Revenues, Line 1g, Column a).

[Universal Report Only]

Total accrued BPHC COVID-19 Supplemental grant(s) draw-down from January 1 to December 31, of the calendar measurement year (Table 9E: Other Revenues, Line 1q, Column a).

[Universal Report Only]

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

N. Special Tests and Provisions

1. Sliding Fee Discounts

Compliance Requirements Health centers must prepare and apply a sliding fee discount schedule (SFDS) so that the amounts owed for health center services by eligible patients are adjusted (discounted) based on the patient's ability to pay as follows:

- a. Sliding fee discounts are applied to fees for health center services provided to all individuals and families with annual incomes at or below 200 percent of the Federal Poverty Guidelines (FPG);
- b. A full discount is applied to fees for health center services provided to individuals and families with annual incomes at or below 100 percent of the FPG, or the health center applies only a nominal charge;

- c. Fees for health center services are discounted based on gradations in family size and income for individuals and families with incomes above 100 and at or below 200 percent of the FPG; and
- d. No sliding fee discount is applied to fees for health center services provided to individuals and families with annual incomes above 200 percent of the FPG.

(42 USC 254b(k)(3)(E), (F), and (G); 42 CFR sections 51c.303(e), (f), and (g); and 42 CFR sections 56.303(e), (f), and (g))

Audit Objectives Determine whether the health center has applied sliding fee discounts to patient charges consistent with its sliding fee discount schedule.

Suggested Audit Procedures

- a. Review the health center's sliding fee discount schedule(s).
- b. Review a sample of financial records for patients treated during the audit period to determine whether patient charges were appropriately adjusted based on income and family size by applying the health center's sliding fee discount schedule. (Note: Auditors are not required to test any documentation used to establish or verify income.)

2. Compliance with Consolidated Appropriations Act

Compliance Requirements Federal funds awarded under the HCP may not be expended for any abortion. These limitations do not apply to an abortion (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed (Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260)).

Audit Objectives Determine whether the health center (HC) performs abortions and if so, whether it has policies and procedures in place to ensure compliance with the Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260).

Suggested Audit Procedures

- a. Inquire of the HC staff and examine the accounting records to determine whether any abortions were performed during the audit period. If no, no further procedures need be undertaken by the auditor.
- b. If abortions were performed during the period, determine whether policies and procedures are in place that address the appropriate use of federal funds awarded under the HCP, specifically related to ensuring that HCP grant funds are not used for abortion activities unless one of the exceptions in the Consolidated Appropriations Act described above is met. If no policies are in place, proceed to

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.268 IMMUNIZATION COOPERATIVE AGREEMENTS****I. PROGRAM OBJECTIVES**

The objective of the Immunization Cooperative Agreement 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 Cooperative Agreements program consists of two parts: discretionary Section 317 immunization funding and VFC financed with mandatory Medicaid (Assistance Listing 93.778) funding.

The objective of the discretionary Section 317 Immunization Cooperative Agreement 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 funding 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 cooperative agreement guidance, has identified the following areas of activity for programmatic emphasis and funding prioritization: reduce the number of indigenous cases of VPDs; 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 organizations 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 cooperative agreement 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 also not cover vaccination 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.

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. 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 this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an "N." See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	N	Y	N	N	Y	N	Y

A. Activities Allowed or Unallowed

1. Discretionary Section 317 cooperative agreements 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).

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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

N. Special Tests and Provisions**1. Control, Accountability, and Safeguarding of Vaccine**

Compliance Requirements 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 Objectives 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 the necessary follow-up procedures were followed if any deficiencies were identified.

2. Record of Immunization

Compliance Requirements 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 Objectives 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 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 should be treated by the grantee as expenditures under a federal award 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 considered as expenditures under a federal award for purposes of determining audit coverage and reporting for those entities.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.423 WAIVERS FOR STATE INNOVATION FOR SECTION 1332 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)****I. PROGRAM OBJECTIVES**

The purpose of the State Innovation Waiver (1332 waiver) is to permit states to pursue innovative strategies for providing their residents with access to high-quality, affordable health insurance while retaining the basic protections of the PPACA (42 USC § 18052). The 1332 waivers allow states to implement innovative ways to provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit.

II. PROGRAM PROCEDURES

Section 1332 provides the secretaries of Health and Human Services (HHS) and the US Department of the Treasury (the Treasury) (collectively referred to in this document as “the Departments”) with the discretion to approve a state’s proposal to waive specific provisions of the PPACA (42 USC § 18052), provided the proposal meets certain requirements (stated above). Upon receipt of an application, the Centers for Medicare & Medicaid Services’ (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) and Treasury’s Office of Tax Policy will coordinate the review and approval process with the Departments and applicable federal agencies (this may vary based on the type of application). CCIIO will provide coordination support, including management of the State Innovation Waiver mailbox. A state seeking a waiver should apply by submitting a completed application in electronic format to stateinnovationwaivers@cms.hhs.gov.

A State Innovation Waiver Cross-Component Work Group (1332 workgroup) includes subject matter experts and key contacts from the departments and other federal agencies, as needed, to examine the scope of each application. Each application is examined to certify that a waiver meets the guardrail requirements including the comprehensiveness standard (as required under the statute). While the 1332 workgroup does not have approval authority itself, it will ensure that the Departments are involved at all levels of the application review process prior to rendering a final decision. Each waiver application is reviewed for completeness, and then approved or denied, as appropriate.

Once a state’s 1332 waiver application has been reviewed and approved, there is a coordinated grants management and oversight and monitoring process. The grant funding is linked to pass-through funding calculations, which are completed annually based on data that states must report back to the departments every year to fulfill regulatory oversight, monitoring, and compliance requirements. The state is entitled to the equivalent of forgone exchange financial assistance (e.g., Premium Tax Credits) that the state would have received absent the waiver. This requires modeling both the waiver and non-waiver health insurance markets in the state, specifically exchange premiums, and the resulting financial assistance the state would have received absent the waiver. This provides for little discretion related to the amount of pass-through funding and

grant-award amount except to devise the most appropriate methodology to model the waiver and non-waiver markets in the state. State Innovation Waivers are available for effective dates beginning on or after January 1, 2017. Funds are available for expenditure by grantees for a period of up to five years effective on the date specified in the grant specific terms and conditions (STCs), and states have the option to extend their waiver program beyond the initial five-year period of performance.

Source of Governing Requirements

The 1332 waiver program is authorized by the PPACA (Pub. L. No. 111-148) (March 23, 2010), which was amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152). The Departments promulgated implementing regulations in 2012, which are codified at 45 CFR Part 155 (Health and Human Services) and 31 CFR Part 33 (Treasury), respectively.

Availability of Other Program Information

1. CCIIO has published general program information, including guidance on application requirements on its website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html.
2. CCIIO has also developed a checklist for Section 1332 State Innovation Waiver applications, including specific items applicable to high-risk pool/state-operated reinsurance program applications at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	N	N	Y	N	Y	Y	N

A. Activities Allowed or Unallowed

1. Activities Allowed

- a. Individual awards are based on the waiver application approved by the Departments and are subject to the STCs in the Notice of Award (NoA). Activities are allowable as indicated in the grant STCs.
- b. 1332 waivers allow the state to waive certain provisions of PPACA and the Internal Revenue Code (IRC) to allow for state innovation. Activities are allowable (as approved in the waiver application approval process) that enable the state to:
 - (1) Modify or eliminate qualified health plan (QHP) certification and the exchanges as the vehicle for determining eligibility for subsidies and enrolling consumers in coverage.
 - (a) *Waives Part I of Subtitle D of the PPACA related to the establishment of QHPs.*
 - (b) *Waives Part II of Subtitle D of the PPACA related to the establishment of health insurance exchanges and related activities.*
 - (2) Modify the rules governing covered benefits and subsidies.
 - (a) *Waives Section 1402 of the PPACA related to cost-sharing subsidies to eligible individuals who purchase non-group health insurance through a health insurance exchange.*
 - (b) *Waives Section 36B of IRC related to premium tax credits to eligible individuals who purchase non-group health insurance through an exchange.*

- (3) Modify or eliminate penalties on large employers who fail to offer affordable coverage to their full-time employees.
 - (a) *Waives Section 4980H of the IRC shared responsibility requirement for large employers (employer mandate).*
 - (b) *Waives Section 5000A of the IRC related to the requirement for individuals to maintain health insurance coverage (individual mandate).*
- c. 1332 waiver funds may be used for all program services consistent with the four criteria or “guardrails” in the statute:
 - (1) *Comprehensive Coverage* – States must provide coverage that is “at least as comprehensive” as coverage absent the waiver.
 - (2) *Affordable Coverage* – States must provide “coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable” as coverage absent the waiver.
 - (3) *Scope of Coverage* – States must provide coverage to “at least a comparable number of residents” as would have been covered without the waiver.
 - (4) *Federal Deficit* – The waiver must not increase the federal deficit.
 - (a) 1332 waivers allow states to modify the rules regarding covered benefits, subsidies, insurance marketplaces, and individual and employer mandates **only** if they meet these statutory “guardrails.”

2. *Activities Unallowed*

- a. 1332 waiver funds may not be used for any program activities that are beyond the scope of the “guardrails” or are not consistent with the state’s approved waiver application and the grant STCs.
- b. Promotional items and capital or operating costs unassociated with the approved activities are not allowable.

B. Allowable Costs/Cost Principles

- 1. Costs charged to federal funds under the 1332 Waiver program must comply with the cost principles at 45 CFR Part 75, Subpart E, and any other requirements or restrictions on the use of federal funding outlined in the grant STCs.
- 2. Grantees should supplement 1332 waiver funds with state funds or other sources of funding to implement the waiver program as needed. States are responsible for

making up any budget shortfalls to ensure that they fully implement the activities of their waiver program.

3. Grantees must comply with the HHS Grants Policy Statement and have approved documentation to prove pass-through funds were used for approved 1332 waiver activities. Sufficient evidence (as indicated in the approved waiver application) is required to substantiate any drawdown of funding from the Payment Management System (PMS).
4. Prospective and retroactive payments are allowed depending on the business model and grantee need in congruence with the STCs.
 - a. Grantees may make **prospective drawdowns** of funds prior to the completion of approved, funded activities after providing sufficient evidence of need when requesting to drawdown funds (as outlined in the waiver application).
 - b. Grantees may make **retroactive drawdowns** of funds as reimbursement for invoices received following completion of approved waiver activities (Reinsurance and Small Business Health Options program waivers fall under this category).
5. Agreed upon indirect costs are allowable using the current approved Negotiated Indirect Cost Rate Agreement.

C. Cash Management

1. Under the 1332 Waiver program, funds awarded in a fiscal year are not required to be expended in that same fiscal year. Grantees may roll over unused funds awarded during the prior year for use in the following fiscal year for purposes of implementing the waiver program.
2. Grantees must comply with the HHS Grants Policy Statement and are required to maintain written policies and procedures to minimize the time elapsing between the transfer of funds from PMS and the disbursement of those funds by the recipient. The amount of time a grantee holds funds may not exceed three days. However, grantees are permitted to have access to the entire award amount in PMS until business needs dictate that they drawdown funds for the 1332 Waiver program.
3. Grantees must comply with the fiscal and budgetary reporting requirements and the grant STCs (SF424 and SF424a).
4. Unless otherwise specified in the grant STCs, grantees will request funds directly from PMS and are not able to hold drawdown funds in their bank account for longer than three days. All funds must either be distributed by the grantee or returned to the Treasury within three days.

5. Grantees are encouraged to use the cash-basis accounting method.
6. Grantees are not required to track the hourly wages of each employee that was paid by the grant vs. paid by program revenue. It is not a program requirement that these employees be tracked by the hour, but rather tracked by a percentage.

I. Procurement and Suspension and Debarment

1. States must comply with the same policies and procedures they use for procurements from their nonfederal funds. Nonfederal entities other than states, including those operating federal programs as subrecipients of states, must follow the procurement standards set out in 2 CFR 200. They must use their own documented procurement procedures, which reflect applicable state and local laws and regulations, provided that the procurements conform to applicable federal statutes and the procurement requirements identified in 2 CFR 200.
2. Nonfederal entities and contractors are subject to the non-procurement debarment and suspension regulations. Grantees must regularly monitor the System for Award Management (SAM) for suspensions and debarments prior to issuing any subawards or contracts. Any parties that are debarred, suspended, or otherwise excluded are ineligible for participation in federal assistance programs or activities.
3. Grantees must comply with the requirement to maintain an active SAM registration. This requires that grantees review and update Central Contractor Registration (CCR) information at least annually after the initial registration, and more frequently if required by changes in the information.

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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L. for audit guidance.

M. Subrecipient Monitoring

See Part 3.M. for audit guidance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.461 HRSA COVID-19 CLAIMS REIMBURSEMENT FOR THE UNINSURED PROGRAM AND THE COVID-19 COVERAGE ASSISTANCE FUND****I. PROGRAM OBJECTIVES**

The HRSA COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured program (HRSA COVID-19 Uninsured Program) and the COVID-19 Coverage Assistance Fund (HRSA COVID-19 CAF) are administered by the Health Resources and Services Administration (HRSA). The HRSA COVID-19 Uninsured Program provides claims reimbursements to eligible health care providers for conducting COVID-19 testing for the uninsured, treating uninsured individuals with a COVID-19 diagnosis, and administering FDA-authorized or FDA-licensed COVID-19 vaccines to uninsured individuals. The HRSA COVID-19 CAF provides COVID-19 vaccine administration fee claims reimbursement to eligible health care providers who provide COVID-19 vaccines to patients enrolled in health coverage that either does not cover vaccine administration fees or does cover the administration fees but has patient cost-sharing.

II. PROGRAM PROCEDURES

This program is administered as a claims reimbursement program for eligible health care providers. For the HRSA COVID-19 Uninsured Program, health care providers who have conducted COVID-19 testing or provided treatment for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020, or administered FDA authorized or FDA-licensed COVID-19 vaccines on or after December 14, 2020, can electronically request claims reimbursement through the program and will be reimbursed generally at Medicare rates, subject to available funding. This program does not provide coding guidance to providers. Rather, the program provides billing guidance to allow providers to identify and submit only claims eligible for reimbursement under this program, which is exclusively for reimbursing providers for COVID-19 testing of uninsured individuals, treatment for uninsured individuals when COVID-19 is the primary reason for treatment, and the administration of licensed or authorized COVID-19 vaccines to uninsured individuals.

Prior to paying claims, HRSA's claims processing contractor performs procedures to identify and reject claims for patients with insurance coverage. If errors or additional coverage are found, the provider receives notice of rejection and may request reconsideration.

For the HRSA COVID-19 CAF, health care providers who have administered FDA authorized or FDA-licensed COVID-19 vaccines on or after December 14, 2020, for individuals whose insurance health plans either do not cover vaccination fees or cover them with patient cost-sharing (underinsured individuals) can electronically request claims reimbursement through the program and will be reimbursed generally at Medicare rates, subject to available funding. Providers will be reimbursed at the national Medicare rate for vaccine administration, and for patient charges related to COVID-19 vaccination, including co-payments for vaccine administration, deductibles for vaccine administration, and co-insurance, subject to available

funding. Prior to paying claims, HRSA's claims processing contractor performs procedures to identify and reject claims for patients who have insurance coverage. If errors or additional coverage are found, the provider receives notice of rejection and may request reconsideration.

For both the UIP and the CAF, steps involve voluntarily enrolling as a provider participant (recipient), signing attesting to the terms and conditions of the program, checking patient eligibility, submitting patient information, submitting claims electronically (subject to Medicare timely filing requirements), and receiving payment via direct deposit.

Source of Governing Requirements

The HRSA COVID-19 Uninsured Program has the following two components:

1. Testing – The reimbursement for COVID-19 testing services is authorized via:
 - Families First Coronavirus Response Act (Pub. L. No. 116-127) (FFCRA) [Division A, Title V, Office of the Secretary, Public Health and Social Service Emergency Fund 134 Stat. 182]
 - Paycheck Protection Program and Health Care Enhancement Act (PPPHCA) (Pub. L. No. 116-139) [134 Stat. 626]

The FFCRA and PPPHCA “testing fund” was fully disbursed on February 17, 2021. As a result, the HRSA COVID-19 Uninsured Program reimbursement of COVID-19 testing services is subsequently authorized via:

- The Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No. 116-136, 134 Stat. 563)
 - Paycheck Protection Program and Health Care Enhancement Act (PPPHCA) (Pub. L. No. 116-139)
 - Coronavirus Relief and Response Supplemental Appropriations Act (CRRSA) (Pub. L. No. 116-260)
 - The American Rescue Plan Act (ARPA) (Pub. L. No. 117-2)
2. Treatment and Vaccine Administration – The reimbursement for COVID-19 treatment services and vaccine administration is authorized via:
 - The Coronavirus Aid, Relief, and Economic Security CARES Act (Pub. L. No. 116-136, 134 Stat. 563)
 - Paycheck Protection Program and Health Care Enhancement Act (PPPHCA) (Pub. L. No. 116-139)
 - Coronavirus Relief and Response Supplemental Appropriations Act (CRRSA) (Pub. L. No. 116-260)

The HRSA COVID-19 CAF is authorized via:

- The Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No. 116-136, 134 Stat. 563)
- Paycheck Protection Program and Health Care Enhancement Act (PPPHCA) (Pub. L. No. 116-139)
- Coronavirus Relief and Response Supplemental Appropriations Act (CRRSA) (Pub. L. No. 116-260)

Under the definition of federal financial assistance, claims paid under the HRSA COVID-19 Uninsured Program and the HRSA COVID-19 CAF are considered other financial assistance. Per the applicability table in 45 CFR section 75.101(b)(1), other financial assistance is not subject to the post federal award or cost principles requirements in 45 CFR Part 75, subparts C, D, and E, respectively, with the exception that 45 CFR section 75.303 (Internal Controls) and sections 75.351 through 75.353 (Subrecipient Monitoring and Management) are applicable.

Under the terms and conditions of the awards, the HRSA COVID-19 Uninsured Program and the HRSA COVID-19 CAF are subject to 45 CFR section 75.302 (Financial management and standards for financial management systems) and 45 CFR sections 75.361 through 75.365 (Record Retention and Access).

Availability of Other Program Information

The following websites provide additional information about the HRSA COVID-19 Uninsured Program claims:

Overview

<https://www.hrsa.gov/CovidUninsuredClaim>

Frequently Asked Questions

<https://www.hrsa.gov/coviduninsuredclaim/frequently-asked-questions>

Terms and Conditions

<https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/uninsured-program-terms-and-conditions-6-21.pdf>

The following websites provide additional information about the HRSA COVID-19 CAF:

Overview

<https://www.hrsa.gov/covid19-coverage-assistance>

Frequently Asked Questions

<https://www.hrsa.gov/covid19-coverage-assistance/frequently-asked-questions>

Resources

<https://covid19coverageassistance.ssigroup.com/resources/resources.aspx>

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	N	N	N	N	N	N	Y

A. Activities Allowed or Unallowed

1. *Activities Allowed*

Required health services as described in the terms and conditions for uninsured individuals:

- a. Reimbursement of payments for COVID-19 testing and testing-related items for individuals who do not have any health care coverage at the time the services were rendered.

- b. Reimbursements of payments for COVID-19 treatment as determined by the program for individuals who do not have any health care coverage at the time the services were rendered.
- c. Reimbursements of payments for COVID-19 vaccine administration fee(s) as determined by the program for individuals who do not have any health care coverage at the time the services were rendered.

Required health services as described in the terms and conditions for underinsured individuals:

- a. Reimbursement for administering COVID-19 vaccinations to individuals with health plans that do not cover, or only partially cover, COVID-19 vaccine administration fees.

2. *Activities Unallowed*

As described in the terms and conditions.

- a. Funds provided will not be used to reimburse expenses that have been reimbursed from other sources or that other sources are obligated to reimburse. The recipient will not include costs for which payment was received in cost reports or otherwise seek uncompensated care reimbursement through federal or state programs for items or services for which payment was received.
- b. If the recipient subsequently receives reimbursement for any items or services for which the recipient requested Payment from the Provider Relief Fund, the recipient will return to HHS that portion of the Payment which duplicates payment or reimbursement from another source.
- c. (HRSA COVID-19 Uninsured Program only) If the recipient, prior to attesting to these terms and conditions, charged any uninsured individuals a fee for COVID-19 testing, testing-related items and services, treatment, or vaccine administration fees for which the recipient subsequently received a payment from this program, the recipient will communicate to the uninsured individuals they do not owe recipient any money for that care or treatment. If an uninsured individual paid the recipient for any portion of such care or treatment, the recipient must return the payment to the uninsured individual in a timely manner.
- d. (HRSA COVID-19 Uninsured Program only) Services not covered by traditional Medicare will also not be covered under this program. (For Medicare coverage see: <https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf>.) In addition, the following services are excluded: any treatment without a COVID-19 primary diagnosis, except for

pregnancy when the COVID-19 code may be listed as secondary; hospice services; and outpatient prescription drugs.

B. Allowable Costs/Cost Principles

While 45 CFR 75, Subpart E – Cost Principles do not apply to the HRSA COVID-19 Uninsured Program and the HRSA COVID-19 CAF, allowable costs charged to the HRSA COVID-19 Uninsured Program and the HRSA COVID-19 CAF must conform to, including the limitations and exclusions of, the terms and conditions.

E. Eligibility

1. Eligibility for Individuals

Services must be for individuals, who at the time the services were provided, were uninsured (UIP) or underinsured (CAF) as described in the terms and conditions.

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

Not Applicable

3. Eligibility for Subrecipients

Not Applicable

N. Special Tests and Provisions

1. Balance Billing

Compliance Requirements Under the terms and conditions of the award the recipient will not engage in “balance billing” or charge any type of cost sharing for any COVID-19 testing, testing-related items and services provided, treatment, or vaccination administration fees for which the recipient receives a payment from this program. The recipient shall consider payment received under this program to be payment in full for such care or treatment. The recipient will not bill the patient for any remaining balance.

Audit Objectives Determine whether recipient complied with the requirement to reframe from “balance billing” or charging any type of cost sharing.

Suggested Audit Procedures

- a. Review the recipients’ billing policies and procedures applicable to patients for which claim reimbursements were received.
- b. Perform procedures to identify client payments or third-party billings for patients for which claim reimbursements were received.

IV. OTHER INFORMATION

Guidance documents on HRSA webpages on the [Official web site of the U.S. Health Resources & Services Administration | \(hrsa.gov\)](https://www.hrsa.gov) website, such as those listed under “Availability of Other Program Information,” are provided only to clarify the applicable laws, regulations, and terms and conditions. Such guidance documents do not create new compliance requirements. However, non-federal entities in substantial compliance with the guidance applicable in these guidance documents at the time of a transaction are considered in compliance with the underlying compliance requirements.

The time between claim submission and verification of allowable claims from the contractor is minimal, therefore, auditees should use the accounting principles applicable for the recipients accounting basis for reporting program expenditures.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.498 PROVIDER RELIEF FUND (PRF) AND AMERICAN RESCUE PLAN (ARP) RURAL DISTRIBUTION

I. PROGRAM OBJECTIVES

Note: This program is considered a “higher risk” program for 2023, pursuant to 2 CFR section 200.519(c)(2). Refer to the “Programs with Higher Risk Designation” section of Part 8, Appendix IV, Internal Reference Tables, for a discussion of the impact of the “higher risk” designation on the major program determination process.

The PRF and ARP Rural Distribution are administered by the Health Resources and Services Administration (HRSA) and support eligible health care providers in the battle against the COVID-19 pandemic. PRF provides relief funds to eligible providers of health care services and support for health care-related expenses or lost revenues attributable to coronavirus. ARP Rural Distribution addresses the disproportionate impact that COVID-19 has had on rural communities and rural health care providers. PRF and ARP Rural Distribution recipients must only use payments for eligible expenses, including services rendered, and lost revenues during the period of availability, as outlined in the table below. Providers must use a consistent basis of accounting to determine expenses. PRF and ARP Rural Distribution recipients may use payments for eligible expenses incurred prior to receipt of those payments (i.e., pre-award costs) dating back to January 1, 2020, so long as they are to prevent, prepare for, and respond to coronavirus.

	Payment Received Period (Payments Exceeding \$10,000 in Aggregate Received)	Period of Availability	PRF and ARP Rural Portal Reporting Time Period
Period 1	April 10, 2020 to June 30, 2020	January 1, 2020 to June 30, 2021	July 1, 2021 to September 30, 2021
Period 2	July 1, 2020 to December 31, 2020	January 1, 2020 to December 31, 2021	January 1, 2022 to March 31, 2022
Period 3	January 1, 2021 to June 30, 2021	January 1, 2020 to June 30, 2022	July 1, 2022 to September 30, 2022
Period 4	July 1, 2021 to December 31, 2021	January 1, 2020 to December 31, 2022	January 1, 2023 to March 31, 2023
Period 5	January 1, 2022 to June 30, 2022	January 1, 2020 to June 30, 2023	July 1, 2023 to September 30, 2023
Period 6	July 1, 2022 to December 31, 2022	January 1, 2020 to December 31, 2023	January 1, 2024 to March 31, 2024

II. PROGRAM PROCEDURES

The PRF and ARP Rural Distribution include the following components and may include additional components established after the date of this Supplement:

For the first phase of the PRF General Distributions, money was distributed proportionate to providers’ share of Medicare fee-for-service reimbursements in 2019. A portion of providers

were automatically sent an advance payment based off the revenue data they submit in CMS cost reports. Providers without adequate cost report data on file needed to submit their revenue information to the General Distribution Portal for additional funds.

For the second and third phases of the PRF General Distribution, Medicaid, Children's Health Insurance Program (CHIP), dental, assisted living, and behavioral health providers were eligible to apply for funds, along with Medicare providers paid under Phase 1 who qualified to receive additional funds.

For the fourth phase of the PRF General Distribution, consistent with the requirements included in the Coronavirus Relief and Response Supplemental Appropriation (CRRSA) Act (Pub. L. No. 116-260), PRF Phase 4 payments were based on providers' changes in operating revenues and expenses from July 1, 2020 to March 31, 2021. Phase 4 also included new elements specifically focused on equity, including reimbursing smaller providers for their changes in operating revenues and expenses at a higher rate compared to larger providers, and bonus payments based on the amount of services providers furnish to Medicaid/CHIP and Medicare beneficiaries. In addition, eligible applicants applied for the ARP Rural funds through the same Application and Attestation Portal that was available to apply for the Phase 4 General Distribution.

Funding for high-impact areas was distributed to hospitals in areas that were particularly impacted by the COVID-19 outbreak based on submission of the hospital's: Tax Identification Number, National Provider Identifier, total number of Intensive Care Unit beds as of April 10, 2020 and June 10, 2020, and total number of admissions with a positive diagnosis for COVID-19 from January 1, 2020 to April 10, 2020, and January 1, 2020 to June 10, 2020.

Funding for Indian Health Service/Tribal facilities was distributed on the basis of operating expenses. Prior to the availability of ARP Rural funding, funding for rural providers was distributed on the basis of operating expenses.

Funding for safety net hospitals was based on Centers for Medicare & Medicaid Services (CMS) cost report data.

Funding for children's hospitals was based on patient service revenue.

Funding for skilled nursing facilities and nursing homes was primarily based on the number of certified beds in the facility, and for the Nursing Home Infection Control Quality Incentive Program payments, data submission to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) Long-term Care Facility Component COVID-19 Module.

Most payments were sent out to providers without application, with requirement for recipients to accept the terms and conditions through an online portal or return funds. The Assistance Listing numbers were not provided at time of payments or included in initial terms and conditions.

Source of Governing Requirements

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. No. 116-136, 134 Stat. 563)

Paycheck Protection Program and Health Care Enhancement Act (PPHCA) (Pub. L. No. 116-139, 134 Stat. 622)

Coronavirus Relief and Response Supplemental Appropriations (CRRSA) Act (Pub. L. No. 116-260)

The American Rescue Plan Act (ARPA) (Pub. L. No. 117-2)

Under the definition of federal financial assistance, PRF and ARP Rural Distributions are considered other financial assistance. Per the applicability table in 45 CFR section 75.101(b)(1), other financial assistance is not subject to the post federal award or cost principles requirements in 45 CFR Part 75, subparts C, D, and E, respectively, with the exception that 45 CFR section 75.303 (Internal Controls) and sections 75.351 through 75.353 (Subrecipient Monitoring and Management) are applicable.

Under the terms and conditions of the award, PRF and ARP Rural Distributions are subject to 45 CFR section 75.302 (Financial management and standards for financial management systems) and 45 CFR sections 75.361 through 75.365 (Record Retention and Access).

Additionally, under the terms and conditions of the award, PRF (Phase 4) and ARP Rural Distributions are subject to 45 CFR section 75.371 (Remedies for non-compliance) and 45 CFR sections 75.305(b)(8).

Availability of Other Program Information

PRF Reporting Portal

<https://prfreporting.hrsa.gov/s/>

Assistance Listing for PRF and ARP Rural Distribution

<https://sam.gov/fal/7886e62bcc404c008669faf8227ffb6a/view>

The following webpages provide additional information about the PRF:

PRF Information

<https://www.hrsa.gov/provider-relief/>

PRF and ARP Rural Distribution Terms and Conditions

<https://www.hrsa.gov/provider-relief/compliance/terms-conditions>

The following websites provide additional information about the ARP Rural Distribution:

<https://www.hrsa.gov/provider-relief/future-payments/phase-4-arp-rural>

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2,

“Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	N	N	N	N	N	N	Y	N	N

A. Activities Allowed or Unallowed

1. *Activities Allowed (All distributions except Skilled Nursing Facility Infection Control Distribution)*

Law (Pub. L. No. 116-136, 134 Stat. 563 and Pub. L. No. 116-139, 134 Stat. 622 and 623, Pub. L. No. 117-2)

To prevent, prepare for, and respond to coronavirus and COVID-19, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus. (Note: Auditors are not expected to test the funding reported as lost revenues to determine if it was expended only for federally defined allowable activities.)

That funds appropriated under this paragraph in this Act shall be available for building or construction of temporary structures, leasing of properties, medical supplies and equipment, including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity.

Payment means a pre-payment, prospective payment, or retrospective payment.

Terms and Conditions

- a. The recipient certifies that the payment will only be used to prevent, prepare for, and respond to coronavirus and COVID-19, and that the payment shall reimburse the recipient only for health care related expenses or lost revenues that are attributable to coronavirus and COVID-19.
- b. The recipient certifies that retaining the payment for at least 90 days without contacting HHS regarding remittance of those funds, is deemed to have accepted the Terms and Conditions.
- c. The recipient must provide or have provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. The Department of Health and Human Services (HHS) broadly views every patient as a possible case of COVID-19.

2. *Activities Allowed (Skilled Nursing Facility Infection Control Distribution)*

Terms and Conditions

Funds may only be used to reimburse the recipient for costs associated with the following items and services (“Infection Control Expenses”):

- a. Costs associated with administering COVID-19 testing, which means an in vitro diagnostic test defined in section 809.3 of title 21, *Code of Federal Regulations* (or successor regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such a test, that:
 - Is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 USC 360(k), 360c, 360e, 360bbb-3);
 - The developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 USC 360bbb-3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
 - Is developed in and authorized by a state that has notified the secretary of HHS of its intention to review tests intended to diagnose COVID-19; or
 - Other test that the secretary determines appropriate in guidance.
- b. Reporting COVID-19 test results to local, state, or federal governments.

- c. Hiring staff, whether employees or independent contractors, to provide patient care or administrative support.
- d. Expenses incurred to improve infection control, including activities such as implementing infection control “mentorship” programs with subject matter experts or changes made to physical facilities.
- e. Providing additional services to residents, such as technology that permits residents to connect with their families if the families are not able to visit in person.
- f. The recipient must provide or have provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.

3. *Activities Allowed (Rural distribution)*

Terms and Conditions

Funds may only be used to reimburse the provider(s) associated with the applicable subsidiary or billing TIN and cannot be transferred or allocated to another entity not associated with the subsidiary or billing TIN. Control and use of the Payment must be delegated to the Recipient that was eligible for and received the Payment.

4. *Activities Unallowed (All distributions)*

Law (Pub. L. No. 116-136, 134 Stat. 563 and Pub. L. No. 116-139, 134 Stat. 622, Pub. L. No. 117-2)

That these funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

Terms and Conditions

Payments may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

B. Allowable Costs/Cost Principles

While 45 CFR 75 Subpart E – Cost Principles do not apply to the PRF and the ARP Rural Distribution, charges to the PRF and the ARP Rural Distribution must be necessary, reasonable, accorded consistent treatment, and conform to the limitations and exclusions of the terms and conditions of the award. The PRF and ARP Rural Distribution Frequently Asked Questions referenced under Availability of Other Information above provides additional guidance and examples.

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*PRF Report*

PRF Reporting Portal (A Public Health Emergency Declaration-PRA Waiver Notice was issued January 14, 2021, applicable to the financial information collected by HRSA from eligible healthcare providers (<https://aspe.hhs.gov/public-health-emergency-declaration-pra-waivers>)).

The PRF reporting portal was launched on July 1, 2021 (<https://prfreporting.hrsa.gov/s/>); refer to the table in the Program Objective section for reporting time period(s). Auditors are expected to test this special reporting for fiscal years ending on or after June 30, 2021. Since the PRF and ARP Rural Distribution amounts to be reported on a recipient's Schedule of Expenditures of Federal Awards (SEFA) are based on the PRF report (see the Other Information section below), and since the PRF report is to be tested as part of the Reporting type of compliance requirement, auditors should consider delaying the commencement of the compliance audit of the PRF program until recipients have completed the PRF report.

Key Line Items – The following line items contain critical information (items are not numbered in report):

- 1. Total Reportable Nursing Home Infection Control Expenses Used in the Reporting Period
 - a. Total Nursing Home Infection Control Expenses – Cell that contains the aggregated total sum
- 2. Total Reportable Other PRF Expenses for Payments Received During Payment Period

- a. Total Other PRF Expenses – Cell that contains the aggregated total sum
- 3. Calculation of Lost Revenues Attributable to Coronavirus
 - a. 2019 Actuals
 - (1) Total Column for Total Revenue/Net Charges from Patient Care (2019 Actuals) – Each cell at the bottom of each quarter (Total revenue/Net Charges from Patient Care) and for each year, 2019, 2020, 2021, 2022 and 2023.
 - b. 2020 Budgeted
 - (1) Total Column for Total Revenue/Net Charges from Patient Care (Budgeted) – Each cell at the bottom of each quarter (Total revenue/Net Charges from Patient Care) and for each year, 2020, 2021, 2022 and 2023.
 - (2) Total Column for Total Revenue/Net Charges from Patient Care (Actuals) – Each cell at the bottom of each quarter (Total revenue/Net Charges from Patient Care) and for each year, 2020, 2021, 2022 and 2023.
 - c. Alternate Method of Calculating Lost Revenues Attributable to Coronavirus
 - (1) Each individual cell in the alternative method – audit back to the narrative and underlying supporting documentation. (**Note:** The auditor is not responsible for determining the reasonableness of the alternative method described in the narrative.)

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

IV. OTHER INFORMATION

Note: Since the PRF and ARP Rural Distribution amounts to be reported on a recipient's Schedule of Expenditures of Federal Awards (SEFA) are based on the PRF report (see Other Information below), and the PRF report is to be tested as part of the Reporting compliance requirement, auditors should consider delaying the commencement of the compliance audit of the PRF and ARP Rural Distribution program until recipients have completed the PRF report.

1. *Webpage Guidance*

Guidance documents accessed by links on the HRSA.gov website such as those listed under “Availability of Other Program Information” are provided only to clarify the applicable laws, regulations, and terms and conditions of the award and do not create new compliance requirements. However, nonfederal entities in substantial compliance with the guidance applicable in these guidance documents are considered in compliance with the underlying compliance requirements.

2. *Schedule of Expenditures of Federal Awards (SEFA) Reporting*

SEFA reporting amounts for this program (including both expenditures and lost revenues) are based upon the PRF report that is required to be submitted to the HRSA reporting portal (described in “L.3 Special Reporting;” <https://prfreporting.hrsa.gov/s/>). Therefore, it is first important to understand the HRSA PRF and ARP Rural Distribution reporting requirements, which are summarized in the following table.

For the PRF and Rural Distribution it is the last day a provider can use the funds (end of the period of availability), which drives inclusion of the PRF amount on the Schedule of Expenditures for Federal Awards (SEFA) in a Single Audit report.

	Payment Received Period (Payments Exceeding \$10,000 in Aggregate Received)	Period of Availability	PRF Portal Reporting Time Period	Fiscal Year Ends (FYE) to include each PRF Period on the Schedule of Expenditures for Federal Awards (SEFA) Reporting
Period 1	April 10, 2020 to June 30, 2020	January 1, 2020 to June 30, 2021	July 1, 2021 to September 30, 2021	Fiscal Year End (FYE) of June 30, 2021 through June 29, 2022
Period 2	July 1, 2020 to December 31, 2020	January 1, 2020 to December 31, 2021	January 1, 2022 to March 31, 2022	FYE of December 31, 2021 through FYEs December 30, 2022
Period 3	January 1, 2021 to June 30, 2021	January 1, 2020 to June 30, 2022	July 1, 2022 to September 30, 2022	FYE of June 30, 2022 through June 29, 2023
Period 4	July 1, 2021 to December 31, 2021	January 1, 2020 to December 31, 2022	January 1, 2023 to March 31, 2023	FYE of December 31, 2022 through FYEs December 30, 2023
Period 5	January 1, 2022 to June 30, 2022	January 1, 2020 to June 30, 2023	July 1, 2023 to September 30, 2023	FYE of June 30, 2023 through June 29, 2024
Period 6	July 1, 2022 to December 31, 2022	January 1, 2020 to December 31, 2023	January 1, 2024 to March 31, 2024	FYE of December 31, 2023 through FYEs June 29, 2024

Summary of SEFA Reporting of PRF for Fiscal Year Ends (FYE) Covered by the 2023 Compliance Supplement

For FYEs of June 30, 2023, and through FYEs of December 30, 2023 recipients should report in the SEFA, the expenditures and lost revenues from the **Period 4 and Period 5** PRF report.

For a FYE of December 31, 2023 and through FYEs of June 29, 2024, recipients should report in the SEFA, the expenditures and lost revenues from both the **Period 5 and Period 6** PRF reports.

For FYEs on or after June 30, 2024, SEFA reporting guidance will be provided in covered under the 2024 Compliance Supplement.

3. *Defining the Entity to be Audited*

The reporting entity required for PRF and ARP Rural Distribution reporting purposes may not align to the reporting entity as defined for financial reporting purposes. It is important to note that the required PRF level of reporting has no bearing on the application of the requirements in 2 CFR 200.514 for defining the entity to be audited for single audit purposes. Thus, for single audits that include PRF and ARP Rural Distribution, the Single Audit must cover the entire operations of the auditee, or, at the option of the auditee, such audit must include a series of audits that cover departments, agencies, and other organizational units that expended or otherwise administered federal awards during such audit period, provided that each such audit must encompass the financial statements and schedule of expenditures of federal awards for each such department, agency, and other organizational unit, which must be considered to be a nonfederal entity.

As a best practice, the recipients may wish to include a footnote disclosure on the SEFA to identify which providers by TIN are included in the audit.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.499 LOW-INCOME HOUSEHOLD WATER ASSISTANCE PROGRAM

I. PROGRAM OBJECTIVE

Congress established the Low-Income Household Water Assistance Program (LIHWAP) as part of the federal government's response to the COVID-19 pandemic. This emergency formula grant program is designed to target assistance to those households with the lowest incomes that pay a high proportion of household income for water and wastewater services. The federal grant is awarded to states, territories and Indian Tribes who will issue funds on behalf of eligible, applicant households to owners or operators of public water systems or treatment works to reduce arrearages of and rates charged to such households for those services.

States, territories, and Indian tribes—the LIHWAP grantees—shall, as appropriate and to the extent practicable, use existing processes, procedures, policies, and systems in place to provide assistance on behalf of low-income households, particularly in coordination with the federal Low Income Home Energy Assistance Program (LIHEAP), except where otherwise noted. Grantees shall provide LIHWAP benefits according to the following priorities: (1) households whose services are disconnected due to non-payment, (2) households whose services are facing an imminent disconnection due to non-payment, and (3) households with only a current bill due (no past due/arrearage amount). Grantees must ensure that benefits and other interventions are sufficient to ensure restoration and/or continuity of services.

II. PROGRAM PROCEDURES

A. LIHWAP Formula Grants

The US Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Community Services (OCS), administers LIHWAP at the federal level. LIHWAP 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) that received fiscal year (FY) 2021 LIHEAP funding were eligible to serve as recipients of direct funding from ACF.

Each grantee is responsible for designing and implementing its own LIHWAP within broad federal guidelines. Grantees must administer their LIHWAP according to their ACF approved plan, and any amendments, and in conformance with the federal ACF Mandatory General Terms and Conditions and the LIHWAP Specific Terms and Conditions. Grantees must establish appropriate systems and procedures to prevent, detect and correct waste, fraud, and abuse, by clients, vendors, and administering agencies.

In order to receive funding, each grantee was required to submit a LIHWAP implementation plan that served as the grantee's application for federal funding and describes how the grantee's LIHWAP will be administered, including a set of program

integrity questions in which the grantee must describe the systems in place to detect and deter fraud, waste, and abuse in its LIHWAP program.

All grantees must have allowed for public participation in the development of their annual plans prior to submission to ACF.

Source of Governing Requirements

LIHWAP was authorized under the Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) and the American Rescue Plan Act of 2021 (Pub. L. No. 117-2).

LIHWAP is subject to all of 45 CFR Part 75, which is the HHS implementation of 2 CFR Part 200, commonly known as the Office of Management and Budget's Uniform Administrative Guidance.

In addition, LIHWAP grantees must administer their LIHWAP according to their respective Plans that they submitted to HHS. Grantees are permitted to submit revised LIHWAP plans within a reasonable amount of time after making significant changes to their policies and/or procedures referenced in their plans.

Grantees must also abide by the [LIHWAP Specific Terms and Conditions](#) and the [ACF General Mandatory Grant Terms and Conditions](#). Both sets of Terms and Conditions can be found here: <https://acf.hhs.gov/grants/mandatory-formula-block-and-entitlement-grants>.

Availability of Other Program Information

The ACF LIHWAP web page (<https://www.acf.hhs.gov/ocs/programs/lihwap>) provides general information about this program, including a section on Policy and Guidance.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an "N." See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	Y	Y	N	N	Y	Y	N

B. Allowable Costs/Cost Principles

1. Allowable Costs

Grantees must provide the bill payment benefits directly to the owners or operators of public water systems or treatment works on behalf of specific, approved households with accounts with such providers.

Benefits on behalf of households are limited to credits to the households' accounts to pay towards arrearages, current and/or future water charges (e.g., a credit to the account). This can include payment towards reconnection fees, late payment fees, and other fees to the extent they are charged to the recipient household in the same fashion as any other account holder with the water provider (no discrimination in fees charged to program recipients or low income customers).

Funds must not be used towards infrastructure purchases, repairs or improvements (e.g., repair or replacement of toilets, pipes, and other related equipment). Funding must not be used towards in-kind benefits to the household.

A reasonable amount of funds may be used for related program outreach and eligibility intake activities.

2. Cost Principles

All of 45 CFR Part 75 applies to this program. Of particular note, grantees must establish and maintain accurate central office cost allocation plans in addition to negotiated indirect cost agreements (see 45 CFR section 75.416).

E. Eligibility

1. Eligibility for Individuals

Grantees must provide benefit payments to water/wastewater companies on behalf of households that are income eligible based on either (a) one or more individuals

are receiving assistance from the LIHEAP, TANF, SSI, SNAP benefits, or certain needs-tested veterans' benefits; or (b) total household income that does 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 must give priority to those households with the highest home water and wastewater costs or needs in relation to income and household size. This includes targeting households with vulnerable members, including a senior (60 years or older), a young child (5 years or younger), and/or a disabled member (disabled defined by the grantee).

Households whose water bills are included in their rent are eligible for program benefits to the extent the household pays rent and provides adequate documentation to show water is provided by the landlord. Payments on behalf of renters must still be made to the owners or operators of public water systems or treatment works, those payments must reduce arrearages of and rates charged to the landlord's account, and the landlord must pass the benefit in full to eligible households in the form of lower rent payments. Grantees must establish consumer protections, such as by issuing two-party checks, sufficient to ensure that the water provider correctly credits the account and that the landlord credits the household's rent bill to reflect the LIHWAP benefit amount.

Grantees must provide funds to owners or operators of public water systems or treatment works ("owners or operators") to reduce arrearages of and rates charged to eligible households for such services. For all payments to owners or operators on behalf of individual households, the grantee must establish procedures to:

- a. notify, or require the owner or operator to notify, each participating household of the amount of assistance paid on its behalf;
- b. assure that the owner or operator will charge the eligible household, in the normal billing process, the difference between the actual amount due and the amount of the payment made by the LIHWAP grant;
- c. assure that any agreement the grantee enters into with an owner or operator under this paragraph will contain provisions to assure that no household receiving assistance under this grant will be treated adversely because of such assistance under applicable provisions of State law or public regulatory requirements;
- d. ensure that the provision of payments to the owner or operator remains at the option of the grantee, in consultation with local subgrantees; and
- e. ensure that the owner or operator provides written reconciliation and confirmation on a regular basis that benefits have been credited appropriately to households and their services have been restored on a

timely basis or disconnection status has been removed if applicable.

Households that rely entirely on well water and/or septic service are ineligible for assistance under this program, unless they qualify for a special other water service such as delivered water under extenuating circumstances.

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.

G. Matching, Level of Effort, Earmarking

1. Matching

Not Applicable

2. Level of Effort

Not Applicable

3. Earmarking

The following limitations apply to LIHWAP formula grants:

a. *Administrative Costs*

- (1) No more than 15 percent of a state's LIHWAP funds for each appropriation (Pub. L. No. 116-260 and Pub. L. No. 117-2) may be used for administrative costs, including both direct and indirect costs. This limitation applies, in the aggregate, to administrative costs at both the state and subrecipient levels. This cap must not be exceeded by supplementing with other federal funds.

H. Period of Performance

Period of Performance/Obligation Period: The LIHWAP formula grant funds payable to the grantee in federal fiscal year 2021 must be obligated by the grantee by September 30, 2023. Funds not obligated by September 30, 2023, must be returned to ACF.

Per 45 CFR section 75.2, the term “obligation” is defined as: “when used in connection with a non-federal entity's utilization of funds under a federal award, *obligations* means orders placed for property and services, contracts and subawards made, and similar transactions during a given period that require payment by the non-federal entity during the same or a future period.”

Expenditure: Grantees must expend (liquidate) the funds, based upon prior valid obligations, no later than 90 calendar days after the close of FY 2023 (i.e., by December 31, 2023).

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 Program* -Not Applicable.
- c. *SF-425, Federal Financial Report* – Applicable – due 90 days after the close of each federal fiscal year

2. Performance Reporting

- a. *LIHWAP Annual Performance and Management Data Report (OMB No - 0970-0578)* – All grantees will need to submit this report by December 31st following each federal fiscal year (e.g., December 31, 2021 for FY 2021 obligations and expenditures and December 31, 2022 for FY 2022 obligations and expenditures, and December 31, 2023 for FY 2023 obligations and expenditures). The report is required per the terms and agreements (see Attachment [A LIHWAP Terms and Conditions State Signature Block \(hhs.gov\)](#)). The report includes key performance indicators such as the number and types of households assisted, the average benefit amount provided to households, and performance measures related to targeting assistance to high water burden households (i.e., households that incur the greatest water bills in relation to household income). [A link to a blank copy of the report and report instructions can be found at the following:](#)

[RPT_LIHWAP_Annual Report_FY2022 \(Not 508-compliant\).xlsx \(live.com\)](#)

and [COMM_LIHWAP_Annual Report Instructions_FY2022\(hhs.gov\)](#).

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

Section 1. Grant Award Amounts #6. The actual administrative cost must not exceed 15% of the total award.

3. Special Reporting

Not Applicable

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

IV. OTHER INFORMATION

Grantees must follow the specific LIHWAP Terms and Conditions associated with the grant awards. They include a number of provisions related to consumer protections, etc. They are accessible here:

<https://www.acf.hhs.gov/sites/default/files/documents/LIHWAP%20Terms%20and%20Conditions%20for%20States.pdf>.

They are also bound by the General Mandatory Terms and Conditions, which are posted here:

https://www.acf.hhs.gov/sites/default/files/documents/general_terms_and_conditions_2019_final.pdf.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.545 CONSUMER OPERATED AND ORIENTED PLAN
[CO-OP] PROGRAM****I. PROGRAM OBJECTIVES**

The purpose of the Consumer Operated and Oriented Plan (CO-OP) program is to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the states in which the issuers are licensed to offer such plans. These CO-OPs are consumer-governed, private, nonprofit health insurers.

II. PROGRAM PROCEDURES

At the federal level, the CO-OP program is administered by the Department of Health and Human Services, through the Centers for Medicare and Medicaid Services (CMS)/Center for Consumer Information and Insurance Oversight (CCIIO). In addition to improving consumer choice and plan accountability, the CO-OP program also seeks to promote integrated models of care and enhance competition in the Health Insurance Exchanges established under sections 1311 and 1321 of the Affordable Care Act (ACA).

Established under Section 1322 of the ACA, the CO-OP program provides loans to capitalize eligible prospective CO-OPs with a goal of having at least one CO-OP in each state, although the statute permits the funding of multiple CO-OPs in any state, provided that there is sufficient funding to capitalize at least one CO-OP in each state.

Solvency loans are loans provided by CMS to a loan recipient in order to meet state solvency and reserve requirements, and start-up loans are loans provided by CMS to a loan recipient for costs associated with establishing a CO-OP. Both types of loans must be used consistent with the loan agreement and applicable statutory and regulatory requirements. Solvency loans are structured in a manner that ensures that the loan amount is recognized by state insurance regulators as “surplus notes” pursuant to National Association of Insurance Commissioners Statutory Statement of Accounting Principles No. 41 (SSAP 41) so that the proceeds of the loans may be counted as assets and contribute to the state-determined capitalization reserve requirements or other solvency requirements (rather than debt) as specified in the insurance regulations for the state in which the loan recipient will offer a CO-OP qualified health plan. Several, but not all, start-up loans to loan recipients have also been structured as surplus notes in the years subsequent to first issuance on a case-by-case basis using specified criteria. For both types of loans, the loan recipient must make loan payments in accordance with the approved repayment schedule in the loan agreement until the loan is paid in full consistent with state reserve requirements, solvency regulations, and requisite surplus note arrangements. For the Start-up Loans, interest accrues from the date of drawdown on the loan amounts that have been drawn down and not yet repaid by the loan recipient. For Solvency Loans, interest accrues in a manner consistent with the requirements of SSAP 41, and/or any applicable state law or regulation. The interest rate for each loan is determined based on the date of award.

Information on what happens when loan recipients fail to make loan payments and conversions can be found in 45 CFR section 156.520 or under 42 USC 18042.

Source of Governing Requirements

The CO-OP program is authorized by the Patient Protection and Affordable Care Act (Pub. L. No. 111-148, which was enacted on March 23, 2010), which was amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152). The two laws are collectively referred to as the “Affordable Care Act.” Section 1322 of the ACA created the Consumer Operated and Oriented Plan program, which is codified at 42 USC 18042, and program regulations are found at 45 CFR sections 156.500 through .520 (45 CFR Part 156, Subpart F—Consumer Operated and Oriented Plan program).

Availability of Other Program Information

Additional information is available on the CCIIO website at <http://cciio.cms.gov/> or at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	N	N	N	N	N	N	N	N	Y	N	N

A. Activities Allowed or Unallowed**1. *Activities Allowed***

In accordance with the loan agreement, these include the following categories and specified limitations:

- a. Start-up loan funds must only be used in accordance with the Business Plan and the Start-Up Loan Disbursement Plan.
- b. For both types of loans, the borrower must use the loan funds only for the following purposes: costs identified in the Business Plan and Disbursement plans, and costs associated with establishing the CO-OP as an operating business.
- c. Costs associated with the initial operations of a CO-OP, including the following:
 - (1) Renting space for issuer administrative operations.
 - (2) Renting or developing information technology systems.
 - (3) Renting or developing provider networks.
 - (4) Hiring a management team with adequate insurance expertise and other administrative personnel.
 - (5) Hiring counsel and consultants to assist with state insurance laws and other licensure requirements.
 - (6) Negotiating and contracting with providers and vendors.
 - (7) Hiring actuaries.
 - (8) Conducting community and prospective member education and educating CO-OP members on the rights and responsibilities of member governance.
 - (9) Developing strategic plans to build enrollment.
 - (10) Establishing and participating in a private purchasing council.
 - (11) Paying for the initial costs of operational and administrative staff.
- d. Cost associated with establishing and maintaining capital and surplus for borrower (including Risk-Based Capital Reserves) consistent with state solvency requirements.

- e. Costs associated with providing information to members regarding their coverage, rights, and responsibilities.

2. *Activities Unallowed*

- a. Start-up loan funds cannot be used to pay for costs associated with purchase of land and construction of facilities, including clinical facilities.
- b. Start-up loan funds cannot be used for clinical expenses, such as medical services providers' salaries or payments; provider clinical space; clinical equipment; administrative staff associated with clinical functions; and clinical equipment (excluding clinical information technology).
- c. Borrowers cannot use any part of the loan funds for any of the following purposes or activities:
 - (1) To carry on propaganda or other activities attempting to influence legislation at the federal, state, or local level of government.
 - (2) To conduct marketing. "Marketing" for this purpose means activities that promote the purchase of a specific health care plan or explain a product's benefit structure to a specific customer. However "marketing" does not include activities related to community outreach, membership development, and membership education.
 - (3) To meet the matching requirements of any other federal program.
 - (4) To cover or pay excessive executive compensation as determined by the lender in its sole but reasonable discretion.
 - (5) To fund activities unrelated to CO-OP planning and establishment, including, but not limited to, staff retreats and promotional giveaways.
 - (6) To pay for services described in Section 1303(b)(1)(B)(i) of the ACA, which states "Abortions for which public funding is prohibited....The services described in this clause are abortions for which the expenditure of federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved."

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. *CMS-10392, Monthly Reporting Requirements (OMB No. 0938-1139)*
- e. *CMS-10392, Quarterly Financial Statement or Annual Financial Statement (OMB No. 0938-1139)* – Attachment 4, National Association of Insurance Commissioners (NAIC) Quarterly Statement and Annual Statement: Financial Statement Underwriting and Investment Exhibit Part 3 – Analysis of Expenses

2. Performance Reporting

Not Applicable.

3. Special Reporting

Not Applicable

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

IV. OTHER INFORMATION

CO-OPs are required to execute promissory notes for both the start-up and solvency loans. Prior loans have continuing compliance requirements. Therefore, the full outstanding balance on the notes must be considered federal awards expended, included in determining Type A programs, and reported as loans on the Schedule of Expenditures of Federal Awards in accordance with 2 CFR Part 200, Subpart F. Since the loan agreements require audited financial statements, CO-OPs may not elect a program-specific audit and must have an annual single audit.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.556 MARYLEE ALLEN PROMOTING SAFE AND STABLE FAMILIES

I. PROGRAM OBJECTIVES

The MaryLee Allen Promoting Safe and Stable Families (PSSF) program provides funds to states and federally recognized Indian tribes, tribal organizations, and tribal consortia (hereafter “tribe”) 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, family reunification, and adoption promotion and support services.

II. PROGRAM PROCEDURES

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 (1) child welfare services under Title IV-B, subparts 1 and 2; (2) a child welfare staff development and training plan; (3) 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 (4) 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 five-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 to states are based on the number of children in the states who received supplemental nutrition assistance program benefits in the previous three years. Grants may also be made to tribes that qualify from reserved funds 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 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. Note: Additional fiscal year (FY) 2021 emergency supplemental

funding was provided for the PSSF program under Pub. L No. 116-260, the Consolidated Appropriations Act, 2021 in section 6(a) of Division X. The PSSF program portion of this funding, totaling \$72,450,000 was allocated to all title IV-B agencies using the existing statutory formula. Program Instruction ACYF-CB-PI-21-04, dated March 8, 2021, contains details and is available as follows: <https://www.acf.hhs.gov/sites/default/files/documents/cb/pi2104.pdf>.

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 629 through 629f. Implementing program regulations are published at 45 CFR parts 1355 and 1357.

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 PSSF program. This information may be accessed at <https://www.acf.hhs.gov/cb/resource/pi1009>

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an "N." See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment/Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement Suspension & Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	Y	Y	N	N	Y	N	N

A. Activities Allowed or Unallowed**1. Activities Allowed**

- a. 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)).
- b. 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) and 45 CFR section 1357.10(c)):
 - (1) 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;
 - (2) 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;
 - (3) Service programs designed to provide follow-up care to families to whom a child has been returned after a foster care placement;
 - (4) Respite care of children to provide temporary relief for parents and other caregivers (including foster parents);
 - (5) 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;
 - (6) 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
 - (7) Case management services designed to stabilize families in crisis such as transportation, assistance with housing and utility payments, and access to adequate health care.
- c. 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); increase parents' confidence and competence in their parenting abilities; afford children a stable and supportive family environment; strengthen parental relationships and promote healthy marriages and otherwise enhance child development, including through mentoring. Beginning on February 9, 2018, and thereafter, services may also be provided to support and retain foster families so they can provide quality family-based settings for children in foster care. Family support services may include (42 USC 629a(a)(2); 45 CFR section 1357.10(c)):

- (1) 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;
- (2) Respite care of children to provide temporary relief for parents and other caregivers;
- (3) Structured activities involving parents and children to strengthen the parent-child relationship;
- (4) Drop-in centers to afford families opportunities for informal interaction with other families and with program staff;
- (5) 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
- (6) Early developmental screening of children to assess the needs of such children, and assistance to families in securing specific services to meet these needs.

d.

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 and to ensure the strength and stability of the reunification. These family reunification services may be provided on behalf of a child in foster care without a time limit. Additionally, in the case of a child who has been returned home, these services and activities may also be provided, but shall only be provided during the 15-month period that begins on the date that the child returns home.

The services and activities for family reunification services are the following (42 USC 629a(a)(7)):

- (1) Individual, group, and family counseling;
- (2) Inpatient, residential, or outpatient substance abuse treatment services;
- (3) Mental health services;
- (4) Assistance to address domestic violence;
- (5) Services designed to provide temporary child care and therapeutic services for families, including crisis nurseries;
- (6) Peer-to-peer mentoring and support groups for parents and primary caregivers;
- (7) Services and activities designed to facilitate access to and visitation of children by parents and siblings; and
- (8) Transportation to or from any of the services and activities described above.

- e. 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)).
- f. 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, "Matching, Level of Effort, Earmarking – Earmarking," for a limitation on the amount of administrative costs.
- g. Program costs, which 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)).

- h. The Supplemental FY 2021 PSSF funds may be used for the same purposes as the regular annual PSSF grant, i.e., to provide community-based family support, family preservation, family reunification and adoption promotion and support services, consistent with the purposes and definitions in sections 430 and 431 of the Social Security Act (42 USC 629 and 629a).

2. *Activities Unallowed*

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 Title 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)). Note: The Supplemental FY 2021 PSSF funds do not require a non-federal share match (100 percent federally reimbursed).

2. Level of Effort

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 (including Supplemental FY 2021 PSSF funds), 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, "Matching, Level of Effort, Earmarking – Earmarking," 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 (42 USC 629f(4)(B)(ii)).

3. Earmarking

- a. States must generally expend a significant portion of their grant (including Supplemental FY 2021 PSSF funds), defined as an amount approximating 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. ACF may approve a state to spend less than 20 percent on a services category if the state provides a strong justification in its CFSP or APSR. (42 USC 629b(a)(4); 45 CFR section 1357.15(s); ACYF-CB-PI-20-13 (found at <https://www.acf.hhs.gov/cb/policy-guidance/pi-20-13>)). This provision is not applicable to tribes per exemption authority (42 USC 629b(b)(2)(A)); 45 CFR section 1357.50(f)(1)(iii)).
- b. States may not expend more than 10 percent of the total program expenditures (Federal and State share) during the fiscal year under the State plan (including Supplemental FY 2021 PSSF funds) for administrative costs (42 USC 629d(d)). This provision is not applicable to tribes per exemption authority (42 USC 629b(b)(2)(A)); 45 CFR section 1357.50(f)(1)(i)).
- c. A state shall use the special allocation provided pursuant to Pub. L. No. 112-34 to support monthly caseworker visits with children who are in foster care with a primary emphasis on activities designed to improving caseworker decision making on the safety, permanency, and well-being of foster children and on activities designed to increase retention, recruitment and training of caseworkers (42 USC 629f(b)(4)(B)(i)). The limitation on

the use of federal funds for administrative costs described in paragraph G.3.b also applies to this special allocation.

H. Period of Performance

Funds under Title IV-B, subpart 2, must be obligated by September 30 of the fiscal year following the fiscal year in which the funds were awarded (45 CFR section 1357.32(g) and Supplemental Terms and Conditions available through a link as follows:

https://www.acf.hhs.gov/sites/default/files/documents/acyf.cb_93.556.promoting-safe-and-stable-families-program-supplemental-terms-and-conditions-fy22.pdf). Note:

Supplemental FY 2021 PSSF funds must be obligated by September 30 of the fiscal year following the fiscal year in which the funds were awarded (September 30, 2021).

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) Note: Separate SF-425 reporting is required for Supplemental FY 2021 PSSF funding.

2. Performance Reporting

Not Applicable

3. Special Reporting

Not Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.558 TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

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; to end dependence of needy parents on government benefits by promoting job preparation, work, and marriage; to prevent and reduce out-of-wedlock pregnancies, including establishing prevention and reduction goals; and to encourage the formation and maintenance of two-parent families.

II. PROGRAM PROCEDURES

A. Overview

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 US Virgin Islands, Guam, and American Samoa) must periodically submit a state plan containing specified information and assurances.

1. *States*

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 TANF’s predecessor programs. The SFAG is a fixed amount to the state subject to reductions based on any penalties assessed. In addition, SFAG amounts will be adjusted for any federally recognized Indian tribes within the state that operate separate tribal TANF programs. States have significant flexibility in designing programs and determining eligibility requirements within broad federal parameters. While states have flexibility and discretion, there are provisions to ensure accountability for results, including requirements for reporting data on expenditures and individuals receiving benefits under the program, and monetary penalties for failure to meet programmatic requirements such as work participation requirements.

The federal TANF block grant program also has an annual cost-sharing requirement, known as maintenance-of-effort (MOE). A state must spend each fiscal year at least 80 percent of its historic state expenditures to provide benefits and services to eligible clientele. If the state meets both its required minimum overall (“all-family”) and two-parent work participation rates for a federal fiscal year (FFY), then the required MOE spending level decreases to 75 percent of its FFY 1994 historic state expenditures. “Historic state expenditures” means the state’s FFY 1994 share of expenditures in the former Aid to Families with

Dependent Children (AFDC), EA, AFDC-Related Child Care, Transitional Child Care, At-Risk Child Care, and JOBS programs. States may not use more than 15 percent of the total amount of countable expenditures for the fiscal year for administrative activities.

2. *Tribes*

Tribal Family Assistance Plans (TFAP) are developed for a three-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 FFY 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.

As also stated in IV, “Other Information - Tribal TANF Grantees under a Pub. L. No. 102-477 Demonstration Project (477),” audits of Indian tribal governments with Tribal TANF in their approved 477 plan must follow the guidance in the 477 Cluster found in the Department of the Interior’s section of Part 4 for this Supplement.

B. Funding

1. *States*

States have options for how to expend federal grant funds and state MOE funds. Certain statutory and regulatory requirements apply depending on whether the source of the funding for a service or benefit is federal funds alone, state MOE funds, or a combination of the two. For this reason, this supplement explains requirements based on how the state reports expenditures for a given service or benefit.

- a. *Federal Only* – A state should report an expenditure as “federal only” when it uses only federal grant funds, without including any MOE funds.
- b. *Commingled Federal/State* – A state should report an expenditure as “commingled” when it uses both federal grant and MOE funds for the benefit or service. Commingled funding of a service or benefit means that the expenditure is subject to all federal funding restrictions, TANF requirements, and MOE limitations, or the most restrictive of these if they conflict.
- c. *Segregated State* – A state should report an expenditure as “segregated state” if it uses MOE funds in the TANF program operated by the state and uses no federal grant funds for the benefit or service.

- d. *Separate State Program (SSP)*– A state should report an expenditure as funded by a “separate state program” if it reports state expenditures as MOE as part of a program, 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, 45 CFR section 260.33 explains the circumstances under which certain state tax relief provisions would count as expenditures.

2. *Tribes*

Similar to states, tribes have options for how to expend federal grant funds and, where applicable, state MOE funds. Certain statutory and regulatory requirements apply depending on whether the source of the funding for a service, or benefit, is federal funds alone, state MOE funds, or a combination of the two. For this reason, throughout this supplement, we explain requirements based on how the tribe reports expenditures for a given service or benefit.

- a. *Federal Only* – A tribe should report an expenditure as “federal only” when it uses only federal grant funds, without including any state-donated MOE funds or tribal funds that are expended in the TANF program operated by the tribe.
- b. *Commingled Federal/State-donated MOE* – A tribe should report an expenditure as “commingled” when it uses both federal grant and state-donated MOE funds for the benefit or service. Commingled funding of a benefit or service means that the expenditure is subject to all federal funding restrictions and state MOE limitations, or the most restrictive of these if they conflict.
- c. *Segregated Tribal* – A tribe should report an expenditure as “segregated tribal” if it uses state MOE funds expended separately in the TANF program operated by the tribe and uses no federal grant funds for the benefit or service. See IV., “Other Information,” for guidance on state MOE expended by tribes.

American Rescue Plan Act of 2021

On March 11, 2021, the president signed the American Rescue Plan Act of 2021 into law (Pub. L. No. 117-2). It establishes the Pandemic Emergency Assistance Fund (PEAF) in section 403(c) of the Social Security Act (the Act). The PEAF provides funding to states (which includes the District of Columbia), tribes administering a TANF program, and five US territories (Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands) to assist needy families impacted by the Coronavirus Disease 2019 (COVID-19) pandemic.

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 are codified at 42 USC 601-619.

The governing regulations for states are those in 45 CFR parts 260–265. Regulations for tribal TANF are in 45 CFR Part 286.

All state and all tribal TANF programs are subject to the provisions in the HHS implementation of 2 CFR Part 200 at 45 CFR Part 75.

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 federally or state-declared disaster. TANF-ACF-PI-2007-08 is available at <https://www.acf.hhs.gov/ofa/resource/policy/pi-ofa/2007/200708/pi200708>.

Other general program information regarding the state and tribal TANF programs is available from the Office of Family Assistance (OFA) website at <https://www.acf.hhs.gov/ofa/programs>.

TANF-ACF-PI-2021-02, dated April 9, 2021, *The Pandemic Emergency Assistance Fund*, provides initial guidance to state, tribal, and territorial agencies administering the TANF program, and other eligible territories, regarding the newly established PEAFF.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	Y	N	N	N	Y	Y	Y

A. Activities Allowed or Unallowed

This program refers 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 (typical for all requirements).

1. States

a. Federal Only

- (1) 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 Title 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)).
- (2) A state may transfer up to 30 percent of its total of current fiscal year funds (not prior fiscal year funds carried into the current fiscal year) received under the SFAG to carry out programs under the Social Services Block Grant (Title XX) (Assistance Listing 93.667) and/or the Child Care and Development Block Grant (Assistance Listing 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 TANF contingency funds under 42 USC 603(b) nor pandemic emergency assistance funds under 42 USC 603(c) (Pub. L. No. 117-2) may be transferred under this authority (42 USC 604(d)). The poverty guidelines are issued each year in the *Federal Register* and HHS

maintains a website that provides the poverty guidelines (<https://aspe.hhs.gov/poverty-research>). When transferred, the funds are subject to the rules of the program to which they are transferred (within statutory restrictions) and should be audited under that program. Please refer to Part IV Item 1, “Transfers out of TANF.”

b. 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)).

c. Federal Only, Commingled Federal/State, Segregated State, Separate State Program

- (1) A state may use funds 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 (Note: In the following sections of this program supplement, these are referenced as TANF purposes 1, 2, 3, and 4, respectively):
 - (a) Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
 - (b) End dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
 - (c) 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
 - (d) Encourage the formation and maintenance of two-parent families.
- (2) 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)).

- (3) A state may use funds 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)).
- (4) A state may use funds to implement electronic benefits transfer system (42 USC 604(g)).
- (5) A state may use funds 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).
- (6) 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 that 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)).

d. Prohibition on Use of Federal TANF and State MOE funds for Juvenile Justice Services

See IV, "Other Information," for area of risk of non-compliance for juvenile justice services.

2. *Tribes*

a. Federal Only

- (1) A tribe may use funds for expenditures for activities that are not permissible under 42 USC 601, but for which the state or tribe was authorized to use Title 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.

- (2) Tribes may not transfer any federal TANF funds to the Social Services Block Grant (Title XX) (Assistance Listing 93.667) or the Child Care and Development Block Grant (Assistance Listing 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)).
- b. Federal Only, Commingled Federal/State-donated MOE, Segregated Tribal
 - (1) A tribe may use funds 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 (Note: In the following sections of this program supplement, these are referenced as TANF purposes 1, 2, 3, and 4, respectively):
 - (a) Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
 - (b) End dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
 - (c) 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
 - (d) Encourage the formation and maintenance of two-parent families.
 - (2) 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)).
 - (3) A tribe may use funds 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)).
 - (4) A tribe may use funds to implement electronic benefits transfer system (42 USC 604(g)).

- (5) A tribe may use funds 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).
- (6) 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)).
- (7) 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 <https://www.acf.hhs.gov/ofa/resource/policy/pi-ofa/2005/pi2005-2htm> (45 CFR section 286.35(a)(1)).
- (8) 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))).

3. *Pandemic Emergency Assistance Fund*

a. All grantees

- (1) States, tribes, and territories (grantees) may use funds to provide certain non-recurrent, short-term (NRST) benefits (described below). Additionally, they may use funds for administrative costs (up to a 15 percent cap for states and territories and up to the negotiated cap for tribes).

- (2) For the purposes of PEAFF, NRST benefits mean cash payments or other benefits that meet the regulatory definition (45 CFR 260.31(b)(1)), but are limited to those that fall into the specific expenditure reporting category mentioned in the legislation (line 15 of the [ACF-196R](#) (PDF), the state financial reporting form for the TANF program). In other words, for this fund, NRST benefits, like all NRSTs under TANF, must: be designed to deal with a specific crisis situation or episode of need; not be intended to meet on-going needs; and not extend beyond four months; **and** (as explained in the instructions for reporting on line 15 of the ACF-196R) NRSTs paid for with PEAFF funds: must only include expenditures such as emergency assistance and diversion payments, emergency housing and short-term homelessness assistance, emergency food aid, short-term utilities payments, burial assistance, clothing allowances, and back-to-school payments; and may **not** include tax credits, child care, transportation, or short-term education and training.

E. Eligibility

1. Eligibility for Individuals

The state or tribal plan provides the specifics on the state or tribal area's definition of financially needy which the state or tribal area uses in determining eligibility. 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. *States*

- (1) Federal Only, Commingled Federal/State, Segregated State, and Separate State Program
 - (a) 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 MOE-funded benefits, services, or "assistance" regardless of the TANF purpose that the expenditure is reasonably calculated to accomplish (see III.A.1.c, "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 Social Security Act or some other definition applicable in state law provided the state can articulate a rational 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 and 602(a)(1)(B)(iii), 42 USC 609(a)(7)(B)(IV), and 42 USC 608(a)(1), 619(2); 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(1), “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.1.c., “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.1.c., “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).

- (b) 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 United States 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 United States 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 United States 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-funded public benefit or an MOE-funded public benefit to otherwise qualified aliens (including nonimmigrants and individuals paroled in the US for less than a year in the case of a non-commingled 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 five years after the date of entry into the United States 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 five-year bar has expired for a qualified alien entering the United States 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 United States 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 five years (8 USC 1613(a)). The five-year bar begins either on the date of the alien's entry into the United States as a qualified alien or on the date the alien residing in the United States becomes a qualified alien, whichever is later. If the alien entered the United States 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 five-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)).

(2) Federal Only and Commingled Federal/State

- (a) 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, Level of Effort, Earmarking – Earmarking,” for testing the limits related to the number of exemptions.)

- (b) A state may not provide assistance to an individual who is under age 18, is unmarried, has a minor child at least twelve 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)).
- (c) 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)).
- (d) 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)).
- (e) 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 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)).

- (f) A state may not use funds to provide cash assistance to an individual during the ten-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)).
 - (g) 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)).
- (3) Federal Only, Commingled Federal/State, Segregated State
- (a) A state shall require that, as a condition of providing assistance, a member of the family assign to the state the rights the family member may have for support from any other person. This assignment may not exceed the amount of assistance provided (42 USC 608(a)(3)).
 - (b) 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 in 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).
 - (c) 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).

- b. 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 the Pandemic Emergency Assistance Fund

- a. The recipients of PEA-funded NRSTs must be financially needy families with children but they do not necessarily have to be eligible for TANF cash assistance. A grantee has the flexibility to determine what needy means for each NRST and may wish to set a higher standard than it does for TANF cash assistance, such as aligning with SNAP or Medicaid income eligibility criteria.
- b. The Income Eligibility Verification System (IEVS) does apply to the PEA, as it is funded under Title IV-A; however, tribes are not subject to the IEVS requirements.

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

Not Applicable

4. Eligibility for Subrecipients

Not Applicable

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

Not Applicable

2. Level of Effort**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 MOE for TANF, whether such state funds are expended as commingled federal/state, segregated state, or separate state program funds. Note that MOE requirements do not apply to subrecipients.

- a. *State 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 – 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)).

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 TANF 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. Any MOE expenditures above this required amount are referred to as “excess MOE.”

Except as provided in paragraph b, immediately below, 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, cash donations by non-governmental third parties (e.g., a non-profit organization, corporation, or other private party), or the value of third-party in-kind contributions. A state's records must show that all the costs are verifiable and meet all applicable requirements in 45 CFR sections 263.2 through 263.6. Third parties must be aware of and agree with the state's intentions and, accordingly, the state's records must include an agreement between the state and the third party permitting the state to count the expenditure toward its MOE requirement (42 USC 609(a)(7)(A) and 609(a)(7)(B)(i)(I); 45 CFR sections 263.1 and 263.2(e)).

Effective October 1, 2008 (i.e., FY 2009 awards), states may claim only *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 <https://www.acf.hhs.gov/ofa/programs/tanf/policy>).

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 of 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.

Section 409(a)(7)(B)(iv)(IV) of the Social Security Act prohibits states from counting toward their MOE requirement expenditures made as a condition of receiving federal funds, unless allowed under Title IV, part A of the Social Security Act.

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, the 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 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., 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). Additional information on application of the "new spending test" for new or additional expenditures may be found in TANF-ACF-PI-2016-04 (<https://www.acf.hhs.gov/ofa/resource/tanf-acf-pi-2016-04>).

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 (Assistance Listing 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 Assistance Listing 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 <https://www.acf.hhs.gov/ofa/programs/tanf/policy>).

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(1), "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)).
- e. *Prohibition on Use of Federal TANF and State MOE funds for Juvenile Justice Services* – See IV, "Other Information" for area of risk of non-compliance for juvenile justice services.

2.2 Level of Effort – Supplement Not Supplant

1. *Pandemic Emergency Assistance Fund*

States, tribes and territories (grantees) may use funds to provide certain non-recurrent, short term (NRST) benefits (described in section A. 3. a. 2.). Additionally, they may use funds for administrative costs (up to a 15-percent cap for states and territories and up to the negotiated cap for tribes). All grantees must use funds to supplement, and not supplant, other federal, state, tribal, territorial, or local funds. Note that the Supplement Not Supplant requirements do not apply to subrecipients.

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, and contingency 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 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).

d. *Pandemic Emergency Assistance Fund*

Grantees may use funds for administrative costs, within limitations. For states (including the District of Columbia) and territories, the law provides a 15 percent cap on administrative expenditures. For tribes, the same cap will apply to administrative costs in the PEAFF that a tribe negotiated for administrative costs in its approved tribal TANF plan.

Note that the Earmarking requirements do not apply to subrecipients.

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)).

L. Reporting

States/Tribes:

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. [ACF-196T](#), *Tribal TANF Financial Report Form (OMB No. 0970-0345)* – Applicable to tribes; Not Applicable to states. This form is not applicable to tribes 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.

- e. *ACF-196R, TANF Financial Report (OMB No. 0970-0446)* – States are required to submit this report quarterly, beginning in FY 2015, 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 regular TANF grant funds and Contingency Fund expenditures. See TANF-ACF-PI-2014-02, available at <http://www.acf.hhs.gov/programs/ofa/resource/tanf-acf-pi-2014-02>, for more information.
- f. [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)).

See IV, “Other Information,” for additional guidance on territories’ spending levels.

2. Performance Reporting

- a. [ACF-199, TANF Data Report \(OMB No. 0970-0338\)](#) and [ACF-343, Tribal TANF Data Report \(OMB No. 0970-0215\)](#) (65 FR 8545, Appendix A, February 18, 2000)

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.

State 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)).

Key Line Items – The following ACF-199 (TANF Data Report) 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:

1. 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*
2. 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*
3. 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*
4. 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 when one- and two-parent families are combined). HHS may penalize the tribe by a maximum of 5 percent of the TFAG for the first violation of this provision. The penalty increases by an additional 2 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).

Key Line Items – The following ACF-343 (Tribal TANF Data Report) line items contain critical information used in making a determination of a tribe's Work Participation Rates.

1. 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	<i>Family Affiliation</i>
Item 48	<i>Work Participation Status</i>
Items 49–62	<i>Adult Work Participation Activities</i>

- b. [ACF 209, SSP-MOE Data Report](#) (OMB No. 0970-0338) – This report is submitted quarterly beginning with the first quarter of FFY 2000.

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

1. Section One – Family-Level Data

Item 9	<i>Type of Family for Work Participation</i>
Item 15	<i>Receives Subsidized Child Care</i>
2. Section One – Person-Level Data

Item 28	<i>Date of Birth</i>
Item 34	<i>Relationship to Head-of-Household</i>
Item 41	<i>Work-Eligible Individual Indicator</i>
Item 42	<i>Work Participation Status</i>
3. Section One – Adult Work Participation Activities

Items 43 – 55	<i>Work Participation Activities</i>
Item 56	<i>Number of Deemed Core Hours for Overall Rate</i>
Item 57	<i>Number of Deemed Core Hours for the Two-Parent Rate</i>
4. Section Three – Active Cases

Item 3	<i>Total Number of SSP-MOE Families</i>
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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 electronically through the On-Line Data Collection (OLDC) System.

Key Line Items – The following 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 24, columns (B) plus (C) of the 4th quarter ACF-196R *TANF Financial Report*; or line 17, column (B) of the ACF-196-TR, *Territorial Financial Report*.

- b. Each grantee must submit form [ACF-196P](#) (OMB No. 0970-0510) to report expenditures for the Pandemic Emergency Assistance Fund within 90 days of the end of each federal fiscal year.

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

1. *Administrative Costs (listed as “Administration” on the form)*
2. *Non-Recurrent, Short-Term Benefits*

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

N. Special Tests and Provisions

Special Tests and Provisions one through five apply to a state’s TANF program, not to a Tribal TANF program.

1. Child Support Non-Cooperation

Compliance Requirements 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 5 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 Objectives Determine whether, after notification by the state Title 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 Title 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 (SSA) for all applicants at the first opportunity (see *Federal Tax Return Information* below).

- d. Information from the US Citizenship and Immigration Services 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 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 2 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 Objectives 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, SSA (excluding federal tax return information, as discussed in the compliance requirements), the US Citizenship and Immigration Services, 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 Requirements 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 1 percent and not more than 5 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 Objectives 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. Lack of Child Care for Single Custodial Parent of Child under Age Six

Compliance Requirements If an individual is a single custodial parent caring for a child under the age of 6, 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 5 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 Objectives 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 6.

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 6.
- 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 Requirements 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 (a) determine whether its work activities may count for participation rate purposes; (b) determine how to count and verify reported hours of work; (c) identify who is a work-eligible individual; and (d) 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 1 percent and not more than 5 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 Objectives 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.

IV. OTHER INFORMATION

1. *Transfers out of TANF*

As described in III.A.1.a (2), "Activities Allowed or Unallowed," states (not tribes) may transfer a limited amount of federal TANF funds into the Social Services Block Grant (Title XX) (Assistance Listing 93.667) and the Child Care and Development Block Grant (Assistance Listing 93.575). These transfers are reflected in lines 2 and 3 of both the quarterly *TANF Financial Report* ACF-196R, 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.

2. *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*."

Tribes may choose to 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 2 CFR Part 200, Subpart F. However, the state-donated MOE is not considered federal awards expended by the tribe.

3. *Tribal TANF Grantees under a Pub. L. No. 102-477 Demonstration Project (477)*

Audits of Indian tribal governments with tribal TANF in their approved 477 plan must follow the guidance in the 477 Cluster found in the Department of the Interior's section of Part IV of this Supplement.

4. *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 (Assistance Listing 93.658); Adoption Assistance (Assistance Listing 93.659) and Independent Living (Assistance Listing 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)).

5. *Prohibition on Use of Federal TANF and State MOE funds for Juvenile Justice Services*

ACF has identified juvenile justice services expenditures as an area of risk for non-compliance and issued a Program Instruction (TANF-ACF-PI-2015-02) (<http://www.acf.hhs.gov/ofa/resource/tanf-acf-pi-2015-02>) to remind TANF jurisdictions that federal TANF and state MOE funds must not be used to provide juvenile justice services, except where authorized under prior law, as explained in the program instruction.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.563 CHILD SUPPORT ENFORCEMENT****I. PROGRAM OBJECTIVES**

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

II. PROGRAM PROCEDURES

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 OCSE.

The state program is an open-ended entitlement program that allows the state to be funded at the federal financial participation (FFP) rate of 66 percent for eligible program costs. Under the tribal program, tribes receive funding for a specified percentage of program costs (during the first three-year period, federal grant funds equal to 90 percent, and for all periods following the initial three-year period 80 percent).

State child support agencies are required to conduct self-reviews of their programs (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). 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 (Assistance Listing 93.558), the Medicaid program (Assistance Listing 93.778), and the Foster Care (Title IV-E) program (Assistance Listing 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 parts 309 and 310.

Both the state and tribal programs are subject to the administrative requirements of 45 CFR part 92 and 2 CFR part 200, as implemented by HHS at 45 CFR part 75, depending on when the award was made. Both state and tribal programs also are subject to the OMB cost principles under 2 CFR part 225 – Cost Principles for state, local, and Indian Tribal governments (OMB Circular A-87) or 45 CFR part 75, subpart E, depending on when the award was made. However, except for 45 CFR section 75.202, the guidance in subpart C of 45 CFR part 75 does not apply to federal awards to carry out Title IV-D of the Social Security Act (45 CFR section 75.101(e)). The state and tribal programs are also subject to 45 CFR part 95.

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 this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment/Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement Suspension & Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	Y	Y	N	N	N	Y	N

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 agreements with appropriate courts and law enforcement officials in accordance with the requirements of 45 CFR section 302.34, and associated administration and short-term training of staff (see paragraph A.2.b, below, for costs of agreements that are unallowable under state programs) (45 CFR section 304.21(a)(state programs); 45 CFR sections 309.145(a)(3)(iii) and 309.145(m) (tribal programs)).

b. State programs

- (1) 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).
- (2) Federal financial participation (FFP) is available for services and activities that are necessary and reasonable to carry out the Title IV-D state plan. This change reflects 45 CFR Part 75, Subpart E Cost Principles which all state child support agencies must use in

determining allowable costs for work performed under federal grants (45 CFR section 304.20(a)(1)).

- (3) FFP is available for bus fare and other minor transportation expenses to allow participation of parents in child support proceedings and related activities such as genetic testing appointments (45 CFR section 304.20(b)(3)(v)).
- (4) FFP is available to increase pro se access to adjudicative and alternative dispute resolution processes in IV-D cases related to the provision of child support services (45 CFR section 304.20(b)(3)(vi)).
- (5) FFP for educational and outreach activities intended to inform the public, parent and family members, and young people who are not yet parents about the Child Support Enforcement program, responsible parenting and co-parenting, family budgeting, and other financial consequences of raising children when the parents are not married to each other (45 CFR section 304.20(b)(12)).

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 Title 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 Title 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 Title 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 Title IV-D actions.
- (6) Costs of guardians *ad litem* in Title 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 in accordance with Section 1912(a)(2) of the Act (42 USC 1396k).
- (5) The following costs associated with agreements 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 agreements that do not meet the requirements of 45 CFR section 303.107 (45 CFR section 304.21(b)).
- (6) FFP is not available for purchased support enforcement services which are not secured in accordance with 304.22 (45 CFR section 304.23(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.

Tribal programs

The federal share of program costs is 90 percent for the first three 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 Performance

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)).

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 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 and replacement designees (referred to as states throughout the remainder of this document, unless specifically discussed as replacement designees) with funds to assist refugees in attaining economic self-sufficiency as soon as possible after their initial placement in United States communities. (The term “refugee” is used to mean an individual who meets the immigration status or category requirements under 45 CFR 400.43 or the additional authorities listed in section II. A., items 3-6, of this document.)

II. PROGRAM PROCEDURES

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 and Medical Assistance (CMA) and (2) Refugee Support Services (RSS).

Source of Governing Requirements

The Refugee and Entrant Assistance program is governed under the following authorities:

1. The Refugee Act of 1980 (Pub. L. No. 96-212) (8 USC 1522), as amended by the Refugee Education Assistance Act of 1980 (Pub. L. No. 96-422), Refugee Assistance Amendments of 1982 (Pub. L. No. 97-363), and Refugee Assistance Extension Act of 1986 (Pub. L. No. 99-605).
2. 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 Vietnam 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 Vietnam 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).
3. Section 107(b)(1)(A) of the Trafficking Victims Protection Act of 2000 (Pub. L. No. 106-386) (22 USC 7101), as amended by the Trafficking Victims Protection Reauthorization Act of 2003 (Pub. L. No. 108-193) and 2005 (Pub. L. No. 109-164), and Section 107(b)(1)(F) of the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (Pub. L. No. 110-457), insofar as they

state that a victim of a severe form of trafficking in persons, potential child victims, and certain other specified family members shall be eligible for federally funded or administered benefits and services to the same extent as a refugee.

4. Section 525, Title V, Division G, Pub. L. No. 110-161 in relation to Iraqi and Afghan aliens granted special immigrant status under Section 101(a)(27) of the Immigration and Nationality Act and their eligibility for resettlement assistance and other benefits available to refugees admitted under Section 207 of the Immigration and Nationality Act; and Sections 1244, Pub. L. No. 110-181 Section 602(b), Title VI, Division F, Pub. L. No. 111-8, regarding the special immigrant status of certain Iraqis and certain Afghans, respectively, as amended by Section 8120, Title VIII, Pub. L. No. 111-118.
5. Division C, Title III, Pub. L. No. 117-43, and Division B, Title III, Pub. L. No. 117-70 in relation to Afghan SQ/SI parolees, Afghan Special Immigrant Conditional Permanent Residents, and Afghan Humanitarian Parolees.

Title IV, Pub. L. 117-128, and Section 147, Division A, Pub. L. 117-180 in relation to Ukrainian Humanitarian Parolees.

Program regulations are at 45 CFR Part 400.

In addition to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards at 45 CFR Part 75, this program also is subject to 45 CFR Part 95, subparts E (Cost Allocation Plans) and F (Automatic Data Processing Equipment and Services Conditions for Federal Financial Participation (FFP)).

Availability of Other Program Information

Additional information is available on the ORR website at <https://www.acf.hhs.gov/orr>.

Subprograms/Program Elements

1. *Cash and Medical Assistance Grants*

CMA grants are made to states following submission of annual program estimates. CMA grants have four major cost components:

- Refugee Cash Assistance (RCA)
- Refugee Medical Assistance (RMA), including Medical Screening
- Unaccompanied Refugee Minor (URM) programming
- Program Administration (overall state Planning and Coordination)

A state may administer the RCA program as a publicly administered program or may form a public/private partnership (PPP) by engaging nonprofit organizations to deliver assistance. A publicly administered RCA program must follow the TANF rules on financial eligibility and payment levels unless the state receives an approved waiver under 45 CFR 400.300 to continue administering RCA according to the rules of the former Aid to Families with Dependent Children (AFDC) program. A public/private program (PPP) may operate according to the content of an ORR-approved PPP plan in alignment with regulation and ORR policy. A replacement designee may base its RCA administration on a state's TANF program or administer a PPP plan, subject to ORR's approval..

a. *Refugee Cash Assistance Eligibility*

(1) *Eligibility Criteria*

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

- (a) They have resided in the United States less than the RCA eligibility period ([currently twelve months](#)) determined by the ORR director in accordance with 45 CFR 400.211 (45 CFR 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 400.51 and 400.53).
- (c) They meet the financial eligibility requirements of the applicable type of RCA program: AFDC-type (45 CFR 400.45), public/private (45 CFR 400.59), or publicly administered (45 CFR 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 departments of State or Justice (45 CFR 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, as defined by the director (45 CFR 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 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 400.77 and 400.82(a)).
- (2) Benefit payments in a state-administered AFDC-type RCA program must be based on the AFDC rate (45 CFR 400.45(f)(2)). Benefit payments in a state-administered TANF-type RCA program must be based on the TANF rate (45 CFR 400.66(a)). Benefit payments in a public/private RCA program may neither exceed the rate described in [ORR PL 22-01](#) (increased from the rate specified in 45 CFR 400.60(a) as authorized by 45 CFR 400.60(d)), nor be less than the state's TANF payment rate (45 CFR 400.60(b)).

b. *Refugee Medical Assistance Eligibility*

(1) *Eligibility Criteria*

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

- (a) They are not eligible for Medicaid or Children's Health Insurance Program (CHIP) but currently receive RCA (45 CFR 400.100(d)); or
- (b) They meet all of the following criteria:
 - (i) They have met the same time eligibility requirement as for RCA (see paragraph E.1.b.(1)(a), above).
 - (ii) They are determined ineligible for Medicaid or CHIP (45 CFR 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 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 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 400.103).
 - (iv) 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 400.79 or a plan for an unaccompanied minor in accordance with 45 CFR 400.112.
- (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 United States less than the time eligibility period will become eligible for RMA for the remainder of the time eligibility period (45 CFR 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 400.100(c)).

- (3) 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 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 400.106). A state may provide medical screening to a refugee provided the screening is in accordance with requirements prescribed by ORR and with written approval from ORR (45 CFR 400.107).

c. *Unaccompanied Refugee Minor Assistance Eligibility*

- (1) A person must meet the definition of an unaccompanied minor (45 CFR 400.111).
- (2) A URM remains eligible for assistance until he/she (a) is reunited with a parent; (b) is united with a nonparental adult to whom legal custody or guardianship has been granted; or (c) has reached the age of 18, or older if the state's Title IV-B plan so prescribes (45 CFR 400.113).

2. *Refugee Support Services Grants*

Beginning in FY 2018, Refugee Social Services funding was renamed to Refugee Support Services (RSS). RSS grants are made to states following submission of an Annual Service Plan. RSS grants are allocated to states by formula according to each state's percentage of the national refugee and entrant population for up to 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. Under RSS, four set-aside grants are issued, Refugee School Impact (RSI), Services to Older Refugees (SOR), Youth Mentoring (YM), and Refugee Health Promotion (RHP) to provide services to specific refugee populations. RSI targeted population is refugee children from birth until 18 years of age. SOR targeted population is 60 and older. YM targeted population is individuals between the ages of 15–24. RHP targeted population is refugees in need of health and well-being support.

a. *Refugee Support Services Eligibility*

- (1) In providing support services, the state must serve refugees in the following order of priority listed under 45 CFR 400.147:
 - (a) All refugees who have resided in the United States 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 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 United States for more than 60 months (45 CFR 400.152(b)).

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	Y	N	N	Y	N	N	Y	Y	N

A. Activities Allowed or Unallowed

CMA program funds are to be used to pay for:

1. *Refugee Cash Assistance (RCA)* – monthly cash benefits for refugees who do not meet the eligibility requirements of the TANF (Assistance Listing 93.558) or Supplemental Security Income (SSI) (Assistance Listing 96.006) programs (45 CFR 400.53) (see III.E.1, “Eligibility – Eligibility for Individuals”).
2. *Refugee Medical Assistance (RMA)* – medical assistance to refugees who do not meet all eligibility requirements for Medicaid (Assistance Listing 93.778) and CHIP (Assistance Listing 93.767) and medical screening to RMA-eligible refugees (45 CFR 400.100) (see III.E.1, “Eligibility – Eligibility for Individuals”).
3. *Medical Screening* – A state may charge refugee medical screening costs to RMA if part of the state plan approved by the ORR director (45 CFR 400.107). If such screening is done during the first 90 days after a refugee’s initial date of ORR eligibility, it may be provided without prior determination of the refugee’s eligibility under 45 CFR 400.94 or 400.100 and may be charged to RMA. States may charge to RMA the cost of medical screenings done later than 90 days after the refugees’ eligibility date only if the refugees had been determined ineligible for Medicaid or CHIP under 45 CFR 400.94 and 400.100 (45 CFR 400.107).
4. *Unaccompanied Refugee Minor (URM) 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) (45 CFR 400.113) (see III.E.1, “Eligibility – Eligibility for Individuals”).
5. *Program Administration* – A state may claim against its CMA grant the reasonable, necessary, and allocable administrative costs:
 - a. Associated with providing RCA, RMA, including medical screening, and assistance and services to unaccompanied refugee minors (45 CFR 400.207).
 - b. Incurred by the local resettlement agencies for providing cash assistance under the public/private RCA program (45 CFR 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 CFR 400.13(c)).

RSS program funds are to be used to pay for:

- Employability Services
- Other Services

- Refugee School Impact (RSI) Set-aside Services
 - Services to Older Refugees (SOR) Set-aside Services
 - Youth Mentoring (YM) Set-aside Services
 - Refugee Health Promotion (RHP) Set-aside Services
1. *Employability Services* – A state may provide the following employability services through the RSS grant:
 - a. Employment services, including development of a family self-sufficiency plan and individual employment plan, job development, job search, and job placement (45 CFR 400.154(a));
 - b. Aptitude and skills testing, employability assessment (45 CFR 400.154(b));
 - c. On-the-job training at the employment site (45 CFR 400.154(c));
 - d. English language training with emphasis on job-related language skills (45 CFR 400.154(d));
 - e. Vocational training when part of an employability plan (45 CFR 400.154(e));
 - f. Skills recertification (45 CFR 400.154(f));
 - g. Child care when necessary for job retention/acceptance or participation in an employability service (45 CFR 400.154(g));
 - h. Transportation when necessary for job retention/acceptance or participation in an employability service (45 CFR 400.154(h));
 - i. Translation and interpreter services when necessary for job retention/acceptance or participation in an employability service (45 CFR 400.154(i));
 - j. Case management services directed toward a refugee's attainment of employment as soon as possible after arrival in the United States (45 CFR 400.154(j)), and
 - k. Assistance in obtaining employment authorization documents (45 CFR 400.154(k)).
 2. *Other Services* – A state may other support services, which may include:

- a. Information and referral services (45 CFR 400.155(a));
 - b. Outreach services designed to familiarize refugees with available services and facilitate access to them (45 CFR 400.155(b));
 - c. Social adjustment services including emergency services, health-related services, and home management services (45 CFR 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 400.155(d) through 155(g));
 - e. Any other service approved by the ORR director that is aimed at helping the refugee attain economic self-sufficiency, family stability, or community integration (45 CFR 400.155(h)); and
 - f. Citizenship and naturalization preparation services (45 CFR 400.155(i)).
3. *Refugee School Impact Services* – A state may provide [Refugee School Impact Services](#), which may include, but are not limited to:
- a. Specialized services and support for eligible youth, which may include English as a Second Language classes, tutoring, newcomer, or transitional programs, after school and summer programs, mentoring, behavioral health supports, programming that supports integration, and services that support the cognitive, social, and emotional growth of preschool-aged children.
 - b. Support for families learning to navigate the US education system, which may include school-specific orientation for both families and students, navigators or cultural brokers, and language access.
 - c. Capacity development for school systems, including education and training for staff around the unique and varied needs of refugees and access to necessary resources. Examples of this allowance may include specialized trainings for school staff, ensuring language access by offering translated documentation, interpretation, and specialized staff dedicated to working with the population.
 - d. Capacity development to remove barriers to culturally responsive child care access.
 - e. Holistic sessions with parents and children to support English language literacy, school preparedness, and community orientation through the promotion of parent-child interactions.

4. *Services to Older Refugees* – A state may provide Services to Older Refugees, which may include, but are not limited to :
 - a. Helping older ORR-eligible populations access mainstream aging services in the community such as information about supportive services, nutrition services, meal delivery, elder abuse, senior community centers, and intergenerational activities.
 - b. Providing older ORR-eligible populations with appropriate services that are not available in the communities, such as interpretation and translation services.
 - c. Creating opportunities for older ORR-eligible populations to live independently as long as possible, including transportation, home care, adult day care, and respite care.
 - d. Developing opportunities for older ORR-eligible populations to connect with their communities to avoid isolation, such as mental health support, community navigators, and opportunities for engagement in social and cultural activities.
 - e. Assisting older ORR-eligible populations on the path to citizenship, especially those at risk of losing Supplemental Security Income or other federal benefits, to naturalize. Services may include civics instruction, counseling, and application assistance.
5. *Youth Mentoring* – A state may provide Youth Mentoring activities, which may include:
 - a. Development of social and life skills.
 - b. Helping youth to learn American culture while maintaining and celebrating the youth's cultural heritage.
 - c. Providing opportunities for social engagement with peers.
 - d. Providing information about opportunities to participate in civic and community services activities.
 - e. Supporting youth in learning English, math, and other skills.
 - f. Providing academic support, such as helping with homework, and assisting with transitions in school such as the transition between middle school and high school or high school to post-secondary education.

- g. Helping youth with career development including skill building, resume drafting, worker's rights, and training opportunities.
 - h. Supporting youth in developing health and financial literacy.
- 6. *Refugee Health Promotion* – A state may provide [Refugee Health Promotion](#) activities, which may include:
 - a. Health education classes and targeted health outreach to individuals.
 - b. Medical and mental health navigation and support.
 - c. Adjustment groups, skill-building networks, or peer support meetings.
 - d. Outreach to mainstream mental health providers versed in trauma-informed services, development of a training curriculum for mainstream providers on refugee mental health, and implementation of strategies to mitigate language barriers in mental health services.

B. Allowable Costs/Cost 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 (see III.A.5, "Activities Allowed or Unallowed"), 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 45 CFR 400.2) may be allocated to the state's CMA grant; and administrative costs of managing the services component of the program must be charged to the RSS grant (45 CFR 400.13).

States must track activities, services, and costs for set-aside programs (RSI, SOR, YM, and RHP) separately from other RSS activities, services, and costs.

E. Eligibility

1. CMA and RSS General Eligibility requirements for individuals

- a. Clients must have either refugee, asylee, Cuban/Haitian entrant, or Amerasian documented status (45 CFR 400.43), be Iraqis or Afghans with Special Immigrant Visas, be Afghan SQ/SI Parolees, Afghan Special Immigrant Conditional Permanent Residents, Ukrainian Humanitarian Parolees, Non-Ukrainians who last habitually resided in Ukraine, or, if

trafficking victims, must have received a certification or eligibility letter from ACF's Office on Trafficking in Persons (OTIP). Those meeting this status will be collectively referred to as "refugees."

- b. A client's eligibility period generally begins on the date he/she arrived in the United States (45 CFR 400.203(a) and 400.204(a)). The eligibility period for asylees begins from the date the person receives a final grant of asylum. The eligibility for a Cuban or Haitian entrant begins from the date the individual was paroled as an entrant or the first time they entered the community, whichever is later. The eligibility period for victims of trafficking begins from the date the person received a certification or eligibility letter from ACF/OTIP. The eligibility date for Afghan humanitarian parolees is October 1, 2021 or the date they entered the community, whichever is later. The eligibility date for humanitarian parolees from Ukraine is May 21, 2022 or the date they received humanitarian parole, whichever is later.

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

Not Applicable

3. Eligibility for Subrecipients

Not Applicable

H. Period of Performance

1. CMA

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 URM 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 URM services, must be expended by the end of the FFY following the FFY in which the grant was awarded (45 CFR 400.210(a)).

2. Refugee Support Services

A state must obligate its Refugee Support 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 (RSS)
- d. *ORR-2, CMA Quarterly Report on Expenditures and Obligations* – Applicable (CMA)

2. Performance Reporting

ORR-6, *Performance Report (OMB No. 0970-0036)* – A state is required to submit the ORR-6, Performance Report, on a semi-annual and annual reporting basis. The report contains a narrative and statistical information on program performance for cash assistance, medical assistance, medical screening, the provision of services to unaccompanied minors, and support services. The current ORR-6 was approved by OMB and all descriptions, schedules, and reporting timelines described here are according to the approved ORR-6. Auditors should check if reports are submitted timely. The ORR-6 is available on this page:

<https://www.acf.hhs.gov/orr/form/report-forms>

3. Special Reporting

Not Applicable

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

IV. OTHER INFORMATION

Note: In instances where a state has elected to withdraw from the program, ORR has the authority to select a nonprofit agency to administer the program as a replacement designee (RD) 45 CFR 400.301(c). The term “state” is used throughout this document to refer to both state governments and replacement designees.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.568 LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

I. PROGRAM OBJECTIVES

The Low-Income Home Energy Assistance Program (LIHEAP) is a block grant program in which states (including Territories and Native American 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 latter three components are only administered when funding for those programs is available and allocated to them.

The objectives of LIHEAP are to help low-income households 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 older individuals, persons with disabilities, and young children.

II. PROGRAM PROCEDURES

A. LIHEAP Block Grants

The U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Community Services, administers LIHEAP 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 Native American 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 income-eligible households in the tribal service area as a percentage of the income-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.

Under the block grant principle, each grant recipient is responsible for designing and implementing its own LIHEAP program, within very broad federal guidelines. Grant recipients must administer their LIHEAP programs according to their HHS accepted LIHEAP Model Plan and any amendments and in conformance with their own implementing rules and policies. Grant recipients must establish appropriate systems and procedures to prevent, detect and correct waste, fraud, and abuse, by clients, vendors, and administering agencies.

To receive funding, each grant recipient is required to submit annually a LIHEAP Model Plan which is an application that describes how the grant recipient's LIHEAP will be

administered. The LIHEAP Model Plan includes a set of program integrity questions in which the grant recipient must describe the systems in place among others to detect and deter fraud, waste, and abuse in its LIHEAP program.

State grant recipients are required to hold a public hearing each year on the proposed Plan for the upcoming federal fiscal year. All grant recipients must allow for public participation in the development of these Plans. If HHS issues a Notice of Funding Opportunity, a separate application is required for those LIHEAP grant recipients that wish to apply for a leveraging incentive award or a REACH grant.

B. Energy Emergency Contingency Funds

In addition to appropriations for the LIHEAP block grant program, Congress may appropriate contingency funds that may be awarded to meet the additional home energy assistance needs of LIHEAP grant recipients 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.

C. Leveraging Incentive Awards

Of the funds appropriated for LIHEAP each year, HHS is allowed to earmark a portion to reward those LIHEAP grant recipients 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 grant recipient or private organizations allocating 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 with nonfederal resources. Grant awards in the current federal fiscal year are based on leveraging activities carried out during the previous federal fiscal year. Leveraging grants are subject to special terms and conditions, which are specified in the grant awards. To receive the leveraging grant, current LIHEAP grant recipients must submit a Leveraging Report detailing leveraged resources, when ACF solicits such Leveraging Report. Grant recipients must keep sufficient documentation, or have access to it, to support the calculations in the report.

D. Residential Energy Assistance Challenge Program

Of the funds appropriated for leveraging incentive awards, HHS may set aside a portion for the REACH program. The REACH program makes competitive grants to LIHEAP grant recipients to help LIHEAP-eligible households reduce their energy vulnerability. The purposes of REACH are to (1) minimize health and safety risks that result from high energy burdens on low-income households, (2) prevent homelessness as a result of inability to pay energy bills, (3) increase efficiency of energy usage by low-income families, and (4) target energy assistance to individuals who are most in need. REACH grants are optional to current LIHEAP grant recipients that submit a separate REACH Plan (when solicited by ACF). State and territory grant recipients that are awarded

REACH grants must administer their REACH grants through community-based organizations. REACH grants are subject to special terms and conditions, which are specified in the grant awards ([42 USC section 8626 b](#)).

Source of Governing Requirements

LIHEAP 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. Requirements specific to LIHEAP are in 45 CFR sections 96.80 through 96.89. LIHEAP is also subject to 45 CFR Part 75, which is the HHS implementation of 2 CFR Part 200, commonly known as the Office of Management and Budget's Uniform Administrative Guidance. According to 45 CFR section 75.101(d), the requirements in Subpart C, Subpart D, and Subpart E do not apply to LIHEAP except for section 75.202 of Subpart C and sections 75.351 through 75.353 of Subpart D. In addition, grant recipients are to administer their LIHEAP according to the statutorily required Plans that they submitted to HHS. Grant recipients are permitted to submit revised LIHEAP Plans within a reasonable amount of time after making substantive changes to their policies and/or procedures referenced in their Plans.

As discussed in Appendix I to the Supplement, "Federal Programs Excluded from the A-102 Common Rule and Portions of 2 CFR Part 200," grant recipients are to use the fiscal policies (including obligation and expenditure of funds) that apply to their own funds in administering LIHEAP. Procedures must be adequate to ensure the proper disbursement of and accounting for federal funds paid to the grant recipient, 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 web page (<https://www.acf.hhs.gov/ocs/low-income-home-energy-assistance-program-liheap>) provides general information about this program.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"). Next the auditor will determine which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below). Finally, the auditor will determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not being subject to the audit. Auditors are not

expected to test requirements that have been noted with an “N.” See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
N	N	Y	Y	N	Y	Y	N	N	Y	Y	N

C. Cash Management

Recipients are limited to draw down only a reasonable amount of federal LIHEAP funding on an incremental basis throughout the year to meet immediate needs. The proportion of funds that are drawn should be directly related to the expenditure of program funds incurred. An excess draw of funds should not occur where interest can be accrued if the funds drawn remain in an interest-bearing bank account for an extended period without being issued out.

E. Eligibility

1. Eligibility for Individuals

Grant recipients 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. Grant recipients may establish lower income eligibility criteria, but no household may be excluded solely based on income if the household income is less than 110 percent of the state's poverty level (42 USC 8624(b)(2)). Grant recipients must give priority to those households with the highest home energy costs or needs in relation to income and household size (42 USC 8624(b)(5)).

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 grant recipient is to give special consideration to local public or private nonprofit 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 grant recipient finds that they meet program and fiscal requirements set by the grant recipient (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 terms and conditions described in the award.

a. *Planning and Administrative Costs*

- (1) No more than 10 percent of a state's LIHEAP funds 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. This cap may not be exceeded by supplementing with other federal funds (42 USC 8624(b)(9)(A); 45 CFR section 96.88(a)).
- (2) A tribal or territorial grant recipient 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) Although as indicated in III.A.5, leveraging incentive award funds may not be used for planning and administrative costs, they may be added to the base on which the maximum amount allowed for planning and administration is calculated according to the federal fiscal year in which the leveraging funds are obligated (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 grant recipient 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 beginning April 1st, and the grant recipient may then obligate and 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 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) Native American tribes/tribal organizations and territories may spend up to the greater of 2 percent or \$100 on such activities (45 CFR section 96.87(c)(1)).

H. Period of Performance

1. At least 90 percent of the LIHEAP block grant funds payable to the grant recipient must be obligated in the first federal fiscal year in which they are awarded. 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 federal fiscal year. Funds not obligated by the end of the second fiscal year of the award must be returned to ACF. There are limits on the time period for expenditure of funds (42 USC 8626) which are communicated to all recipients of the award. Grant recipients must expend funds according to rules that govern their own public assistance funds.
2. Leveraging incentive award funds and REACH funds must be obligated in the federal fiscal year in which they are awarded or the following federal 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)).

3. 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

LIHEAP Performance Data Form (OMB No 0970-0449) – State grant recipients must submit this report by January 31st regarding the prior federal fiscal year. The first section of the report is the Grant recipient Survey that collects and reports data on sources and uses of LIHEAP funds. The Grant recipient Survey includes Section III: Estimated Sources of Funds and Section IV: Estimated Use of LIHEAP Funds. Note: that these are referencing obligated not expended funding. The rest of the report is regarding performance metrics, mostly related to home energy burden targeting and reduction, as well as the continuity of home energy service. The Grantee Survey obligation amounts should be compared with the Carryover and Reallotment and FFR-425 reports. This reconciliation is needed to make sure the obligated balances for the program year being tested are accurate. See [LPMD Instructions](#) for more background.

Key Line Items ():

1. *“Uses of Funds” represent a state’s obligation of federal LIHEAP funds, not expenditure of federal LIHEAP funds. In some cases, obligated funds are not actually expended until after the end of the federal fiscal year.*
2. *The total “Uses of Funds” (shown in Item 45 of Section IV) should equal the total “Sources of Funds” (shown in Item 16 of Section III).*

3. *“Other LIHEAP assistance.” This would include federal LIHEAP funds used to provide “other crisis assistance,” such as furnace or air conditioner repairs or replacements.*

3. Special Reporting

- a. *LIHEAP Carryover and Reallotment Report (OMB No. 0970-0106) – <https://omb.report/icr/202204-0970-018/doc/120709300>* Grant recipients must submit this 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 more than the maximum carryover limit are subject to reallotment to other LIHEAP grant recipients in the following fiscal year and must also be reported (42 USC 8626).

Key Line Items:

1. *“Carryover amount”*
2. *“Reallotment amount”*

- b. *Annual Report on Households Assisted by LIHEAP (OMB No. 0970-0060) <https://omb.report/icr/202211-0970-005>* – 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 and any type of LIHEAP assistance (heating, cooling, crisis, and weatherization); and (2) the number of households served that contained young children, elderly, or persons with disabilities, or any vulnerable household for each component. Territories with annual allotments of less than \$200,000 and all Native American tribes are required to report only on the number of households served for each program component (42 USC 8629; 45 CFR section 96.82).

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

1. *Section 1 – LIHEAP Assisted Households*
2. *Section 2 – LIHEAP Applicant Households*

- c. *Quarterly Performance and Management Report (OMB No. 0970-0589) <https://omb.report/icr/202205-0970-017/doc/121847100>* – Grant recipients must submit data and information about LIHEAP during the current FY, including success, challenges, needs and innovations. The quarterly reports focus on assisted households, performance management, obligation of funding, changes made due to anticipated increase in energy bills, collaboration with other utility programs, and training and technical assistance needs.

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

1. *Section 1* – Total Households Assisted
2. *Section 2* – Performance Management
3. *Section 3* – Estimated Use of Funds
4. *Section 4* – LIHEAP Program Implementation and Support

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

M. Subrecipient Monitoring

Grant recipients must ensure that subrecipients are using LIHEAP grant funds from the grant recipient for their intended purposes. Up to 10% of a subrecipient's LIHEAP grant can be used for administrative transactions and any administrative expenditures that exceed 10% must be from non-federal sources. If a weatherization program is implemented, up to 15% of a subrecipient's LIHEAP grant can be used towards weatherization. A grant recipient may request that a special waiver be approved by the HHS to exceed this 15% threshold. If the special waiver is approved by the HHS, the maximum amount that the subrecipient can use towards weatherization cannot exceed 25% of the LIHEAP grant. Up to 5% of a subrecipient's LIHEAP grant can be used for Assurance 16 administration which is intended to develop information and energy education materials to LIHEAP clients over an extended period. Up to a 10% maximum of a subrecipient's LIHEAP grant can be carried over from the first year into the second year. In addition to ensuring that the previously described thresholds of a subrecipient's LIHEAP grant are properly met, a grant recipient's monitoring activity should ensure that subrecipient LIHEAP grant expenditures are energy related transactions, which are allowable, reasonable, and allocable. This will ensure that the proper financial and management of controls are in place for LIHEAP administration.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.569 COMMUNITY SERVICES BLOCK GRANT****I. PROGRAM OBJECTIVES**

The objective of the Community Services Block Grant (CSBG) is to provide assistance to states and local communities, working through a network of community action agencies and other neighborhood-based organizations, for the reduction of poverty, the revitalization of low-income communities, and the empowerment of low-income families and individuals in rural and urban areas to become fully self-sufficient (particularly families who are attempting to transition off a state program carried out under part A of Title IV of the Social Security Act) and (1) to provide services and activities having a measurable and potential major impact on causes of poverty in the community or those areas of the community where poverty is a particularly acute problem; (2) to provide activities designed to assist low-income participants, including the elderly poor, to: (a) secure and retain meaningful employment; (b) attain an adequate education; (c) make better use of available income; (d) obtain and maintain adequate housing and a suitable living environment; (e) obtain emergency assistance through loans or grants to meet immediate and urgent individual and family needs, including health services, nutritious food, housing, and employment-related assistance; (f) remove obstacles and solve problems which block the achievement of self-sufficiency; (g) achieve greater participation in the affairs of the community; and (h) make more effective use of other related programs; (3) to provide on an emergency basis for the provision of such supplies and services, nutritious foodstuffs, and related services, as may be necessary to counteract conditions of starvation and malnutrition among the poor; and (4) to coordinate and establish linkages between governmental and other social services programs to assure the effective delivery of such services to low-income individuals.

In addition to the CSBG block grants to states, the Office of Community Services funds additional discretionary projects for technical assistance include the Center of Excellence (COE) for Human Capacity and Community Transformation (HCCT), eleven Regional Performance and Innovation Consortia (RPIC), a Learning Communities Resource Center, and a Legal Training and Technical Assistance Center.

II. PROGRAM PROCEDURES

CSBG 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 nonprofit organizations (and, in special circumstances, public organizations) that plan, develop, implement, and evaluate local programs. These instructions are provided for audits of states as defined by the CSBG Act at 42 USC 9902(5), for audits of eligible entities as defined by the CSBG Act at 42 USC 9902(1) and audits of other subrecipients expending CSBG funds. Eligible entities are those entities that were in place the day before October 27, 1998, or as designated by the process codified at 42 USC

9909. For all practical purposes, eligible entities are those entities identified in the state CSBG plan that are designated to receive a portion of at least 90 percent of the CSBG funds provided to a state. Auditors may obtain the state plan from the state or review the contract/grant provided by the state to the entity to determine if they are an eligible entity or other subrecipient. For tribes and tribal organizations that receive CSBG as part of the Pub. L. No. 102-477 demonstration projects, refer to the 477 cluster at 4-15.025 for testing guidance. For tribes and tribal organizations that receive CSBG funding directly from the federal government, the auditor should use the testing guidance for the states.

Source of Governing Requirements

CSBG was reauthorized under the Community Opportunities, Accountability, and Training and Education Act of 1998 (Pub. L. No. 105-285) and is codified at 42 USC 9901 et seq. 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 75 (the HHS implementation of 2 CFR Part 200). 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 this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	N	Y	N	N	N	Y	Y

A. Activities Allowed or Unallowed**1. Activities Allowed**

- a. *States*: States are required to distribute at least 90 percent of CSBG funds to eligible entities, see Special Tests and Provisions for testing of the amounts distributed to these entities. States may use retained funds to achieve CSBG 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; and
 - (8) Administrative functions (42 USC 9901 and 9907(b)).
- b. *Eligible Entities and Other Subrecipients*: Eligible entities and other subrecipients may use CSBG funds for any programs, services, or other activities related to achieving the broad goals of CSBG, 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; and
 - (6) Plan, coordinate, and develop linkages among public (federal, state, and local), private, and nonprofit resources, including religious organizations, to improve their combined effectiveness in ameliorating poverty (42 USC 9901, 42 USC 9907(1)).
 - c. Supplemental funds appropriated by the Coronavirus Aid, Relief, and Emergency Services (CARES) Act (Pub. L. No. 116-136) may be used for allowable CSBG purposes to prevent, prepare for, and respond to the coronavirus. In responding to the coronavirus, CSBG grantees may consider the economic impact of the coronavirus.
- 2. *Activities Unallowed: Applicable to States and Eligible Entities/Other Subrecipients*
 - 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 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

- 1. *States:* CSBG is exempt from the provisions of OMB cost principles at the state level. As a block grant, state cost principles requirements apply to CSBG at the state level. However, states must apply OMB administrative cost principles (45 CFR Part 75, Subpart E) to subgrantees receiving CSBG funds (42 USC 9916(a)(1)(B)), 45 CFR 75.101(d)(1)).
- 2. *Eligible Entities and Other Subrecipients:* Eligible entities and other subrecipients of CSBG funds are subject to the cost principles in the Uniform Administrative Requirements in 45 CFR Part 75, Subpart E.

E. Eligibility**1. Eligibility for Individuals or Households**

- a. *States:* 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 website (<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)).

Update: The CARES Act allows a state to adopt a revised poverty guideline but it may not exceed 200 percent of the HHS-determined poverty guidelines. This permission is in effect for fiscal years 2020 and 2021.

- b. *Eligible Entities/Other Subrecipients:* The official poverty guidelines 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 website (<http://aspe.hhs.gov/poverty/>). The CSBG Act, at 42 USC 9902(2), grants the state the authority to adopt a revised poverty threshold but it may not exceed 125 percent of the HHS-determined poverty guidelines. Audit procedures should be designed to test whether recipients of CSBG services meet the federal poverty guidelines, or a more restrictive poverty threshold established by a state.

Update: The CARES Act allows a state to adopt a revised poverty guideline but it may not exceed 200 percent of the HHS-determined poverty guidelines. This permission is in effect for fiscal years 2020 and 2021.

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

Not Applicable

3. Eligibility for Subrecipients

Not applicable to eligible entities and other subrecipients.

H. Period of Performance

1. *States:* 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. *Eligible Entities:* 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 9 section 9907(a)(2)).

- a. Note: The CSBG Act, at 42 USC 9907(a)(3), requires states to recapture and redistribute unused CSBG funds. However, this provision has been overridden by annual appropriations law by requiring states to carryforward unused funds to be used by the specific entity. Auditors should determine the legal requirements for the period under review.

M. Subrecipient Monitoring

1. States

States must conduct full on-site reviews of each eligible entity once every three 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)). Audit tests should be designed to test whether the state:

- (1) Has performed a full onsite monitoring of each eligible entity within the past three years;
- (2) Has completed a full onsite monitoring of a newly designated entity immediately after the completion of the first year in which the entity received CSBG funds;
- (3) Has conducted appropriate follow up reviews if necessary; and
- (4) Has conducted other reviews as appropriate, including reviews of entities with programs that have had other federal, state, or local grants terminated for cause.
- (5) 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) receive an improvement plan from the subgrantee within 60 days; and (4) not later than 30 days after receiving the improvement plan either approve it or specify the reasons why it cannot be approved (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)).

2. *Eligible Entities/Other Subrecipients*

If eligible entities or other subrecipients of CSBG use a subaward to achieve the objectives of CSBG, the eligible entities and other subrecipients are required to comply with the provisions of 45 CFR 75.351 through 75.353 (45 CFR 75.101(d)).

Audit Objectives To determine if the eligible entity or other subrecipient complied with the subrecipient monitoring and management requirements.

Suggested Audit Procedures

- a. Select a sample of CSBG sub-awards or contracts during the period.
- b. Examine the procedures performed to determine if the subrecipient/contractor determination was made in accordance with 45 CFR 75.351.
- c. Examine the contract or sub-award to determine if the eligible entity or other subrecipient communicated the required information as detailed in 45 CFR 75.352(a).
- d. For the sub-awards and contracts that were determined to be subrecipients, review the procedures for compliance of 45 CFR 75.352(b) through (h) to determine that there is reasonable assurance that the CSBG funds were adequately protected, and services were provided to the community as expected.

N. Special Tests and Provisions

1. States: 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 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.

Suggested Audit Procedures

- a. Determine the state's procedures for issuance of subgrant awards or contracts, including any standards for administrative lead time.
- 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.

2. Tri-Partite Board Compliance – Only Applicable to Eligible Entities

The CSBG Act at 42 USC 9910(a), requires nonprofit organizations administer CSBG through a board comprising:

- One-third (1/3) of the members be elected representatives in the community or their designee (the elected official must be holding office on the date of selection). There is a provision that allows for appointed government officials, or their designee, to be counted in meeting this requirement.
- Not fewer than one-third (1/3) of the board members are chosen in a democratic selection process adequate to assure that these members of the board are representative of the low-income individuals and families served. Additionally, each low-income representative must reside in the neighborhood served.
- The remaining board members are officials and members of business, industry, labor, religious, law enforcement, education, or other major groups and interests in the community served.

The CSBG Act at 42 USC 9910(b), requires that public organizations administer CSBG through a Tri-Partite board. This board shall have members selected by the organization and shall be composed so as to assure that no less than one-third (1/3) of the members are chosen in accordance with democratic selection procedures adequate to assure that these members:

- Are representative of low-income individuals and families served in the neighborhood served;
- Reside in the neighborhood served; and
- Are able to actively participate in the development, planning, implementation, and evaluation of the programs funded by CSBG; or

- The statute allows states to specify, in the alternative, another mechanism for public organizations to assure decision making and participation by low-income individuals in the development, planning, implementation, and evaluation of programs funded by CSBG.

The CSBG Act does not provide for a grace period for eligible entities to get into compliance, though it is not prohibited by the Act. There are provisions within the Act that prevent the state from delaying or stopping funding or de-designating an eligible entity without providing technical assistance and the opportunity to correct deficiencies. For this reason, the states are encouraged to develop a policy or procedure that allows a grace period to fill Tri-Partite board vacancies.

Compliance Requirements Eligible entities must comply with the Tri-Partite board requirement. If an eligible entity has vacancies during the audit period that reduce the representation of low-income communities or public elected/appointed officials, that exceed the length of time permitted by the state, the auditor should report a finding. If the state has not elected to create a policy or procedure to permit a reasonable amount of time to fill a vacancy, the auditor should report a finding for any vacancy during the period that reduced the required representation below the required threshold.

Audit Objectives To determine if the eligible entity maintained a Tri-Partite board during the audit period.

Suggested Audit Procedures

- a. Obtain the board rosters, including the areas of representation at the beginning and end of the audit period.
- b. For any changes in the board roster, inquire of organization management the dates of the changes.
- c. Obtain the policy or procedure communicated by the state to the eligible entity for adherence to the Tri-Partite board requirement.
- d. Determine if the low-income or public representation vacancies exceeded the length of time permitted by the state.

IV. OTHER INFORMATION

Transfers

As described in Part 4, Social Services Block Grant (SSBG) program (Assistance Listing 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 are subject to the requirements of the CSBG 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.

McKinney-Vento Homeless Assistance Programs and Corporation for National and Community Service AmeriCorps Programs

Since FY 2009, the appropriations acts providing funds for the McKinney-Vento Homeless Assistance programs has included language authorizing grantees under those programs to use other federal funds as match unless prohibited by the statute of the other program. OCS has determined that the CSBG Act does not prohibit the use of CSBG funds as match for the McKinney-Vento Homeless Assistance programs and the Corporation for National and Community Service' AmeriCorps programs. Any CSBG funds claimed as match for these Homeless Assistance programs must be used for CSBG purposes and in accordance with the CSBG requirements.

Tribal CSBG Grantees under a Pub. L. No. 102-477 Demonstration Project (477)

Audits of Indian tribal governments with the CSBG program in their approved 477 Plan will follow Version 2 reporting and, therefore, must follow the guidance in the 477 Cluster found in the Department of the Interior's section of Part 4 of this Supplement. See the "Note" at the beginning of the 477 Cluster for additional information.

2019 CSBG Disaster Supplemental

In federal fiscal year 2019, Congress appropriated additional CSBG funds under the Additional Supplemental Appropriations for Disaster Relief Act, 2019 (Pub. L. No. 116-20). These funds are to be issued to states to address the consequences of hurricanes Florence and Michael, Typhoon Mangkhut, Super Typhoon Yutu, and wildfires and earthquakes occurring in calendar year 2018 and tornadoes and floods occurring in calendar year 2019 in those areas for which a presidential disaster has been declared. These funds are to be reported on the Schedule of Expenditures of Federal Awards as CSBG funds, though the states and entities are required to account for these expenditures separately. CSBG Disaster Supplemental funds are subject to the requirements of the CSBG and the additional requirement that these funds must be used to address needs directly resulting from the presidentially declared disaster. CSBG Disaster Supplemental funds, when expended, 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 of CSBG Disaster Supplemental funds should be shown as expenditures of this program when such amounts are expended.

2020 CARES Act Supplemental

In federal fiscal year 2020, Congress appropriated additional CSBG funds under the CARES Act (Pub. L. No. 116-136). These funds are to be issued to states, tribes, and territories to prevent, prepare for, and respond to coronavirus. These funds are to be reported on the Schedule of Expenditures of Federal Awards as CSBG funds, though the states and entities are required to account for these expenditures separately in their own accounting records. CSBG CARES Supplemental funds are subject to the requirements of the CSBG and the additional requirement

that these funds must be used to prevent and prepare for the coronavirus and to respond to the impact of the coronavirus. CSBG CARES Supplemental funds, when expended, 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 of CSBG CARES Supplemental funds should be shown as expenditures of this program when such amounts are expended.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.489 CHILD CARE DISASTER RELIEF****ASSISTANCE LISTING 93.575 CHILD CARE AND DEVELOPMENT BLOCK GRANT****ASSISTANCE LISTING 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 (tribes) 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.

II. PROGRAM PROCEDURES

The Office of Child Care (OCC), Administration for Children and Families (ACF), Department of Health and Human Services (HHS), administers the CCDF. The CCDF consists of three distinct funding sources: Discretionary Fund (Assistance Listing 93.575), Mandatory Fund (Assistance Listing 93.596), and Matching Fund (Assistance Listing 93.596). Some states, territories, and tribes are also eligible for Child Care Disaster Relief funds (Assistance Listing 93.489); these funds may be used for any allowable CCDF activity as well as for construction or renovation of child care facilities to support recovery from specified federally declared disasters and emergencies. Additionally, under the Temporary Assistance for Needy Families (TANF) program (Assistance Listing 93.558), a state may transfer TANF funds to CCDF and, if so, the funds transferred in are treated as Discretionary Funds (42 USC 604(d); 45 CFR section 98.54(a)).

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, territories, and tribes, and is effective for a three-year period. For states, the current three-year plan covers FY2022-2024. For tribes, the three-year plans relevant to this audit period cover FY2020-2022 and FY2023-2025 (see “Source of Governing Requirements” below for more context).

Following ACF approval of the plan, funds are awarded to a Lead Agency based on statutory/regulatory formulas. The Lead Agency is the designated state, territorial or tribal entity that is accountable for administering the CCDF program. 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 state and territory Lead Agencies offer parents certificates for the purchase of child care services), grantees have flexibility in designing programs and offering services. For example, CCDF funds may be used in collaborative efforts with Head Start (Assistance Listing 93.600), including Early Head Start, 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/Early

Head Start and the CCDF is strongly encouraged by sections 640(g)(1)(D) and (E), 640(h), 641(d)(2)(H)(v), and 642(e)(3) of the Head Start Act in the provision of full working day, full calendar year comprehensive services. In order to implement such collaborative programs, which share, for example, space, equipment or materials, grantees may layer several funding streams so that seamless services are provided.

Pub. L. No. 102-477

Tribes may operate the CCDF program under a consolidated Pub. L. No. 102-477 project. Pub. L. No. 102-477 refers to the Indian Employment, Training, and Related Services Demonstration Act of 1992, which was amended by the Indian Employment, Training, and Related Services Consolidation Act of 2017 (Pub. L. No. 106-568). The purpose of this initiative 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. Tribes participating under a Pub. L. No. 102-477 project submit consolidated plans and reports to the Department of the Interior, which serves as the lead federal agency for Pub. L. No. 102-477. The separate 477 Cluster is applicable for an audit of an Indian tribal government's approved 477 Plan. See IV, "Other Information" – Tribal CCDF grantees under a Pub. L. No. 102-477 Project (477).

Source of Governing Requirements

The Discretionary Fund (Assistance Listing 93.575) is authorized by the CCDBG Act of 1990, as amended (most recently by the CCDBG Act of 2014 (Pub. L. No. 113-186), discussed further below), and codified at 42 USC 9857 et seq. The Mandatory and Matching Funds (Assistance Listing 93.596) are authorized under section 418 of Title IV-A of the Social Security Act as amended and codified at 42 USC 618. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. No. 116-136) and the Consolidated Appropriations Act of 2021 and Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA Act) of 2021 (Pub. L. No. 116-260) both provide supplemental appropriations to prevent, prepare for, and respond to the coronavirus. The American Rescue Plan Act (ARP Act) (Pub. L. No. 117-2) (<https://www.congress.gov/public-laws/117th-congress>) provided supplemental funds for child care stabilization to support the child care sector during and after the COVID-19 public health emergency as well as additional supplemental appropriations that can be used for broader CCDF purposes and are not limited to addressing coronavirus impacts. The Child Care Disaster Relief funds (Assistance Listing 93.489) are appropriated by the Supplemental Appropriations for Disaster Relief Act of 2019 (Pub. L. No. 116-20). The CCDF (i.e., Assistance Listings 93.575, 93.596, and 93.489) is subject to the regulations at 45 CFR parts 98 and 99.

The CCDBG Act of 2014 made a number of substantive changes to program requirements, including provisions related to eligibility of children, consumer education, and health and safety (including monitoring inspections and criminal background checks).

On September 30, 2016, HHS published a final rule to update the CCDF regulations at 45 CFR parts 98 and 99 based on the reauthorized Act.

The reauthorized Act did not address how most of its provisions apply to tribal Lead Agencies, so this was clarified in the final rule. Under the rule, tribal Lead Agencies are subject to a tiered set of requirements based on the size of their CCDF funding allocation. For the FY2020–FY2022 and FY2023–2025 CCDF plan cycles, the allocation size was based on the FY 2016 allocation.

Other than 2 CFR section 200.202 and sections 200.330 through 200.332, as implemented by 45 CFR sections 75.202 and 75.351 through 75.353, CCDF is not subject to the post federal award or cost principles requirements in 2 CFR Part 200, subparts D and E, respectively, or the associated HHS implementing regulations at 45 CFR Part 75.

Availability of Other Program Information

OCC’s website (<https://www.acf.hhs.gov/occ>) provides general information on this program.

For guidance on CCDF CARES Act funding, see Information Memorandum 2020-01 at <https://www.acf.hhs.gov/occ/policy-guidance/ccdf-discretionary-funds-appropriated-cares-act-public-law-116-136-passed-law>

For guidance on CCDF CRRSA Act funding, see Information Memorandum 2021-01 at <https://www.acf.hhs.gov/occ/policy-guidance/ccdf-discretionary-funds-appropriated-crrsa-act-public-law-116-260-signed-law>

For guidance on CCDF ARP Act supplemental funding, see Information Memorandum 2021-03 at <https://www.acf.hhs.gov/occ/policy-guidance/ccdf-acf-im-2021-03>

For guidance on CCDF ARP Act stabilization funding, see Information Memorandum 2021-02 at <https://www.acf.hhs.gov/occ/policy-guidance/ccdf-acf-im-2021-02>

For FAQs on CCDF COVID supplemental funding, see: <https://www.acf.hhs.gov/occ/faq/stabilizing-child-care-and-covid-19-faqs>

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

Note: To address program monitoring risk associated with the CCDF Stabilization grants added to this program as part of the ARP Act, OMB has authorized HHS to add “Reporting” as a

compliance requirement subject to audit. This requirement will be included as an additional requirement in the supplement until the CCDF Stabilization grants are fully expended.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	Y	Y	N	N	Y	Y	Y

A. Activities Allowed or Unallowed

1. *Activities Allowed for CCDF Funds Other Than ARP Act Stabilization Funds*
 - a. Funds may be used for child care services in the form of certificates, grants, or contracts (42 USC 9858c(c)(2)(A)).
 - b. Funds may be used for activities that improve the quality or availability of child care services, consumer education, and parental choice (42 USC 9858e).
 - c. Funds may be used for activities that improve access to child care services, including the use of procedures to permit enrollment of homeless children (after an initial eligibility determination) while required documentation is obtained; training and technical assistance on identifying and serving homeless children and their families; and specific outreach to homeless families (42 USC 9858c(c)(3)(B)(i)).
 - d. Funds may be used for any other activity that the Lead Agency deems appropriate to (a) promote parental choice; (b) provide comprehensive consumer education information to help parents and the public make informed choices about child care services and promote involvement by parents and family members in the development of their children in child care settings; (c) deliver high-quality, coordinated early childhood care and education services to maximize parents' options and support parents trying to achieve independence from public assistance; (d) improve the overall quality of child care services and programs by implementing the health, safety, licensing, training and oversight standards established in the CCDBG Act and in state law and regulations; (e) improve child care and development of participating children; and (f) increase the number and

percentage of low-income children in high-quality child care settings (42 USC 9857 and 9858c(c)(3)(B)).

- e. Improvements or upgrades to a facility which are not specified under the definitions of construction or major renovation (see III.A.2.c(1) below) may be considered minor remodeling and are, therefore, allowed as follows:
 - (1) For other than sectarian organizations, funds may be used for the minor remodeling of child care facilities
 - (2) 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)).
- f. Supplemental funds appropriated by the CARES Act (Pub. L. No. 116-136) and the CRRSA Act (Pub. L. No. 116-260) may be used for allowable CCDF purposes to prevent, prepare for, and respond to the coronavirus. For example, funds from both of these supplemental appropriations may be used to provide continued payments and assistance to child care providers in the case of decreased enrollment or closures related to coronavirus, and to assure that they are able to remain open or reopen.
- g. Additional supplemental discretionary funds provided by the ARP Act (other than the stabilization funds) are not limited to addressing coronavirus but can be spent for any allowable CCDF uses.

2. *Activities Allowed for CCDF ARP Act Stabilization Funds*

- a. States, territories, and tribes shall use stabilization funds appropriated by the ARP Act (Pub. L. No. 117-2) to make awards to child care providers to support the stability of the child care sector during and after the COVID-19 public health emergency. Child care providers may use stabilization funds to cover the following expenses: (A) personnel costs, including payroll and salaries or similar compensation for an employee (including any sole proprietor or independent contractor), employee benefits, premium pay, or costs for employee recruitment and retention; (B) rent (including rent under a lease agreement) or payment on any mortgage obligation, utilities, facility maintenance or improvements, or insurance; (C) personal protective equipment, cleaning and sanitization supplies and services, or training and professional development related to health and safety practices; (D) purchases of or updates to equipment and supplies to respond to the COVID-19 public health emergency; (E) goods and services necessary to maintain or resume child care services; and (F) mental health supports for children and employees.

3. *Activities Unallowed*

- a. 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)).
- b. 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)).
- c. 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)).
 - (1) “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).
 - (2) *Exception:* Tribal Lead Agencies 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.
 - (3) *Exception:* State, territory, and tribal Lead Agencies may use Child Care Disaster Relief Funds (Assistance Listing 93.489) for renovating, repairing, or rebuilding child care facilities with ACF approval (Pub. L. No. 116-20).

B. Allowable Costs/Cost Principles

As indicated in Appendix I to the Supplement, “Federal Programs Excluded from the A-102 Common Rule and Portions of 2 CFR Part 200,” grantees (Lead Agencies) 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).

E. Eligibility

1. Eligibility for Individuals

Eligibility for Children Receiving CCDF Subsidies. 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 Lead Agency in its approved Plan. A Lead Agency is the designated state, territorial, or tribal entity to which the CCDF grant is awarded and that is accountable for administering the CCDF program.

- a. For state Lead Agencies and territory Lead Agencies, and for those tribal Lead Agencies with Grant Year 2016 allocations of at least \$250,000, 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. Lead Agencies may choose to provide services during periods of job search. Tribal Lead Agencies may elect to use state or tribal median income (42 USC 9858n(4); 45 CFR sections 98.20(a) and 98.81(b)). Tribal Lead Agencies also have the option for categorical eligibility (considering any Indian child within the service area eligible for services) if the tribe's median income is below 85 percent of the state median income, provided that services go to those with the highest need.

State, territory, and tribal Lead Agencies may use supplemental funds appropriated by the CARES Act (Pub. L. No. 116-136), the CRRSA Act (Pub. L. No. 116-260), and the ARP Act (Pub. L. No. 117-2) to provide child care assistance to health care sector employees, emergency responders, sanitation workers, and other workers deemed essential during the response to the coronavirus, without regard to the income eligibility requirements. The Lead Agency may define which workers are considered essential in accordance with any relevant state, territorial, and tribal laws or policies.

- b. State Lead Agencies, territory Lead Agencies, as well as those tribal Lead Agencies with Grant Year 2016 allocations of at least \$250,000, must establish minimum 12-month eligibility periods before re-determining eligibility of CCDF families and must consider a child to be eligible between eligibility re-determinations, regardless of (1) changes in income (as long as income does not exceed 85 percent of state/territory/tribal median income); or (2) temporary changes in participation in work, training, or education activities. If a parent experiences a non-temporary loss of job, education, or training that affects eligibility, Lead Agencies have the option—but are not required—to terminate assistance prior to the next re-determination (i.e., prior to the end of the minimum 12-month eligibility period). However, if a Lead Agency exercises this option, the Lead Agency must provide (prior to terminating the subsidy) a period of continued assistance of at least three months to allow parents to engage in job search, resume work, or attend an education or training program as soon as possible. (42 USC 9858c(c)(2)(N)).

- c. Because a child meeting eligibility requirement at the most recent eligibility determination or re-determination is considered eligible between re-determinations as described in paragraph b. above, any payment for such a child shall not be considered an error or improper payment due to a change in the family's circumstances (45 CFR sections 98.21(a)(4) and 98.68(c)(2)). There is no federal requirement for Lead Agencies to recoup CCDF overpayments, except in instances of fraud as defined by the Lead Agency (45 CFR section 98.68(b)(2)).
- d. States and territories must have procedures to permit enrollment of homeless children (after an initial eligibility determination) while required documentation is obtained. States and territories must also have a grace period that allows children experiencing homelessness and children in foster care to receive services while providing families a reasonable time to take any necessary action to comply with immunization and health and safety requirements.
- e. State Lead Agencies, territory Lead Agencies, as well as those tribal Lead Agencies with Grant Year 2016 allocations of \$250,000 or more, must 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 (42 USC 9858c(c)(3)(B)(i); 45 CFR section 98.45(k)). Lead Agencies may exempt families meeting criteria established by the Lead Agency from making copayments and must establish a payment rate schedule for child care providers caring for subsidized children (45 CFR section 98.45). State, territory, and tribal Lead Agencies may use supplemental funds appropriated by the CRRSA Act (Pub. L. No. 116-260) for costs of providing relief from copayments and tuition payments for families and for paying that portion of the child care provider's costs ordinarily paid through family copayments.
- f. State Lead Agencies, territory Lead Agencies, as well as those tribal Lead Agencies with Grant Year 2016 allocations of \$250,000 or more, must, to the extent practicable, implement enrollment and eligibility policies that support the fixed costs of providing child care services by delinking provider reimbursement rates from an eligible child's occasional absences, for example by paying based on a child's enrollment rather than attendance or paying for a specified amount of absences (42 USC 9858c(c)(2)(S), 45 CFR 98.45(l)(2)). Lead Agencies are not required to limit authorized child care services strictly based on the work, training, or educational schedule of the parent(s) or the number of hours the parent(s) spend in work, training, or educational activities (45 CFR section 98.21(g)).

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

The award of CCDF funds to a 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 (42 USC 9858m(c)(5); 45 CFR section 98.80(d)).

3. Eligibility for Subrecipients

Lead agencies determine eligibility for any subrecipients used to implement portions of the CCDF program, such as entities implementing quality improvement activities.

4. Eligibility for Child Care Providers Receiving CCDF ARP Act Stabilization Funds

States, territories, and tribes shall use stabilization funds appropriated by the ARP Act (Pub. L. No. 117-2) to make payments to qualified child care providers to support the stability of the child care sector during and after the COVID-19 public health emergency. To be qualified to receive stabilization funds, a provider on the date of application for the award must either be: (1) open and available to provide child care services, or (2) closed due to public health, financial hardship, or other reasons relating to the COVID-19 public health emergency. In addition, the provider must either (1) be eligible to serve children who receive CCDF subsidies at the time of application for stabilization funds, or (2) be licensed, regulated, or registered in the state, territory, or tribe as of March 11, 2021, and meet applicable state and local health and safety requirements at the time of application for stabilization funds.

Child care providers include centers, family child care providers, and other providers that meet the qualifying eligibility criteria. Child care stabilization funds included in the ARP Act are for the benefit of qualified child care providers and are considered payments made to beneficiaries of a federal program. Qualified providers receiving ARP Act Stabilization funds are therefore not categorized as “sub-recipients” as defined at 45 CFR 75.2 but instead as beneficiaries. The Single Audit Act requirements at 45 CFR Subpart F and the sub-recipient monitoring requirements at 45 CFR 75.352 do not apply to beneficiaries.

In their application for stabilization funds, a child care provider must certify:

1. That the provider will, when open and providing services, implement policies in line with guidance and orders from corresponding state, territorial, tribal, and local authorities and, to the greatest extent possible, implement policies in line with guidance from the Centers for Disease Control and Prevention (CDC).

2. For each employee, the provider must pay at least the same amount in weekly wages and maintain the same benefits for the duration of the stabilization funding.
3. The provider will provide relief from copayments and tuition payments for the families enrolled in the provider's program, to the extent possible, and prioritize such relief for families struggling to make either type of payment.

Lead Agency must maintain documentation for child care providers receiving ARP Act stabilization funds to verify that child care providers met eligibility criteria, and that the providers gave the required certifications as part of their applications for funding.

G. Matching, Level of Effort, Earmarking

The matching and MOE requirements apply only to the Matching Fund (Assistance Listing 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 Performance"). The matching and MOE amounts are reported on the CCDF Financial Report (ACF-696) (see III.L., "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 (Assistance Listing 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 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). The ARP Act (Pub. L. No. 117-2) increased the amount of matching funds and waived the matching requirement on the increased portion of funds for FY 2021 and FY 2022. Information about matching fund amounts and other CCDF allocation amounts can be found at <https://acf.hhs.gov/occ/grant-funding/ccdf-funding-allocations>.
- 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. Level of Effort

2.1 Level of Effort – *Maintenance of Effort*

If a state requests Matching Funds (Assistance Listing 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*

The annual appropriations law for CCDF Discretionary Funds (Assistance Listing 93.575), the CARES Act (Pub. L. No. 116-136), and the CRRSA Act (Pub. L. No. 116-260) all specify that funds shall be used to supplement, not supplant State general revenue funds for child care assistance for low-income families. Funds appropriated by the ARP Act (Pub. L. No. 117-2) shall be used to supplement and not supplant other federal, state, and local public funds expended to provide child care services for eligible individuals.

3. Earmarking

- a. *Administrative Earmark* – A state/territory Lead Agency may not spend on administrative costs more than five percent of total CCDF awards expended (i.e., the total of Assistance Listings 93.575, 93.596, and 93.489 with the exception of any ARP Act stabilization funds and of any Disaster Relief funds spent on construction and renovation) and any state expenditures for which Matching Funds (Assistance Listing 93.596) are claimed (42 USC 9858c(c)(3)(C); Pub. L. No. 116-20; 45 CFR section 98.52).

Tribal Lead Agencies are allowed 15 percent of the amount expended under Assistance Listings 93.575, 93.596, and 93.489 (with the exception of any ARP Act stabilization funds and of any Disaster Relief funds spent on construction and renovation) for administrative costs. Tribes with at least 50 children under age 13 are provided a base amount, 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 base amount 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. For FY 2017 and later fiscal years, the base amount was \$30,000 (45 CFR sections 98.61(c), 98.83(h), and 98.83(i)).

The administrative costs maximum applies to all CCDF expenditures in the aggregate, including supplemental CCDF funding provided by the CARES Act (Pub. L. No. 116-136), the CRRSA Act (Pub. L. No. 116-260), and the ARP Act (Pub. L. No. 117-2), excluding the stabilization funds provided by ARP.

The following activities are not considered administrative costs (45 CFR section 98.54(b)):

- (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.

Child care stabilization funds provided by the ARP are not subject to the CCDF administrative cost limitation. Rather, a state or territory that receives these funds shall reserve not more than 10 percent to administer stabilization funds, provide technical assistance and support for applying for and accessing the funding opportunity, publicize the availability of the funds, carry out activities to increase the supply of child care, and provide technical assistance to help child care providers. A tribal lead agency may reserve up to 20 percent of stabilization funds for these activities.

- b. *Quality Earmark* – For FY 2020 and succeeding fiscal years, states and territory Lead Agencies must spend on quality activities, as provided in the state/territorial plan, not less than nine percent of CCDF funds

expended (i.e., the total of Assistance Listings 93.575, 93.596, and 93.489 with the exception of any CARES Act, CRRSA Act, and ARP Act, and of any Disaster Relief funds spent on construction and renovation) and any state expenditures for which Matching Funds (Assistance Listing 93.596) are claimed (45 CFR section 98.53). States and territory Lead Agencies must spend at least an additional three percent on quality improvement for infants and toddlers (45 CFR section 98.50(b)).

All tribal Lead Agencies must spend at least eight percent on quality activities for FY 2020 and FY 2021. Tribal Lead Agencies with CCDF allocations of \$250,000 and higher must spend at least an additional three percent on quality improvement for infants and toddlers starting in FY 2019. The base amount (discussed in paragraph 3.a above, *Administrative Earmark*) is not included in the amount against which the quality earmark is calculated (45 CFR sections 98.53(a), and 98.83(g)).

Quality spending requirements do not apply to supplemental funds provided by the CARES Act (Pub. L. No. 116-136), the CRRSA Act (Pub. L. No. 116-260), and the ARP Act (Pub. L. No. 117-2).

c. *Direct Spending Earmarks*

- (1) From the aggregate amount of Discretionary funds (Assistance Listing 93.575) and Disaster Relief funds (Assistance Listing 93.489) provided for a year (with the exception of any CARES Act, CRRSA Act, and ARP Act, and of any Disaster Relief funds used for construction or major renovation), state Lead Agencies, territory Lead Agencies, as well as those tribal Lead Agencies with allocations of at least \$250,000 must reserve funds for administrative costs (described in paragraph 3.a above, *Administrative Earmark*) and the minimum amount required for quality activities (described in paragraph 3.b above, *Quality Spending Earmark*).
- (2) From the remainder, the Lead Agency must use not less than 70 percent to fund direct services. In addition, states and territories must spend not less than 70 percent of the Mandatory and federal and state share of Matching funds (Assistance Listing 93.596) to provide child care assistance to families who: (1) receive Temporary Assistance for Needy Families (TANF) assistance; (2) are attempting through work activities to transition off TANF; and (3) are at risk of becoming dependent on TANF (45 CFR section 98.50(e) and (f)).
- (3) Direct spending requirements do not apply to supplemental funds provided by the CARES Act (Pub. L. No. 116-136), the CRRSA Act (Pub. L. No. 116-260) and the ARP Act (Pub. L. No. 117-2).

H. Period of Performance

1. Discretionary Funds (Assistance Listing 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 (Assistance Listing 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 (Assistance Listing 93.596). If no Matching Funds are requested for the fiscal year, then the Mandatory Funds (Assistance Listing 93.596) are available until liquidated (45 CFR section 98.60(d)).
3. Mandatory Funds (Assistance Listing 93.596) for territories 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.
4. Mandatory Funds (Assistance Listing 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)).
5. Matching Funds (Assistance Listing 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)).
6. Child Care Disaster Relief Funds (Assistance Listing 93.489) not used for construction or renovation 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 (Pub. L. No. 116-20).
7. Child Care Disaster Relief Funds (Assistance Listing 93.489) used for construction or renovation must be obligated by the end of the fourth fiscal year after award and expended by the end of the fifth fiscal year after award (Pub. L. No. 116-20).

For example, availability periods for grant year 2021 funds awarded on any date in FY 2021 (October 1, 2020 through September 30, 2021):

If Source of Obligation Is –	Obligation must Be Made by End of –	Obligation must Be Liquidated by End of –
FY 2021 Discretionary (Assistance Listing 93.575)	FY 2022 (i.e., by 9/30/2022)	FY 2023 (i.e., by 9/30/2023)
FY 2021 Mandatory (State) (Assistance Listing 93.596)	FY 2021 (i.e., by 9/30/2021 but ONLY if Matching Funds are used)	No requirement for liquidation by a specific date
FY 2021 Mandatory (Territories) (Assistance Listing 93.596)	FY 2021 (i.e., by 9/30/2021)	FY 2022 (i.e., by 9/30/2022)
FY 2021 Mandatory (Tribes) (Assistance Listing 93.596)	FY 2022 (i.e., by 9/30/2022)	FY 2023 (i.e., by 9/30/2023)
FY 2021 Matching (Assistance Listing 93.596)	FY 2021 (i.e., by 9/30/2021)	FY 2022 (i.e., by 9/30/2022)

If Source of Obligation Is –	Obligation must Be Made by End of –	Obligation must Be Liquidated by End of –
FY 2021 Child Care Disaster Relief— Not Used for Construction or Renovation (Assistance Listing 93.489)	FY 2022 (i.e., by 9/30/2022)	FY 2023 (i.e., by 9/30/2023)
FY 2021 Child Care Disaster Relief— Used for Construction or Renovation (Assistance Listing 93.489)	FY 2024 (i.e., by 9/30/2024)	FY 2025 (i.e., by 9/30/2025)

TANF funds (Assistance Listing 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)).

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)).

Supplemental funds provided under the CARES Act (Pub. L. No. 116-136), the CRRSA Act (Pub. L. No. 116-260), and the ARP Act (Pub. L. No. 117-2) have specific obligation and liquidation timeframes that are outlined below:

	Obligation must Be Made by End of –	Obligation must Be Liquidated by End of –
FY 2020 Discretionary supplemental funds provided under the CARES Act (Pub. L. No. 116-136) (Assistance Listing 93.575)	FY 2022 (i.e., by 9/30/2022)	FY 2023 (i.e., by 9/30/2023)
FY 2021 Discretionary supplemental funds provided under the CRRSA Act (Pub. L. No. 116-260) (Assistance Listing 93.575)	FY 2022 (i.e., by 9/30/2022)	FY 2023 (i.e., by 9/30/2023)
FY 2021 Discretionary supplemental funds provided under the ARP Act (Pub. L. No. 117-2) (Assistance Listing 93.575)	FY 2023 (i.e., by 9/30/2023)	FY 2024 (i.e., by 9/30/2024)
FY 2021 Child care stabilization funds provided by the ARP Act (Pub. L. No. 117-2) (Assistance Listing 93.575)	FY 2022 (i.e., by 9/30/2022)	FY 2023 (i.e., by 9/30/2023)

In accordance with the CCDBG Act of 2014 and 45 CFR 98.19, The Office of Child Care approved waivers for some tribes and territories, upon request, to extend the obligation and liquidation periods of some CCDF funding (both regular CCDF and COVID supplemental funds).

L. Reporting

1. Financial Reporting

ACF-696, *Child Care and Development Fund Financial Report (OMB No 0970-0510)* is due quarterly from states and territories. The ACF-696T, *Child Care and*

Development Fund Financial Report for Tribes (OMB No. 0970-0510) 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-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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

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. The contents of the written agreement may vary based on the role the subrecipient is asked to assume or the type of product undertaken, but must include, at a minimum, tasks to be performed, a schedule for completing tasks, a budget which itemizes categorical expenditures, and indicators or measures to assess performance. 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 Requirements As part of their CCDF plans, Lead Agencies must certify that procedures are in effect (e.g., monitoring and enforcement) to ensure that providers serving children who receive subsidies comply with all applicable health and safety requirements. This includes verifying and documenting 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 health and safety. These requirements must address eleven specific areas—including first aid and CPR, safe sleeping practices, and administration of

medication—and child care workers must be trained in these areas (42 USC 9858c(c)(2)(I); 45 CFR section 98.41).

Audit Objectives 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, including any monitoring and enforcement procedures, for ensuring child care provider compliance with relevant health and safety requirements for those providers serving children who receive subsidies. This review should include, at a minimum, relevant information in the Lead Agency's CCDF Plan.
- c. Review a sample of Lead Agency files for child care providers serving children who receive subsidies to verify that the Lead Agency followed its procedures for ensuring child care provider compliance with relevant state health and safety requirements, including training requirements.

2. Fraud Detection and Repayment

Compliance Requirements 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 Objectives 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 the Lead Agency followed its procedures related to authenticating that a payment was actually fraudulent and as applicable recover payment.

3. Tribal Lead Agencies - Protection of Federal Interest in Real Property and Facilities

Compliance Requirements CCDF can only be used for construction or major renovation of child care facilities in two instances: (1) a tribal Lead Agency that is approved to use CCDF for construction or major renovation; or (2) a state, territory, or tribal Lead Agency that is approved to use Disaster Relief funds (Assistance Listing 93.489) for construction or major renovation. The requirements for construction and renovation of child care facilities by tribal Lead Agencies are described in 45 CFR section 98.84. As required by this section, OCC established uniform procedures in program instruction CCDF-ACF-PI-2016-05, “Procedures for Requests for Tribal Lead Agencies to Use Child Care and Development Fund (CCDF) Funds for Construction or Renovation of Child Care Facilities” (<https://www.acf.hhs.gov/occ/resource/ccdf-acf-pi-2016-05>). The requirements for using Disaster Relief funds (Assistance Listing 93.489) for construction and renovation are described in program instruction CCDF-ACF-PI-2019-06.

Facilities activities (construction, major renovation, and disposition) are initiated through the submission of Form SF-429 (cover sheet) and applicable Attachments B (*Request to Acquire, Improve or Furnish*) or C (*Disposition or Encumbrance Request*).

In instances where federal interest provisions apply, at the commencement of construction or major renovation of a facility with CCDF funds, the tribal Lead Agency must record a Notice of Federal Interest in the appropriate official records of the jurisdiction in which the facility will be located (unless the facility will be located on tribal lands held in trust by the US government). In the case of Disaster Relief funds (Assistance Listing 93.489), federal interest is limited to 10 years, and does not apply to privately-owned family child care homes. The full requirements for the protection of the federal interest are described in program instructions CCDF-ACF-PI-2016-05 and CCDF-ACF-PI-2019-06.

Audit Objectives Determine whether the federal interest in real property and facilities is protected by the required Notice of Federal Interest and language content and the required prior written approvals were obtained from ACF.

Suggested Audit Procedures

- a. Review the appropriate documentation (e.g., Lead Agency’s general ledger accounts and the meeting minutes of its governing body) and inquire of the tribal Lead Agency’s management to identify if any of the following transactions, which are subject to the requirements for protecting the federal interest, occurred during the audit period and, if so, that the required prior written approvals were obtained from ACF:
 - (1) Construction or major renovation of a facility, including a modular unit.
 - (2) Sale, lease, or encumbrance, such as a mortgage of real property or a facility (including modular units).

- (3) Changes in approved use of facilities.
- b. For construction, or major renovation during the audit period, ascertain if the Notice of Federal Interest was required, and if so, whether it was properly recorded in the locality's official real property records and, for a modular unit, if this Notice was properly posted in a conspicuous place. A Notice is not required for a facility on tribal lands held in trust by the US government; however, there is still a federal interest in any facility constructed or renovated with CCDF funds.
- c. Review the Notices of Federal Interest and mortgage agreements and other security instruments executed during the audit period to ascertain if the documents include the required language content.
- d. For sales, leases, and encumbrances and property used for a different purpose during the audit period, review the change in use to ascertain if the tribal Lead Agency obtained and complied with the requirement for ACF prior written approval.

4. Child Care Provider Eligibility for ARP Act Stabilization Funds

Compliance Requirements To be qualified to receive ARP Act stabilization funds, a provider on the date of application for the award must either be: (1) open and available to provide child care services, or (2) closed due to public health, financial hardship, or other reasons relating to the COVID-19 public health emergency. In addition, the provider must either (1) be eligible to serve children who receive CCDF subsidies at the time of application for stabilization funds, or (2) be licensed, regulated, or registered in the state, territory, or tribe as of March 11, 2021 and meet applicable state and local health and safety requirements at the time of application for stabilization funds. In their application for stabilization funds, a child care provider must certify:

- a. That the provider will, when open and providing services, implement policies in line with guidance and orders from corresponding state, territorial, tribal, and local authorities and, to the greatest extent possible, implement policies in line with guidance from the CDC.
- b. For each employee, the provider must pay at least the same amount in weekly wages and maintain the same benefits for the duration of the stabilization funding.
- c. The provider will provide relief from copayments and tuition payments for the families enrolled in the provider's program, to the extent possible, and prioritize such relief for families struggling to make either type of payment.

Audit Objectives Determine whether Lead Agencies ensure that child care providers receiving ARP Act stabilization funds meet eligibility criteria, including providing required certifications.

Suggested Audit Procedures

- a. Review a sample of Lead Agency documentation for child care providers receiving ARP Act stabilization funds to verify that child care providers met eligibility criteria, and that the providers gave the required certifications as part of their applications for funding.

IV. OTHER INFORMATION

Funding Sources Within the CCDF Cluster

In federal fiscal year 2019, Congress appropriated additional CCDF funds under the Supplemental Appropriations for Disaster Relief Act of 2019 (Pub. L. No. 116-20). In federal fiscal year 2020, Congress appropriated additional CCDF funds under the CARES Act (Pub. L. No. 116-136). In fiscal year 2021, Congress appropriated additional CCDF funds under the CRRSA Act (Pub. L. No. 116-260) and the ARP Act (Pub. L. No. 117-2). The ARP funds included both supplemental CCDF funds and child care stabilization funds. Although there are some differences in the rules governing each funding source, expenditures of funds from all of these sources should be included in the audit universe for CCDF Lead Agencies and the total expenditures of the CCDF Cluster for purposes of (1) determining Type A programs and (2) completing the Schedule of Expenditures of Federal Awards (SEFA). However, CCDF Lead Agencies are required to account for these expenditures separately in their own accounting records. Furthermore, a footnote on the SEFA showing amounts by funding source (CCDBG, CCDF Mandatory and Matching, CCDF Disaster Relief, CCDF CARES, CCDF CRRSA, CCDF ARP supplemental, CCDF ARP child care stabilization funds) in the CCDF Cluster is encouraged.

Transfer of Funds to CCDF

Under the TANF program (Assistance Listing 93.558), a state may transfer TANF funds to CCDF and the funds transferred are treated as Discretionary Funds under CCDF. 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 Project

Audits of Indian tribal governments with tribal CCDF in their approved 477 Plan with reporting under Version 2 forms (75 FR 57970 (September 26, 2014)) must follow the guidance in the 477 Cluster found in the Department of the Interior's section of Part 4 of this Supplement.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.356 HEAD START DISASTER RECOVERY FROM
HURRICANES HARVEY, IRMA, AND MARIA****ASSISTANCE LISTING 93.600 HEAD START****I. PROGRAM OBJECTIVES**

The objective of the Assistance Listing 93.600 Head Start program (including Early Head Start and Early Head Start-Child Care Partnerships) is to promote school readiness of low-income children (including American Indians, Alaska Natives, and migrant and seasonal farm workers) by enhancing children's cognitive, social, and emotional development.

The objective of Coronavirus Aid, Relief, and Economic Security Act (CARES Act) funding in the amount of \$750,000,000 appropriated for the Office of Head Start (OHS) is to pay the costs associated with Head Start program actions and activities undertaken to prevent, prepare for, and respond to the impacts of the coronavirus.

The objective of Coronavirus Response And Relief Supplementary Appropriation Act (CRRSA) funding in the amount of \$250,000,000 appropriated for OHS is to pay the costs associated with Head Start program actions and activities undertaken to prevent, prepare for, and respond to the impacts of the coronavirus.

The objective of American Rescue Plan (ARP) funding in the amount of \$1,000,000,000 appropriated for OHS is not limited to actions and activities undertaken to prevent, prepare for, and respond to the coronavirus and may also be used for the same objective as Assistance Listing 93.600: to promote school readiness of low-income children (including American Indians, Alaska Natives, and migrant and seasonal farm workers) by enhancing children's cognitive, social, and emotional development.

CARES Act, CRRSA and ARP funding was awarded in an amount that bears the same ratio to the portion available for allocation as the number of enrolled children served by the Head Start agency bears to the number of enrolled children served by all Head Start agencies. The objective of the Consolidated Appropriations Act (CCA) funding of \$11,036,820,000, an increase of \$289 million over fiscal year (FY) 2021, is to carry out the purposes of the Head Start Act. The CCA specifies that any amount of the funds provided for Quality Improvement may be used on any of the activities specified in the Head Start Act. Programs are not bound by the requirements that at least 50% of the funds be used for staff compensation or that no more than 10% of funds be used on transportation. The CCA also provides a Cost-of-Living Adjustment which must be used to permanently increase the Head Start pay scale by no less than 2.28% and be applied from the start of a recipient's FY 2022 budget period, which may need to be retroactively applied.

Comprehensive services are provided to enrolled children, pregnant women, and their families, which include health, nutrition, social, and other services determined to be necessary by family needs assessments, in addition to education and cognitive development services.

Assistance Listing 93.356

The objective of the Assistance Listing 93.356 disaster recovery is to provide for Head Start expenses directly related to the consequences of 2017 hurricanes Harvey, Irma, and Maria, including making payments under the Head Start Act.

The objective of Public Law No: 116-20, Additional Supplemental Appropriations for Disaster Relief Act of 2019, provides \$55,000,000 in emergency funding for necessary Head Start expenses directly related to the consequences of Hurricanes Florence and Michael, Typhoon Mangkhut, Super Typhoon Yutu, wildfires and earthquakes occurring in calendar year 2018 and floods occurring in calendar year 2019.

II. PROGRAM PROCEDURES

The OHS, Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS), administers the Head Start program, COVID-19 response funds, and disaster recovery funds.

Services for children ages 3–5 are funded by a Head Start award and services for pregnant women and children ages 0–3 are funded by an Early Head Start award. Early Head Start services may include those delivered through a partnership with existing child care centers or family child care homes under funding specially designated as an Early Head Start – Child Care Partnership award. Grant recipients may receive one-time awards, primarily for health and safety-related facility improvement activities.

Comprehensive center-based or home-based services are provided to enrolled children, pregnant women, and their families. These include health, nutrition, social, and other services determined to be necessary by a family needs assessment, in addition to education and cognitive development services. Services are designed to be responsive to each child's and family's ethnic, cultural, and linguistic heritage.

OHS makes Head Start awards to local public, nonprofit agencies, and for-profit entities known as Head Start Agencies (HSA). The awards are made for a period not-to-exceed five years. A HSA may enter into an agreement with a delegate agency (subrecipient) for delivery of Head Start services; however, the HSA (pass-through entity) retains legal and fiscal responsibility for the grant. Delegate agencies may be public, nonprofit, or for-profit organizations. HSAs must establish and implement procedures for the ongoing monitoring of each delegate agency (42 USC 9836a(d) and 45 CFR sections 1303.30 and 32).

Assistance Listing 93.356 funds may be used for allowable Head Start expenditures as specified in the terms and conditions of the grant award.

CARES Act and CRRSA funds may be used to pay the costs associated with Head Start program actions and activities undertaken to prevent, prepare for, and respond to the impacts of the coronavirus.

Source of Governing Requirements

The Head Start program is authorized under the Improving Head Start for School Readiness Act of 2007 (Pub. L. No. 110-134 (42 USC 9831-9852)).

On September 7, 2016, OHS promulgated new regulations governing program operations, referred to as the Head Start Program Performance Standards (HSPPS) (45 CFR parts 1301 through 1305). HSPPS became effective beginning November 7, 2016, although some provisions are deferred as noted in the regulations. The full implementing program regulations are 45 CFR parts 1301 through 1305.

Assistance Listing 93.356 was established based on appropriations in the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123, 132 Stat. 93) and supplemental appropriations for fiscal year ending September 30, 2018 (Pub. L. No. 116-20).

Requirements for use of CARES Act funds to prevent, prepare for, and respond to the coronavirus were established by The Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020 (Pub. L. No. 116-136).

Requirements for use of CRRSA funds to prevent, prepare for, and respond to the coronavirus were established by the Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260).

Requirements for use of ARP funds were established by the American Rescue Plan Act of 2021 (Pub. L. No. 117-2).

Requirements for the use of the FY 2022 Head Start appropriation were established by the Consolidated Appropriations Act, 2022 (Public Law No: 117-103).

Availability of Other Program Information

The Early Childhood Learning and Knowledge Center (ECKLC) (<http://eclkc.ohs.acf.hhs.gov/hslc>) is the OHS website that provides information about the Head Start program. ECKLC also provides information specific to Assistance Listing 93.356 in ACF-IM-HS-17-02, dated September 20, 2017, *Disaster Recovery from 2017 Hurricanes* and ACF-PI-HS-18-02, dated April 9, 2018, *Hurricanes Harvey, Irma, and Maria Disaster Assistance Funds*. Information about funds available for expenses directly related to the consequences of natural disasters that occurred in 2018 and 2019 can be found in ACF-PI-HS-19-01, dated September 17, 2019, *Disaster Recovery Funding for 2018 and 2019 Disasters*. Information about available COVID-19 supplemental funds for Head Start programs can be found in ACF-PI-HS-20-04, dated May 21, 2020, *Update to Funding for FY 2020 Supplemental Funds in Response to the Coronavirus Disease 2019 (COVID-19)*; ACF-PI-HS-21-01, dated February 19, 2021, *FY 2021 Head Start Funding Increase*; and ACF-PI-HS-21-03, dated May 4, 2021, *FY 2021 American Rescue Plan Funding Increase for Head Start Programs*. Information about the use of the FY 2022 Head Start appropriation is further outlined in ACF-PI-HS-22-02, dated April 14, 2022, *FY 2022 Head Start Funding Increase*.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a

direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	N	Y	N	N	N	N	Y	Y	Y

A. Activities Allowed or Unallowed

1. Funds may be used for the following program services consistent with HSPPS:
 - 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. Ensuring that programs have qualified staff that promote the language skills and literacy growth of children and that provide children with a variety of skills that have been identified, through scientifically based reading research, as predictive of later reading achievement (42 USC 9835(a)(5)(B)(iv));
- h. Increasing the duration of 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));
- i. Improving community-wide strategic planning and needs assessments and collaboration efforts, including outreach (42 USC 9835(a)(5)(B)(vi));
- j. Transporting children safely except that not more than 10 percent of designated quality improvement funds may be used for transportation costs (42 USC 9835(a)(5)(B)(vii) and 45 CFR Part 1310);
- k. 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));
- l. Correcting areas of noncompliance or deficiencies and developing quality improvement plans (42 USC 9836a(e));

- m. 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 HSA; and ensuring the necessary membership on the governing body (42 USC 9837(c)(1));
 - n. 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 HSA's effectiveness and progress in meeting program goals and objectives as well as in implementing and complying with HSPPS (42 USC 9836a(g));
 - o. 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));
 - p. Provision of family needs assessments that include consultation with parents (including foster parents, grandparents, and kinship caregivers) (42 USC 9837(b)(7));
 - q. Outreach and information to parents of limited English proficient children in an understandable and uniform format (42 USC 9837(b)(11));
 - r. 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));
 - s. Implementation of a research-based early childhood curriculum (42 USC 9837(f)(3)); and
 - t. In the case of an 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 that no financial assistance shall be extended in any case in which the costs of developing and administering a program exceed 15 percent of the total costs, including the required nonfederal contributions to such costs. The term "development and administrative costs" means costs incurred in accordance with an approved Head Start budget that do not directly relate to the provision of program component services, as described under paragraph 1, above (42 USC 9839(b) and 45 CFR section 1301.32 (a)).

3. With ACF prior written approval, HSAs may use funds 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 of existing facilities, and purchase of vehicles used for programs conducted at the Head Start facilities (42 USC 9839(f) and (g)). *Major renovation* means any individual or collection renovation that has a cost equal to or exceeding \$250,000. It excludes minor renovations and repairs except when they are included in a purchase application (45 CFR section 1305.2).
4. Funds may not be used by HSAs 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. HSAs and delegate agencies must use funds from USDA's Child and Adult Care Food Program (Assistance Listing 10.558) as the primary source of payment for children's nutritional services (meals and snacks). Head Start funds may be used only to cover those allowable costs not covered by USDA (45 CFR section 1302.44(b)).
6. Funds may be used for professional medical and oral health services when no other funding source is available. When funds are used for such services, HSAs and delegate agencies must have written documentation of their efforts to access other available sources of funding (45 CFR section 1302.42(e)(2)).
7. Additional requirements for awards made under Assistance Listing 93.356:
 - a. The terms and conditions of the award specify the allowable Head Start expenditures for which the funds must be used. ACF-PI-HS-18-02 lists the following types of allowable expenses.
 - (1) Facilities
 - (2) Materials, Supplies, and Equipment
 - (3) Program Operations
 - (4) Additional Health, Mental Health, Dental, and Nutrition Services
 - (5) Training and Technical Assistance (T/TA)
 - (6) Disaster Recovery Expenses Incurred Prior to Availability of Funds

- b. HSAs are eligible to submit more than one application for disaster recovery funds and may receive multiple awards depending on the type of funds requested and complexity (e.g., facilities) of funded projects.
 - c. Funds may not be used to pay for costs that are reimbursed by the Federal Emergency Management Agency (FEMA), under a contract for insurance, or by self-insurance. HSAs must advise ACF in writing of the receipt of such funds and reimburse ACF for any costs incurred under the award that are subsequently reimbursed by FEMA, under a contract for insurance or self-insurance. HSAs may submit Head Start disaster recovery applications during the pendency of FEMA requests and insurance claims (Pub. L. No. 115-123, 132 Stat. 93).
- 8. Additional requirements for awards made from CARES Act and CRRSA funds:
 - a. [ACF-PI-HS-20-04](#) describes the funding process and allowable use of CARES Act and CRRSA funds. Grantees are afforded broad discretion to utilize CARES Act and CRRSA funds to respond to COVID-19 in consideration of community circumstances and programmatic needs.
 - b. Extensive guidance to grantees to support their response to the coronavirus has been provided by OHS through its official website, the Early Childhood Learning and Knowledge Center (ECLKC), at the following link: <https://eclkc.ohs.acf.hhs.gov/about-us/coronavirus/ohs-covid-19-updates>.

B. Allowable Costs/Cost Principles

- 1. Costs meet general criteria for allowability, including being necessary and reasonable for the performance of the federal award, allocable thereto and adequately documented (45 CFR sections 75.403, 75.404, and 75.405).
- 2. Shared and indirect costs attributable to common or joint use of personnel, 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)).
- 3. Federal funds (including charges to indirect cost pools) may not be used to pay any part of the compensation of an individual employed by a HSA, if such compensation, including nonfederal funds, exceeds an amount equal to the rate payable for level II of the Executive Schedule under section 5313 of title 5, United States Code (42 USC 9848(b)).

F. Equipment and Real Property Management

1. Real property, equipment, and intangible property, that are acquired or improved with a federal award must be held in trust by the nonfederal entity as trustee for the beneficiaries of the project or program under which the property was acquired or improved. The HHS awarding agency may require the nonfederal entity to record liens or other appropriate notices of record to indicate that personal or real property has been acquired or improved with a federal award and that use and disposition conditions apply to the property (45 CFR section 75.323 and 45 CFR section 1303 – Subpart E).
2. Real property acquired or improved under a federal award must be used for the authorized purpose so long as it is needed for that purpose, during which time the HSA may not dispose of, replace or encumber the property without prior ACF approval (45 CFR section 75.318; 45 CFR section 75.308(c)(1)(xi)).
3. Equipment acquired under a federal award must be used for the authorized purposes of the project during the period of performance, or until the property is no longer needed for the purposes of the project. A HSA may not dispose of, replace, or encumber title to equipment without prior ACF approval (45 CFR section 75.319; 45 CFR section 75.308(c)(1)(xi)).
4. Property records must be maintained for equipment acquired under a federal award that include a description of the property, a serial number or other identification number, the source of funding for the property (including the FAIN), who holds title, the acquisition date, and cost of the property, percentage of federal participation in the project costs for the federal award under which the property was acquired, the location, use and condition of the property, and any ultimate disposition data including the date of disposal and sale price of the property. A physical inventory of the property must be taken and the results reconciled with the property records at least once every two years.

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

SF-429 – Real Property Status Report and SF-429-A General Reporting (OMB No. 4040-0016). These forms are filed annually based upon the end of the budget period. The annual SF-429 is required for all grantees and must indicate whether the grantee has reportable real property. If so, a separate SF-429-A must be completed for each parcel of real property reported and accompany the annual SF-429. Auditors should check for timely submission of SF-429 reports.

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

M. Subrecipient Monitoring

HSAs 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. Grant recipients 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)).

N. Special Tests and Provisions

1. Protection of Federal Interest in Real Property and Facilities

Compliance Requirements Head Start uses specific terms related to real property and facilities, which are defined at 45 CFR section 1305.2, including construction, facility, federal interest, major renovation, and modular unit.

Facilities activities (purchase, construction, major renovation, subordination of a federal interest, refinancing, and disposition) are initiated through the submission of Form SF-429 (cover sheet) and applicable attachments B (*Request to Acquire, Improve or Furnish*) or C (*Disposition or Encumbrance Request*).

With written prior approval from ACF, a HSA may use Head Start funds to purchase, construct, or renovate (major) a facility, including using Head Start funds to pay ongoing purchase costs which include principal and interest on approved loans (45 CFR sections 1303.40 through 1303.44).

A HSA that uses Head Start funds to purchase real property or purchase, construct, or renovate (major) a facility appurtenant to real property (either owned or leased) must record a Notice of Federal Interest (also referred to as “reversionary interest”) (45 CFR sections 1303.46). The Notice of Federal Interest must include the required language content from 45 CFR section 1303.47(a) and be properly recorded in the official real

property records for the jurisdiction where the facility is or will be located. A similar Notice of Federal Interest is required for leased facilities on land the HSA does not own (45 CFR section 1303.47(b)).

An HSA that uses Head Start funds to purchase or renovate (major) a modular unit must post a Notice of Federal Interest which includes the required language content in clearly visible locations on the exterior and the interior of the modular unit (45 CFR sections 1303.46(b)(4) and 47(c)).

An HSA cannot mortgage, use as collateral for a credit line or for other loan obligations, or sell or transfer to another party, a facility, real property, or a modular unit it has purchased, constructed, or renovated (major) with Head Start funds, without the prior written approval of ACF (45 CFR sections 1303.48 and 1303.51). A HSA must include specific language in any mortgage agreement or other security instrument that encumbers real property or a modular unit constructed or purchased with Head Start fund to ensure protection of ACF interests (45 CFR section 1303.49).

An HSA must have written approval from ACF before it can use real property, a facility, or a modular unit subject to federal interest for a purpose other than that for which the HSA's application was approved (45 CFR section 1303.48(b)).

Audit Objectives Determine whether the federal interest in real property and facilities is protected by the required Notice of Federal Interest and language content and the required prior written approvals were obtained from ACF.

Suggested Audit Procedures

- a. Review the HSA's general ledger accounts and the meeting minutes of its governing body and inquire of HSA management to identify if any of the following transactions, which are subject to the requirements for protecting the Federal interest, occurred during the audit period and, if so, that the required prior written approvals were obtained from ACF:
 - (1) Purchase of real property or purchase, construction, or major renovation of a facility, including a modular unit.
 - (2) Sale, lease, or encumbrance, such as a mortgage of real property or a facility (including modular units).
 - (3) Changes in approved use of facilities.
- b. For purchase, construction, or major renovation during the audit period, ascertain if the required Notice of Federal Interest was properly recorded in the locality's official real property records and, for a modular unit, if this notice was properly posted on the exterior and interior of the modular unit.

- c. Review the notices of federal interest and mortgage agreements and other security instruments executed during the audit period to ascertain if the documents include the required language content.
- d. For sales, leases, and encumbrances and property used for a different purpose during the audit period, review the change in use to ascertain if the HSA obtained and complied with the requirement for ACF prior written approval.

2. Program Governance

Compliance Requirements OHS has found a high correlation between HSAs that fail to comply with the program governance requirements and HSAs that have serious fiscal problems, which puts both the HSA and the Head Start programs they administer at risk.

The governing body has legal and fiscal responsibility for the HSA. The HSA governing body must include not less than one member with a background and expertise in fiscal management or accounting and not less than one licensed attorney familiar with issues that come before the governing body. If the types of persons described above are not available to serve as members of the governing body, the governing body must use a consultant, or other individual(s) with relevant expertise who must work directly with the governing body (42 USC 9837(c)(1)(B)).

A HSA must share accurate and regular financial information with the governing body and the policy council, including monthly financial statements, including credit card expenditures and the financial audit (42 USC 9837(d)(2)(A) and (E)).

The governing body's responsibilities include approving financial management, accounting, and reporting policies, and compliance with laws and regulations related to financial statements, including the

- a. approval of all major financial expenditures of the agency;
- b. annual approval of the operating budget of the agency;
- c. selection (except when a financial auditor is assigned by the state under state law or is assigned under local law) of independent financial auditors; and
- d. monitoring of the agency's actions to correct any audit findings and of other action necessary to comply with applicable laws (including regulations) governing financial statement and accounting practices (42 USC 9837(c)(1)(E)(iv)(VII)(aa) through (dd)).

The auditee has provided training and technical assistance to the governing body and policy council to support understanding of financial information provided to them and support effective oversight of the Head Start award (42 USC 9837(d)(3)).

Audit Objectives Determine whether the entity complied with the program governance requirements for (a) composition and qualifications of board members, (b) providing

financial information to the governing body and policy council, and (c) providing training to the governing body and policy council.

Suggested Audit Procedures

1. Identify the HSA's governing body member who is an attorney and ascertain if that individual is licensed and has the required familiarity with issues that come before the governing body, or that the governing body used a consultant, or another individual with relevant expertise with the required qualifications who worked directly with the governing body.
2. Identify the HSA's governing body member with fiscal management or accounting expertise and ascertain if that individual has the required background and expertise or that the governing body used a consultant, or another individual with the required qualifications who worked directly with the governing body.
3. Ascertain if the HSA shared the required monthly financial information with the governing body and the policy council.
4. Determine whether the HSA has established written policies and procedures that identify major financial expenditures approvable by the governing body. If the HSA does not have written policies and procedures that identify or define major financial expenditures determine whether the HSA has an identifiable practice for identifying major financial expenditures submitted for approval to the governing body. Ascertain if written policies and procedures or an identifiable procedure exists and whether the policy, procedure or practice was followed by the HSA. If no such policy, procedure or practice exists and no governing body minutes reflect approval of expenditures identified as major financial expenditures, the auditor should determine that major financial expenditures are not submitted to the governing body for approval.
5. Governing body minutes or similar records should also reflect approval of all funding applications (Head Start and disaster recovery), selection of the independent auditor, attention to corrective action on audit findings and the annual report to the public.
- 6.
7. Ascertain if governing body and policy council members have received training and technical assistance related to their fiscal responsibilities.

IV. OTHER INFORMATION

Monitoring of HSAs and delegate agencies by OHS has identified the following areas of risk for deficiencies in internal controls and noncompliance.

B. Allowable Costs/Cost Principles

1. Many Head Start grantees, such as community action agencies, have multiple funding streams and few revenue sources other than federal awards. Federal programs only cover costs that are reasonable, allowable, and allocable for the accomplishment of the program objectives leaving the entity with limited options to cover unallowable costs.
2. The Head Start program often provides the largest proportion of the overall funding of HSAs and funds are immediately available to be drawn down in the Payment Management System. These factors create a risk that shared costs are over-allocated or billed entirely to Head Start. In some cases, costs of shared central services, such as equipment, information and communications systems, and rent are charged entirely to Head Start when the costs should be allocated to all programs that benefit.
3. A large portion of Head Start costs are payroll and grantees may fail to maintain adequate documentation of shared staff time or charge those costs based on the application budget rather than reconciling to actual hours worked. For example:
 - a. A teacher working for both Head Start and Child Care or a director for multiple programs erroneously charged entirely to Head Start.
 - b. Double charging the same costs by including them in the indirect cost rate and direct charging them through allocation (e.g., administrative staff).
 - c. Large dollar costs charged through journal entries to move costs between programs or between program years without adequate support.
 - d. Rent charged at full fair market value instead of depreciation or use allowance under capital or related party leases.
4. Transactions with related parties resulting in excessive charges. For example, paying rental rates in excess of fair market value.
5. Applicable only to expenditures charged to Assistance Listing 93.356:
 - a. Failure to notify ACF of FEMA or insurance proceeds or reimbursements for expenses already funded with Head Start disaster recovery funds.
 - b. Failure to obtain required prior written approval from ACF for purchase, construction, or major renovation of facilities. Major renovation means any individual or collection renovation that has a cost equal to or exceeding \$250,000. It excludes minor renovations and repairs except when they are included in a purchase application (45 CFR section 1305.2).
 - c. Failure to document costs and their relationship to the consequences of hurricanes Harvey, Irma, Maria, and allowability based on the specific terms and conditions of the award.

6. Applicable only to CARES Act and CRRSA funds:

- a. Failure to maintain documentation to demonstrate that the use of CARES Act and CRRSA funds was related to the coronavirus.
- b. Expenses charged to CARES Act and CRRSA funds awarded by OHS also charged to another federally financed program.
- c. CARES Act and CRRSA funds are subject to certain fiscal flexibilities established by OHS and continuing through December 31, 2020, described in [ACF-IM-HS-20-03](#). See, in particular, paragraphs 5 and 6 regarding allowable costs.
- d. CARES Act and CRRSA funds must be spent in accordance with cost principles described in 45 CFR Part 75, Subpart E taking into account the unique circumstances affecting spending decisions during COVID-19. Per 45 CFR Part 75, Subpart E CARES Act and CAA funds may not be included as a cost or used to meet cost sharing or matching requirements of any other federally financed program in either the current or a prior period.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 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 tribal 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"). Note: Supplemental fiscal year (FY) 2020 funding was provided for the CWS program under Pub. L No. 116-136, Title VIII of Division B, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). This funding, totaling \$45 million, was allocated to all title IV-B agencies using the existing statutory formula. Program Instruction ACYF-CB-PI-20-11, dated June 8, 2020, contains details and is available through a link as follows: <https://www.acf.hhs.gov/cb/policy-guidance/pi-20-11>.

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 (1) Child Welfare Services, services promoting safe and stable families under Title IV-B, subpart 2; (2) a child welfare staff development and training plan; (3) 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; (4) 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 FY toward meeting each goal and objective in the five-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.

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.

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 CWS program. This information may be accessed at <https://www.acf.hhs.gov/cb/laws-policies>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment/Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement Suspension & Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	Y	Y	N	N	Y	N	N

A. Activities Allowed or Unallowed

1. *Activities Allowed*

a. Funds may be used for the following purposes (42 USC 621):

- (1) Protecting and promoting the welfare of all children;
- (2) Preventing the abuse, neglect, or exploitation of children;

- (3) Supporting at-risk families through services that allow children to remain with their families or return to their families in a timely manner;
- (4) Promoting the safety, permanence, and well-being of children in foster care and adoptive families; and
- (5) Providing training, professional development, and support to ensure a well-qualified workforce.
- (6) Supplemental FY 2020 CARES Act funding may be used to prevent, prepare for, or respond to, coronavirus in a manner consistent with the above listed CWS program purposes. See Program Instruction ACYF-CB-PI-20-11, dated June 8, 2020, contains details and is available as follows:
<https://www.acf.hhs.gov/cb/policy-guidance/pi-20-11>.

- b. Funds may be used for administrative costs, subject to the limitation in III.G.3.b, “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) ((42 USC 622(b)(14) and (c) and 624(e)).

2. *Activities Unallowed*

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**

Funds are federally reimbursed at 75 percent of allowable expenditures. The Title IV- B agency’s contribution may be in cash, donated funds, and non-public third-party in-kind contributions (42 USC 623 and 45 CFR section 1357.30(e)(1)). The Federal Financial Participation (FFP) rate may be reduced (and the state matching rate increased by a corresponding amount) based on a determination that the state failed to meet performance standards for caseworker visits with children in foster care in the preceding federal fiscal year (FFY) (see II.L.2 “Performance Reporting” below). The Children’s Bureau notifies states of any adjustment to the matching requirements through correspondence to the state agency. (Tribes are not subject to the caseworker visit data requirements.) Note: The

Supplemental FY 2020 CARES Act funds do not require a non-federal share match (100 percent FFP rate). Any reduction in FFP applying to a state's regular allotment under the CWS program for not meeting the caseworker visit standards, per 42 USC 624(f), does not apply to the Supplemental FY 2020 CARES Act funds.

2. Level of Effort

Not Applicable

3. Earmarking

- a. No more than 10 percent of the federal share of expenditures of the state or tribe with respect to activities funded from amounts provided under Title IV-B, subpart 1 (including any Supplemental FY 2020 CARES Act funds) may be used for administrative costs (42 USC 622(b)(14) and (c) and 624(e)).
- b. A state may not use federal funds under Title IV-B, subpart 1 (including any Supplemental FY 2020 CARES Act funds) for child care, foster care maintenance or adoption assistance payments in excess of the amount of Title IV-B, subpart 1 funds it spent on these activities from such payments for FY 2005 (42 USC 624(c)). This limitation is not applicable to tribes.
- c. A 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 (42 USC 624(d)). This limitation is not applicable to tribes.

H. Period of Performance

Funds under Title IV-B, subpart 1, must be obligated by September 30 of the fiscal year following the fiscal year in which the funds were awarded (45 CFR section 1357.30(i) and Supplemental Terms and Conditions available through a link as follows: https://www.acf.hhs.gov/sites/default/files/documents/FY%2022%20ACYF.CB_.93.645.Stephania%20Tubbs%20Jones%20Child%20Welfare%20Services%20Program%20Supp%20TCs%20-%20rev%20011022.pdf). Note: Supplemental FY 2020 CARES Act funds must be obligated by September 30 of the fiscal year following the fiscal year in which the funds were awarded (September 30, 2021). These funds may also be used to restore amounts for obligations incurred to prevent, prepare for, and respond to, COVID-19 beginning January 20, 2020 and prior to the effective date of the Federal award.

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 Note: Separate SF-425 reporting is required for Supplemental FY 2020 CARES Act funding.

2. Performance Reporting

Not Applicable

3. Special Reporting

Not Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 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 Title IV-E agency and need temporary placement and care outside their homes.

II. PROGRAM PROCEDURES**Overview**

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, the US Virgin Islands, and federally recognized Indian tribes, Indian tribal organizations, and tribal consortia with approved Title IV-E plans, based on a Title 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 Foster Care program provides federal matching funds to Title IV-E agencies with approved Title IV-E plans for maintenance assistance payments to provide safe and stable out-of-home care to eligible children placed in qualifying foster care settings. The program also provides matching funds for child placement and other administrative or training costs associated with serving these children and others determined to be candidates for the Title IV-E Foster Care program or those either found to be at-risk of becoming or identified as a sex trafficking victim.

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 (Assistance Listing 93.659); Guardianship Assistance (Assistance Listing 93.090) at agency option; Kinship Navigator (Assistance Listing 93.471) at agency option; Prevention (Assistance Listing 93.472) at agency option; and John H. Chafee Foster Care Program for Successful Transition to Adulthood (Assistance Listing 93.674), as well as Child Welfare Services (Assistance Listing 93.645) and Promoting Safe and Stable Families (Assistance Listing 93.556) programs (Title IV-B of the Social Security Act, as amended) (Assistance Listing 93.556) funds available to states and those tribes qualifying for at least a minimum grant of \$10,000); and the Social Services Block Grant program (Assistance Listing 93.667) (Title XX of the Social Security Act, as amended) (states only)). The Title IV-E agency may either directly administer the Foster Care program or supervise its administration by local level agencies. When the program is administered by a state, in accordance with the approved Title 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. When 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 Preventing Sex Trafficking and Strengthening Families Act (Pub. L. No. 113-183) and the Family First Prevention Services Act (Pub. L. No. 115-123). Implementing regulations are at 45 CFR parts 1355, 1356, and 1357.

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 Title IV-E plan.

The regulations at 45 CFR Part 75 specifying uniform administrative requirements, cost principles, and audit requirements for HHS awards are applicable to the Foster Care program. However, in accordance with 45 CFR sections 75.101(e)(1)(iii) and 75.101(e)(2), except for 45 CFR section 75.202, the guidance in Subpart C of 45 CFR Part 75 does not apply.

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 at <https://www.acf.hhs.gov/cb/laws-policies>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an "N." See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	N	N	N	N	Y	Y	Y

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 Title 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 a child care 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. Title IV-E agencies may claim Title IV-E foster care maintenance payments and administrative costs consistent with 45 CFR 1356.60(c) for a child placed with a parent in a licensed residential family-based treatment facility for substance abuse for up to 12 months (42 USC 672(j) and 672(a)(2)(C)).
- 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)). 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)).
- d. Funds may be expended for short-term training of (1) relative guardians; (2) state/tribe-licensed or state/tribe-approved child welfare agencies

providing services to children receiving Title IV-E assistance; (3) child abuse and neglect court personnel; (4) agency, child or parent attorneys; (5) guardians ad litem; and (6) court appointed special advocates (42 USC 674(a)(3)(B B)).

- e. 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)).
- f. 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 costs for the administration of the Foster Care program include those associated with eligibility determination and redetermination; independent legal representation by an attorney for a title IV-E eligible child in foster care, a child who has been determined as a candidate for placement in title IV-E-Foster Care or for the parents of such a child; 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) and Child Welfare Policy Manual section 8.1B Q/A's #30-32).
- g. Funds may be expended for activities defined as sex trafficking administrative activities (see list of examples below). These activities are meant to combat sex trafficking on behalf of any child or youth in the placement, care, or supervision of the Title IV-E agency who is at-risk of becoming a sex trafficking victim or who is identified as a sex trafficking victim. Such children do not need to be Title IV-E eligible and include those who are not removed from home; those who have run away from foster care and are under age 18 or such higher age elected under Section 475(8) of the Social Security Act; and youth who are not in foster care who are receiving services under the John H. Chafee Foster Care Program for Successful Transition to Adulthood (Assistance Listing 93.674) and at the option of the agency, youth under age 26 who were or were never in foster care (42 USC 671(a)(9), USC 671(a)(34), and 671(a)(35)).

Examples of activities allowable as sex trafficking administration include:

- developing and implementing policies and procedures to identify, document in agency records, and determine appropriate services for victims of sex trafficking

- conducting sex trafficking screenings and documenting victims of sex trafficking in agency files
- determining appropriate services for individuals identified as such victims, including referrals to services
- completing reports required for law enforcement and ACF of children or youth who the agency identifies as being a sex trafficking victim
- developing and implementing protocols to locate and assess children missing from foster care, including screening the child to identify if the child is a possible sex trafficking victim

Since the Title IV-E agency is not limited to performing the activities described above on behalf of individuals meeting Title IV-E eligibility requirements, application of a Title IV-E foster care participation rate is not needed in allocating these allowable administrative costs to the Title IV-E Foster Care program (42 USC 671(a)(9) and (a)(34), as amended by Pub. L. No. 113-183, and the Child Welfare Policy Manual section 8.1 Q/A#7).

- h. To the extent that allowable activities constituting training and administrative costs are allocated to the program through application of a Title IV-E participation rate (sometimes called the eligibility, penetration, or discount rate), this rate must be calculated by dividing the number of Title IV-E foster care eligible children by the total number of children in foster care pursuant to the definition of foster care in 45 CFR section 1355.20. The numerator is comprised of the total number of children in foster care determined to meet all Title IV-E eligibility requirements. A Title IV-E agency may also include in the numerator otherwise eligible children placed with relatives pending foster family home approval or licensure (for the lesser of the average time it takes to license a foster home or 12 months) and children moving from a facility that is not licensed to one that is for up to one month pursuant to Section 472(i)(1) of the Social Security Act. The denominator comprises the total number of children who are in foster care, including those that are Title IV-E eligible and those that are not or have not yet been determined Title IV-E eligible. Any methodology for claiming administrative costs, including the calculation of the participation rate described above, must be a part of the state's approved cost allocation plan or a tribe's approved cost allocation methodology (42 USC 672(i) and 674(a)(3), 2 CFR Part 225 or 45 CFR Part 75, as applicable, in accordance with 45 CFR section 75.110, 45 CFR section 95.507(b)(4), 45 CFR section 1355.20, and Child Welfare Policy Manual section 8.1C Q/A#8).

- i. 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).
- j. Funds may be expended for costs related to design, implementation, and operation of a statewide or tribal automated child welfare information system (S/TACWIS) that received any required ACF approval by July 31, 2016, or a comprehensive child welfare information system (CCWIS), which receives any required ACF approval on or after August 1, 2016. Funds for S/TACWIS costs are available only for expenditures made prior to or during the transition period of August 1, 2016 through July 31, 2018. Funds are available for CCWIS qualifying costs for expenditures made on or after August 1, 2016. CCWIS expenditures must be separately reported from other automated systems costs and are limited to automated systems that have been classified as such by ACF and that comport with all applicable project and design requirements as well as approved funding levels. CCWIS developmental and operational costs for specific automated functions may or may not qualify for CCWIS cost allocation. This determination is based on whether the involved functionality meets applicable project and non-duplication requirements. These amounts must thus be further separately reported based on the cost allocation classification. (45 CFR sections 1355.52, 1355.53, 1355.54, 1355.56, 1355.57, 1356.60(e) and 95.611).
- k. Under Section 1130 of the Social Security Act, Title IV-E agencies may be granted authority to operate a demonstration project as set forth in ACF-approved terms and conditions. Any such terms and conditions applicable to the program identify the specific provisions of the Social Security Act that are waived, the additional activities deemed allowable, and the scope and duration (which may not exceed a maximum of five total years unless specifically approved for further continuation) of the demonstration project. All demonstration project operational activities, excluding project evaluation, must have ended no later than September 30, 2019. The demonstration project must remain cost neutral to the federal government, as provided for in a methodology contained in the approved project terms and conditions involving either a matched comparison group or a capped allocation (42 USC 1320a–9 and Section 201 of Pub. L. No. 112-34).

Allowable activities for which funds may be expended under an approved demonstration project are as follows:

- (1) Costs incurred prior to project implementation for the development of the project that are included in an approved Developmental Cost Plan (42 USC 1320a–9 and Section 201 of Pub. L. No. 112-34).

- (2) Costs incurred at any point during the project lifespan for project evaluation in accordance with an approved Project Evaluation Plan (42 USC 1320a–9 and Section 201 of Pub. L. No. 112-34).
- (3) Costs for otherwise Title IV-E allowable program activities provided as part of the operation of a demonstration project (i.e., to the extent that geographic and Title IV-E funding category components are included in the scope of the approved project) on behalf of Title IV-E eligible children to the extent that the approved cost neutrality limit or payment schedule (if applicable) is not exceeded (42 USC 1320a–9 and Section 201 of Pub. L. No. 112-34).
- (4) Costs for approved specified project intervention activities performed as part of the operation of a demonstration project on behalf of designated children and families (including those approved activities cited as otherwise Title IV-E unallowable) to the extent that the approved cost neutrality limit or payment schedule (if applicable) is not exceeded (42 USC 1320a–9 and Section 201 of Pub. L. No. 112-34).
- (5) Costs for other activities performed throughout the jurisdiction of the Title IV-E agency deemed as allowable through specifically approved Title IV-E waiver provisions (including those approved activities cited as otherwise Title IV-E unallowable) to the extent that the approved cost neutrality limit or payment schedule (if applicable) is not exceeded (42 USC 1320a–9 and Section 201 of Pub. L. No. 112-34).

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 (except for school supplies and the cost of reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement in foster care) or other expenses not outlined in 42 USC 675(4)(A).
- c. Costs of conducting investigations of allegations of sex trafficking or other forms of child abuse or neglect or for providing social services, such as counseling or treatment, to victims of sex trafficking or other children or youth (Child Welfare Policy Manual section 8.1 Q/A#7 available at

https://acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=34).

B. Allowable Costs/Cost Principles

Both states and tribes are subject to the requirements of 2 CFR Part 200, Subpart E, as implemented by HHS at 45 CFR Part 75. States also are subject to the cost allocation provisions and rules governing allowable costs of equipment of 45 CFR Part 95 (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)).

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).

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 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 twelfth 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)).

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) Voluntary Placement

- (a) *Agreement* – A voluntary placement agreement must be entered into by a parent or legal guardian of the child who is a relative specified in Section 406(a) (as in effect on July 16, 1996) and from whose home the child was removed (42 USC 672(a)(2)(A)(i); 45 CFR section 1356.22(a)). A voluntary placement agreement entered into between a youth age 18 or older and the Title IV-E agency can meet the removal criteria in Section 472(a)(2)(A)(i) of the Social Security Act. In this situation, the youth age 18 or older is able to sign the agreement as his/her own guardian (Program Instruction ACYF-CB-PI-10-11 dated July 9, 2010, section B).
- (b) *Best interests of the child determination* – 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 Title IV-E agency administering the approved Title IV-E plan or any other public agency under a valid agreement with the cognizant Title IV-E agency (42 USC 672(a)(2)).

- c. A child (except if in placement (new or an existing placement) on or after October 1, 2018, with a parent residing in a licensed residential family-based treatment facility for substance abuse) 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)).

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 of age (as the Title IV-E agency may elect) remains eligible as a child when the youth meets prescribed conditions for continued maintenance payments. For a youth age 18 or older, who is entering or re-entering foster care after attaining age 18 consistent with the criteria above, AFDC eligibility is based on the youth without regard to the parents/legal guardians or others in the assistance unit in the home from which the youth was removed as a younger child (e.g., a child-only case). A youth over age 18 must also (as elected by the Title 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) and Program Instruction ACYF-CB-PI-10-11 dated July 9, 2010, section B). For the period from December 27, 2020 through September 30, 2021 (hereinafter, COVID-19 flexibility period), the title IV-E agency may not require a youth to leave foster care solely due to age and must permit any youth who left foster care due to reaching the state/tribe’s maximum age to voluntarily re-enter foster care. There is no upper age limit on remaining in foster care or re-entering foster care during this period. The title IV-E agency, during this period, also may not determine a youth in care or one who re-enters foster care as ineligible for title IV-E foster care maintenance payments due to failure to meet the education and employment conditions. These changes are addressed in Program Instruction ACYF-CB-PI-21-04, dated March 9, 2021 and

available as follows: <https://www.acf.hhs.gov/cb/policy-guidance/pi-21-04>

Title IV-E agencies may also request ACF approval of flexibility as per the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Specifically, a request may be made to allow claiming of title IV-E reimbursement on behalf of an otherwise eligible youth up to age 19, 20 or 21 who is unable to fulfill the education or employment conditions outlined in §475(8)(B)(iv) of the Act as a direct result of the pandemic. The title IV-E agency must provide notice of the option to re-enter foster care to each youth who aged out during the COVID-19 flexibility period. (Division X, Sections 4(a), 4(b) and 4(d)(2)(D) of Pub. Law No. 116-260, 42 U.S.C. §5121 et seq. and Program Instruction ACYF-CB-PI-20-10 dated May 8, 2020).

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, Question and Answer No. 24 of the Child Welfare Policy Manual available at https://acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=8).

- d. Beginning October 1, 2018, a child placed with a parent residing in a licensed residential family-based treatment facility for substance abuse who meets all the Title IV-E foster care eligibility requirements except the AFDC eligibility requirements in sections 472(a)(1)(B) and (3) of the Social Security Act shall be eligible for Title IV-E foster care maintenance payments for a period of not more than 12 months. The recommendation for such placement must be specified in the child's case plan before the placement. The treatment facility must provide, as part of the treatment for substance abuse, parenting skills training, parent education, and individual and family counseling and these services must be provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing. Although the treatment facility must be licensed, there is no requirement that it meet the Title IV-E licensing and background check requirements for a child care institution. Eligibility is limited for a period of not more than 12 months to foster care maintenance payments which includes such things as the cost of providing food, clothing, shelter, and daily supervision. Since a licensed residential family-based treatment facility for substance abuse is not a child care institution, the Title IV-E foster care maintenance payments may not

include the costs of administration and operation of the facility. Title IV-E agencies may claim administrative costs during the 12-month period consistent with 45 CFR 1356.60(c) for the administration of the Title IV-E program, which includes such things as case management (42 USC 672(a)(2)(C) and 672(j)).

- e. 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. During the COVID-19 public health emergency period as declared by the Secretary of HHS, title IV-E agencies may request ACF approval of flexibility as per the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Specifically, a request may be made to allow claiming of title IV-E reimbursement on behalf of an otherwise eligible child who is placed in a foster family home that is provisionally or conditionally approved or licensed, if the declared major disaster precludes full completion of the licensing process. The title IV-E agency must complete as many of the requirements for licensure as practicable, considering local requirements related to physical/social distancing guidelines and shelter in place orders. The title IV-E agency must complete any remaining licensing requirements as soon as it is safe to do so in accordance with local and state health authorities. The title IV-E agency also must ensure that the foster family home is safe for children (42 U.S.C. §5121 et seq. and Program Instruction ACYF-CB-PI-20-10 dated May 8, 2020).

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 that 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)).

- f. Beginning October 1, 2019 (or the elected delayed effective date of up to two years), limitations on Title IV-E foster care maintenance payments are applicable for new placements made in a child care institution if that facility does not meet specified setting requirements. A “specified setting”, as per Section 472(k) of the Social Security Act (Act) (42 USC 672) includes only those child care institutions as follows:

- (1) A qualified residential treatment program (QRTP) as defined in Section 472(k)(4) of the Act. (42 USC 672). During the COVID-19 public health emergency period as declared by the Secretary of HHS, title IV-E agencies may request ACF approval of flexibility as per the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Specifically, if conditions related to the COVID-19 pandemic prevent a facility from completing its accreditation or reaccreditation as a QRTP, the title IV-E agency may request flexibility to allow claiming reimbursement of title IV-E expenses on behalf of an otherwise eligible child who is placed in the QRTP only during the time the requirement is unable to be met as a result of the major disaster. The facility must meet all other statutory requirements, including that the QRTP is licensed or approved (42 U.S.C. §5121 et seq. and Program Instruction ACYF-CB-PI-20-10 dated May 8, 2020).
- (2) A setting specializing in providing prenatal, post-partum, or parenting supports for youth.
- (3) In the case of a child who has attained 18 years of age, a supervised setting in which the child is living independently.
- (4) A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims, in accordance with section 471(a)(9)(C) of the Act.

A QRTP placement must also meet additional requirements to avoid Title IV-E funding limitations as follows:

- (5) An assessment to determine the appropriateness of such placement must be completed by a “qualified individual” within 30 days after the placement as per Section 475A(c)(1) of the Act. If this deadline is not met, no foster care maintenance payments may be claimed for the duration of the placement (including those for the first two weeks of care) on behalf of the child.
- (6) A court determination on the appropriateness of this placement must be made within 60 days of the start of each such placement. If this deadline is not met, foster care maintenance payments on behalf of the child may be Title IV-E claimed for only the first 60 days of the placement.
- (7) If the required assessment determines that the placement of a child in a QRTP is not appropriate, a court disapproves such a placement under Section 475A(c)(2) of the Act, or other circumstances exist where the child is transitioning from a QRTP placement to another

setting further Title IV-E foster care maintenance payments claiming is limited, as per Section 472(k)(3)(B) of the Act, to the period necessary to transition, up to 30 days after the cited action takes place.

If the placement in a child care institution does not meet the requirements for a specified setting, Title IV-E foster care maintenance payments are limited to covering a two-week period for each placement. Payments for any continuous child care institution placements with a start date prior to the effective date for Section 472(k)(2) of Act are not time limited.

Otherwise, allowable administrative costs for an eligible child placed in a child care institution may be Title IV-E claimed for the period of such placement regardless of whether the facility meets the specified setting requirements (42 USC 672(k) and 42 USC 675A(c)).

- g. Beginning October 1, 2019 (or the elected delayed effective date of up to two years for Section 472(k) of the Act), the definition of a foster family home is revised from the one in federal regulations at 45 CFR 1355.20(a) to include only the home of an individual or family that meets requirements as follows:
- (1) Is licensed or approved by the Title IV-E agency in the state in which it is situated as a foster family home.
 - (2) Is licensed or approved by a tribal authority with respect to a foster family home on or near an Indian Reservation, or a tribal authority of a tribal Title IV-E agency with respect to a foster family home in the tribal Title IV-E agency's service area
 - (3) Meets the standards established for the licensing or approval.
 - (4) Provide care for not more than six children in foster care. This limitation may be exceeded, at the option of the Title IV-E agency as requested, for any of the reasons specified at Section 472(c)(1)(B)(i-iv) of the Act.
 - (5) The individual(s) in whose care a child has been placed in foster care reside in the home with the child and the Title IV-E agency has determined such individual(s) as being:
 - (a) Licensed or approved to be a foster parent; and
 - (b) Deemed capable of adhering to the reasonable and prudent parent standard; and
 - (c) Providing 24-hour substitute care for children placed away from their parents or other caretakers.

A foster family home may not then include “group homes, agency-operated boarding homes or other facilities licensed or approved for the purpose of providing foster care...” as previously permitted in federal regulations at 45 CFR 1355.20(a) if that facility is not the home of an individual or family where the foster parent resides (42 USC 672(c)(1)).

- h. 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 had 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. 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 on October 1, 2009.

The statutory provisions apply to all prospective foster parents who are newly licensed or approved after the Title IV-E agency’s authorized date for implementation of the fingerprint-based background check provisions. Title IV-E agencies may also require that certain other adult individuals living in the home be subject to a criminal records check. The completion or lack of completion of criminal records checks for persons other than prospective foster parents does not, however, impact Title IV-E eligibility (42 USC 671(a)(20)(B); Pub. L. No. 109-248, Section 152(c)(2); 45 CFR sections 1356.30(b) and (c); and the Child Welfare Policy Manual section 8.4F Q/A#4 available at https://acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=62). During the COVID-19 public health emergency period as declared by the Secretary of HHS, title IV-E agencies may request ACF approval of flexibility as per the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Specifically, in situations where only name-based criminal record checks were completed for prospective foster parents, the title IV-E agency may request flexibility to complete the fingerprint-based checks of national crime information databases (NCID) by as soon as it can safely do so (42 U.S.C. §5121 et seq. and Dear Colleague Letter dated April 15, 2020). <https://www.acf.hhs.gov/cb/policy-guidance/guidance-regarding-fingerprint-and-caseworker-visit-requirements-during-covid-19>

- i. A Title 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 five 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)(B); Pub. L. No. 109-248, Section 152(c)(2) and (3)).

- j. 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)). Effective October 1, 2018, unless a legislative delay is approved, the safety considerations in the child-care institution licensing file must consist of proof that criminal background checks, including fingerprint-based criminal records checks of national crime information databases (as defined in section 534(f)(3)(A) of Title 28, United States Code) and child abuse and neglect registry checks for all adults working at the child-care institution were conducted. Title IV-E agencies may use alternative procedures to conduct these criminal records and child abuse registry checks. However, if the agency elects to use an alternate procedure, such procedures must still provide for conducting both checks on every adult working in the institution and the agency must describe in its approved Title IV-E Plan why alternative procedures for conducting the checks are appropriate for the agency (42 USC 671(a)(20)(D)). During the COVID-19 public health emergency period as declared by the Secretary of HHS, title IV-E agencies may request ACF approval of flexibility as per the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Specifically, in situations where only name-based criminal record checks were completed, the title IV-E agency may request flexibility to complete the fingerprint-based checks of NCID for adults working in a child care institution as soon as it can safely do so (42 U.S.C. §5121 et seq. and Dear Child Colleague Letter dated April 15, 2020).
<https://www.acf.hhs.gov/cb/policy-guidance/guidance-regarding-fingerprint-and-caseworker-visit-requirements-during-covid-19>
- k. 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 671(a)(15) to prevent the need for, or if, necessary to pursue, removal of the child from the home.
 - (b) The Title IV-E agency has made, not less often than every six months, a determination (or redetermination) as to whether the child remains at imminent risk of removal from the home (42 USC 672(i)(2)).
 - (c) Pre-placement administrative costs may be paid on behalf of a child determined to be a candidate for foster care only if all of the following requirements are met:
 - (i) A child who is a potentially Title IV-E eligible child is at imminent risk of removal from the home and the Title IV-E agency is either pursuing the removal of the child from the home or providing reasonable efforts to prevent the removal in accordance with Section 471(a)(15) of the Social Security Act (42 USC 672(i)(2)(A)).

- (ii) No earlier than the month in which the Title IV-E agency has made and documented a determination that the child is a candidate for foster care as evidenced by at least one of the following (section 8.1D, Question and Answer No. 2 of the Child Welfare Policy Manual):
 - (A) A defined case plan, which clearly indicates that absent effective preventive services, foster care is the planned arrangement for the child.
 - (B) An eligibility determination form which has been completed to establish the child's eligibility under Title IV-E. Eligibility forms used to document a child's candidacy for foster care should include evidence that the child is at serious risk of removal from home.
 - (C) Evidence of court proceedings in relation to the removal of the child from the home, in the form of a petition to the court, a court order, or a transcript of the court's proceedings. These proceedings include those where the Title IV-E agency is required to obtain a judicial determination sanctioning or approving such an attempt to prevent removal with respect to reasonable efforts or initiates efforts to obtain the judicial determinations related to the removal of a child from home.
- (iii) The Title IV-E agency determines that the planned out-of-home placement for the child will be a foster care setting (section 8.1D, Question and Answer No. 11 of the Child Welfare Policy Manual).
- (iv) In order to claim child specific candidate administrative costs, the Title IV-E agency may either (section 8.1C, Question and Answer No. 3 of the Child Welfare Policy Manual):
 - (A) individually determine those children who are Title IV-E foster care candidates and claim 100 percent of the child specific

allowable administrative costs incurred on behalf of these children, or

- (B) allocate costs to benefiting programs considering a determination both of candidacy for foster care and of potential Title IV-E eligibility; using a Title IV-E foster care participation rate is one acceptable means of allocation.

- (v) The Title IV-E agency re-determines at least every six months that the child remains at imminent risk of removal from the home. If the Title IV-E agency does not make this determination at the six-month point, it must cease claiming administrative costs on behalf of the child (42 USC 672(i)(2)(B) and section 8.1D, Question and Answer No. 5 of the Child Welfare Policy Manual).
- (vi) Candidate administration on behalf of eligible children is limited to any allowable Title IV-E administrative cost that comports with or is closely related to one of the listed activities at 45 CFR section 1356.60(c)(2). The costs of investigations, physical or mental examinations or evaluations and services related to the prevention of placement are not foster care administrative costs and are therefore not reimbursable (section 8.1B, Question and Answer No. 1 of the Child Welfare Policy Manual).

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

Not Applicable

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* – Not Applicable

- d. *CB-496, Title IV-E Programs Quarterly Financial Report (OMB No. 0970-0510)* – 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:

1. *Part 1, Expenditures, Estimates and Caseload Data*, columns (A) through (D) (sections A and E (Foster Care Program))
 2. *Part 2, Prior Quarter Expenditure Adjustments – Foster Care*, columns (A) through (E)
 3. *Part 3, Foster Care, Adoption Assistance and Guardianship Demonstration Projects*, Foster Care Post-Demonstration Costs and Funding Certainty Grant Calculations, columns (A) through (F)
2. Performance Reporting
Not Applicable
 3. Special Reporting
Not Applicable
 4. Special Reporting for Federal Funding Accountability and Transparency Act
See Part 3.L for audit guidance.

N. Special Tests and Provisions

1. Payment Rate Setting and Application

Compliance Requirements Title IV-E agencies establish payment rates for maintenance payments (e.g., payments to foster parents, child care institutions or directly to youth). Payment rates may also be established for Title IV-E administrative expenditures (e.g., payments to child placement agencies or other contractors, which may be either subrecipients or vendors) and for other services. Payment rates must provide for proper allocation of costs between foster care maintenance payments, administrative expenditures, and other services in conformance with the cost principles. The Title IV-E agency's plan approved by ACF must provide for periodic review of payment rates for foster care maintenance payments at reasonable, specific, time-limited periods established by the Title IV-E agency to ensure the rate's continuing appropriateness for the administration of the Title IV-E program (42 USC 671(a)(11); 45 CFR section 1356.21(m)(1); 45 CFR section 1356.60(a)(1) and (c)).

Audit Objectives Determine whether (1) the Title IV-E agency reviewed foster care maintenance payment rates for continued appropriateness in accordance with its established periodicity schedule; (2) the Title IV-E agency established foster care maintenance and administrative expenditure payment rates which provide only for costs which are necessary for the proper and efficient administration of the program and which are for allowable costs (i.e., reasonable, allowable, and properly allocated in compliance with the applicable cost principles and program requirements); and (3) charges to the program were based upon the established payment rates properly applied and the charges to the program were properly classified as foster care maintenance payments or administrative expenditures.

Suggested Audit Procedures

- a. Identify the Title IV-E agency's schedule for the required periodic review to determine the continued appropriateness of amounts paid as foster care maintenance payments and ascertain if the current foster care maintenance payment rates were last reviewed and adjusted in accordance with the Title IV-E agency established schedule.
 - b. Review the Title IV-E agency's policies and procedures for establishing foster care maintenance and administrative expenditure payment rates to ascertain if these policies and procedures will properly determine that the costs charged to the program based upon these payment rates will be allowable.
 - c. Test a sample of Title IV-E foster care maintenance and administrative expenditure payment rates to ascertain if the rates have been properly calculated in accordance with the Title IV-E agency's policies and procedures to ensure only allowable costs are charged to the program.
 - d. Test a sample of Title IV-E foster care rate-based maintenance payments to ascertain if they were based upon the established payment rates per the Title IV-E agency's rate schedule and that these rates were properly applied to ensure that only costs allowable as maintenance payments were charged to the program.
 - e. Test a sample of Title IV-E foster care rate based administrative expenditures to ascertain if they were based upon the established payment rates per the Title IV-E agency's rate schedule and that these rates were properly applied to ensure that only costs allowable as administrative expenditures were charged to the program.
2. Former Operation of a Foster Care Demonstration Project (Applicable Only for Title IV-E Agencies with ACF Approval to Operate a Foster Care Demonstration Project)

Compliance Requirements Those Title IV-E agencies that receive approval to operate a foster care demonstration project for a specified period of time must do so in accordance with ACF-approved terms and conditions that define the operational parameters and the waivers granted. The funding for operation of such a project is subject to a cost neutrality limit that is calculated either through an experimental design (involving experimental

group cases and either a control or matched comparison group process) or an established capped allocation table for identified populations (including agency-wide) in specific funding categories.

All Title IV-E agencies that operate a foster care demonstration project are also simultaneously continuing to operate the traditional (non-demonstration) foster care program for some portion of the agency's service population and/or funding. Operation of a foster care demonstration project, therefore, includes both the continuation of assistance payments and, where applicable, administration or training under the existing approved Title IV-E Plan and provision of project interventions or other waiver-based services for an identified population. Demonstration project operational costs, to the extent that they provide payments, administration or training that is allowable for traditional Title IV-E foster care funding, must be in compliance with all applicable Title IV-E requirements (unless waived) and are subject to separate identification as part of financial reporting. Funding is also available, subject to separate ACF approvals, for the costs of demonstration project developmental and evaluation costs.

Audit Objectives Determine for those Title IV-E agencies with an approved operational foster care demonstration project whether (1) the Title IV-E agency properly tracked and classified those costs consisting of demonstration project operational, developmental, or evaluation costs; (2) the Title IV-E agency separately identified those project operational costs that are reportable as Title IV-E allowable costs (without a waiver) from other project operational costs; (3) the Title IV-E agency properly identified the applicable project operational cost neutrality limits and cumulative project operational costs for each relevant funding category; and (4) the Title IV-E agency properly tracked and classified those costs consisting of Title IV-E foster care (non-demonstration) costs.

Suggested Audit Procedures

- a. Determine whether a Title IV-E agency is operating a foster care demonstration project and, if so, review the applicable terms and conditions as approved by ACF.
- b. Review the Title IV-E agency's cost tracking procedures for segregating costs properly classified as a component of the approved foster care demonstration project as developmental costs, evaluation costs, or operational costs.
- c. Test a sample of Title IV-E claims (current quarter and any prior quarter adjustments) reported on Form CB-496 Part 3 designated as foster care demonstration project developmental or evaluation costs to determine that the claims are properly classified and reported and that they comply with applicable approvals.
- d. Test a sample of Title IV-E claims (current quarter and any prior quarter adjustments) reported on Form CB-496 Part 3 designated as foster care demonstration project operational costs in each of the funding categories reported to determine that the claims are properly classified as project operational costs

based on (1) the funding category is within the scope of the project's operational costs, (2) the type of cost, (3) the population served, and (4) the applicable period.

- e. Test a sample of Title IV-E claims (current quarter and any prior quarter adjustments) reported on Form CB-496 Part 3 designated as foster care demonstration project operational costs in each of the funding categories reported to determine that the claims are properly reported as either "Title IV-E Operations" costs (i.e., Title IV-E allowable without the approved demonstration project) or as "Project Intervention and Other Waiver Based Expenditures" (i.e., Title IV-E allowable only with the approved demonstration project).
 - f. Review the Title IV-E agency's Form CB-496 Part 3 reported "Cumulative Cost Neutrality Limit" (for the current quarter and the next quarter estimate) in applicable funding categories to ensure that it is consistent with a calculation through the applicable period as designated in the demonstration project's approved terms and conditions or, if applicable, an ACF approved quarterly payment schedule.
 - g. Review the Title IV-E agency's Form CB-496 Part 3 reported "Currently Reported and Cumulatively Funded Operational Costs" (for the current quarter and the next quarter estimate) in applicable funding categories to ensure that it is consistent with a calculation through the applicable period based on any such claims submitted on reports for previous periods.
 - h. Test a sample of Title IV-E claims (current quarter and any prior quarter adjustments) reported on Form CB-496 Part 1 as foster care (non-demonstration) costs in each of the funding categories identified in the project's approved terms and conditions as included within project operational costs to determine that the claims are properly classified as outside of project operational costs based on (1) specific exclusions contained in the project's approved terms and conditions, (2) the type of cost, (3) the population served, and (4) the applicable period.
3. Post-Demonstration Costs (Applicable Only for Title IV-E Agencies with ACF Approval to Operate a Foster Care Demonstration Project Which Was Operational Through September 30, 2019)

Compliance Requirements Those Title IV-E agencies that were formerly approved to operate a foster care waiver demonstration project under section 1130 of the Social Security Act (Act) (42 USC 1320a-9) and operated such a project through September 30, 2019 may elect to separately report specified costs for applicable periods in FFYs 2020 and 2021 to be considered for a Funding Certainty Grant for each of these FFYs as per section 602(c)(2)(A) of Public Law (P.L.) No. 116-94 (the Family First Transition Act) (42 USC 1320a-9 (g)). If so, the former waiver demonstration project agency must separately report all title IV-E foster care quarterly expenditures and/or estimates for applicable periods in FFYs 2020 and 2021 (i.e. the two FFYs after the demonstration project operational period ended) that are classifiable as post-demonstration costs in Part 3, section E of Form CB-496 in accordance with specified reporting form instructions. A

Funding Certainty Grant is payable only if, and to the extent, that the reported total federal share post-demonstration cost claims for all applicable periods in each of the two FFYs (assessed separately for each FFY) is lower than the established Annual Funding Certainty Level for the involved Title IV-E agency.

The costs to be reported as “post demonstration costs” are for performance of activities that would have been classified as within project operations chargeable or allocable to a former title IV-E foster care demonstration project which was operational on September 30, 2019 in accordance with Section 1130 of the Act (42 USC 1320a-9) and with the approved terms and conditions for that project. All post-demonstration costs must be title IV-E allowable without consideration of any waivers that were formerly in effect as per the terms and conditions (in effect on August 30, 2019) of a demonstration project.

If post-demonstration cost reporting is elected, such costs must be fully reported in applicable funding categories for all applicable periods in FFYs 2020 and 2021. This includes current quarter claims and any prior quarter adjustment claims made within two years of the last day of the fiscal quarter in which the expenditure was made. Therefore, the last available reporting period for post-demonstration costs for the fourth quarter of FFY 2021 applicable period will be on the CB-496 report for the quarter ending June 30, 2023. Although that report will be due on July 30, 2023, a revision may be submitted as late as September 30, 2023 (two years after the end of the last quarter considered for Funding Certainty Grant purposes).

Audit Objectives Determine for those Title IV-E agencies that qualify for and elect to report post-demonstration costs whether (1)) the Title IV-E agency properly tracked and classified those costs in all applicable funding categories consisting of post-demonstration costs; (2) the Title IV-E agency did not report the same program costs as both regular program and post-demonstration costs; (3) all reported post-demonstration costs consist of Title IV-E allowable costs (without a waiver); (3) the Title IV-E agency properly reported post-demonstration costs based on the FFY of the applicable period when the expenditure was made (either FFY 2020 or FFY 2021); and (4) the Title IV-E agency properly tracked and classified those FFY 2020 and FFY 2021 Title IV-E foster care program expenditures not reportable as post-demonstration costs.

Suggested Audit Procedures

- a. Determine whether a Title IV-E agency that formerly operated a foster care demonstration project as of September 30, 2019 is, or is not, reporting title IV-E foster care claims post-demonstration cost for FFYs 2020 and 2021 applicable periods. If not, determine if this is based on its election not to seek a Funding Certainty Grant for or one or both of these FFYs. If post-demonstration cost claims are being reported, review the applicable terms and conditions of the title IV-E agency’s demonstration project that were in effect on August 30, 2019 as approved by ACF.

- b. Review the Title IV- E agency’s cost tracking procedures for identifying those funding categories and segregating costs properly classified as post-demonstration costs.
- c. Compare total quarterly Title IV-E claims (current quarter and any prior quarter adjustments for that applicable period) reported on Form CB-496 Part 3, Section E as foster care post-demonstration costs for FFY 2020 and FFY 2021 in each of the funding categories to determine whether there is any indication that a significant portion of such claims were not reported for one or more quarters. If so, identify whether underreporting has occurred and, that the title IV-E agency has controls in place to report any such omitted claims within the permitted two-year period for that quarter.
- d. Test a sample of Title IV-E claims (current quarter and any prior quarter adjustments) reported on Form CB-496 Part 3, Section E designated as foster care post-demonstration costs in each of the funding categories reported to determine that the claims are properly classified as post-demonstration costs for either FFY 2020 or FFY 2021 based on (1) the funding category is within the scope of the former project’s title IV-E allowable operational costs, (2) the type of cost, (3) the population served, and (4) the applicable period.
- e. Test a sample of Title IV-E claims for applicable periods in FFY 2020 and FFY 2021 (current quarter and any prior quarter adjustments) reported on Form CB-496 Part 1 as foster care (non-demonstration related) costs in each of the funding categories identified in the former demonstration project’s approved terms and conditions (as of August 31, 2019) as included within project operational costs to determine that the claims are properly classified as outside of the scope of post-demonstration costs based on (1) specific exclusions contained in the former project’s approved terms and conditions, (2) the type of cost, (3) the population served, and (4) the applicable period. A further assessment should be made to assure that the claim was not duplicative of an amount reported on Form CB-496 Part 3 in section E as post-demonstration costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 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**A. Overview**

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 ongoing subsidy and/or non-recurring payments to parents who adopt eligible children with special needs and enter into an adoption assistance agreement.

Funding is provided to the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. 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 Title 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 Title IV-E agency to Title 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 Title IV-E training expenditures. In addition, the program authorizes federal matching funds for Title 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 Title IV-E agency for this program also administers ACF funding provided for other Social Security Act programs (e.g., Foster Care (Assistance Listing 93.658), Guardianship Assistance (Assistance Listing 93.090) at agency option and John H. Chafee Foster Care Program for Successful Transition to Adulthood (Assistance Listing 93.674) programs (Title IV-E of the Social Security Act); Child Welfare Services (Assistance Listing 93.645) and Promoting Safe and Stable Families (Assistance Listing 93.556) programs (Title IV-B of the Social Security Act, as amended) (Assistance Listing 93.556 funds available to states and those tribes qualifying for at least a minimum grant

of \$10,000); and the Social Services Block Grant program (Assistance Listing 93.667) (Title XX of the Social Security Act, as amended) (states only). The Title 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 Title 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.

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.

An adoption assistance agreement is a written agreement between the prospective adoptive parents, the Title 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 Title 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.

B. Other

Adoption Savings

Title IV-E agencies are required to enter into an adoption assistance agreement with the prospective adoptive parents of any child who meets specified criteria by applying differing, and less restrictive, program eligibility criteria (specified in III.E.1.a.(1)(a) and (c), "Eligibility - Eligibility for Individuals," of this program supplement). This results in some number of children who, under previously applied program eligibility criteria, would not have been determined as Title IV-E eligible, but who will now be determined as Title IV-E eligible for adoption assistance. Each Title IV-E agency is required to calculate and spend an amount equal to any savings in Title IV-E agency expenditures as a result of applying the differing program eligibility criteria for a FFY for services permitted under Title IV-B or IV-E. These non-federal funds are a component of this program and are hereafter referred to as "adoption savings."

Beginning in FFY 2015, each Title IV-E agency is required to annually calculate and report on adoption savings. The calculation must be in accordance with procedures established by the Children's Bureau. The report must identify the methodology used to calculate the savings, how savings are spent, and on what services.

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 Preventing Sex Trafficking and Strengthening Families Act (Pub. L. No. 113-183) and the Family First Prevention Services Act (Pub. L. No. 115-123). Implementing regulations are published at 45 CFR parts 1355 and 1356.

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 Title IV-E Plan.

The regulations at 45 CFR part 75 specifying uniform administrative requirements, cost principles, and audit requirements for HHS awards are applicable to the Adoption Assistance program. However, in accordance with 45 CFR sections 75.101(e)(1)(iii) and 75.101(e)(2), except for 45 CFR section 75.202, the guidance in subpart C of 45 CFR part 75 does not apply.

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 at <https://www.acf.hhs.gov/cb/laws-policies>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an "N." See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment/Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement Suspension & Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	Y	N	Y	N	N	N	Y	N	N

A. Activities Allowed or Unallowed

1. *Adoption Assistance Subsidies*

Funds may be expended for adoption assistance subsidy payments made on behalf of eligible children (see III.E.1, “Eligibility – Eligibility for Individuals”), in accordance with a written and binding adoption assistance agreement. 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 (in accordance with the Title IV- E agency’s rate schedule) the child would have received in a foster family home; however, the amount of the subsidy payments may be up to 100 percent of that 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 Title 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 Title IV-E agency for adoption placements (including nonrecurring costs) are considered an administrative expenditure and are subject to the matching requirements in III.G.1.e, “Matching, Level of Effort, Earmarking – Matching” (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 (1) relative guardians; (2) state/tribe-licensed or state/tribe-approved child welfare agencies providing services to children receiving Title IV-E assistance; (3) child abuse and neglect court personnel; (4) agency, child or parent attorneys; (5) guardians ad litem; and (6) court appointed special advocates (42 USC 674(a)(3)(B)).
- 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)).

4. *Demonstration Projects*

Under Section 1130 of the Social Security Act, Title IV-E agencies may be granted authority to operate a demonstration project as set forth in ACF-approved terms and conditions. Any such terms and conditions applicable to the program identify the specific provisions of the Social Security Act that are waived, the additional activities that are deemed as allowable, and the scope and duration (which may not exceed a maximum of 5 total years unless specifically approved for further continuation) of the demonstration project. The demonstration project must remain cost neutral to the federal government, as provided for in a methodology contained in the approved project terms and conditions involving either a matched comparison group or a capped allocation. All approved demonstration projects were required to end no later than September 30, 2019 (42 USC 1320a–9 and Section 201 of Pub. L. No. 112-34).

B. Allowable Costs/Cost Principles

Both states and tribes are subject to the requirements of OMB cost principles in 2 CFR part 200, subpart E, as implemented by HHS at 45 CFR part 75. States also are subject to the cost allocation provisions and rules governing allowable costs of equipment of 45 CFR part 95 (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 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 multi-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 subsequent FYs through FY 2017, the age to apply the revised “applicable child” program rules decreases by two years. The applicable age for agreements entered into in FY 2018 through FY 2024 is dependent on the date of the agreement. For agreements entered into in FY 2018 between October 1 and December 31, 2017, children of any age may be eligible according to the revised criteria in FY 2018. However, for agreements entered into between January 1, 2018 and June 30, 2024, only those children who turn 2 or older in the FY the agreement is entered into may be eligible according to the revised criteria. As of July 1, 2024, a child of any age covered by a newly entered into agreement will meet the applicable child definition (see applicable age table below) (42 USC 673(e)(1)(B)).

Applicable Age Table – Based on Date Adoption Assistance Agreement is Entered Into

In the case of fiscal year:	The applicable age is:
2010	16
2011	14
2012	12
2013	10
2014	8
2015	6
2016	4
2017	2
2018 (through December 31, 2017)	Any age
2019 to 2023	2
2024 (through June 30, 2024)	2
2024 (July 1, 2024 or later)	Any age
2025 (or fiscal years thereafter)	Any age

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 childcare 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 Title 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 Title 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 SSI and the Title 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 Title 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 on October 1, 2009.

The statutory provisions apply to all prospective adoptive parents who are newly approved after the Title IV-E agency's authorized date for implementation of the fingerprint-based background check provisions. Title IV-E agencies may also require that certain other adult individuals living in the adoptive home be subject to a criminal records check. The completion or lack of completion of criminal records checks for persons other than prospective adoptive parents does not, however, impact Title IV-E eligibility (42 USC 671(a)(20)(B); Pub. L. No. 109-248, Section 152(c)(2); 45 CFR sections 1356.30(b) and (c); and the Child Welfare Policy Manual section 8.4F Q/A#4).

- (f) The prospective adoptive parent(s) and any other adult living in the home who has resided in the provider home in the preceding five 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)(B); 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 Title IV-E agency determines that the child has a mental or physical disability which warrants the continuation of assistance); (ii) the Title IV-E agency determines that the parent is no longer legally responsible for the support of the child; or (iii) the Title 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 of age (as the Title 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 Title 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 Title 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 may be a separate document or part of an agreement for state/tribe or federal adoption assistance payment or services (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 agreement was signed at the time of, or prior to, the final decree of adoption and claims must be filed with the Title IV-E

agency within two years of the date of the final decree of adoption (45 CFR section 1356.41(e)(2)).

- (4) The state or tribe has determined that the child is a child with special needs (45 CFR section 1356.41(d)).
 - (5) The child has been placed for adoption in accordance with applicable state or tribal laws (45 CFR section 1356.41(d)).
 - (6) The child need not meet the categorical eligibility requirements at Section 473(a)(2) (45 CFR section 1356.41(d)).
 - (7) 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

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/A#2)

8/16/02). The matching and cost sharing provisions of 45 CFR section 75.306 do not apply to this program (45 CFR sections 1355.30(i) and 1355.30(n)(1); 45 CFR section 201.5(e)). However, for program expenditures made in FY 2012 and thereafter, tribes receiving Title IV-E are permitted to use in-kind funds from any allowable third-party sources to provide up to the full required non-federal share of administrative or training costs (42 USC 679c(c)(1)(D), 45 CFR section 1356.68(c)).

- 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 at <http://www.aspe.hhs.gov/health/fmap.htm> (42 USC 674(a)(1); 45 CFR section 1356.60(a)).

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 at <http://www.gpo.gov/fdsys/pkg/FR-2011-08-01/pdf/2011-19358.pdf>. Information on specific tribal FMAP rates for many tribes applicable for each FY and a table where such rates can be calculated for unlisted tribes is posted on the Children's Bureau's website and is available at <https://www.acf.hhs.gov/cb/focus-areas/tribes>. The calculated FMAP rate for each tribe 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 (1) relative guardians; (2) state/tribe-licensed or state/tribe-approved child welfare agencies providing services to children receiving Title IV-E assistance; (3) child abuse and neglect court personnel; (4) agency, child or parent attorneys; (5) guardians ad litem; and (6) court appointed special advocates is 75 percent in FY 2013 and thereafter (42 USC 674(a)(3)(B)).
- 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 Title 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. Level of Effort

2.1 Level of Effort – *Maintenance of Effort*

A Title IV-E agency is required to spend an amount equal to any savings (hereafter referred to as “adoption 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 for any services that may be provided under Title IV-B or IV-E (42 USC 673(a)(8)) as follows:

- a. For periods prior to FFY 2015, Title IV-E agencies had the flexibility to determine the methodology for calculating adoption savings and were not required to provide a specific accounting of adoption savings funds to ACF.
- b. Effective October 1, 2014, all Title IV-E agencies must:
 - (1) Calculate the adoption savings (if any) resulting from the application of differing program eligibility rules (42 USC 673(a)(2)(A)(ii)) to all applicable children for a fiscal year, using a methodology specified by ACF or an alternate methodology proposed by the Title IV-E agency and approved by ACF (42 USC 673(a)(8)(A) as amended by Pub. L. No. 113-183 and Program Instruction ACYF-CB-PI-15-06, dated May 22, 2015).
 - (2) Report (see III.L.1.d, “Reporting – Financial Reporting,” of this program supplement) annually to ACF (i) the methodology used to make the calculation of adoption savings, without regard to whether any savings are found; (ii) the amount of any annual adoption savings; and (iii) how such adoption savings are spent, accounting for and

reporting the spending separately from any other spending reported to ACF under Title IV-B or IV-E ((42 USC 673(a)(8)(B) as amended by Pub. L. No. 113-183 and Program Instruction ACYF-CB-PI-15-09, dated December 2, 2015).

- (3) Adoption savings must be expended for services that may be provided under the Title IV-B or IV-E programs; at least 30 percent of which must be spent on post-adoption services, post-guardianship services and services to support positive permanent outcomes for children at risk of entering foster care. At least two-thirds (2/3) of the 30 percent must be spent on post-adoption and post-guardianship services ((42 USC 673(a)(8)(D)(i) as amended by Pub. L. No. 113-183).
- (4) There is no requirement that adoption savings be expended in the same FFY for which they are calculated. Title IV-E agencies must, however, use adoption savings to supplement and not supplant any federal or non-federal funds used to provide any service under Title IV-B or IV-E ((42 USC 673(a)(8)(D)(ii), as amended by Pub. L. No. 113-183). (**Note:** The auditor would be required to test compliance with the earmarking requirements of paragraph (b)(3) only during the audit period in which the Title IV-E agency reports (or expects to report) in its annual report (see paragraph (b)(2)) that the earmarking percentages have been met for one or more FFYs for which they are applicable).

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* – Not Applicable

- d. *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.

Beginning with the FFY 2015 reporting period, the Annual Adoption Savings Calculation and Accounting Report, CB-496 Part 4, must be submitted to provide information on the calculation and expenditure of adoption savings. The CB-496 Part 4 is due once a year with the CB-496 quarterly submission for the fourth quarter of the FFY. This report captures adoption savings calculations based on utilization of the Children's Bureau methodology, or an approved alternate methodology, and relevant CB-496 Part 1 reported expenditures submitted on quarterly reports for the current FFY.

A separate calculation of adoption savings is required for the current FFY (Column A) and for prior reported FFYs (Column B). The current FFY calculation considers title IV-E Adoption Assistance claims reported on Form CB-496 Part 1 quarterly submissions for the current FFY as current quarter amounts and any prior-quarter adjustment of expenditures (increasing or decreasing) identified (Part 2, Column D) as for applicable periods within the current FFY. The prior reported FFYs calculation considers any relevant reported prior-quarter adjustment of expenditures (increasing or decreasing) submitted on a Form CB-496 Part 1 report for quarterly periods within the current FFY but identified (Part 2, Column D) as applicable to periods in prior FFYs subject to adoption savings reporting.

The CB-496 Part 4 also contains a report of the expenditure of adoption savings for the current reporting FFY. The report separately identifies amounts expended during the current reporting FFY (Column A) and amounts spent in an earlier FFY subject to adoption savings reporting (Column B), but either not previously reported or adjusted from a previously reported amount.

The CB-496 Part 4 report further contains information on cumulative (beginning with FFY 2015) calculated and expended adoption savings amounts.

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

1. *Part 1, Expenditures, Estimates and Caseload Data*, columns (A) through (D) (Sections B and E (Adoption Assistance Program))

2. *Part 2, Prior Quarter Expenditure Adjustments – Adoption Assistance*, columns (A) through (E)
3. *Part 3, Foster Care, Adoption Assistance and Guardianship Assistance Demonstration Projects*, columns (A) through (F)
4. *Part 4, Annual Adoption Savings Calculation and Accounting Report*, columns (A) through (C)

2. Performance Reporting

Not Applicable

3. Special Reporting

Not Applicable

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 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. The funds transferred by the US insular areas or territories for administration under the authority of SSBG and known as the Consolidated Block Grant or CBG subscribe to the objectives and principles of SSBG.

II. PROGRAM PROCEDURES

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 and territory's population following receipt and review of the state's and territory's report on the proposed use of funds for the coming year, which serves as the state's and territory's plan. States and territories 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 and territory 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.

Under the block grant philosophy, each state and territory is responsible for designing and implementing its own SSBG program, within very broad federal guidelines. States and territories must administer their SSBG program according to their approved plan and any amendments and in conformance with their own implementing rules and policies.

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. Governing requirements pertaining to the consolidated grants to the territories, also known as the Consolidated Block Grant (CBG), may be found at Title V of the Omnibus Territories Act (Pub. L. 95-134), as amended. The implementing regulations for SSBG 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 75 (the

HHS implementation of 2 CFR Part 200) 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 to this Supplement, “Federal Programs Excluded from the A-102 Common Rule and Portions of 2 CFR Part 200,” states and territories are to use the fiscal policies that apply to their own funds in administering SSBG. Procedures must be adequate to ensure 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).

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	N	Y	N	N	Y	Y	N

A. Activities Allowed or Unallowed

1. *Activities Allowed*

- a. 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, seniors, individuals with developmental or physical disabilities, and individuals facing substance use disorders (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)).

- b. A state and territory 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)).
- c. A state and territory 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 (Assistance Listing 93.991); Block Grants for Prevention and Treatment of Substance Abuse (Assistance Listing 93.959); Maternal and Child Health Services Block Grant to the states (Assistance Listing 93.994); Low-Income Home Energy Assistance (Assistance Listing 93.568); and Community Services Block Grant (93.569) (42 USC 1397a(d); 45 CFR section 96.72).

2. *Activities Unallowed*

Funds may not be used for:

- a. 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) (Assistance Listing 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 substance use disorder 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)).
- j. The state may not use the amount transferred in from TANF (Assistance Listing 93.558) for programs, services or activities for individuals, children, or their families whose incomes exceed the 200 percent of the federal poverty guidelines. The official poverty guideline is revised annually by HHS (42 USC 604(d)(3)(A) and 9902(2)). 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/>). Additional information on this transfer in is provided in IV, "Other Information."

B. Allowable Costs/Cost Principles

The Omnibus Budget Reconciliation Act of 1981 authorized the SSBG. In 45 CFR 75.101(d)(1), this award has been exempted from most of the cost principles (Subpart E) of the Uniform Administrative Requirements. This applies to states, territories, and subrecipients.

The HHS block grant rules allow block grantees to obligate and expend SSBG funds in accordance with the laws and procedures applicable to the obligation and expenditure of their own funds at 45 CFR 96.30(a). States and territories may apply their own

accounting standards on subrecipients, apply the Uniform Administrative Requirements, or allow subrecipients to use their own policies and procedures.

H. Period of Performance

SSBG funds must be expended by the state in the fiscal year allotted or in the succeeding fiscal year (42 USC1397a(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

- a. Post-Expenditure Report (OMB #0970-0234):

<https://omb.report/omb/0970-0234>

The 42 USC 1397e requires states and territories to submit to the federal administering agency, the Office of Community Services, an annual Post Expenditure Report no later than six months following the close of the fiscal year.

Key Line Item

- (1) The number of eligible individuals who received services paid for in part or in whole with federal funds under the SSBG.
- (2) The amount of Social Services Block Grant funds spent in providing each service;
- (3) The method(s) by which each service is provided, showing separately services provided by public agencies, private agencies, or both;
- (4) The criteria applied in determining eligibility for each service such as income eligibility guidelines, sliding fee scales, the effect of public assistance benefits, and any requirements for enrollment in school or training programs; and
- (5) Each state or territory's definition of "child," "adult," and "family."
- (6) **TANF Funds** Transferred into SSBG –Amount reported on this line item should be consistent with the TANF federal financial report (ACF-196R).

3. Special Reporting

Not Applicable

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

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 and territory 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/ACF-196R, 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.

Consolidation of Grants to the Insular Islands

Insular areas, including the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands, may apply for a consolidated grant under 45 CFR Part 97. A consolidated grant award administratively combines allocations from two or more programs into one award. An insular area may apply for a consolidated grant in lieu of filing an individual application for any eligible.

The application process requires grantees to specify the amount of funds proposed for consolidation and the titles of the programs that are the sources of funds that are to be consolidated in their SSBG Intended Use Plan and Pre-Expenditure Report. Requests are reviewed by the program office and approval is recommended to the Office of Grants Management for processing.

Funds awarded under a consolidated grant must adhere to the statute and regulations of the SSBG program. Programs eligible for consolidation are specified in 45 CFR Part 97.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.671 FAMILY VIOLENCE PREVENTION AND SERVICES/DOMESTIC VIOLENCE SHELTER AND SUPPORTIVE SERVICES

I. PROGRAM OBJECTIVES

The purpose of this program is to assist states and Native American tribes (including Alaska Native Villages), tribal organizations (tribes) and territories in efforts to increase public awareness about, and primary and secondary prevention of family violence, domestic violence, and dating violence; and assist states and tribes in efforts to provide immediate shelter and supportive services for victims of family violence, domestic violence, or dating violence, and their dependents.

II. PROGRAM PROCEDURES

The Family Violence Prevention and Services Act (FVPSA) is designed to assist states in their efforts to support the establishment, maintenance, and expansion of programs and projects to: (1) prevent incidents of family violence, domestic violence, and dating violence; (2) provide immediate shelter, supportive services, and access to community-based programs for victims of family violence, domestic violence, or dating violence, and their dependents; and (3) provide specialized services for children exposed to family violence, domestic violence, or dating violence, including victims who are members of underserved populations (45 CFR 1370.10(a)).

The FVPSA states and tribal formula grant funds shall be used to identify and provide subawards to eligible entities for programs and projects within the state that are designed to prevent incidents of family violence, domestic violence, and dating violence by providing immediate shelter and supportive services; grant use may include paying for the operating and administrative expenses of the facilities for a shelter for adult and youth victims of family violence, domestic violence, or dating violence, and their dependents; and may be used to provide prevention services to prevent future incidents of family violence, domestic violence, and dating violence (42 USC 10408(a) and 42 USC 10408(b)(1)(A)).

To be eligible for funds, each state and tribe must submit an annual application. States and tribes are required to develop and submit a plan detailing the establishment, maintenance, and expansion of programs and projects to prevent incidents of family violence, domestic violence, and dating violence; to provide immediate shelter, supportive services, and access to community-based programs for victims of family, domestic, and dating violence, and their dependents; and to provide specialized services for children exposed to family, domestic, or dating violence, including victims who are members of underserved populations. This plan should look at all the needs across the state to help it distribute funding, conduct outreach, and provide training and technical assistance as appropriate with all its available resources

State Formula Grants

The state is required to distribute no less than 95 percent of the funds awarded to it from FVPSA.

Each state's grant award shall be \$600,000 with the remaining funds allotted to each state based on the ratio of the population of all states (42 USC 10405(a)(2)).

Tribal Formula Grants

Ten percent of the amount appropriated to FVPSA is allocated to tribal programs according to 42 USC 10403(a)(1) of FVPSA that is not reserved under 42 USC 10403(a)(2)(A)(i).

Source of Governing Requirements

The FVPSA program is authorized under 42 USC 10408 for states and 42 USC 10401 for tribes and implementing regulations at 45 CFR 1370.

On March 11, 2021, [the American Rescue Plan Act of 2021](#) was signed into law, which provided a total of \$152 million to State and Tribal Domestic Violence and Shelter Programs. The funds were awarded in FFY 2021 and are available until September 30, 2025.

Availability of Other Program Information

Additional information can be found in the Notice of Funding Opportunities (NOFO) and Program Information (PI) Memorandums issued by the Family Violence Prevention and Services Program Office, specifically:

- Standing Announcement for Family Violence Prevention and Services/Domestic Violence Shelter and Supportive Services/Grants to Native American Tribes (including Alaska Native Villages) and Tribal Organizations – [HHS-2021-ACF-ACYF-FVPS-1961](#)
- Standing Announcement for Family Violence Prevention and Services/Domestic Violence Shelter and Supportive Services/Grants to States – [HHS-2021-ACF-FVPS-1962](#)
- Program Instruction: 2021 American Rescue Plan – Supplemental COVID-19 Funds ([ACF-PI-FVPSA-21-01, issued May 20, 2021](#))
- Program Instruction: 2021 American Rescue Plan – Supplemental COVID-19 Testing, Vaccine Access, Mobile Health Units Access Funds ([ACF-PI-FVPSA-21-03, issued October 25, 2021](#))
- Program Instruction: 2021 American Rescue Plan – Supplemental COVID 19 Funds - Rape Crisis Centers and Sexual Assault Programs ([ACF-PI-FVPSA-21-4, issued October 29, 2021](#))
- Program Instruction: 2021 American Rescue Plan – Supplemental COVID 19 Funds – Culturally Specific; Sexual Assault; Domestic Violence; Community-Based ([ACF-PI-FVPSA-21-05, issued October 29, 2021](#))

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment/Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement Suspension & Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	Y	N	Y	N	N	N	N	Y	N

A. Activities Allowed or Unallowed

1. *Activities Allowed*

- a. State and tribal funds may be used for the following activities – but not limited to these activities:
 - (1) Provision of immediate shelter and related supportive services to adult and youth victims of family violence, domestic violence, or dating violence, and their dependents, on a regular basis, including paying for the operating and administrative expenses of the facilities for such shelter ([42 USC 10408\(b\)\(1\)\(A\)](#));
 - (2) Assistance in developing safety plans and supporting efforts of victims of family violence, domestic violence, or dating violence to make decisions related to their ongoing safety and well-being ([42 USC 10408\(b\)\(1\)\(B\)](#));

- (3) Provision of individual and group counseling, peer support groups, and referral to community-based services to assist family violence, domestic violence, and dating violence victims, and their dependents, in recovering from the effects of the violence (42 USC 10408(b)(1)(C));
- (4) Provision of services, training, technical assistance, and outreach to increase awareness of family violence, domestic violence, and dating violence, and increase accessibility to services (42 USC 10408(b)(1)(D));
- (5) Provision of culturally and linguistically appropriate services (42 USC 10408(b)(1)(E));
- (6) Provision of services for children exposed to family violence, domestic violence, or dating violence, including age-appropriate counseling, supportive services, and services for the non-abusing parent that support that parent's role as a caregiver, which may, as appropriate, include services that work with the non-abusing parent and child together (42 USC 10408(b)(1)(F));
- (7) Provision of advocacy, case management services, and information and referral services concerning issues related to family, domestic, or dating violence intervention and prevention, including the following: (1) assistance in accessing related federal and state financial assistance programs; (2) provision of legal advocacy to assist victims and their dependents; (3) provision of medical advocacy, including referrals for appropriate health care (including mental health, alcohol, and drug abuse treatment), but not to include reimbursement for any health care services; (4) assistance locating and securing safe and affordable permanent housing and homelessness prevention services; (5) provision of transportation, child care, respite care, job training and employment services, financial literacy services and education, financial planning, and related economic empowerment services; and (6) provision of parenting and other educational services for victims and their dependents (42 USC 10408(b)(1)(G)); and
- (8) Provision of prevention services, including outreach to underserved populations (42 USC 10408(b)(1)(H)); Additional detail or "bullets."

As detailed in ACF-PI-FVPSA-21-01, 2021 American Rescue Plan Act Supplement grant funds may be used to:

- (1) **Prevent:** Activities that assist domestic violence survivors by providing supportive services, shelter options, and supplies, which will reduce the exposure and risk of COVID-19.

- (2) **Prepare:** Activities that include assessing needs of survivors during the COVID-19 public health emergency. Activities that provide training, information, and assistance necessary to ensure the continuity of domestic violence services. Assessing the capacity of local domestic violence programs and tribes' emergency operation plans and plans to address the needs of survivors and reduce the exposure and risk of COVID-19. Please note that the provision of remote services continues to be an allowable activity.
- (3) **Respond:** Activities and technical assistance for ensuring the continuity of domestic violence services during the COVID-19 public health crisis which includes responding to issues including adapting to fluctuating needs and circumstances. Please note that the provision of remote services continues to be an allowable activity.

As detailed in ACF-PI-FVPSA-21-4, 2021 American Rescue Plan Act Rape Crisis Centers and Sexual Assault Program Supplemental COVID-19 Funds may be used to:

- (1) **Transition to Virtual Services:** Funding may be used to develop, implement, and assess innovative virtual services that increase access to rape crisis and sexual assault services for survivors in the service area, as well as for underserved communities; and can be adapted and scaled across the state, territory, tribe or local community. All costs associated with designing, implementing, and assessing ways to optimize the use of virtual services for survivors of sexual assault that have been impacted by the COVID-19 public health emergency.
- (2) **Data Security:** Costs associated with protecting the confidentiality, integrity, and availability of survivor services information, including safeguarding data from accidental and intentional disclosure. Funds may be used to support the safety of survivor data, including servers, firewall protection software, and training for personnel and survivors on topics such as proper use of devices and service portals, security of passwords, and available data safety features.
- (3) **Prevent:** Activities that assist sexual assault survivors by providing virtual services, supportive services, temporary housing assistance, mobile advocacy services, and supplies that will ensure survivors of sexual assault receive the care, support and services they need while reducing the exposure to and risk of contracting the COVID-19 virus.

- (4) **Prepare:** Activities and technical assistance that include assessing needs of sexual assault survivors during the COVID-19 public health emergency. Activities that provide training, information, and assistance necessary to ensure the continuity of rape crisis centers and sexual assault services.
- (5) **Respond:** Activities and technical assistance for ensuring the continuity of sexual assault programs and rape crisis center services, culturally specific programs, and tribal programs during the COVID-19 public health emergency, which includes responding to issues such as adapting to fluctuating needs and changing circumstances.
- (6) **Workforce Expansion, Capacity Building and Supports:** Utilized for workforce-related expansions and supports, or to reimburse sub-recipients or contractors.

As detailed in ACF-PI-FVPSA-21-03, 2021 American Rescue Plan Act Supplemental COVID-19 Testing, Vaccine Access, Mobile Health Units Access Funds may be used for:

- (1) **COVID-19 Testing:** Can be used for COVID-19 testing and mitigation-related expenses or to reimburse subrecipients for such expenses. Assist states, territories and tribes with expanding testing and mitigation-related activities to the best address the needs of the local communities in the service area(s).
- (2) **COVID-19 Vaccine Access:** Provide resources for states, territories and tribes to provide access to COVID-19 vaccines for domestic violence survivors and their dependents including individuals from vulnerable and medically underserved communities. Funds may be used to address any barriers to vaccines that may be experienced by domestic violence survivors and their dependents.
- (3) **Mobile Health Units:** Funding to assist states, territories, tribes, domestic violence shelters, domestic violence programs, culturally specific programs, and rural communities with establishing partnerships with health departments, hospitals, and Indian Health Services facilities to access mobile health units to mitigate the spread of COVID-19. The funding can be used to establish and maintain contracts with mobile health units for regularly scheduled visits or on-call visits to domestic violence program, culturally specific organizations, tribes, or rural communities to mitigate the spread of COVID-19.
- (4) **Workforce Expansion, Capacity Building, and Supports:** Funds can be used for COVID-19 workforce related expansion

and supports, or to reimburse subrecipients for such costs.

Expenses to secure and maintain adequate personnel to carry out COVID-19 testing, COVID-19 mitigation activities, or mobile health unit coordination activities.

- b. Funds may be used for administrative costs, subject to the limitation in G.3.a, “Matching, Level of Effort, Earmarking – Earmarking.”

2. *Activities Unallowed*

Funds may not be used for the purchase or construct facilities.

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

Eligible entities for state subawards under 42 USC section 10408(c): To be eligible to receive a subaward from a state, an entity shall be—

- (1) a local public agency, or a nonprofit private organization (including faith-based and charitable organizations, community-based organizations, tribal organizations, and voluntary associations) that assists victims of family violence, domestic violence, or dating violence, and their dependents, and has a documented history of effective work concerning family violence, domestic violence, or dating violence; or
- (2) a partnership of two or more agencies or organizations that includes (i) an agency or organization described in paragraph (1), and (ii) an agency or organization that has a demonstrated history of serving populations in their communities, including providing culturally appropriate services.

G. Matching, Level of Effort, Earmarking

1. Matching

Grants funded by the states will meet the matching requirements in 42 USC section 10406(c)(4). No grant shall be made to any entity other than a state or tribe unless the entity agrees that, with respect to the cost to be incurred by the entity in carrying out the program or project for which the grant is awarded, the entity will make available (directly or through donations from public or private entities) nonfederal contributions in an amount that is not less than \$1 for every \$5 of federal funds provided under the grant. The nonfederal contributions

required may be in cash or in kind.

Tribal Grantees Only: A tribe, as defined as defined in 42 USC section 10402(5), is exempt from the match requirement under the FVPSA. Tribes are not required to provide match (see 42 USC 10406(c)(4)).

The determination of whether the match is exempt or required for a tribal consortium depends on the entities that comprise or make up the consortium. Tribal consortium is “a partnership between one or more tribes (including qualifying Alaska Native villages and entities) that authorizes a single tribal organization or nonprofit organization to submit an application and administer the FVPSA grant funds on their behalf. A tribal consortium may also consist of a group of tribal organizations or nonprofit organizations.” A tribal consortium comprised of a group of tribes is exempt from providing a match, and a tribal consortium comprised of a group of tribal organizations or nonprofit organizations is required to provide a match.

2021 American Rescue Plan Act Supplemental Funds (1) Rape Crisis Centers and Sexual Assault Program Supplemental COVID-19; (2) COVID-19 Testing, Vaccine Access, Mobile Health Units Access Funds; (3) Culturally Specific Special Issue Resource Centers: There is no matching requirement for state or tribal grantees for the ARP supplemental grant funds.

2. Level of Effort

Not Applicable

3. Earmarking

- a. States may use no more than 5 percent for costs related to administration, monitoring, or oversight, including the cost to attend required FVPSA grantee meetings.

2021 American Rescue Plan Act Supplemental COVID-19 Funds: Not more than five (5) percent of the FVPSA grant funds may be used for state administrative costs.

2021 American Rescue Plan Act Rape Crisis Centers and Sexual Assault Program Supplemental COVID-19 Funds: Each state, territory, or tribe may not use more than five (5) percent of grant funds for administrative costs.

2021 American Rescue Plan Act Supplemental COVID-19 Testing, Vaccine Access, Mobile Health Units Access Funds: Each state, territory, or tribe may not use more than five (5) percent of grant funds for administrative costs.

2021 American Rescue Plan Act Culturally Specific Special Issue Resource Centers Supplemental COVID 19 Funds: Each Culturally Specific Special Issue Resource Center, National Indian Resource Center, and Alaskan Native Tribal Resource Center on Domestic

Violence are allowed to use five (5) percent of grant funds for administrative and evaluation costs to administer, monitor, evaluate, and report on subrecipient' implementation.

M. Subrecipient Monitoring

1. The Office of Management and Budget Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR Part 75) require pass-through entities to evaluate each subrecipient's risk for noncompliance in order to determine the appropriate monitoring level, monitor the activities of the subrecipient organizations to ensure that the subaward is in compliance with applicable federal statutes and regulations and terms of the subaward, and verify that subrecipients are audited as required by Subpart F of the Uniform Guidance. (See 45 CFR 75.352 (a) through (h)).
 - a. Recipients must ensure that all requirements imposed by the federal government are flowed down to subrecipients so that the federal award is used in accordance with federal statutes, regulations, and the terms and conditions of the federal award.
 - b. Recipients are also responsible for monitoring any additional requirements that its subrecipient must meet for the state to meet its own responsibility to HHS, including identification of any required financial and performance reports.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.676 UNACCOMPANIED ALIEN CHILDREN PROGRAM

I. PROGRAM OBJECTIVES

The objective of the Unaccompanied Alien Children Program is to provide for the care and placement of unaccompanied alien children who are apprehended by the US Department of Homeland Security, Immigration, and Customs Enforcement agents, Border Patrol agents, or other federal law enforcement agencies and transferred into the custody of the Office of Refugee Resettlement pending resolution of their claims for relief under US immigration law case or release to parent, adult family members or another responsible adult sponsor.

II. PROGRAM PROCEDURES

The Office of Refugee Resettlement (ORR), Administration for Children and Families (ACF), a component of the Department of Health and Human Services (HHS), administers this program. ORR enters into cooperative agreements with nonfederal entities to provide temporary shelter and other child welfare-related services to unaccompanied alien children in ORR custody. Residential care services begin once an unaccompanied alien child (UAC) arrives at an ORR facility and ends when the UAC is released from ORR custody to a sponsor, turns 18 years of age, or the UAC's immigration case results in a final disposition of removal from the United States. Residential care and other child welfare-related services are provided by state-licensed residential care programs in the least restrictive setting appropriate for the UAC's age and needs.

Source of Governing Requirements

This program is authorized under the Homeland Security Act of 2002 (Pub. L. No. 107-296) (6 USC 279).

Availability of Other Program Information

An ORR policy guide is on the ORR website (<https://www.acf.hhs.gov/orr>) at <https://www.acf.hhs.gov/orr/resource/children-entering-the-united-states-unaccompanied>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, "Matrix of Compliance Requirements"), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a "Y" in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as "N," it has been identified as not

being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	N	Y	Y	N	Y	Y	N

A. Activities Allowed or Unallowed

Funds may only be used for activities and categories listed in the approved budget to provide temporary shelter and other child welfare-related services for the care of an UAC placed with the nonfederal entity by ORR.

B. Allowable Costs/Cost Principles

1. Less-than-arm’s-length leasing arrangements exceeding allowable costs. Grantees may lease facilities from parties with which they have a less-than-arm’s-length relationship but are limited in what amount they may charge based on 45 CFR 75.465(b) and (c). Under these limitations, only costs of ownership such as depreciation, maintenance costs, taxes, and insurance are allowable. Common arrangements that fall within these restrictions are leases with parent or affiliated organizations, leases with partially or wholly-owned subsidiaries, and leases where the lessor is an entity that is partially or wholly-owned by individuals who are executives, board members, or employees of the grantee organization.
2. Excessive charges for facility expenditures related to leasing agreements. Grantees that lease facilities under an arm’s length arrangement are unable to incur and charge ownership type costs to the grant. This includes normal costs of ownership such as depreciation, maintenance costs, taxes, and insurance.

The portion of arm’s length leases, in which the grantee is required to pay any combination of property taxes, property insurance, and maintenance/repair costs (also referred to as single, double, or triple net leases) separate from the base rental amount, are unallowable for the purposes of reimbursement eligibility under the federal award.

Costs associated with leasing arm’s length facilities are limited to fair market rental fees as explained in 45 CFR 75.465(a).

3. Improper direct charging of costs related to the acquisition, construction, or major capital improvements of real property. Funding under this program cannot be directly used for any of these purposes. Expenses such as direct charges of acquisition costs, mortgage principal and interest payments, and direct charges for alterations to real property which are considered major capital improvements* and required to be capitalized and depreciated under GAAP, are unallowable as direct charges to UAC awards (except based on explicit written prior approval from the grants official at the awarding agency). Only depreciation properly calculated (see 45 CFR 75.436), recorded, and supported by the grantee organization in accordance with GAAP may be charged to UAC awards.

*Major capital improvements are those alterations and renovations (A&R) which exceed \$150,000. The UAC grants may pay for up to an aggregate of \$150,000 in “minor” alterations and renovations (those that are not major), per parcel, per project period. Further information is available at the ACF Property Guidance site: <https://www.acf.hhs.gov/grants/real-property-and-tangible-personal-property>.

4. Related party transactions improperly categorized by the grantee. Procurements that are issued to parent/subsidiary/affiliated organizations where the relationship falls within the definition of less-than-arm’s-length when there is a real or apparent conflict of interest cannot be considered competitively awarded as defined by 45 CFR 75.327(c). Consequently, it is improper to categorize these transaction types under the contract budget line item and include additional revenue in excess of actual expenditures incurred (i.e., profit). These transactions should be treated under the original nature of the work performed (i.e., salaries, supplies) and charged based on the actual expenditures incurred and evidenced by the grantee.
5. Budgeted costs are being utilized as the basis for estimated drawdown of funds and completing required reporting to ACF. Amounts approved under budget line items in grant awards are not automatically approved for drawdown. Drawdowns and the related reporting of expenditures to ACF via the Standard Form (SF)-425, “Federal Financial Report,” must be based on actual expenditures incurred. Additionally, SF-425 reporting must be based on the entity’s basis for accounting (e.g., cash or accrual).
6. Cost categories which are not always clearly direct or indirect by nature (administrative staff, depreciation) and therefore could easily be charged as either under this program are in some instances being charged as both. Costs may be charged as either direct or indirect, but not both, in accordance with 45 CFR 75.412.
7. Record retention non-compliance regarding facility files/depreciation schedules. An organization’s records pertinent to a federal award must be retained for a period of three years from the date of submission of the final expenditure report in accordance with 45 CFR 75.361. Therefore, records related to depreciation

expense (purchase settlements, appraisals, construction invoices, useful life determinations) charged to a federal award for such events as the acquisition (through any method, including donation) and major A&R of real property must be maintained for the life of the period that depreciation is being expensed.

8. Prior written approval is required for the expenditures outlined in 45 CFR 75.407. The grantee must request prior approval in writing to ACF before obligating or incurring the costs. Requests for prior approval must be explicit enough so that ACF can identify the purpose and cost of the expenditure. Approval of budgets that include general budgetary descriptions and budget line-item totals are insufficient. Additionally, grantees must receive written approval from an authorized member of ACF. A lack of response is not, in itself, approval.

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
- d. *SF-428 Tangible Personal Property Report* – Submission within 90 days of project period end (close-out of the award) including all applicable attachments

2. Performance Reporting

- a. *SF-PPR ACF, Performance Progress Report* - Applicable

3. Special Reporting

Not Applicable

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.686 ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA****I. PROGRAM OBJECTIVES**

The objective of this program is to reduce new Human Immunodeficiency Virus (HIV) infections in the United States to fewer than 3,000 per year by 2030. To achieve this objective, the program provides financial and technical resources to the 39 Ryan White HIV/AIDS Program (RWHAP) Part A funded Eligible Metropolitan Areas (EMAs) or Transitional Grant Areas (TGAs) whose service area includes one or more of the identified 48 HIV high burden counties and the EMAs of Washington, DC, and San Juan, PR; the RWHAP Part B funded states identified as having a rural HIV burden (Alabama, Arkansas, Kentucky, Mississippi, Missouri, Oklahoma, and South Carolina); and the RWHAP Part B Program of the state of Ohio on behalf of Hamilton County. These resources are awarded to the indicated RWHAP Part As and Bs to implement strategies, interventions, approaches, and core medical and support services to reduce new HIV infections in the United States.

II. PROGRAM PROCEDURES

The Department of Health and Human Services (HHS) leads the planning efforts for the Ending the HIV Epidemic in the U.S. (EHE), which is implemented through the Health Resources and Services Administration (HRSA) and other HHS Agencies. While the EHE initiative is a multi-agency effort, the program procedures outlined in this Compliance Supplement are only applicable to assistance awards issued and managed by HRSA's HIV/AIDS Bureau.

Under this program, cooperative agreements are awarded annually to 39 RWHAP Part A funded Eligible Metropolitan Areas (EMAs) or Transitional Grant Areas (TGAs) whose service area includes one or more of the identified 48 HIV high burden counties and the EMAs of Washington, DC, and San Juan, PR; seven RWHAP Part B funded states identified as having a rural HIV burden (Alabama, Arkansas, Kentucky, Mississippi, Missouri, Oklahoma, and South Carolina); and the RWHAP Part B Program of the state of Ohio on behalf of Hamilton County. (For a complete list of EHE initiative eligible jurisdictions visit:

<https://www.hrsa.gov/grants/find-funding/hrsa-20-078> and download Notice of Funding Opportunity-HRSA 20-078.)

HRSA assesses the technical merit of each funding application through an objective review process. Application instructions and critical indicators for review criteria are provided to inform applicants and reviewers of proposal expectations and standards for evaluation. Competing applications are reviewed by nonfederal reviewers for technical merit recommendations. Applications are reviewed and evaluated against the following criteria: (1) Need; (2) Response; (3) Evaluative Measures; (4) Impact; (5) Resources and Capabilities; and (6) Support Requested. The highest ranked applications receive consideration for award within available funding ranges.

Applicants must describe how proposed activities will expand access to HIV care and treatment in the targeted jurisdictions to treat people with HIV rapidly and to effectively reach sustained

viral suppression. Additionally, applicants must demonstrate how their proposed strategy will respond quickly to HIV cluster detection efforts for those people with HIV needing care and treatment.

Jurisdictions funded under the EHE initiative use assistance resources in conjunction with the RWHAP parts A and B systems of HIV care and treatment to develop, implement, and/or enhance innovative approaches to engage people with HIV who are newly diagnosed, not in care, and/or not virally suppressed, as well as to provide rapid access to a comprehensive continuum of high-quality HIV care and treatment services. This program is designed to provide additional funding to EHE initiative jurisdictions to deliver HIV care and treatment services and systems enhancements to meet the goals of the initiative. Technical assistance and systems coordination services are also provided to jurisdictions to assist the recipients on (1) implementing work plan activities, innovative approaches, and interventions, (2) coordinating and integrating their initiative plans, funding sources, and programs with the existing HIV care delivery systems, and (3) identifying existing and new stakeholders to build capacity and advance progress in achieving the goals of the initiative.

Funded jurisdictions may use a variety of service delivery mechanisms. Jurisdictions may provide some or all services directly or through subaward agreements with other service providers/subrecipients.

Source of Governing Requirements

The EHE initiative is authorized under Section 311(c) (42 USC 243(c)) and title XXVI (42 USC 300ff-11 et seq.) of the Public Health Service Act.

The EHE initiative has no specific program regulations.

Availability of Other Program Information

Further information about the EHE initiative is available at <https://ryanwhite.hrsa.gov/>.

Information on allowable uses of funds under the RWHAP is contained in policy notices and standards found at <https://ryanwhite.hrsa.gov/grants/policy-notice>. However, due to the unique nature of this funding, EHE initiative recipients have the opportunity to implement a broader approach to addressing HIV in their communities than what exists in services authorized by the RWHAP legislation. Notice of Funding Opportunity HRSA-20-078 (https://grants.hrsa.gov/2010/Web2External/Interface/Common/EHBDisplayAttachment.aspx?dm_rtc=16&dm_attid=81272b5b-dc96-4828-97db-67a83536da45) provides additional information regarding the use of these funds, including which of the RWHAP statutory requirements are applicable to this funding.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then

determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

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Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	N	N	Y	Y	Y	Y	N

A. Activities Allowed or Unallowed

1. *Activities Allowed*

- a. Funds may be used to support EHE initiative services and infrastructure associated with a broader approach to addressing HIV in the community than exists in services authorized by the RWHAP legislation. For example, the only requirement for determining eligibility is that the individual has an HIV diagnosis. There is no requirement that individuals served are low-income or that initial eligibility is documented prior to services being provided. Initiative services (e.g., linkage to care) are services and activities that do not fit neatly within the RWHAP service categories. These services may be innovative and creative with a focus on ending the HIV epidemic. HRSA prior approval is required for use of funds outside of existing allowable RWHAP costs and service categories. Infrastructure activities are associated with the development and expansion of data systems. This may include technical assistance on the type, design, and building of new data systems, bridging existing systems to achieve data integration, improving data entry to decrease burden and increase accuracy, training of staff and providers on collecting and using data, and employing experts to provide accurate and in-depth data analysis.
- b. Funds may be used to support core medical services for eligible clients. Core medical services encompass the following services: (1) outpatient and ambulatory health services; (2) AIDS Drug Assistance Program

treatments defined under 42 USC 300ff-26; (3) AIDS pharmaceutical assistance; (4) oral healthcare; (5) early intervention services described in 42 USC 300ff-51(e); (6) health insurance premium and cost sharing assistance for low-income individuals in accordance with 42 USC 300ff-15; (7) home healthcare; (8) medical nutrition therapy; (9) hospice services; (10) home and community-based health services as defined under 42 USC 300ff-14(c); (11) mental health services; (12) substance abuse outpatient care; and (13) medical case management, including treatment adherence services. Core medical and support services are important to assist in the diagnosis of HIV infection, linkage to care for people with HIV, retention in care, and the provision of HIV treatment. Services must relate to HIV diagnosis, care, and support, and must adhere to established clinical practice standards consistent with [HHS HIV clinical treatment guidelines](#). However, to increase innovation and to ensure access to the hardest-to-reach populations, there is no requirement to expend 75 percent of the award on core medical services (PCN 16-02, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf>)

- c. Funds may be used to pay the costs of providing support services that are needed for people with HIV to achieve their medical outcomes. These services include, but are not limited to, outreach services, nonmedical case management, medical transportation, translation, and referrals for healthcare and support services. Support services are subject to approval of the secretary of HHS or designee (PCN 16-02, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf>).

- d. Funds may be used for administrative expenses. However, no more than 10 percent of the award can be used for administrative expenses. Administrative expenses at the recipient level are activities related to: routine grant administration and monitoring activities, including the receipt and disbursement of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, compliance with grant conditions and audit requirements; and all activities associated with the recipient's contract award procedures; the development of requests for proposals, contract proposal review activities, negotiation and awarding of contracts, monitoring of contracts through telephone consultation, written documentation or onsite visits, reporting on contracts, and funding reallocation activities.

Administrative expenses at the subrecipient level include: (1) usual and recognized overhead activities, including established indirect rates for agencies; (2) management oversight of specific programs funded under the EHE initiative; and (3) other types of program support such as quality assurance, quality control, and related activities (exclusive of clinical

quality management (PCN 15-01, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-01.pdf>).

- e. Funds may be used for the establishment of a clinical quality management (CQM) program to assess the extent to which medical services that are provided to patients are consistent with the most recent HHS HIV clinical treatment guidelines and related opportunistic infections, and, as applicable, 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. However, no more than 5 percent of the award can be used for clinical quality management expenses. For further guidance on CQM programs, refer to PCN 15-02, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-02-cqm.pdf>.
- f. Funds may be used for planning and evaluation activities. Planning and evaluation cost are associated with stakeholder engagement and process and outcome evaluation activities. Planning and evaluation costs may not exceed 10 percent of the grant award. Collectively, recipient administration and planning and evaluation cost may not exceed 15 percent of the grant award (42 USC 300ff-28(b)(4)).

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-15(a)(6) and 300ff-27(b)(7)(f)).
- b. Funds may not be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug (Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113), Division H, Title V, Section 520, and subsequent appropriations, as applicable. Other elements of syringe services programs may be allowable if in compliance with applicable HHS and HRSA-specific guidance. For further guidance on use of HRSA funds on syringe services programs, see <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>.
- c. Funds may not be used to purchase or improve land or to purchase, construct or make permanent improvement to any building (42 USC 300ff-14(i) and 300ff-22(f)). (Minor alterations and renovations to an

existing facility to make it more suitable for the purposes of the award program are allowable with prior HRSA approval.)

- d. Funds may not be used to contract with or grant financial assistance to any providers of care that do not have a participation agreement under the state plan approved under title XIX of the Social Security Act, or, if not qualified to receive payments under such state plan (42 USC 300ff-14(g)).
- e. Funds may not be used to support clinical research.
- f. Funds may not be used to purchase Pre-Exposure Prophylaxis (PrEP) medications and related medical services or Post-Exposure Prophylaxis (PEP), as the person using PrEP or PEP does not have HIV and therefore not eligible for EHE initiative-funded or RWHAP-funded medication. For further guidance, see the HAB Program Letter on PrEP at <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/prep-letter-06-22-2016.pdf>.
- g. Funds may not be used to support international travel.
- h. Funds may not be used to make cash payments to intended recipients of services (42 USC 300ff-14(i) and 300ff-22(f)).

B. Allowable Costs/Cost Principles

Costs charged to federal funds under this program must comply with the cost principles at 45 CFR Part 75, Subpart E, and any other requirements or restrictions on the use of federal funding.

J. Program Income

The Notice of Award provides guidance on the use of program income. The addition method is used for EHE initiative award recipients. Program income must be used for activities described in III.A.1, “Activities Allowed.”

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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 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. CHIP is a joint federal and state program that provides health coverage to uninsured children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage. States may also choose to provide CHIP coverage, such as prenatal, delivery and postpartum care to targeted low-income uninsured individuals. See [Children's Health Insurance Program \(CHIP\) | Medicaid](#) for published guidance and information. 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.

II. PROGRAM PROCEDURES**A. Overview**

The following paragraphs are intended to provide a high-level, overall description of how CHIP generally operates. It is not practical to provide a complete description of program procedures because CHIP 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

Title XXI authorizes grants to states that initiate and expand health insurance programs for uninsured, low-income children. CHIP is administered by the states but is jointly funded by the federal government and 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. States can design their CHIP program in one of three ways:

1. **Separate CHIP:** a program under which a state receives federal funding to provide child health assistance to uninsured, low-income children that meets the requirements of section 2103 of the Act.
2. **Medicaid expansion CHIP:** a program under which a state receives federal funding to expand Medicaid eligibility to optional targeted low-income children that meets the requirements of section 2103 of the Act.

3. Combination CHIP: a program under which a state receives federal funding to implement both a Medicaid expansion and a separate CHIP.

Each state is provided an annual CHIP allotment. States must provide matching funds to get their federal funding allotment. 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. CHIP expenditures are matched by the federal government according to the states Enhanced Federal Medical Assistance Percentage (E-FMAP) and subject to their annual allotment.

To be eligible for funds under this program, states must submit a state child health plan (CHIP state plan). CHIP state plans and amendments to those plans are approved by CMS on behalf of the Secretary of the Department of Health and Human Services. The amendments are reviewed by an intra-departmental team, which must decide whether to approve or disapprove the amendment within a 90-day period. This “90-day clock” can be stopped by CMS sending the state a formal written request for additional information from the state and can be restarted at the same point when a response is formally received from the state. Copies of CHIP state plans are available on Medicaid.gov at <https://www.medicaid.gov/chip/state-program-information/index.html>.

Pursuant to section 2107(e)(1)(B) of the Act, cross referencing Title XIX requirements at 1902(a)(25) of the Act, states must take reasonable measures to determine the legal liability of third parties to pay for services furnished under the CHIP state plan. Such reasonable measures could include:

- Collect health insurance information during the initial eligibility application process and the redetermination process.
- Conduct diagnosis and trauma code edits to identify specific codes which could denote trauma related injury.
- Conduct data exchanges with:
 - state wage information collection agencies,
 - SSA wage and earnings files,
 - state title IV-A agencies,
 - state motor vehicle accident report files, and
 - state workers' compensation or Industrial Accident Commission files.

Waivers

The state may apply for a waiver of CHIP federal requirements under section 1115 of the Act. Waivers are intended to provide the flexibility needed to enable states to try

experimental, pilot, or demonstration projects that, in the judgment of the Secretary, are likely to assist in promoting the objectives of the CHIP program. Where approved by the Secretary, and subject to specific safeguards for the protection of beneficiaries and the program, waivers allow exceptions to CHIP state plan requirements and permit the state to implement innovative programs or activities on a time-limited basis, permit states to try new or different approaches to the efficient and cost-effective delivery of health care services to children or adapt their programs to the special needs of particular areas or groups of beneficiaries. The Secretary will approve only demonstration projects that are consistent with key principles of the CHIP statute. States' waiver authority is found at section 2107(e)(2)(A) of the Act (42 USC 1397gg(e)(2)(A)), which extends to CHIP the Medicaid waiver authority at section 1115 of the Act (42 USC 1315).

Medicaid and the CHIP play critical roles in helping states and territories respond to public health emergencies (PHEs) and disasters, including the outbreak of the Novel Coronavirus Disease 2019 (COVID-19). Over the course of the COVID-19 PHE, state Medicaid and CHIP agencies adopted many flexibilities offered by the CMS to respond effectively to local outbreaks, including changes to modify eligibility requirements and benefit packages. In addition, states made program changes to comply with the requirements of the Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127), as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No. 116-136). Section 6008 of the FFCRA provides states with a temporary 6.2 percentage increase to the Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Act for certain Medicaid expenditures if states meet certain conditions, including a continuous enrollment condition for most Medicaid beneficiaries who were enrolled in the program as of March 18, 2020 through the end of the month in which the COVID-19 PHE ends.

CMS provided program flexibilities and federal matching funds for certain services that should be considered when planning single audits, as described below. In some instances, certain audit steps may not be relevant during this review period in light of the flexibilities offered to states. The flexibilities are unique to individual states and follow the typical documentation process, including CMS approval of state plans and waivers, in accordance with regulations and guidance. Note that CMS guidance on COVID-related flexibilities is updated regularly, and auditors should reference the latest CMS guidance available on Medicaid.gov at Tools and Checklists for States.

On March 3, 2022, CMS issued [State Health Official letter #22-001](#), which expands on earlier guidance designed to ensure that when the PHE ends and states resume routine operations, renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage. It is important for auditors to be aware of the requirements and flexibilities implemented by the state Medicaid or CHIP agency in response to the COVID-19 PHE so that a state is not determined to be out of compliance with requirements that would have been in place absent the PHE.

Background

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

On December 22, 2020, CMS issued State Health Official (SHO) letter #20-004, entitled Planning for the Resumption of Normal State Medicaid, CHIP, and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>). This SHO letter provided guidance on returning to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent where legally permissible and otherwise appropriate, ending the expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE. As the PHE has been extended, the December 2020 guidance was updated through SHO letter #21-002 (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>) and SHO letter #22-001 (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>). States should have documentation available to describe the temporary changes made to their programs in response to the PHE as well as their plans for returning to normal operations following the PHE.

Some of the major areas to note include the following:

a. Telehealth

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

encounters during the COVID-19 PHE, many states have significantly accelerated adoption of telehealth, including through telephonic modalities, across a wide variety of disciplines.

b. Beneficiary Eligibility and Enrollment

States are facing a number of challenges due to the ongoing COVID-19 PHE that will leave many states with large volumes of pending eligibility and enrollment actions when the PHE ends. Different states have utilized different eligibility and enrollment flexibilities available during the PHE. As each state determines which flexibilities to maintain and which flexibilities to end, states are expected to develop an operational plan that documents and tracks compliance, including the timelines for making changes to application and renewal processing and verifications. Additional information is provided in SHO letter #21-002 and SHO letter #22-001 on planning for the resumption of normal operations at the conclusion of the PHE, which is available on Medicaid.gov at [SHO# 21-002: Updated Guidance Related to Planning for the Resumption of Normal CHIP and BHP Operations Upon Conclusion of the COVID-19 PHE \(medicaid.gov\) and sho22001.pdf \(medicaid.gov\)](#)

All states will need to develop a comprehensive “unwinding operational plan” to restore routine operations in Medicaid when the PHE eventually ends. States are permitted to use a phased approach to complete processing of any pending applications and resume timely and accurate determinations of eligibility on all new applications within four months after the eventual end of the PHE. To account for the time needed to complete renewals, CMS will consider states to be in compliance with the 12-month unwinding period announced in the August 2021 SHO provided that the state has initiated all renewals and other outstanding eligibility actions by the last month of the 12-month period. States will have two additional months (14 months total) to complete all pending actions initiated during the 12-month unwinding period.

The flexibilities afforded to states as they respond to the PHE related to beneficiary eligibility and enrollment could lead to unintended vulnerabilities and risks. CMS reiterates the importance of states considering the appropriate program integrity activities related to beneficiary eligibility and enrollment.

c. Managed Care

As previously described in CMS guidance (<https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>), if a benefit or other identified flexibility is covered under a state plan, waiver, or demonstration, CMS encourages states to amend their managed care plan contracts, if not already included, to extend the same flexibilities to the managed care plans during the COVID-19 PHE. States may also amend their managed care contracts and assess if changes are needed to capitation rates to account for the COVID-19 PHE.

d. Other Benefits and Changes

In response to the COVID-19 PHE, many states have implemented emergency measures to ensure that Medicaid and CHIP beneficiaries continue to have access to essential health services. Specific to CHIP, states have submitted disaster relief state plan amendments (SPAs) to suspend, add, and revise policies that could prevent enrollees from accessing needed care during the PHE.

Payment Error Rate Measurement (PERM) Program

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

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 and made 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.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. No. 111-3) reauthorized CHIP through fiscal year (FY) 2013. The Patient Protection and Affordable Care Act (ACA) (Pub. L. No. 111-148) reauthorized CHIP through 2019 and extended CHIP funding through FY 2015. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. No. 114-10) extended CHIP funding through FY2017. Most recently, Congress extended federal funding for the CHIP through September 30, 2027, through the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (referred to as the HEALTHY KIDS Act and included in Pub. L. No. 115-120) and the Advancing Chronic Care, Extenders, and Social Services Act (referred to as the ACCESS Act and included in Pub. L. No. 115-123).

The Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) established a new requirement to extend full Medicaid eligibility to citizens of the Freely Associated States who are living in the United States under the Compacts of Free Association (COFA).

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

Availability of Other Program Information

States and other interested parties can access information on the department’s policies on this and other issues at <http://www.medicaid.gov/>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	Y	Y	N	N	Y	N	Y

A. Activities Allowed or Unallowed

1. *Activities Allowed*

States have general flexibility in allocating their individual allotments toward activities needed to operate the CHIP (section 2105 of the Act (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; expenditures for translation or interpretation services in connection with the enrollment of, retention of, and use of services under Title XXI by individuals for whom English is not their primary language

(as found necessary by the Secretary for the proper and efficient administration of the state plan); and other reasonable costs incurred by the state to administer the plan (42 USC 1397ee).

Managed Care

A state may use managed care for the delivery of some or all its CHIP benefits and services for either all or a subset of the CHIP populations served under the CHIP state plan. Under managed care, the delivery of benefits and services are through contracted arrangements between state CHIP agencies and managed care plans that accept a set per member per month (capitation) payment for the services.

States must comply with the managed care regulations at 42 CFR Part 457, Subpart L, for utilization of a managed care delivery system. These regulations align CHIP rules with those of other health insurance coverage programs, such as Medicaid and the Marketplace, to reflect how states purchase managed care for beneficiaries and to strengthen the consumer experience and key consumer protections.

CHIP managed care guidance can be found at <https://www.medicaid.gov/chip/managed-care/index.html>.

Health Services Initiatives (HSI)

Under section 2105(a)(1)(D)(ii) of the Act (42 USC 1397ee(a)(1)(D)(ii)), states have the option to develop state-designed HSIs that improve the health of low - income and targeted low-income children. Under implementing regulations at 42 CFR § 457.10, HSIs are activities that protect the public health, protect the health of individuals, improve or promote a state's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals related to improving the health of children. HSIs may also be directed at low-income pregnant women or parents; however, HSIs may only provide services for adults if the project directly improves the health of children.

Federal funding for HSIs is expended from a state's available CHIP allotment for a fiscal year. Under section 2105(c)(2)(A) of the Act (42 USC 1397ee(c)(2)(A)), claims for HSIs and certain other expenditures such as administrative expenses cannot exceed 10 percent of the total amount of title XXI funds expended for a fiscal year, calculated as described at 42 CFR 457.618(c). . States must fund all CHIP state plan benefits before using allotment for HSIs.

HSIs are implemented through an amendment to the CHIP state plan. States' approved HSI programs are described in section 2.2 of the CHIP state plan template. HSI budget information is provided at section 9.10 of the CHIP state plan.

CHIP HSI guidance can be found at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib090420.pdf>.

Premium Assistance

A state may pay premiums for employer sponsored insurance on behalf of a CHIP beneficiary if it is cost effective to do so. When providing premium assistance, states must ensure that children have access to all mandatory benefits provided under the CHIP state plan, and that they are not required to incur greater out-of-pocket costs for premiums, deductibles, co-payments, or similar cost sharing charges than under the CHIP state plan. Individual state premium assistance programs are described in the CHIP state plan.

2. *Activities Unallowed*

Federal funds may not be expended under the CHIP state plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit 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 (Section 2105(e) of the Act (42 USC 1397ee(c)(7))).

B. Allowable Costs/Cost Principles

1. CHIP regulations under 42 CFR 457.628(a) make the Medicaid requirements at 42 CFR 433.50 through 433.74 regarding sources of nonfederal share and Health Care-Related Taxes and Provider Related Donations applicable to CHIP in the same manner as they apply to state Medicaid programs. Before calculating the amount of FFP, certain revenues received by a state will be deducted from the state's medical assistance expenditures. The revenues to be deducted are (1) donations made by health care providers or related entities (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of out-stationed eligibility workers); and (2) impermissible health care-related taxes that exceed a specified limit (Section 1903(w) of the Act (42 USC 1396b(w)); 42 CFR 433.57).

- (a) "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 CHIP 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) the donating provider, (2) providers furnishing the same class of items and services as the donating provider, or (3) any related entity (42 CFR 433.58(d) and 433.66(b)).
- (b) Permissible health care-related taxes are those taxes that are broad-based; uniformly applied to a class of health care items, services, or providers;

and do not hold a taxpayer harmless for the costs of the tax. A tax program for which CMS has granted a waiver may also be considered permissible health care-related taxes. Health care-related taxes that do not meet these requirements are impermissible health care-related taxes (42 CFR 433.68(b)).

These provisions apply to the 50 states and the District of Columbia, except those states whose entire Medicaid program is operated under a waiver granted under Section 1115 of the Act (42 CFR 433.50(c)).

2. The 42 CFR 457.628(b) makes 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (except as specifically excepted) applicable to the CHIP program.
3. The 42 CFR 457.1203 requires each CHIP managed care plan to calculate and report a medical loss ratio (MLR) for rating periods in CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018. Under 42 CFR 457.1203(f), if a state elects to mandate a minimum MLR for a CHIP managed care program, that minimum MLR must be at least 85 percent.

With regard to capitation rate setting for CHIP managed care plans, under 42 CFR 457.1203(a), states must use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at Section 457.10. In addition, for Medicaid and CHIP managed care plans, the rates must be developed so that the managed care plan is projected to meet an 85 percent MLR (42 CFR 457.1203(c)(1)).

E. Eligibility

Auditors may 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, eligible individuals and presumptively eligible individuals may be combined with III.A, “Activities Allowed or Unallowed” and III.B, “Allowable Costs/Cost Principles” such as, was the service incurred during the period the individual was eligible to receive benefits and was the provider paid the correct amount for the service billed.

The state verifies the financial and nonfinancial factors of eligibility, with two exceptions described below, by checking electronic data sources in accordance with federal requirements at 42 CFR 457.380 and state requirements (as documented in the CHIP state plan, verification plan, and eligibility manual). The state is required (as described at 42 CFR 457.965) to maintain facts in the case file to support the eligibility determination. When data sources used by the state are not available to the auditor, or information is not required to be available for the period under audit, auditors would not be expected to test verification other than the requirement to maintain information in the case file. For states that accept applicant self-attestation for household size or income, and do not require

further verification or documentation, the auditors are not expected to test beyond the requirements of the state.

The exceptions to the verification process described above are eligibility determinations made by an Exchange, either the Federally-facilitated Exchange (FFE) or a State-based Exchange (SBE), elements of a determination made by an express lane agency, and presumptive eligibility determinations made by qualified entities. In states that have an agreement with the FFE or SBE, through which the Exchange determines CHIP eligibility, the state relies on the verifications conducted by the Exchange and auditors are not expected to test verification. When express lane eligibility is used, the CHIP agency relies upon elements of a determination made by an express lane agency. For presumptive eligibility determinations, the qualified entity accepts attestation of all needed information and states may not require verification or documentation of any eligibility criteria. When testing a presumptive eligibility determination, auditors are not expected to test verification.

1. Eligibility for Individuals

a. Eligibility Determination

- (1) Eligibility for CHIP is based on the application of modified adjusted gross income and household definition, in addition to other permissible eligibility standards, for example standards relating to geographic area, age (up to, but not including age 19), and insurance status. In addition to meeting these standards, in order to be eligible for CHIP, a child must be uninsured (determined ineligible for Medicaid and not covered through a group health plan or creditable health insurance, a citizen or meet immigration requirements, a resident of the state, and eligible within the state's CHIP income range, based on family income, and any other specified rules in the CHIP state plan) see <https://www.medicaid.gov/chip/eligibility/index.html>. 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 a higher household income without covering children with a lower household income, nor deny eligibility based on a child having a preexisting medical condition. States are required to include in their CHIP state plans a description of the standards used to determine the eligibility of targeted low-income children. CHIP state plans should be consulted for specific information concerning individual eligibility requirements (42 CFR 457.315 and 457.320, 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 its CHIP state plan (Section 2112(b) of the Act).

- (2) CHIP beneficiaries must either be US citizens or qualified noncitizens (aliens). 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, or unless the state has adopted the option to provide coverage to these lawfully residing children, as authorized under Section 214 of CHIPRA (42 USC 1396b(v)(4)(ii)). 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 457.320(b)(6)).

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, including lawfully residing COFA migrants, 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 (codified at section 2107(e)(1)(N) of the Act, cross referencing section 1903(v)(4) of the Act (42 USC 1396b(v)(4)).

The Extending Government Funding and Delivering Emergency Assistance Act (Pub. L. No. 117-43) provided that Afghan evacuees who enter the United States as parolees or with a Special Immigrant Visa are eligible for CHIP to the same extent as refugees, for a limited time period, provided that they meet all other eligibility requirements. Additional information is provided in the November 1, 2021 fact sheet on Health Coverage Options for Afghan Evacuees at <https://www.medicaid.gov/medicaid/eligibility/downloads/hlth-cov-option-afghan-evac-fact-sheet.pdf>.

- (3) States must accept applications submitted online, by telephone, via mail, or in person. This includes electronic, telephonically recorded, and handwritten signatures. The CHIP agency must have facts in the case record to support the agency's eligibility determination, including a record of verification of income and citizenship or satisfactory immigration status for each individual.

The state must provide notice of its decision concerning eligibility and provide timely and adequate notice of the basis for discontinuing assistance (42 CFR sections 457.330, 457.340).

- (4) States are directed, at 42 CFR 457.340(d), to determine eligibility promptly and without undue delay. The determination of eligibility may not exceed 45 days (42 CFR 435.912).
- (5) Regulations 42 CFR 457.348 and 457.350 require coordination between the CHIP agency and other insurance affordability programs, including an Exchange. Typically, electronic accounts must be transferred from the CHIP agency to the Exchange and vice versa. States utilizing the FFE must enter into an agreement in which the FFE makes either a determination or an assessment of CHIP eligibility and sends the individual's electronic account to the agency for enrollment (FFE determination) or a final determination and enrollment (FFE assessment). Additional information may be found in the July 25, 2016 CMCS Informational Bulletin on Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace") (<https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib072516.pdf>).
- (6) When determining eligibility for a child, the CHIP agency may rely on elements of a determination made by an express lane agency (as defined in Section 4 of the CHIP state plan template) as to whether a child satisfies one or more requirements of CHIP eligibility. The CHIP agency may use an income determination from an express lane agency without regard to differences in budget unit, income disregards, deeming, or other differences in methodology between the express lane agency and CHIP. Auditors are not expected to test verification of express lane determinations relied upon by the CHIP Agency. This policy is set out at sections 2107(e)(1)(H) and 1902(e)(13) of the Act (42 USC 1397gg(e)(1)(H) and 1396a(e)(13) respectively); more information is available in state Health Official Letter #10-003, issued on February 4, 2010 (<https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10003.pdf>).

b. Eligibility Verification

- (1) States must request information from reliable electronic data sources, including other agencies in the state and other state and federal programs to the extent that such information is determined useful in verifying the financial eligibility of an individual. As described in the state's verification plan and in state policies and

procedures, this may include information from agencies such as the state Wage Information Collection Agency, the Social Security Administration, and the Internal Revenue Service. States may also use information related to eligibility or enrollment from other state programs such as the Supplemental Nutrition Assistance Program. If information provided by or on behalf of an individual is reasonably compatible with information obtained from the electronic data sources, as described in the state's verification plan, then the agency must determine or renew eligibility based on such information and may not require the individual to provide any further documentation. If the information is not reasonably compatible, then the agency must provide the individual with a reasonable period of time to explain the discrepancy or furnish additional information (42 CFR 457.380; 42 CFR 435.952).

- (2) States may choose to accept self-attestation of information needed to determine or renew eligibility except with respect to income and citizenship or immigration status. When self-attestation is accepted, further information, including documentation, cannot be required from the individual. In such cases, the auditor would not be expected to test documentation other than required by the state. States must follow the requirements described at 42 CFR 457.380 for verification and documentation of income and citizenship and immigration status.

c. Periodic Renewal

As required at 42 CFR 435.916 and 42 CFR 457.343, states must renew enrollees' CHIP eligibility once every 12 months and no more frequently than once every 12 months. When renewing eligibility, states must first attempt to renew based on reliable information available to the agency without requiring information from the individual. If sufficient information is not available to complete a renewal, or if the state has information that suggests that the beneficiary is ineligible, the state must provide the beneficiary with a prepopulated renewal form and inform the individual of any additional information or documentation needed to determine eligibility. Additional information may be found in the CMCS Informational Bulletin on Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements issued on December 4, 2020 ([Medicaid and Children's Health Insurance Program Renewal Requirements](#)).

d. Continuous Eligibility During Pregnancy & Postpartum Coverage

Pregnant adolescents eligible as "targeted low-income children" in CHIP can receive prenatal and postpartum care along with other child health assistance, and states may extend CHIP eligibility to "targeted low-income

pregnant individuals” too, through the end of the 60-day postpartum period. Section 9812 of the American Rescue Plan Act (Pub. L. 117-2) gave states a new state plan option, beginning April 1, 2022, to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid and CHIP. If a state elects the option in Medicaid, pregnant “targeted low-income children,” and individuals eligible as “targeted low-income pregnant individuals” who are enrolled in a separate CHIP must also receive the extended postpartum coverage. The 12-month postpartum period begins on the last day of a beneficiary’s pregnancy and extends through the end of the month in which the 12-month period ends. Individuals eligible for extended postpartum coverage are also entitled to continuous eligibility, so they remain eligible during pregnancy and the postpartum period regardless of any changes in circumstances including income. States have the option to extend child health assistance to “unborn children” who meet other applicable eligibility criteria for coverage under the CHIP state plan, thereby providing prenatal coverage to pregnant individuals who themselves are not eligible for CHIP. However, postpartum coverage for pregnant individuals who received services during pregnancy on behalf of their unborn child is limited and these individuals are not eligible for extended postpartum coverage. Additional information may be found in SHO# 21-007 (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf>).

e. Presumptive Eligibility

Presumptive eligibility (PE) is a state option to facilitate enrollment and immediate access to services for children who are likely eligible for CHIP without having to wait for a full application to be processed. CHIP regulations at 42 CFR 457.355 outline the requirements for establishing a program of presumptive eligibility for children. The options elected by each state are described in the CHIP state plan.

When electing the PE option, states designate qualified entities, such as health care providers, community-based organizations, and schools to make PE determinations. These qualified entities are trained on the state’s PE screening process and state-specific requirements for PE. In many states, qualified entities also help individuals to complete the full application process. A qualified entity is responsible for collecting and recording all information necessary to make a PE determination.

To be determined presumptively eligible, an individual must meet the basic requirements of eligibility as a targeted low-income child, including household income at or below the standard established by the state. In addition to the basic requirements of the eligibility group, states may, but are not required to, consider state residency and US citizenship or eligible

immigration status when making a PE determination. Other information that would be collected on a full application, cannot be required for a PE determination. In addition, individuals attest to all information needed for a PE determination. States may not require verification or documentation of any eligibility criteria as a condition of presumptive eligibility.

The PE period begins the day on which the qualified entity makes the PE determination. The end date varies depending on whether or not the individual submits a CHIP application. If the individual submits a CHIP application by the last day of the month following the month in which PE was determined, the PE period will continue until full CHIP eligibility is either approved or denied. If the individual does **not** submit a CHIP application, the PE period ends on the last day of the month following the month in which PE was determined. States must adopt reasonable standards regarding the number of PE periods that will be authorized for an individual.

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

- a. 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 1905(b) of the Act Medicaid FMAP rate from 100, taking 30 percent of the difference, and then adding it to the 1905(b) Medicaid FMAP rate. The Enhanced FMAP for CHIP is generally about 15 percentage points higher than the Medicaid rate. For example, if a state has a 50% match rate for Medicaid, they may have a 65% match rate for CHIP. The Enhanced FMAP is calculated in accordance with section 2105(b) of the Act, 42 USC 1397ee(b), which provides that the Enhanced FMAP for a state shall not exceed 85 percent except during the periods of October 1, 2015 through September 30, 2019, where the enhanced FMAP was increased by 23 percentage points (not to exceed 100 percent) and October 1, 2019 through September 30, 2020, where the enhanced FMAP is reduced to an increase of 11.5 percentage points (not to exceed 100 percent). The increase to the enhanced FMAP does not apply to certain categories of expenditures as described in the last sentence of 42 USC 1397ee(b).

Calculated FMAPs and enhanced FMAPs may be found at [Federal Register: Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2021 Through September 30, 2022](#) (42 USC 1397ee(a) and (b)). Because the EFMAP under section 2105(b) of the Act is calculated using the 1905(b) FMAP as a “base,” in general, any fluctuations to the 1905(b) FMAP amount for a period will affect the EFMAP determination under 2105(b) of the Act for such period unless otherwise precluded in statute.

- b. A qualifying state as described under section 2105(g) of the Act, 42 USC 1397ee(g) may elect to be paid from the state’s allotment for any of FYs 2009 through 2027, 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 (section 2105(g)(4) of the Act (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. Level of Effort

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. The maintenance of effort (MOE) provisions at section 2105(d)(3) and sections 1902(a)(74) and 1902(gg)(2) of the Act (42 USC 1397ee(d)(3) and 1396a(a)(74) and (gg)(2)) specify that as a condition of receiving federal funding for CHIP or Medicaid (with certain exceptions), states must maintain Medicaid and CHIP “eligibility standards, methodologies, and procedures” for children that are no more restrictive than those in effect on March 23, 2010. The MOE requirement was first implemented under the American Recovery and Reinvestment Act (ARRA) and extended by the Patient Protection and Affordable Care Act (ACA). Section 3002 of the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (referred to as the HEALTHY KIDS Act and included in Pub. L. No. 115-120) extends the MOE requirements for children in CHIP and Medicaid through FY 2023, and Section 50101 of the Advancing

Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in Pub. L. No. 115-123), extends the MOE requirements for children in CHIP and Medicaid through FY 2027. Section 3002 of the HEALTHY KIDS Act amends the MOE provisions such that starting in FY 2020 and through FY 2027, the MOE provision is applicable to children in families with incomes that do not exceed 300 percent of the FPL. States with eligibility levels above 300 percent of the Federal Poverty Level (FPL) will have the option of maintaining or reducing existing coverage levels to 300 percent FPL at that time.

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; (d) expenditures for translation and interpretation services in connection with the enrollment, retention, and use of services under Title XXI by individuals for whom English is not their primary language (as found necessary by the Secretary for the proper and efficient administration of the CHIP state plan); and (e) 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 CHIP 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 Performance

The availability of allotment amounts determined under section 2104(m) of the Act for FY 2009 and each fiscal year thereafter, shall remain available for expenditure by the state through the end of the succeeding fiscal year as provided under section 2104(e) of the Act. (i.e., the year of award and one subsequent fiscal year) (42 USC 1397dd(e)).

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-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:

- 1. *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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

N. Special Tests and Provisions

1. Provider Eligibility (Screening and Enrollment)

Compliance Requirements In order to receive CHIP payments, CHIP providers must: (1) be licensed in accordance with federal, state, and local laws and regulations to participate in the CHIP program (42 CFR 457.900); (2) screened and enrolled in accordance with 42 CFR Part 455, Subpart E (sections 455.400 through 455.470); and make certain disclosures to the state (42 CFR 457.990(a), cross referencing 455.107). CHIP managed care network providers are subject to the same disclosure, screening, enrollment, and termination requirements that apply to Medicaid fee-for-service providers in accordance with 42 CFR Part 438, Subpart H. Guidance was provided to states in the Medicaid Provider Enrollment Compendium (MPEC) at <https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf> to enroll CHIP providers into their Medicaid programs to ensure that they meet federal requirements. Providers who have been barred from participation by the OIG exclusion list are not eligible to be enrolled in the CHIP program (42 CFR 457.990, 42 CFR 455 Subpart E). Lists may be found at https://oig.hhs.gov/exclusions/?utm_source=oigNewsletter&utm_medium=oig-nl-nav&utm_campaign=leie-nl.

Audit Objectives Determine whether CHIP providers of medical services have the required medical licenses and are eligible to participate in CHIP in accordance with federal, state, and local laws and regulations.

Suggested Audit Procedures

- a. Obtain an understanding of the CHIP state plan's provisions required licensure and entering into agreements with providers.
- b. Select samples from both CHIP fee-for-service providers and managed care network providers to ascertain if the:
 - (1) The provider is screened, licensed, and enrolled in accordance with the CHIP state plan and the requirement of 42 CFR 455 Subpart E.
 - (2) The provider complied with the requirements of the CHIP state plan.
 - (3) The provider was not on the OIG's exclusion list at the time the services were provided.

2. Refunding of Federal Share of CHIP Overpayments to Providers

Compliance Requirements Federal regulations at 42 CFR 457.628 make the regulations at CFR 433.312 through 433.322 regarding overpayments applicable to CHIP. CMS rules at 42 CFR 433 Subpart F describe the requirements State Medicaid Agencies (SMAs) are to follow related to refunding the federal share of Medicaid overpayments made to providers. Pursuant to 1903(d)(2)(C) of the Act (42 USC 1396b), states have up to one (1) year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS via Form CMS-64 Summary, Line 9C1- Fraud, Waste & Abuse Amounts, regardless of whether recovery is made from the provider, for which the federal share must be refunded to CMS via Form CMS-21 Summary, Line 4 - Adjustments Decreasing Claims - Collections. The state must credit the federal share to CMS as outlined under 42 CFR 433.320(a)(2) either in the quarter in which the recovery is made or in the quarter in which the one-year period following discovery ends, whichever is earlier, with limited exceptions. Under 42 CFR 433.316(d), for overpayments resulting from fraud, if not collected within one year of discovery, the SMA has until 30 days after the final judgment of a judicial or administrative appeals process to return the federal share.

Additionally, in accordance with 42 CFR 433.320(a)(4), the state will be charged interest for any non-recovered, non-refunded overpayment amounts. Any appeal rights extended to a provider does not extend the date of discovery (42 CFR 433.316(h)).

The repayment of the federal share is not required in cases where the state is unable to obtain recovery because the provider has filed for bankruptcy or the provider is otherwise out of business as outlined in 42 CFR 433.318.

The 42 CFR 433.320(c)(1) allows for downward adjustment previously credited to CMS if it is properly based on the approved CHIP state plan, federal law and regulations governing Medicaid, and the appeals resolution process specified in state administrative policies and procedures. States are not able to enter into settlement agreements with providers that reduces the federal share of the overpayment in order to avoid the expense of litigation. The Departmental Appeals Board (DAB) decision No. 1391 from February 19, 1993 (<https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1993/dab1391.html>), addressed overpayment settlements between the states and providers. This decision affirmed that states may not reduce the federal share by settling overpayment receivables for less than the actual amount of the overpayment based on anticipated success in litigation or made simply to avoid administrative costs or litigation expenses.

For managed care, SMAs are required per 42 CFR 438.608(d)(1) to specify in each managed care contract how recoveries of provider overpayments must be treated. The refunding of the federal share of any overpayment recovered by an MCP is dependent on the retention policy outlined in the contract between the state and the MCP as required under 42 CFR 438.608(d)(1). If the state requires the MCP to refund overpayments to the state, the state must refund the federal share of that overpayment to CMS in accordance with the regulations at 42 CFR 433.312. The state must apply the FMAP rate in effect at the time the overpayment was made to determine the amount to be refunded to CMS.

Audit Objectives Determine whether the SMA reported and returned CHIP provider overpayments in accordance with federal requirements.

Suggested Audit Procedures

- a. Review applicable federal laws and regulations, including 1903(d)(2)(C) of the Act (42 USC 1396b), 42 CFR 433 Subpart F, and the Departmental Appeals Board Decision No. 1391.
- b. Obtain an understanding of the process to identify overpayments.
- c. Obtain managed care contract(s) to determine how recoveries made by managed care plans to providers are treated.
- d. Perform tests to ascertain if the federal share has been returned accurately in accordance with federal laws and regulations, including ensuring the full amount was refunded and any downward adjustment was made.

3. Medical Loss Ratio (MLR)

Compliance Requirements For all contracts, the state must ensure that each managed care organization (MCO), prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) submits a report described in 42 CFR 457.1203(e), which cross-references the data elements for Medicaid managed care plans in 42 CFR 438.8(k) and 438.8. The report should contain the required 13 data elements in the regulation, reflect the correct reporting years, and contain an attestation of accuracy regarding the

calculation of the MLR. The state should have a method to indicate when the report(s) are due from plans and should not accept multiple submissions from plans unless the capitation rates are revised retroactively.

Audit Objectives Determine whether the state's oversight of the content and submission of MLR reports meets the federal requirements.

Suggested Audit Procedures

- a. Perform procedures to ascertain if the state obtained the required MLR reports;
- b. Verify the 13 required elements are included;
- c. Verify the reporting period covered is 12 months;
- d. Verify the report contains an attestation statement to address accuracy;
- e. Ascertain if the state did not permit plans to submit multiple MLR reports for a specific reporting year except when a state had retroactive changes to capitation payments.

4. Managed Care Financial Audit

Compliance Requirements Two types of audits are required for managed care:

1. Audited Financial Reports – The contract with each MCO, PIHP, and PAHP must require them to submit to the state audited financial reports specific to the Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards (42 CFR 438.3(m)).
2. Periodic Audits – Effective no later than for rating periods for contracts starting on or after July 1, 2017, the state must periodically, but no less frequently than once every three years, conduct, or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of each MCO, PIHP, and PAHP and post the results of these audits on its website (42 CFR Part 438, Subpart H (as adopted in CHIP at 42 CFR 457.1285); May 6, 2016, *Federal Register* (81 FR 27497); OMB No. 0938-0920)).

Audit Objectives Determine whether the required audits were conducted and the audit reports for the Periodic Audits were posted on the state's website.

Suggested Audit Procedures

- a. Review the state's policies and operating procedures for obtaining audited financial reports, conducting these required audits, and for posting the Periodic Audits on the state's website.

- b. Perform tests to ascertain if: (1) the state obtained annually the required Audited Financial Reports from each MCO, PIHP, and PAHP; and (2) the independent auditor's reports on the financial report stated the audit was conducted in accordance with generally accepted auditing standards.
- c. Perform tests to ascertain if: (1) the state conducted or contracted for the required Periodic Audits for each MCO, PIHP, and PAHP at least once in the most recent three-year period; and (2) the audits were posted on the state's website.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.775 STATE MEDICAID FRAUD CONTROL UNITS****ASSISTANCE LISTING 93.777 STATE SURVEY AND CERTIFICATION OF HEALTH CARE PROVIDERS AND SUPPLIERS (Title XVIII) MEDICARE****ASSISTANCE LISTING 93.778 MEDICAL ASSISTANCE PROGRAM (Medicaid; Title XIX)**

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

I. PROGRAM OBJECTIVES

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

Medical Assistance Program

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

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

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

documentation should support the consideration. In addition, even though the state Medicaid Fraud Control Units (MFCUs) and State Survey and Certification of Health Care Providers and Suppliers have substantially fewer federal expenditures than Medicaid, they are clustered with Medicaid because these programs provide significant controls over the expenditures of Medicaid funds. It is unlikely that the expenditures for these two programs would be material to the Medicaid cluster; however, noncompliance with the requirements to administer these controls may be material.

Medicaid Fraud Control Units (MFCUs)

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

State Survey and Certification of Health Care Providers and Suppliers

The objective of the State Survey and Certification of Health Care Providers and Suppliers program is to determine whether the providers and suppliers of health care services under the Medicare program are in compliance with regulatory health and safety standards and conditions of participation/coverage. For certain types of providers, compliance with these health and safety standards are also required as a condition of Medicaid participation, and the Medicaid program contributes to program costs accordingly.

II. PROGRAM PROCEDURES

A. Overview

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

Administration

The Medicaid program is jointly financed by the federal and state governments and administered by the states. For purposes of this program, the term “state” includes the 50 states, the District of Columbia, and five United States territories: the US Virgin Islands, Puerto Rico, Guam, American Samoa, and the Commonwealth of the Northern Mariana

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

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

Medicaid State Plans

States administer the Medicaid program under a CMS-approved state plan for each state. The Medicaid state plan is a comprehensive written statement submitted by the State Medicaid Agency (SMA) describing the nature and scope of its Medicaid program. A state plan for Medicaid consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of each particular state's program. The state plan references the applicable federal regulation and statute for each requirement.

The state plan contains all information necessary for CMS to determine whether the state plan can be approved to serve as a basis for determining the availability of federal financial participation. The state plan must specify a single state agency (hereinafter referred to as the "State Medicaid Agency – SMA") established or designated to administer or supervise the administration of the state plan. The state plan must also include a certification by the state attorney general that cites the legal authority for the SMA to administer or supervise the administration of the state plan and make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

The state plan also describes methodologies to pay providers for covered care and services under the Medicaid program. The payment methodologies must be clear and auditable to ensure that payments are disbursed only to qualified providers, in the appropriate amount, for medically necessary services covered by the Medicaid program

and provided to eligible beneficiaries under a fee-for-service arrangement. Payments must also be based on claims that are adequately supported by medical records, and payments must not be duplicated.

At any time, a state may propose changes to the state plan through a state plan amendment (SPA). A state submits a SPA to CMS when a state proposes to modify its state plan to make changes to its Medicaid program design, policies, or operational approach. States must submit SPAs to CMS to reflect changes in federal and state law, regulation, policy, or court decisions. States must also seek amendments to the state plan whenever necessary to reflect material changes in State law, organization, or policy, or in the State's operation of the Medicaid program. This is outlined at 42 CFR 430.12. Federal and state governments use the SPA process to negotiate and agree on the terms of the amendment.

The SPA submission is reviewed by CMS to determine whether the proposal meets federal requirements. A SPA will be considered approved unless CMS, within 90 days after receipt of the SPA, sends the state written notice of disapproval. If more information is required to determine whether the proposal can be approved, CMS sends the state a request for additional information (RAI) within 90 days after receipt of the SPA. States have 90 days from the issuance of the RAI to provide a response to CMS. If the state does not respond within this 90-day period, CMS may choose to disapprove the SPA. Once the state submits the requested information, a new 90-day review clock begins and CMS must decide to approve or disapprove the SPA. While CMS maintains state submission records, copies of approved SPAs are available on CMS' Medicaid.gov website <https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html> or can be obtained from the SMA. More information about SPA and 1915 waiver processing can also be found at Medicaid.gov at <https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html>.

In accordance with an approved state plan or approved waiver (see the Waivers and Demonstrations section below), CMS makes quarterly grant awards to the state to cover the federal share of Medicaid expenditures for services and program administration. The grant award authorizes the state to draw federal funds as needed to pay the federal portion, as determined through the application of the Federal Medical Assistance Percentage (FMAP) or other applicable federal matching rate set by statute, of approved Medicaid expenditures. The amount of the quarterly grant is initially determined on the basis of quarterly budget estimates submitted by the SMA on the Form CMS-37. Thirty days after the end of the quarter, states must submit the Form CMS-64, which includes expenditures and recoveries and other items that reduce expenditures for the quarter and prior period expenditures. Quarterly, CMS reviews the state's expenditures for accuracy and allowability, then CMS issues a finalization grant reconciling the initial grant award determined on the basis of budget estimates to the actual expenditures reported on the Form CMS-64. The amounts reported on the Form CMS-64 and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. States use

the Medicaid Budget and Expenditure System (MBES) to electronically submit the Form CMS-37 and Form CMS-64 directly to CMS.

Waivers and Demonstrations

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

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

Actions that states may take under waivers of section 1915 of the Act include, but are not limited to: (1) implementing a primary care case-management system or a specialty physician system; (2) designating an entity to act as a central broker in assisting Medicaid beneficiaries to choose among competing health care plans; (3) limiting beneficiaries' choice of providers to providers that fully meet reimbursement, quality, and utilization standards, which are established under the state plan and are consistent with access, quality, and efficient and economical furnishing of care; and (4) including as medical assistance, under its state plan, home and community-based services (HCBS) furnished to beneficiaries who would otherwise need inpatient care that is furnished in a hospital, nursing facility or other institutional settings, and is reimbursable under the state plan. A state may also obtain a waiver of statutory requirements to provide an array of HCBS, which may permit an individual to avoid institutionalization (42 CFR Part 441, Subpart G). Depending on the type of requirement being waived, a waiver may be effective for initial periods ranging from two to five years, with varying renewal periods. Copies of approved SPAs are available on CMS' Medicaid.gov website

<https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html>. More information about SPA and 1915 waiver processing can also be found at Medicaid.gov at <https://www.medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html>. The section 1115 demonstrations main page is located at <https://www.medicaid.gov/medicaid/section-1115-demonstrations/index.html>. Lists of states 1115 demonstrations can be found at <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>. CMS approves a state's Medicaid section 1115 demonstration only if it determines the demonstration to be likely to assist in promoting the objectives of title XIX of the Act.

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

Beneficiary Eligibility

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

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

States must provide payment for Medicare premiums and cost-sharing for certain older adults and people with disabilities who are entitled to Medicare Part A, and whose income and resources do not exceed specified standards (Section 1902(a)(10)(E)) of the Act (42 USC 1396a(a)(10)(E)). There are four mandatory eligibility groups, collectively called the Medicare savings program eligibility groups, each of which has its own eligibility requirements and coverage limitations. Depending on the group, the medical assistance available ranges from payment of all Medicare premiums and cost-sharing expenses to payment of only the Medicare Part A or Part B premiums.

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

Services

Medicaid expenditures include payments for services rendered to eligible beneficiaries, such as inpatient and outpatient hospital services, prescribed drugs, nursing facility services, and physicians' services. A listing of mandatory and optional Medicaid benefits can be found at <https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html>. For a Medicaid payment to be considered valid, it must comply with the requirements of Title XIX, as amended (42 USC 1396 et seq.), and implementing federal regulations. Determinations of payment validity are made by individual states in accordance with approved state plans under broad federal guidelines.

Some states have managed care arrangements under which the state enters into a contract with a managed care plan, such as an insurance company, to arrange for or provide medical services. The state pays a risk-based periodic fixed rate per person (capitation payment) to the managed care plan for each beneficiary enrolled in that plan; the capitation payment is paid without regard to the actual medical services utilized by each beneficiary for the time period covered by the payment. There are three types of managed care plans that can be paid capitation rates: managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (42 CFR 438.2). Managed care plans are required to provide covered services in accordance with the managed care plan's contract with the state and pursuant to federal regulations at 42 CFR Part 438.

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

Addendum for the Public Health Emergency (PHE)

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

CMS provided for program flexibilities and federal matching funds for certain services that should be considered when planning single audits, as described below. In some instances, certain audit steps may not be relevant during this review period in light of the flexibilities offered to states. The flexibilities are unique to individual states and follow the typical documentation process, including CMS approval of state plans and waivers, in

accordance with regulations and guidance. Note that [CMS guidance](#) on COVID-related flexibilities is updated regularly, and auditors should reference the latest CMS guidance available on Medicaid.gov at [Tools and Checklists for States | Medicaid](#). It is important for auditors to be aware of the requirements and flexibilities implemented by the state Medicaid or CHIP agency in response to the COVID-19 PHE so that a state is not determined to be out of compliance with requirements that would have been in place absent the PHE. In addition, to be eligible to receive the temporary FMAP increase under section 6008 of FFCRA states are required to maintain the enrollment of all Medicaid beneficiaries who were enrolled as of or after March 18, 2020, through the end of the month in which the PHE ends, with certain exceptions. This requirement, described at section 6008(b)(3) of the FFCRA and 42 CFR 433.400 is often referred to as the continuous enrollment condition. The continuous enrollment condition does not impact a state's obligation to continue to conduct renewals of eligibility and to act on changes in beneficiary circumstances. However, it does prohibit a state from disenrolling a beneficiary who is determined ineligible, except under certain circumstances and many states have been unable to complete the full renewal process for beneficiaries in order to ensure they remain enrolled through the end of the month in which the PHE ends to comply with the continuous enrollment condition.

CMS recognizes that states will not be able to immediately complete the large volume of eligibility and enrollment work before them when the PHE ends. On March 3, 2022, CMS issued [State Health Official letter #22-001](#), which expands on earlier guidance designed to ensure that when the PHE eventually ends and states resume routine operations, including terminations of eligibility, renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage. States will have a 12 month "unwinding period" to distribute and initiate renewals for their total Medicaid and CHIP caseload. [CMS guidance](#) on unwinding requirements, strategies, and flexibilities is updated regularly, and auditors should reference the latest CMS guidance available on www.Medicaid.gov/unwinding.

Background

On January 31, 2020, the Secretary of Health and Human Services (HHS) declared a PHE, effective as of January 27, 2020, for the entire United States to aid the nation's health care community in responding to COVID-19. On March 13, 2020, the president declared the ongoing COVID-19 pandemic of sufficient severity and magnitude to warrant an emergency declaration for all states, tribes, territories, and the District of Columbia pursuant to section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 USC 5121-5207 (the "Stafford Act"), with a retroactive effective date of March 1, 2020. Since the initial declaration, the PHE has been renewed several times, with the latest renewal effective through May 11, 2023 and will end thereafter. During a PHE or disaster, CMS can rely on various legal authorities to grant states emergency flexibilities critical to ensuring that states can respond to the crisis expeditiously to protect and serve the general public.

On December 22, 2020, CMS issued State Health Official (SHO) letter #20-004, entitled Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>). This SHO letter provided guidance on returning to regular operations, including ending temporary authorities when the PHE concludes, making temporary changes permanent where legally permissible and otherwise appropriate, ending the expiring FFCRA provisions, and addressing pending eligibility and enrollment actions that developed during the PHE. As the PHE has been extended, the December 2020 guidance was updated through SHO letter #21-002 (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf>) and SHO letter #22-001 (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>). States should have documentation available to describe the temporary changes made to their programs in response to the PHE, as well as their plans for returning to normal operations following the PHE.

Some of the major areas to note include the following:

1. *Telehealth*

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

2. *Beneficiary Eligibility and Enrollment*

States are facing a number of challenges due to the ongoing COVID-19 PHE that will leave many states with large volumes of pending eligibility and enrollment actions when the PHE ends. Different states have utilized different approaches to implement the continuous enrollment condition and the eligibility and enrollment

flexibilities available during the PHE. For example, some states adopted the optional COVID-19 eligibility group (extended under the American Rescue Plan (Pub. L. No. 117-2) to include treatments for COVID-19) and other states adopted new income and/or resource disregards under the state plan for the period of the PHE. As each state determines which flexibilities to maintain and which flexibilities to end, states are expected to develop an operational plan that documents and tracks compliance, including the timelines for making changes to application and renewal processing and verifications. Additional information is provided in SHO letter #21-002 and [SHO letter #22-001](#) on planning for the resumption of normal operations at the conclusion of the PHE.

All states will need to develop a comprehensive “unwinding operational plan” to restore routine operations in Medicaid when the PHE eventually ends. CMS is not requiring states to use a particular template to document their plan and states do not need to submit their plans to CMS for approval. States are permitted to use a phased approach to complete processing of any pending applications and resume timely and accurate determinations of eligibility on all new applications within four months after the eventual end of the PHE. To account for the time needed to complete the large volume of eligibility and enrollment work when the PHE ends, states may take 12-months to initiate all renewals and other outstanding eligibility actions and have two additional months (14 months total) to complete all pending actions initiated during the 12-month unwinding period. States may adopt strategies to ensure renewals are distributed and processed in a manner that maintains continuity of coverage for eligible individuals and facilitates seamless coverage transitions for those who become eligible for other insurance programs. As discussed in SHO letter #22-001, CMS has determined that states may seek approval to use section 1902(e)(14)(A) authority in a time-limited manner to implement strategies to protect beneficiaries in addressing the challenges states may face as they transition to routine operations during the unwinding period.

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

3. *Managed Care*

As previously described in CMS guidance <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>, if a benefit or other identified flexibility is covered under the Medicaid state plan, Medicaid waiver, or a state demonstration, CMS encourages states to amend their managed care plan contracts, if not already included, to extend the same flexibilities to managed care

plans (MCPs) during the COVID-19 PHE. States may also amend their managed care contracts and assess if changes are needed to capitation rates to: (1) reflect temporary increases in Medicaid fee-for-service (FFS) provider payment rates where an approved state directed payment requires plans to pay FFS rates; (2) require MCPs to make certain retainer payments allowable under existing authorities to certain habilitation and personal care providers; and (3) utilize state directed payments, when in compliance with 42 CFR 438.6(c) and CMS guidance, to require MCPs to temporarily enhance provider payment under the MCP contract.

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

B. Control Systems

Utilization Control and Program Integrity

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

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

Inpatient Hospital and Long-Term Care Facility Audits

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

the establishment of payment rates. The SMA must provide for periodic audits of the financial and statistical records of the participating providers. Such audits could include desk audits of cost reports in addition to field audits. These audits are an important control for the SMA in ensuring that established payment rates are proper.

Automated Data Processing (ADP) Risk Analyses and System Security Reviews

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

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

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

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

- a. Control Environment
- b. Systems Development and Maintenance
- c. Logical Security
- d. Physical Access
- e. Computer Operations
- f. Input Controls

- g. Output Controls
- h. Processing Controls

Medicaid–Enterprise Systems

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

A module of the MES is normally used to process payments for most Medicaid services. The Operations Management business area supports the Claims Receipt, Claims Adjudication, and Point-of-Service subsystems to process provider claims for Medicaid care and services to eligible medical assistance recipients. Many edits and controls are generally implemented to identify aberrant billing practices for follow-up by the state. The state plan will describe the administration of each state's claims-processing subsystems.

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

C. Related Programs

Medicare Savings Program

The Medicare Buy-In Program, which includes QMB (Qualified Medicare Beneficiary), SLMB (Specified Low-Income Medicare Beneficiary), QI (Qualified Individual), and Qualified Disabled and Working Individuals (QDWI), commonly referred to as the Medicare savings program, is designed to protect low-income Medicare beneficiaries from the significant and growing costs required to cover Medicare premiums, deductibles, coinsurance, and copayments. The program connects the two largest public health programs in the country, Medicare and Medicaid, as Medicaid pays for all or part of the Medicare premium and/or cost-sharing amounts for individuals who are financially eligible.

The QMB program serves individuals with modest assets with combined incomes that do not exceed 100 percent of the federal poverty level. For example, in 2022 the asset limit for the QMB program is \$8,400 for an individual and \$12,600 for couples and the monthly income limits in 2022 are \$1,153 for an individual and \$1,546 for couples for all

states excluding Alaska and Hawaii. If individuals are eligible for the QMB program, the state Medicaid program pays their Medicare Part B premiums as well as Medicare Part A premiums for those who are not eligible for premium-free Part A, and their Medicare deductibles, coinsurance, and copayments.

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

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

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

Indian Health Care

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

- a. Special treatment for certain AI/AN financial interests—as described at 42 CFR 435.603(e)(3), certain types of AI/AN income are excluded when determining household income based on modified adjusted gross income (MAGI).
- b. Protections related to the imposition of enrollment fees, premiums, and cost sharing charges—as described at 42 CFR 447.56(a)(1)(x), AI/ANs cannot be charged any enrollment fees or premiums if they are eligible to receive items or services furnished by an Indian health care provider, and they are exempt from all cost sharing if they are both eligible to receive and have received items or services furnished by an Indian health care provider or through referral under contract health services (CHS), now, Purchased Referred Care (PRC). In addition, 42 CFR 447.56(c)(2) prohibits any cost sharing-related reduction in payment due under Medicaid to the Indian health care provider serving an AI/AN (i.e., a state must pay these providers the full Medicaid payment rate for furnishing the service).
- c. Managed care protections – Network and coverage requirements related to AI/AN protections within managed care are codified at 42 CFR 438.14(b). These protections address network adequacy, access, claims payment, and disenrollment for AI/AN beneficiaries.

- d. Requirements for payment to Indian Health Service (IHS)/Tribal facilities – States receive 100 percent FMAP for Medicaid services provided to AI/ANs through an IHS /Tribal facility. Per SHO letter #16-002, states receive 100 percent FMAP for services provided to AI/ANs by non-IHS/Tribal providers when a care coordination agreement is in place between an IHS/Tribal facility and a non-IHS provider, and other requirements of the SHO letter are met. Payment methodologies, including rates, for all services provided by IHS/Tribal facilities and non-IHS/Tribal providers are described in the Medicaid state plan.
- e. Per January 18, 2017 FAQs (<https://www.medicaid.gov/federal-policy-guidance/downloads/faq11817.pdf>), CMS provided a grace period to permit IHS/Tribal facilities to continue to claim Medicaid reimbursement under the clinic services benefit at 42 C.F.R. § 440.90 (including at the IHS All Inclusive Rate (AIR)) for services provided outside of the “four walls” of the facility. The grace period ended January 30, 2021. Recognizing the need to focus limited resources on addressing the COVID-19 PHE, CMS extended a grace period previously granted to permit such claims through October 31, 2021; a CMCS Informational Bulletin issued on October 4, 2021, further extended this grace period to nine months after the COVID-19 PHE ends (<https://www.medicaid.gov/sites/default/files/2021-10/cib10421.pdf>).

Payment Error Rate Measurement (PERM) Program

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

Medicaid Eligibility Quality Control (MEQC) Program

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

Source of Governing Requirements

The federal law that authorizes these programs is Title XIX of the Social Security Act (Title XIX), enacted in 1965 and subsequently amended (42 USC 1396 et seq.). The federal regulations applicable to the Medicaid program are found in 42 CFR parts 430 through 456, 1002, and 1007.

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

Awards under the Medical Assistance Program (Assistance Listing 93.778) are subject to the requirements of 45 CFR Part 95 and the cost principles under Office of Management and Budget Circular A-87/2 CFR Part 200, Subpart E.

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

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

Availability of Other Program Information

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

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

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

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	Y	N	Y	N	N	N	Y	N	Y

General Audit Approach for Medicaid Payments

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

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

1. Dependence upon large and complex ADP systems to process the large volume of Medicaid transactions for fee for services arrangements.
2. Medical services are normally provided directly to an eligible beneficiary without prior approval by the state.
3. Medical service providers normally determine the scope and medical necessity of the services.
4. Notice to the state that a service was rendered is after-the-fact when a claim for payment is issued.
5. Payments systems do not include a review of original detailed documentation supporting the claim prior to payment.
6. Complex payment structures for various medical services may exist, including significance of proper coding of services for fee for service (e.g., billing by diagnosis-related groupings (DRG)). Managed care and waiver based programs

are dependent on the respective SPA and resulting agreements with the providers. Managed care programs are dependent on the authority for the program and the contracts with the managed care plans.

7. Payment rates and policies differ among service types and delivery methods, such as fee for service arrangements, managed care, and waivers (e.g., inpatient hospital, physicians, prescription drugs and drug rebates, and risk-based capitation payments for a specific set of covered services).
8. State contracts with third parties, such as managed care plans, to provide or arrange for services for all or part of beneficiary care. Managed care plans have contracts with providers to create networks. Managed care plans may also subcontract with other managed care plans and/or administrative services organizations to delegate some of their contractual obligations.

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

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
Managed Care Waiver	X	X	X	X
Home and Community Based Waiver Program	X		X	

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

A. Activities Allowed or Unallowed

1. *Summary* – FFP funds can be used only for Medicaid benefit payments (as specified in the state plan, federal regulations, or an approved waiver/demonstration), expenditures for administration and training, expenditures for the State Survey and Certification Program, and expenditures for the establishment and operation of state MFCUs (42 CFR 435.10, 440.210, 440.220, and 440.180). Payments may only be made to providers determined by the SMA to be eligible to participate in the Medicaid program. See III.N.4., “Provider Eligibility (Screening and Enrollment)” for related testing.
2. *Case Management Services* – Medicaid case management services may fall under the category of an administrative expense or as an optional medical state plan benefit. The term “case management services” means services that will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. Services, programs, and providers to which the individual is gaining access do not have to be specifically medical in nature and may include services for securing shelter, personal needs, and so forth (e.g., services provided by community mental health boards, county offices of aging). Case management services are an area of risk because of the high growth of expenditures and prior experience that indicates problems with the documentation of case management expenditures.

With the exception of case management services (covered under a periodic payment (usually monthly) for each beneficiary) or risk-based managed care, federal regulations typically require the following documentation for case management services: date of service; name of recipient; name of provider agency and person providing the service; nature, extent, or units of service; and place of service (section 1915(g) of the Act (42 USC 1396n(g)); 42 CFR Part 434).

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

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

3. *Managed Care* – A state may obtain a waiver of statutory requirements under 1915(a) or (b) waivers, or amend its state plan under 1932(a) authority, or use 1115(a) demonstration authority, in order to develop a managed care delivery system that is intended to more effectively addresses the health care needs of its population. For example, a waiver/SPA/Demonstration may involve the use of

managed care plans for the delivery of some or all Medicaid benefits for selected beneficiaries. Managed care plans' networks of providers must be eligible to participate in the program at the time services are rendered, payments to managed care plans should only be for eligible beneficiaries for the proper period and use the proper rate cell, and the capitation rates must be actuarially sound. Generally, FFS Medicaid should not pay a beneficiary's claims for services that are covered by the managed care plan contract. States should ensure that capitated payments to managed care plans are discontinued when a beneficiary is no longer enrolled in a plan. All Medicaid managed care guidance can be found at <https://www.medicaid.gov/medicaid/managed-care/guidance/index.html>.

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

4. *Medicaid Health Insurance Premiums* – A state may pay premiums for employer sponsored insurance or private group health insurance, on behalf of a Medicaid beneficiary, if it is cost effective to do so. When providing premium assistance, states must ensure that participating beneficiaries have access to all benefits available to other Medicaid beneficiaries, and that they are not required to incur greater out-of-pocket costs for premiums, deductibles, co-payments, or similar cost sharing charges than other Medicaid beneficiaries. A state's policy related to premium assistance is described in the Medicaid state plan.
5. *Disproportionate Share Hospital* – FFP is available for payments to states for qualifying hospitals that serve a disproportionate number of low-income patients with special needs. The state plan must specifically define a disproportionate share hospital and the method of calculating the rate for these hospitals. Section 1923 of the Act limits DSH payments on a state-wide basis to annual DSH allotments and on a hospital-specific basis to each qualifying hospital's uncompensated care costs. Section 1923(j) of the Act (42 USC 1396r(4) (*OMB PRA 0938-0746*)) also requires each state to obtain, and submit to CMS, an annual independent certified audit of their Medicaid DSH to determine compliance with the hospital-specific DSH limit for individual hospitals within their program. These audits must be completed no later than the last day of the Federal fiscal year ending three years from the end of the Medicaid State plan rate year. Completed audit reports are due to CMS no later than 90 days after completion. 42 CFR 455.300-304 specifies the details and timing for these audits. If the audit identifies an individual hospital overpayment the auditor should determine whether the state plan allows for redistribution to other hospitals that were reimbursed under their hospital specific DSH limit. Please see <https://www.Medicaid.gov/medicaid/financial-management/medicaid-disproportionate-share-hospital-dsh-payments/index.html>.

6. *Home and Community-Based Services (HCBS)* – A state may obtain a waiver of statutory requirements to provide an array of HCBS which may permit an individual to avoid institutionalization primarily through 1915(c) of the Act (42 CFR Part 441, Subpart G). States may also offer HCBS under their state plan under authority provided by section 1915(i) of the Act. States must operate their HCBS programs in accordance with certain “assurances,” including three assurances related to quality of care. To meet these assurances, states must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries.
7. *Medicare Part B Buy-In* – 42 CFR 431.625(d)(1) specify

FFP funds are available for state payment of

- Medicare Part B premiums for cash assistance recipients (SSI/SSP) and “deemed” cash recipients;
- Part A or B premiums, deductibles, coinsurance, and copays for QMBs; and
- Part B premiums for SLMBs and QIs.

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

B. Allowable Costs/Cost Principles

1. States must have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Such third party resources should be exhausted prior to paying claims with program funds. Where third party liability is established after the claim is paid, reimbursement from the third party should be sought (section 1915 of the Act 42 USC 1396k; 42 CFR 433.135 through 433.154).
2. Before calculating the amount of FFP, certain revenues received by a state will be deducted from the state’s medical assistance expenditures. The revenues to be deducted are (1) donations made by health care providers or related entities (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of out-stationed eligibility workers); and (2) impermissible health care-related taxes. The requirements for provider-related donations and health care-related taxes are specified in section 1903(w) of the Act and implementing regulations at 42 CFR 433 Subpart B.

These provisions apply to the 50 states and the District of Columbia, except those states whose entire Medicaid program is operated under a waiver granted under Section 1115 of the Social Security Act (42 CFR Part 433.50(c)).

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

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

Generally, in order for payment to be available for covered outpatient drugs, drug manufacturers are required to have entered into a rebate agreement and meet various product and price reporting requirements, in addition to paying rebates. As part of the product and price reporting requirements, manufacturers must certify to CMS all covered outpatient drugs and, on a quarterly basis, are required to provide their average manufacturer’s price and their best price for each covered outpatient drug, as applicable. Based on these data, CMS calculates a unit rebate amount for each drug, which it then provides to states. No later than 60 days after the end of the quarter, the SMA must provide drug utilization data to manufacturers, including drug utilization data of those Medicaid beneficiaries enrolled in managed care plans.

4. In the “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability” final rule, published in the *Federal Register* on May 6, 2016 (81 FR 27498), CMS adopted medical loss ratio (MLR) requirements for Medicaid and CHIP managed care programs. The state must require each Medicaid managed care plan to calculate and report a MLR for rating periods starting on or after July 1, 2017; and require each CHIP managed care plan to calculate and report a MLR for rating periods in CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018. If a state elects to mandate a minimum MLR, that minimum MLR must be at least 85 percent.

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

5. *Non-Disproportionate Share Hospital Supplemental Payments* – States make supplemental payments to hospitals and other providers such as nursing homes and physician groups that serve high-cost Medicaid beneficiaries. The upper payment limit (UPL) against which non-disproportionate share hospital supplemental payments are measured is codified at 42 CFR 447.272 for Institutional Services and 42 CFR 447.321 for Outpatient Hospital and Clinic Services.
6. *Non-Risk Contracts* – Non-risk contracts are defined in 42 CFR 438.2 as contracts between a state and a PIHP or PAHP under which the contractor (1) is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362 of this chapter; and (2) may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits.
7. *American Rescue Plan Act of 2021 (ARP) section 9817* - provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS) beginning April 1, 2021 and ending March 31, 2022. CMS released State Medicaid Director SMD letter #21-003, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>, on May 13, 2021, to provide guidance to states on the implementation of section 9817 of the ARP, and subsequently released SMD letter #22-002 extending the deadline to fully expend state funds equivalent to the amount of federal funds attributable to the increased FMAP (<https://www.medicaid.gov/federal-policy-guidance/downloads/smd22002.pdf>). CMS expects states to expend the funds by March 31, 2025.

As described in SMD #21-003, states must comply with two program requirements to receive the increased FMAP for HCBS expenditures: (1) federal funds attributable to the increased FMAP must be used to supplement existing state funds expended for Medicaid HCBS in effect as of April 1, 2021; and (2) states must use the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS

under the Medicaid program. CMS requires participating states to submit both an initial and quarterly HCBS spending plan and narrative to CMS on the activities that the state has implemented and/or intends to implement to enhance, expand, or strengthen HCBS under the Medicaid program to demonstrate that the state is supplementing, but not supplanting, existing state funds expended for Medicaid HCBS. Many of these activities are eligible for Medicaid matching funds after states submit Form CMS-64 after the end of each quarter. However, some of the activities are not eligible for Medicaid matching funds, and states are only required to report spending on quarterly Spending Plans submitted to CMS. A state's approved Spending Plan and subsequent quarterly updates are listed on the CMS website (<https://www.medicaid.gov/medicaid/home-community-based-services/guidance/arp-section-9817-state-spending-plans-and-narratives-and-cms-approval-letters/index.html>) or obtained from the state.

Discrepancies between what the state reported spending on its Spending Plan and documentation of actual spending would constitute a potential violation of the 9817 requirements that states must use the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement existing state funds expended for Medicaid HCBS.

E. Eligibility

As discussed in the General Audit Approach for Medicaid Payments, the auditor may coordinate 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, eligible individuals and presumptively eligible individuals are combined with III.A, "Activities Allowed or Unallowed" and III.B, "Allowable Costs/Cost Principles" such as, was the service incurred during the period the individual was eligible to receive benefits and was the provider paid the correct amount for the service billed."

The state verifies the financial and nonfinancial factors of eligibility, with the exceptions described below, by checking electronic data sources in accordance with federal requirements at 42 CFR 435.948 through 435.956 and state requirements (as documented in the state plan, verification plan and eligibility manual). The state is required (as described at 42 CFR 435.914) to maintain facts in the case file to support the eligibility determination. When data sources used by the state are not available to the auditor, or information is not required to be available for the period under audit, auditors would not be expected to test verification other than the requirement to maintain information in the case file. For states that accept applicant self-attestation for certain factors of eligibility such as household composition, and do not require further verification or documentation, the auditors are not expected to test beyond the requirements of the state.

The exceptions to the verification process described above are eligibility determinations made by an Exchange, either the Federally Facilitated Exchange (FFE) or a State-based Exchange (SBE), elements of a determination made by an express lane agency, and presumptive eligibility (PE) determinations made by qualified entities. In states that have delegated eligibility determinations to the FFE or a SBE, the state relies on the

verifications conducted by the Exchange and auditors are not expected to test verification. When express lane eligibility is used, the SMA relies upon elements of the determination made by an express lane agency. For PE determinations, the qualified entity accepts attestation of all needed information and states may not require verification or documentation of any eligibility criteria. When testing a PE determination, auditors are not expected to test verification.

1. Eligibility for Individuals

To participate in Medicaid, federal law requires states to cover certain groups of individuals. Examples of these mandatory eligibility groups are Infants and Children under Age 19, Pregnant Women, and Individuals Receiving Supplemental Security Income (SSI). States may also elect to extend coverage to optional groups of individuals. Examples of optional eligibility groups are Individuals Needing Treatment for Breast or Cervical Cancer, Optional State Supplement Recipients, and Family Opportunity Act Children with a Disability. The Families First Coronavirus Response Act (Pub. L. No. 116-127), as amended by section 9811 of the American Rescue Plan (Pub. L. No. 117-2), established a new optional Medicaid eligibility group at section 1902(a)(10)(A)(ii)(XXIII) of the Act (42 USC 1396a(a)(10)(A)(ii)(XXIII)) for individuals who are uninsured; this eligibility group is available only during the period of the COVID-19 PHE and coverage under the group is limited to testing and treatment for COVID-19. In addition, states have the option to provide coverage to medically needy individuals who have income and/or resources that exceed the eligibility standards otherwise applicable to such individuals. Mandatory, optional, and medically needy coverage options are described at 42 CFR Part 435, subparts B, C, and D and the options elected by a state are detailed in its Medicaid state plan.

Eligibility for Medicaid includes both financial and nonfinancial requirements and each eligibility group can have its own specific standards. Financial eligibility for most individuals is based on MAGI, which is described at 42 CFR 435.603. MAGI-based income is calculated using the financial methodologies defined in section 36B of the Internal Revenue Code with certain exceptions, such as the exclusion of certain types of AI/AN income (described above) and special rules for individuals who do not expect to file taxes or to be claimed as a tax dependent (non-filer rules). MAGI-based financial eligibility determinations include only an income test; states cannot apply a resource test when determining eligibility based on MAGI.

Certain groups of individuals are excepted from the use of MAGI. MAGI-excepted individuals are described at 42 CFR 435.603(j) and include individuals whose eligibility does not require a determination of income by the agency, such as individuals who are eligible based on their receipt of SSI; individuals whose eligibility for Medicaid is determined based on being age 65 or older or having blindness or a disability (often referred to as aged, blind or disabled, or ABD); and individuals being evaluated for coverage as medically needy.

When making non-MAGI financial eligibility determinations, states generally apply the income and resource methodologies of the most closely associated cash assistance program. For most individuals, the SSI financial eligibility methodology would be applied, including SSI rules related to both income and resources, in accordance with 42 CFR 435.601 and 435.602. Most MAGI-excepted eligibility determinations include a resource (sometimes called “asset”) standard. However states have flexibility to modify resource standards by disregarding certain types or amounts of resources.

Certain nonfinancial requirements, such as age limitations, pregnancy, or parent/caretaker requirements, apply only to specific eligibility groups. Other non-financial requirements apply to all eligible individuals. Medicaid beneficiaries must generally be residents of the state in which they are receiving Medicaid, and they must be either US citizens or qualified non-citizens (referred to as aliens in the statute). Many 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 was granted the qualified alien immigration status, unless the alien is exempt from the five-year waiting period under 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, subject to the five-year waiting period under 8 USC 1613. States also have the option to provide Medicaid coverage to lawfully residing pregnant women and children under age 21 in accordance with 42 USC 1396b(v)(4), which provides coverage to all lawfully present non-citizens who are otherwise eligible for Medicaid, including during the five-year waiting period, for those otherwise subject to it under 8 USC 1613. 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.

The Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) established a new requirement effective December 27, 2020, for states to extend full Medicaid eligibility to citizens of the Freely Associated States (the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau) living in the United States under the Compacts of Free Association (COFA). Additional information is provided in SHO letter #21-005 regarding Medicaid Eligibility for COFA Migrants available at <https://www.medicaid.gov/sites/default/files/2021-10/sho21005.pdf>.

The Extending Government Funding and Delivering Emergency Assistance Act (Pub. L. No. 117-43) provided that Afghan evacuees who enter the United States as parolees or with a Special Immigrant Visa are eligible for Medicaid or CHIP to the same extent as refugees, for a limited time period, provided that they meet all other eligibility requirements. Additional information is provided in the November 1, 2021 fact sheet on Health Coverage Options for Afghan Evacuees at

<https://www.medicaid.gov/medicaid/eligibility/downloads/hlth-cov-option-afghan-evac-fact-sheet.pdf>.

To facilitate immediate access to services for individuals who are likely Medicaid eligible, without having to wait for a final eligibility determination to be made, states may establish a program of PE. Under this option, the state authorizes certain health care providers, schools, and/or other outside entities (referred to as “qualified entities”) to screen for Medicaid eligibility and immediately enroll individuals who appear to be eligible. PE is time limited and ends within two months unless the individual submits a full Medicaid application.

The processes used by states to determine and renew eligibility for Medicaid must comply with certain federal requirements, which are described at 42 CFR Part 435, Subpart J. State processes for presumptive eligibility are described at 42 CFR Part 435, Subpart L. However, states have flexibility within this framework to establish processes that meet the unique needs of their state. Specific requirements to be considered when auditing eligibility determinations for individuals include:

a. Eligibility Determination

- (1) States must accept applications submitted online, by telephone, via mail, or in person. This includes electronic, telephonically recorded, and handwritten signatures. The SMA must have documentation in the case record to support the agency’s eligibility determination, including a record of verification of income and citizenship or satisfactory immigration status for each individual. The state must provide notice of its decision concerning eligibility and provide timely and adequate notice of the basis for denial or termination of assistance (section 1137(d) of the Act 42 USC 1320b-7(d); 42 CFR 435.907, 435.914, 435.917, 431.17, 431.211, 431.213, 431.214).
- (2) Federal law requires that certain types of information be collected during the application process. As a condition of eligibility, each individual seeking Medicaid must furnish his or her Social Security number (SSN) as described at 42 CFR 435.910. If the individual does not recall his/her SSN or has not been issued an SSN, the state must assist the individual in obtaining or applying for an SSN. This requirement does not apply if the individual (a) is not eligible to receive an SSN, (b) does not have an SSN and may be issued an SSN only for a valid non-work reason, or (c) refuses to obtain a SSN because of well-established religious objections.
- (3) States are directed, at 42 CFR 435.912, to determine eligibility promptly and without undue delay. For individuals applying for Medicaid on the basis of disability, the determination of eligibility

may not exceed 90 days. For all other applicants, the determination of eligibility may not exceed 45 days.

- (4) The 42 CFR 435.1200 requires coordination between SMAs and other insurance affordability programs, including an Exchange. Typically, electronic accounts must be transferred from the Medicaid/CHIP agency to the Exchange and vice versa. States utilizing the FFE must enter into an agreement in which the FFE makes either a determination or an assessment of MAGI Medicaid/CHIP eligibility and sends the individual's electronic account to the SMA for enrollment (FFE determination) or a final determination and enrollment (FFE assessment). Additional information may be found in the July 25, 2016, CMCS Informational Bulletin on Coordination of Eligibility and Enrollment between Medicaid, CHIP, and the Federally Facilitated Marketplace (FFM or "Marketplace") <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf>.
- (5) When determining eligibility for a child, SMAs may rely on elements of a determination made by an express lane agency (as defined in section 2.1(e) of the Medicaid state plan) as to whether a child satisfies one or more requirements of Medicaid eligibility. The SMA may use an income determination from an express lane agency without regard to differences in budget unit, income disregards, deeming, or other differences in methodology between the express lane agency and Medicaid. Auditors are not expected to test verification of express lane determinations relied upon by the SMA. Additional information may be found in section 1902(e)(13) of the Act (42 USC 1396a(e)(13)) and SHO letter #10-003 issued on February 4, 2010.

b. Eligibility Verification

- (1) States must request information from reliable electronic data sources, including other agencies in the state and other state and federal programs to the extent that such information is determined useful in verifying the financial eligibility of an individual. As described in the state's verification plan for MAGI determinations, and in state policies and procedures for both MAGI and non-MAGI determinations, this may include information from agencies such as the State Wage Information Collection Agency, the Social Security Administration, and the Internal Revenue Service. States may also use information related to eligibility or enrollment from other state programs such as the Supplemental Nutrition Assistance Program. For MAGI determinations, if information provided by or on behalf of an individual is reasonably compatible with

information obtained from the electronic data sources, as described in the state's verification plan, then the agency must determine or renew eligibility based on such information and may not require the individual to provide any further documentation. If the information is not reasonably compatible, then the agency must provide the individual with a reasonable period of time to explain the discrepancy or furnish additional information (42 CFR 435.948 and 435.952).

- (2) States may choose to accept self-attestation of information needed to determine or renew eligibility except with respect to income, SSN, and citizenship or immigration status. When self-attestation is accepted, further information, including documentation, cannot be required from the individual. In such cases, the auditor would not be expected to test documentation other than required by the state. States must follow the requirements described at 42 CFR 435.948 through 435.956 for verification and documentation of income and citizenship and immigration status.
- (3) Asset Verification Program – Section 1940 of the Act (42 USC 1396w) requires states to have a mechanism in place to verify assets, through access to information held by financial institutions, for purposes of determining or renewing Medicaid eligibility when an asset test is applicable for aged, blind, and disabled Medicaid applicants or beneficiaries.

c. Periodic Renewal

As required at 42 CFR 435.916, states must renew MAGI-based determinations of eligibility once every 12 months and no more frequently than once every 12 months. For non-MAGI beneficiaries, states must renew eligibility at least once every 12 months as described in the Medicaid state plan. When renewing eligibility, states must first attempt to renew based on reliable information available to the agency without requiring information from the individual. If sufficient information is not available to complete a renewal, or if the state has information that suggests that the beneficiary is ineligible, the state must provide the beneficiary with a renewal form and inform the individual of any additional information or documentation needed to determine eligibility. For MAGI-based determinations, the renewal form must be prepopulated with the most recent and reliable information known to the agency. Consistent with regulations at 42 CFR 435.930(b), the agency must continue to furnish Medicaid to beneficiaries who have returned their renewal form and all requested documentation unless and until they are determined to be ineligible for eligibility under all groups covered by the

state. Additional information may be found in the CMCS Informational Bulletin on Medicaid and Children's Health Insurance Programs (CHIP) Renewal Requirements issued on December 4, 2020

(<https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf>).

d. Continuous Eligibility During Pregnancy & Postpartum Coverage

All pregnant Medicaid beneficiaries are eligible under the state plan for at least pregnancy-related services through the end of the month in which the 60-day period, beginning on the last day of pregnancy, ends regardless of the eligibility group in which the beneficiary is enrolled, and regardless of any changes in income that would otherwise result in a loss of eligibility. Section 9812 of the American Rescue Plan Act (Pub. L. 117-2) gave states a new state plan option, beginning April 1, 2022, to provide 12 months of extended postpartum coverage to pregnant individuals enrolled in Medicaid. The 12-month postpartum period begins on the last day of a beneficiary's pregnancy and extends through the end of the month in which the 12-month period ends. Similar to the 60-day postpartum period, individuals are entitled to the extended postpartum coverage regardless of the eligibility group in which the individual is enrolled. However, pregnant individuals eligible for extended postpartum coverage are also entitled to continuous eligibility, so they remain eligible during pregnancy and the postpartum period regardless of any changes in circumstances including income and other factors of categorical eligibility.

The availability of continuous coverage under the extended postpartum coverage option renders any regular renewal scheduled before the end of the 12-month postpartum period unnecessary. Rather, the Medicaid agency must conduct the renewal at the end of the individual's extended 12-month postpartum period in accordance with renewal regulations at 42 CFR 435.916. A state may, but is not required to, conduct redeterminations and periodic renewals of eligibility based on available information without requesting information from the individual during a period of continuous eligibility, and if appropriate, move the individual to a new eligibility group as long as the transition to the new group would not result in a loss of or reduction in coverage (e.g., reduction in benefits, increase in premiums or cost sharing).

Additional information on the extended postpartum coverage option may be found in SHO# 21-007 (<https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf>).

e. Presumptive Eligibility

States have the option to establish PE for specific eligibility groups, as described at 42 CFR Part 435 Subpart L. In general, states must provide

PE for pregnant women and children before extending PE to most other MAGI-based eligibility groups. The options elected by each state are described in the Medicaid state plan.

When electing the PE option, states designate qualified entities, such as health care providers, community-based organizations, and schools to make PE determinations. These qualified entities are trained on the state's PE screening process and state-specific requirements for PE. In many states, qualified entities also help individuals to complete the full application process. A qualified entity is responsible for collecting and recording all information necessary to make a PE determination.

To be determined presumptively eligible, an individual must meet the basic requirements of an eligibility group for which PE is available. For example, to be presumptively eligible for the Infants and Children Under Age 19 group, the individual must be a child aged 18 or younger and must have household income at or below the standard established by the state for this group. When determining income, states may use a simplified method such as gross income. In addition to the basic requirements of the eligibility group, states may, but are not required to, consider state residency and US citizenship or eligible immigration status when making a PE determination. Other information that would be collected on a full application, cannot be required for a PE determination. In addition, individuals attest to all information needed for a PE determination. States may not require verification or documentation of any eligibility criteria as a condition of presumptive eligibility.

The PE period begins the day on which the qualified entity makes the PE determination. The end date varies depending on whether or not the individual submits a Medicaid application. If the individual submits a Medicaid application by the last day of the month following the month in which PE was determined, the PE period will continue until full Medicaid eligibility is either approved or denied. If the individual does not submit a Medicaid application, the PE period ends on the last day of the month following the month in which PE was determined. States must adopt reasonable standards regarding the number of PE periods that will be authorized for an individual.

f. Eligibility for Inmates of Public Institutions

As described in subdivision (A) in the matter following section 1905(a)(30) of the Act (42 USC 1396d(a)(30)) the provision of FFP for inmates of public institutions (in this case, correctional institutions) is limited to inpatient services furnished to inmates when they are patients in a medical institution. To implement this payment exclusion, states historically terminated the eligibility and enrollment of beneficiaries when they entered a correctional institution. However, section 1001 of the

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. No. 115-271) added a new paragraph (84) to section 1902(a) of the Act (42 USC 1396a), which (1) prohibits states from terminating the Medicaid eligibility of an “eligible juvenile” who becomes an inmate of a public institution, (2) requires states to process applications submitted by incarcerated youth, and (3) requires states to redetermine the Medicaid eligibility of eligible juveniles before their release from a public institution. State Medicaid Director letter #21-002 (available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf>) describes the options available to states to suspend eligibility or benefits rather than terminating Medicaid eligibility, and it describes the requirements for renewals, notices, fair hearings and other related matters.

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

Not Applicable

3. Eligibility for Sub-recipients

Not Applicable

G. Matching, Level of Effort, Earmarking

1. Matching

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

2. Level of Effort

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

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

3. Earmarking

A state waiver may contain an earmarking requirement.

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. 0938-1265)* – Required to be used in lieu of the SF-425, Federal Financial Report (for all components of the cluster other administrative costs of the state MFCUs), prepared quarterly, and submitted electronically to CMS within 30 days after the end of the quarter. Various provisions of the Act provide for an FMAP that is increased either permanently, or temporarily. Lines and forms on the CMS-64 that reflect these increases present more risk than others. States must report expenditures on the CMS-64 that reflect the date of payment, not the date of service, to obtain the correct FMAP (see 42 CFR 430.30(c)).

2. Performance Reporting

Not Applicable

3. Special Reporting

Not Applicable

4. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

N. Special Tests and Provisions**1. Utilization Control**

Compliance Requirements The state plan must provide methods and procedures to safeguard against unnecessary utilization of care and services (42 CFR Part 456). The SMA must implement a statewide surveillance and utilization control program that (1) safeguards against unnecessary or inappropriate use of Medicaid services against excess payments, (2) assess the quality of those services, and (3) provides for the control of the utilization of all services provided under the state plan in accordance with 42 CFR 456 Subparts B-I. The SMA 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 SMA may conduct this review directly or may contract with an independent entity (42 CFR sections 456.5, 456.22 and 456.23).

Audit Objectives Determine whether the state has established and implemented procedures to safeguard against unnecessary utilization of care and services.

Suggested Audit Procedures

- a. Determine if the SMA established and implemented procedures to conduct utilization reviews.
 - (1) Obtain an understanding of the procedures used by the SMA to conduct utilization reviews.
 - (2) Evaluate the qualifications of the personnel conducting the reviews. Ascertain that the individuals possess the necessary skill or knowledge by considering the following:
 - (a) professional certification, license, or specialized training;
 - (b) the reputation and standing of licensed medical professionals in the view of peers if relevant; and
 - (c) experience in the type of tasks to be performed.

- (3) Ascertain if the personnel performing the utilization review are organized sufficiently independent of other Medicaid operations to objectively perform their function.
 - (4) Ascertain if the SMA or independent entity's sampling plan was properly designed and executed.
- b. Test a sample of the cases examined by SMA or the independent entity and ascertain if such examinations were in accordance with the SMA's procedures or in accordance with the SMA's contract with the independent entity.

2. Inpatient Hospital and Long-Term Care Facility Audits

Compliance Requirements The SMA pays for inpatient hospital services and long-term care facility services through the use of rates that are economic and efficient and are in accordance with the state plan. To the extent the state pays reconciled costs, the SMA must provide for the filing of uniform cost reports for each participating provider in order to establish payment rates. The SMA 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 447.253).

Audit Objectives Determine whether the SMA performed inpatient hospital and long-term care facility audits as required and established in the state plan.

Suggested Audit Procedures

- a. Review the state plan and SMA 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, determine if the sampling plan was carried out as planned.
- c. Select a sample of audits and ascertain if the audits were in compliance with the SMA's audit procedures.

3. ADP Risk Analysis and System Security Review

Compliance Requirements SMAs must establish and maintain a program for conducting periodic risk analyses to ensure that appropriate and cost effective safeguards are incorporated into new and existing systems. SMAs must perform risk analyses whenever significant system changes occur. SMAs 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 SMA shall maintain reports on its biennial ADP system security reviews, together with pertinent supporting documentation, for HHS on-site reviews (45 CFR 95.621).

Audit Objectives Determine whether the SMA has performed the required ADP risk analyses and system security reviews.

Suggested Audit Procedures

- a. Review the SMA's policies and procedures, and document the frequency, timing, and scope of ADP security reviews. This should include any Service Organization Control (SOC) 1 type 2 reviews following statement on Standards for Attestation Engagements (AT) Section 801, Reporting on Controls at a Service Organization that may have been performed on outside processors (service organizations).
- b. Evaluate 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 to determine if findings were identified and what actions the SMA took to address the findings.

4. Provider Eligibility (Screening and Enrollment)

Compliance Requirements In order to receive Medicaid payments, providers must: (1) be licensed in accordance with federal, state, and local laws and regulations to participate in the Medicaid program (42 CFR 431.107 and 447.10; and Section 1902(a)(9) of the Act (42 USC 1396a(a)(9)); (2) screened and enrolled in accordance with 42 CFR Part 455, Subpart E (sections 455.400 through 455.470); and make certain disclosures to the state (42 CFR Part 455, Subpart B, sections 455.100 through 455.106). Medicaid managed care network providers are subject to the same disclosure, screening, enrollment, and termination requirements that apply to Medicaid fee-for-service providers in accordance with 42 CFR Part 438, Subpart H. States must also follow guidance issued in the Medicaid Provider Enrollment Compendium (MPEC) at <https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf> to enroll providers into their Medicaid programs.

Providers who have been barred from participation by the OIG exclusion list are not eligible to be enrolled in the Medicaid program (see 42 CFR 455.436). Lists may be found at https://oig.hhs.gov/exclusions/?utm_source=oigNewsletter&utm_medium=oig-nl-nav&utm_campaign=leie-nl.

Audit Objectives Determine whether Medicaid providers of medical services have the required medical licenses and are eligible 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 samples from both Medicaid fee-for-service providers and managed care network providers to ascertain if:
 - (1) The provider is screened, licensed, and enrolled in accordance with the state plan and the requirement of 42 CFR 455 Subpart E.
 - (2) The agreement with the provider complies with the requirements of the state plan, including the disclosure requirement of 42 CFR 455 Subpart B.
 - (3) The provider complied with the requirements of the state plan, including the disclosure requirements of 42 CFR 455 Subpart B and Section 1.4 of the MPEC at <https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf>.
 - (4) The provider was not on the OIG's exclusion list at the time the services were provided.

5. Provider Health and Safety Standards

Compliance Requirements Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/IID (42 CFR Part 442). The standards may be modified in the state plan.

Audit Objectives Determine whether the state ensures that hospitals, nursing facilities, and ICF/IID 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 providers who received payments for each provider type (i.e., hospitals, nursing facilities, and ICF/IID) and ascertain if the SMA has documentation that the provider has met the prescribed health and safety standards.

6. Medicaid Fraud Control Unit (MFCU)

Compliance Requirements States must have (1) methods and criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring credible allegations of fraud cases to law enforcement officials (42 CFR 455.13). Credible allegations of provider fraud must be referred to the state MFCU or an appropriate law enforcement agency in states with no certified MFCU (42 CFR 455.21). For those States that rely on Medicaid managed care organizations, regulations require that managed care contracts include provisions for the prompt referral of any potential fraud to the State Medicaid agency or directly to the MFCU. 42 CFR 438.608(a)(7).

States are required as part of their Medicaid state plans to maintain a MFCU, unless the HHS Secretary determines that a MFCU would not be cost-effective. States must have an agreement between the MFCU and the SMA, which includes methods of coordination and procedures for referring potential fraud, including potential fraud arising in managed care networks. 42 CFR 455.21(c); 1007.9(d).

Audit Objectives Determine whether the state has established and implemented procedures to: (1) identify suspected fraud cases; (2) investigated these cases; and (3) referred credible allegations of fraud cases to the MFCU, or in jurisdictions without a MFCU, to another office with authority to prosecute cases of provider fraud, and to ensure that the state accurately reports overpayment recoveries resulting from MFCU activities on the CMS-64 in accordance with sections 1903(d)(2)(C) and (D) of the Act.

Suggested Audit Procedures

- a. Ascertain if the Medicaid Agency has a program integrity function with qualified staff to comply with the requirements contained in 42 CFR 455.13.
- b. Ascertain if the state has a MFCU and, if not, it has received a waiver from the HHS Secretary and has alternate policies and procedures in place to detect Medicaid fraud and abuse.
- b. Examine the current memorandum of understanding (MOU) between the MFCU and State Medicaid Agency and ascertain whether the MOU for the MFCU and state comply with the requirements of sections 455.21(c) and 1007.9(d)
- c. Obtain an understanding of the State's policies and procedures that ensure credible allegations of provider fraud are identified and referred from the Medicaid Agency to the MFCU or in jurisdictions without an MFCU, to another office with authority to prosecute.

For States in which Medicaid services are delivered in whole or in part by managed care organizations, obtain an understanding of how referrals originating from managed care organizations are referred to the Medicaid agency and/or to the MFCU when Medicaid services are delivered by in whole or in part by a managed care organization.

- d. Select a sample of cases maintained by the Medicaid Agency involving the identification and investigation of potential fraud. Ascertain whether those cases identified credible allegations of provider fraud and if those 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.

To the extent that the auditor selects a sample of MFCU cases to verify that credible allegations of fraud were referred to the MFCU, confine the sample to closed, rather than open, investigative cases.

For those States that deliver some or all Medicaid services through managed care organizations, ascertain that credible allegations of fraud originating from the managed care organizations were referred to the MFCU.

- e. Obtain records monetary recoveries identified as a result of MFCU activities and ascertain whether the overpayments and other recoveries were appropriately reported on the CMS-64.

7. Refunding of Federal Share of Medicaid Overpayments to Providers

Compliance Requirements The 42 CFR 433 Subpart F outlines the requirements SMAs are to follow related to refunding the federal share of Medicaid overpayments made to providers. Pursuant to 1903(d)(2)(C) of the Act (the Act) (42 USC 1396b), states have up to one (1) year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS via Form CMS-64 Summary, Line 9.C1- Fraud, Waste & Abuse Amounts, Line 9.C2-OIG Complaint False Claims Act, 9.D Other, 9.E. – RAC Collections, 9.F. – PERM Collections or 9.G. – MEQC Collections regardless of whether recovery is made from the provider. The state must credit the federal share to CMS as outlined under 42 CFR 433.320(a)(2) either in the quarter in which the recovery is made or in the quarter in which the one-year period following discovery ends, whichever is earlier, with limited exceptions. Under 42 CFR 433.316(d), for overpayments resulting from fraud, if not collected within one year of discovery, the SMA has until 30 days after the final judgment of a judicial or administrative appeals process to return the federal share.

Additionally, in accordance with 42 CFR 433.320(a)(4), the state will be charged interest for any non-recovered, non-refunded overpayment amounts. Any appeal rights offered to the provider does not extend the date of discovery per 42 CFR 433.316(h).

The repayment of the federal share is not required in cases where the state is unable to obtain recovery because the provider has filed for bankruptcy or the provider is otherwise out of business as outlined in 42 CFR 433.318.

The 42 CFR 433.320(c)(1) allows for downward adjustments previously credited to CMS if it is properly based on the approved state plan, federal law and regulations governing Medicaid, and the appeals resolution process specified in state administrative policies and procedures. States are not able to enter into settlement agreements with providers that reduces the federal share of the overpayment in order to avoid the expense of litigation. The Departmental Appeals Board (DAB) decision No. 1391 from February 19, 1993 (<https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1993/dab1391.html>), addressed overpayment settlements between the states and providers. This decision affirmed that states may not reduce the federal share by settling overpayment receivables for less than the actual amount of the overpayment based on anticipated success in litigation or made simply to avoid administrative costs or litigation expenses.

For managed care, SMAs are required per 42 CFR 438.608(d)(1) to specify in each managed care contract how recoveries of provider overpayments must be treated. The refunding of the federal share of any overpayment recovered by an MCP is dependent on the retention policy outlined in the contract between the state and the MCP as required under 42 CFR 438.608(d)(1). If the state requires the MCP to refund overpayments to the state, the state must refund the federal share of that overpayment to CMS in accordance with the regulations at 42 CFR 433.312. The state must apply the FMAP rate in effect at the time the overpayment was made to determine the amount to be refunded to CMS.

Audit Objectives Determine whether the SMA reported and returned Medicaid provider overpayments in accordance with the federal requirements.

Suggested Audit Procedures

- a. Review applicable federal laws and regulation, including 1903(d)(2)(C) of the Act (42 USC 1396b), 42 CFR 433 Subpart F, and the Departmental Appeals Board Decision No. 1391.
- b. Obtain an understanding of the process to identify overpayments.
- c. Obtain managed care contract(s) to determine how recoveries made by MCPs to providers are treated.
- d. Perform tests to ascertain if the federal share has been returned accurately in accordance with federal laws and regulations, including ensuring the full amount was refunded and any downward adjustments were made.

8. Medicaid Recovery Audit Contractors (RACs)

Compliance Requirements Under Section 1902(a)(42)(B)(i) of the Act (42 USC 1396a) and 42 CFR section 455 Subpart F, states and territories are required to establish programs to contract with one or more Medicaid RAC for the purpose of identifying underpayments and overpayments, and recouping overpayments under the state plan and under any waiver of the state plan with respect to all services for which payment is made to any entity under such plan or waiver. States must establish these programs in a manner consistent with State law, and generally in the same manner as the Secretary contracts with contingency fee contractors for the Medicare Fee-For-Service RAC program under Section 1893(h) of the Act (42 USC 1395ddd).

Section 1902(a)(42)(B)(i) of the Act (42 USC 1396a) specifies that states shall establish programs under which they contract with Medicaid RACs subject to such exceptions or requirements as the Secretary may require for purposes of a particular state. Under 42 CFR section 445.516(a), a state may request an exception to some or all of the Medicaid RAC contracting requirements by receiving an approved State Plan Amendment. As such, not all states have Medicaid RAC programs.

Under 42 CFR section 455.502, states must comply with reporting requirements

describing the effectiveness of their Medicaid RAC programs by reporting overpayments that are collected in connection with the Medicaid RAC program on the CMS-64.

Under 42 CFR section 455.508, an entity that performs the functions of a Medicaid RAC must enter into a contract with a state to carry out any of the activities described in 42 CFR section 455.506. The entity must demonstrate to a state that it has the technical capability to carry out the activities described in 42 CFR section 455.506 (42 CFR section 455.508(a)); must hire a minimum of 1.0 FTE contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant state licensing authorities and has relevant work and educational experience (42 CFR section 455.508(b)); must hire certified coders unless the state determines that certified coders are not required for the effective review of Medicaid claims (42 CFR section 455.508(c)); must work with the state to develop an education and outreach program, which includes notification to providers of audit policies and protocols (42 CFR section 455.508(d)); and must provide minimum customer service measures including: a toll-free customer service telephone number in all correspondence sent to providers and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone; compiling and maintaining provider approved addresses and points of contact; mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request; and notifying providers of overpayment findings within 60 calendar days (42 CFR section 455.508(e)).

Under 42 CFR section 455.506, Medicaid RACs must review claims submitted by providers for which payment has been made under section 1902(a) of the Act (42 USC 1396a) or under any waiver of the state plan to identify underpayments and overpayments and recoup overpayments for the states. States may exclude Medicaid managed care claims from review by Medicaid RACs (42 CFR section 455.506(a)(1)); may coordinate with Medicaid RACs regarding the recoupment of overpayments (42 CFR section 455.506(b)); must coordinate the recovery audit efforts of their RACs with other auditing entities (42 CFR section 455.506(c)); must make referrals of suspected fraud and/or abuse, as defined in 42 CFR section 455.2, to the MFCU or other appropriate law enforcement agency (42 CFR section 455.506 (d)); and must set limits on the number and frequency of medical records to be reviewed by the RACs, subject to requests for exception from RACs to states (42 CFR section 455.506(e)).

Audit Objectives To determine whether the state has established a Medicaid RAC (42 CFR section 455.502) with an eligible contractor (42 CFR section 455.508) and is conducting the required Medicaid RAC activities (42 CFR section 455.506) in accordance with the approved state plan, and any approved exceptions (42 CFR section 455.516).

Suggested Audit Procedures

Obtain an understanding of the state plan's provisions and approved exceptions for Medicaid RACs.

- a. Ascertain whether waivers approved under 42 CFR section 445.516(a), and their expiration dates, are applied as required by the State.
- b. Verify the state entered into a contract(s) with a Medicaid RAC(s) consistent with federal requirements (42 CFR section 455.508).
- c. Verify the state is coordinating the recovery audit efforts of their RACs with other auditing entities (42 CFR section 455.506(c)).
- d. Verify the state has procedures to make referrals of suspected fraud and/or abuse, as defined in 42 CFR section 455.2, to the MFCU or other appropriate law enforcement agency (42 CFR section 455.506(d)). Verify if the state has made referrals of suspected fraud and/or abuse in accordance with their procedures.
- e. Verify the state set limits on the number and frequency of medical records to be reviewed by the RACs and complied with those limits (42 CFR section 455.506(e)).
- f. Ascertain whether the state complied with reporting requirements by providing Medicaid RAC program performance results on its CMS-64 report on Form CMS 64.90 RAC (42 CFR section 455.502).

9. Medical Loss Ratio (MLR)

Compliance Requirements For all contracts, the state must ensure that each MCO, PIHP, and PAHP submits a report with the data elements specified in 42 CFR 438.8(k). The report should contain the required 13 data elements noted in the regulation, reflect the correct reporting years, and contain an attestation of accuracy regarding the calculation of the MLR as required in 42 CFR 438.8(n). The state should have a policy and procedure to indicate when the report(s) are due from plans and should not accept multiple submissions from plans unless the capitation payments are revised retroactively.

Audit Objectives Determine whether the state's oversight of the content and submission of MLR reports meets the requirements.

Suggested Audit Procedures

- a. Perform procedures to ascertain if the state obtained the required MLR reports;
- b. Verify the 13 required elements are included;
- c. Verify the reporting period covered is 12 months;
- d. Verify the report contains an attestation statement to address accuracy;
- e. Ascertain if the state did not permit plans to submit multiple MLR reports for a specific reporting year except when a state had retroactive changes to capitation payments.

10. Managed Care Financial Audit

Compliance Requirements Two types of audits are required for managed care:

1. Audited Financial Reports – The contract with each MCO, PIHP, and PAHP must require them to submit to the state an audited financial report specific to the Medicaid contract on an annual basis. These audits must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards (42 CFR section 438.3(m)).
2. Periodic Audits – Effective no later than for rating periods for contracts starting on or after July 1, 2017, the state must periodically, but no less frequently than once every three years, conduct, or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of each MCO, PIHP, and PAHP and post the results of these audits on its website (42 CFR section 438.602(e) and (g); May 6, 2016, *Federal Register* (81 FR 27497); OMB No. 0938-0920).

Audit Objectives Determine whether the required audits were conducted and the audit reports for the Periodic Audits were posted on the state's website.

Suggested Audit Procedures

- a. Review the state's policies and operating procedures for obtaining audited financial reports, conducting these required audits and for posting the Periodic Audits on the state's website.
- b. Perform tests to ascertain if: (1) the state obtained annually the required Audited Financial Reports from the MCO, PIHP, and PAHP; and (2) the independent auditor's report on the financial report stated the audit was conducted in accordance with generally accepted auditing standards.
- c. Perform tests to ascertain if: (1) the state conducted or contracted for the required Periodic Audits for the-MCO, PIHP, and PAHP at least once in the most recent three year period; and (2) the audits were posted on the state's website.

11. External Quality Review Organization (EQRO)

Compliance Requirements The SMA must ensure that each managed care organization is evaluated annually on quality, timeliness, and access to the health care services by an EQRO. The state must ensure that the EQRO conducting such reviews is competent and independent (42 CFR 438 Subpart E, 42 CFR 438.354).

Audit Objectives Determine whether the SMA has ensured the EQRO's conducting the annual reviews meet the requirements for competence and independence.

Suggested Audit Procedures

- a. For states with managed care perform procedures to ascertain if:
 - (1) The SMA's policies and procedures meet the requirement to ensure the EQROs are competent and independent.

IV. OTHER INFORMATION

Portion of Medicaid (Title XIX) Expenditures Claimed at CHIP Enhanced FMAP

As described in Part 4, CHIP (Assistance Listing 93.767), III.A.1, "Activities Allowed or Unallowed," certain qualifying states meeting the criteria provided in section 2105(g) of the Social Security Act, 42 USC 1397ee(g), may opt to receive the CHIP enhanced FMAP for certain Medicaid program expenditures. For certain qualifying states that choose this option, the enhanced portion of such expenditures (that is, the portion that is equal to the difference between the CHIP enhanced FMAP and the standard Medicaid FMAP) is funded by their available CHIP allotments. Qualifying states were permitted to use up to 20 percent of their CHIP allotment to fund the enhanced portion of such Medicaid expenditures for allotments through the fiscal year 2008 CHIP allotment and up to 100 percent of their available CHIP allotments beginning with the fiscal year 2009 CHIP allotment. The qualifying states, determined by CMS under section 2105(g) of the Act, 42 USC 1397ee(g) 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 Payment Findings

Auditors should be alert to the following that have been identified in audit findings both as noncompliance and material weaknesses: If these items are identified, the auditors should determine if further review is appropriate.

1. Beneficiary Eligibility Determinations

Findings related to internal control deficiencies for eligibility determinations include:

- eligibility determination and renewal were not performed timely and/or performed within the timeliness standards;
- eligibility determinations are not made accurately;
- lack of internal controls over obtaining adequate documentation to support eligibility determinations, when applicable;
- eligibility system data was not accurate;

- beneficiary information was not verified according to the state's verification plan;
- program staff did not have sufficient knowledge of program requirements and policies due to high turnover and/or a lack of training; and
- MEQC review staff were not functionally and physically separate from both the eligibility determination staff and the Medicaid policy staff.

2. Medicaid Claims Processing

Findings related to significant weaknesses in Medicaid claims processing include:

- 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;
- 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);
- review of cost report and recoupment of rate adjustments were not timely.

3. Other areas of weaknesses identified include:

- 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 was in file or in the state MES;
- inadequate internal control related to implementation of MES module;
- inadequate internal control regarding user access to the MES modules, including terminated employees' user access rights; and
- MES module was not programmed and updated timely and accurately with proper information.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.870 MATERNAL, INFANT, AND EARLY CHILDHOOD
HOME VISITING GRANT PROGRAM****I. PROGRAM OBJECTIVES**

The goals of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs 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 programs include 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). Per Section 511(h)(2)(B) of the Social Security Act (42 USC 711(h)(2)(B)), nonprofit organizations with an established record of providing early childhood home visiting programs or initiatives in a state or several states are eligible for funding to provide services in states that are not participating in the programs. The legislation requires that awardees 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.

These programs are 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 programs in partnership with the Administration for Children and Families (ACF), with awards under this Assistance Listing number made by HRSA (ACF awards are made under Assistance Listing 93.508). 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 US Virgin Islands, the Commonwealth of the Northern Mariana Islands, and America Samoa to conduct needs assessments, and to those entities and nonprofit organizations providing services in states that are not participating in the programs, to 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, voluntary, evidence-based home visiting services to pregnant women and families with young children from birth to age 5. Nonprofit organizations are required to carry out the program based on the needs assessment conducted by the state.

Also, to the greatest extent practicable, nonprofit organizations are subject to the program requirements that apply to states (e.g., coordination with other programs under Title V of the Social Security Act and the 10 percent limitation on costs associated with administering the award).

Source of Governing Requirements

These programs are authorized under the Social Security Act, Title V, 511(c) (42 USC 711(c)), as amended by the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123), Title VI, Subtitle A.

Availability of Other Program Information

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

The Notices of Funding Opportunity (NOFO) under Assistance Listing 93.870 include HRSA-21-050 (formula grants), HRSA-17-102, and HRSA-17-101. These may be found online at <https://grants.hrsa.gov/webexternal/fundingOpp.asp>. The NOFOs also are available in the archives at <https://www.grants.gov/> through an advanced search using Assistance Listing 93.870.

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 19 evidence-based models can be found at <https://homvee.acf.hhs.gov/HRSA-Models-Eligible-MIECHV-Grantees>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	N	N	N	N	N	Y	Y	Y	Y	N

A. Activities Allowed or Unallowed

1. *Activities Allowed*

As specified in the NOFOs, funds may be used to:

- a. identify unmet needs and target at-risk communities; based on the most recent and approved statewide needs assessment, or as updated to meet the requirement set forth in section 50603 of the Bipartisan Budget Act of 2018.
- b. develop the infrastructure and capacity needed to implement and sustain evidence-based maternal, infant, and early childhood home visiting programs in those communities; and
- c. 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).

2. *Activities Unallowed*

As stated in the NOFOs, funds may not be used to support the delivery or costs of direct medical, dental, mental health, or legal services; however, some limited

direct services may be provided (typically by the home visitor) to the extent required in fidelity to an evidence-based model approved for use.

B. Allowable Costs/Cost Principles

Costs charged to federal funds under this program must comply with the cost principles at 45 CFR Part 75, Subpart E, and any other requirements or restrictions on the use of federal funding.

J. Program Income

The Notice of Award provides guidance on the use of program income. 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. Special Reporting for Federal Funding Accountability and Transparency Act

Part 3.L for audit guidance.

M. Subrecipient Monitoring

- 1. The HHS Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR Part 75) requires pass-through entities: (1) to evaluate each subrecipient's risk of noncompliance in order to determine the appropriate monitoring level; (2) monitor the activities of subrecipient organizations to ensure that the subaward is in compliance with applicable federal statutes and regulations and terms of the subaward; and (3) verify that subrecipients are audited as required under this guidance. Specifically, the grantee must conduct monitoring activities in accordance with sections 75.351 through 75.353 of Subpart D of 45 CFR Part 75.

2. Grantees must ensure that all requirements imposed by the federal government are passed down to subrecipients so that the HHS award is used in accordance with federal statutes, regulations, and the terms and conditions of the award.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.914 HIV EMERGENCY RELIEF PROJECT GRANTS
(RYAN WHITE HIV/AIDS PROGRAM PART A)****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 people with HIV and those who have AIDS (as reported to and confirmed by the Centers for Disease Control and Prevention (CDC)). 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, supplemental project-based funding, and formula-based Minority AIDS Initiative (MAI) funding is provided to eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) to develop, organize, and operate health and support services programs for people with HIV 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 and will continue to receive such assistance unless they fail to meet the legislative requirements related to unobligated balances.

II. PROGRAM PROCEDURES

The Health Resources and Services Administration (HRSA), a component of the Department of Health and Human Services (HHS), administers the HIV emergency relief programs. Eligibility for Ryan White HIV/AIDS Program (RWHAP) Part A grants depends, in part, on the number of confirmed AIDS cases within a statutorily specified “metropolitan area.” The secretary of HHS uses the Office of Management and Budget’s (OMB) census-based definitions of a Metropolitan Statistical Area (MSA) in determining the geographic boundaries of a RWHAP metropolitan area. HHS relies on the OMB geographic boundaries in effect when a jurisdiction was or is (if newly eligible) initially funded under RWHAP Part A. A metropolitan area is not eligible if it does not have an overall population of 50,000 or more.

HRSA uses data reported to and confirmed by CDC to determine eligibility. An EMA is a metropolitan area for which there has been reported to, and confirmed by, the director of the CDC a cumulative total of more than 2,000 cases of AIDS for the most recent five calendar-year periods for which data are available. A TGA is a metropolitan area for which there has been reported to, and confirmed by, the director of the CDC a cumulative total of at least 1000, but fewer than 2000, cases of AIDS during the most recent period of five calendar years for which data are available. MAI funding is awarded using a formula that is based on the distribution of HIV/AIDS cases among racial and ethnic minorities.

After subtracting the amount available for MAI project assistance, HRSA must make at least two-thirds (66 2/3 percent) of the appropriated amount available for the EMAs' and TGAs' formula allocation and award the remainder as supplemental funding on the basis of demonstrated need and other factors. EMAs and TGAs are funded from the formula, supplemental, and MAI allocation on the basis of a single application and a combined award.

Funds are made available to the chief elected official of the EMA or TGA 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 fiscal year (FY) 2007 and beyond are exempt from the requirement to establish and use an HIV health services planning council but must provide a process for obtaining community input as prescribed in the RWHAP Part A legislation.

Consistent with funding and service priorities established through the public planning process, the receiving jurisdiction uses the funds to provide assistance to public entities or private nonprofit or for-profit entities to deliver or enhance HIV/AIDS-related core medical and support services and, within established limits, for associated administrative and clinical quality management activities. Administrative activities include EMA or TGA oversight of service provider performance and adherence to their subrecipient obligations. Most of these service providers are nonprofit organizations.

Source of Governing Requirements

This program is authorized under sections 2601–2610 of Title XXVI of the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Pub. L. No. 111-87) and is codified at 42 USC 300ff-11 through 300ff-20. The MAI is authorized under Section 2693(b)(2)(A) of the Public Health Service Act, 42 USC 300ff- 121(b)(2)(A).

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at 45 CFR Part 75. As per 45 CFR parts 75.201 and 301, recipients may use a fixed-award instrument to obtain services based on a reasonable estimate of actual cost and based on performance and results related to improvement of program outcomes.

There are no program regulations specific to this program.

Availability of Other Program Information

Additional information about this program is available at <https://ryanwhite.hrsa.gov/>.

Additional information on allowable uses of funds under this program is contained in policy notices and standards found at <https://ryanwhite.hrsa.gov/grants/policy-notice> and <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	Y	N	N	N	N	Y	N	Y	N

A. Activities Allowed or Unallowed

1. *Activities Allowed*

Funds may be used only for core medical services, support services, clinical quality management, and administrative expenses (42 USC 300ff-14(a)).

- a. Core medical services with respect to people with HIV (including co-occurring conditions (i.e., one or more adverse health conditions of an individual with HIV, 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 people with HIV to achieve their medical outcomes (those outcomes affecting the HIV-related clinical status of an individual with HIV) (for example, respite care for persons caring for people with HIV, 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. Clinical quality management means assessing the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infections, and as applicable, developing strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services (42 USC 300ff-14(h)(5)(A)). Policy Clarification Notice #15-02, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-02-cqm.pdf>.
- d. Administrative expenses at the recipient level include (1) activities related to 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) and 300ff-12(b)).
- e. Subrecipient administrative expenses include usual and recognized overhead activities, including those that are reimbursed through approved indirect cost rates; 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)(4)).

2. *Activities Unallowed*

- a. 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)).

- b. 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)).
- c. Funds may not be used to make cash payments to intended recipients of RWHAP services (42 USC 300ff-14(i)) and Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds, Policy Clarification Notice #16-02, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf>.
- d. Funds may not be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug (Consolidated Appropriations Act, 2016, Division H, Title V, Section 520 (Pub. L. No. 114-113) and subsequent appropriations, as applicable). Other elements of syringe services programs may be allowable if in compliance with applicable HHS and HRSA-specific guidance.
- e. 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 low-income individuals with HIV or, in certain circumstances, families of people with HIV. 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 for Subrecipients

The EMA or TGA may make funds available to public or private nonprofit 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)).

J. Program Income

The Notice of Award provides guidance on the use of program income. The addition method is used for this program. Program income must be used for activities described in III.A.1, “Activities Allowed.”

M. Subrecipient Monitoring

1. The HHS Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR Part 75) requires pass-through entities: (1) to evaluate each subrecipient's risk of noncompliance in order to determine the appropriate monitoring level; (2) to monitor the activities of subrecipient organizations to ensure that the subaward is in compliance with applicable federal statutes and regulations and terms of the subaward; and (3) to verify that subrecipients are audited as required under this guidance. Specifically, the recipient must conduct monitoring activities in accordance with sections 75.351 through 75.353 of Subpart D of 45 CFR Part 75.
2. Recipients must ensure that all requirements imposed by the federal government are passed down to subrecipients so that the HHS award is used in accordance with federal statutes, regulations, and the terms and conditions of the award.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.917 HIV CARE FORMULA GRANTS (RYAN WHITE HIV/AIDS PROGRAM PART B)****I. PROGRAM OBJECTIVES**

The objective of this program is to assist states and territories in improving the quality, availability, and organization of healthcare and support services for low-income, uninsured, and underinsured people with Human Immunodeficiency Virus (HIV).

II. PROGRAM PROCEDURES

The Department of Health and Human Services (HHS) administers the Ryan White HIV/AIDS Program (RWHAP) Part B through the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB). Grants are awarded annually, on a formula basis, to all 50 states, the District of Columbia, Puerto Rico, 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, HAB. 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 six specified program components: (1) HIV care consortia, (2) home and community-based care, (3) health insurance continuation program, (4) provision of treatments, (5) state direct services, and (6) Minority AIDS Initiative (MAI). This includes the state's plans for the AIDS Drug Assistance Program (ADAP). ADAP funding is provided to the state as a separate formula amount in addition to the base formula grant amount and can only be used for ADAP services.

States may use a variety of service delivery mechanisms. States may provide some or all services directly or may enter into subawards with local HIV care consortia, associations of public and nonprofit healthcare and support service providers, and community-based organizations that plan, develop, and deliver services for low-income, uninsured, and underinsured people with HIV. The state also may delegate some of its authority to monitor provider agreements to a "lead agency" (fiscal agent), with specific responsibilities contained in a formal agreement between the state and that agency. Finally, the state may provide subawards to healthcare or other service providers.

Source of Governing Requirements

The RWHAP Part B formula grant program is authorized under Sections 2611-2623 of Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Pub. L. No. 111-87) and codified at 42 USC 300ff-21 through 300ff-31b. The MAI is authorized under Section 2693(b)(2)(B) of the Public Health Service Act, 42 USC 300ff-121(b)(2)(B).

There are no regulations specific to the RWHAP Part B.

Availability of Other Program Information

Further information about the RWHAP Part B is available at <https://ryanwhite.hrsa.gov/>.

Additional information on allowable uses of funds under this program is contained in policy notices and standards found at <https://ryanwhite.hrsa.gov/grants/policy-notice> and <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/fiscal-monitoring-partb.pdf>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	Y	N	Y	N	N	Y	N	Y	N

A. Activities Allowed or Unallowed

1. *Activities Allowed*

- a. Grant funds (and required matching funds) may be used for core medical services, support services, planning and evaluation, clinical quality management, and administrative expenses (42 USC 300ff-22(a); 42 USC 300ff-28(b)).

- (1) Core medical services with respect to people with HIV (including the co-occurring conditions of the individual) means (1) outpatient and ambulatory health services; (2) AIDS Drug Assistance program treatments; (3) AIDS pharmaceutical assistance; (4) oral healthcare; (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 healthcare; (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 people with HIV to achieve their medical outcomes (those outcomes affecting the HIV-related clinical status of people with HIV) (for example, respite care for persons caring for people with HIV, outreach services, medical transportation, linguistic services, referrals for healthcare 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) Clinical quality management means assessing the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infections, and as applicable, developing strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services (42 USC 300ff-28(b)(3)(E)(i) and Policy Clarification Notice #15-02, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-02-cqm.pdf>).
- (4) Administrative expenses at the recipient 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) planning and evaluation activities (42 USC 300ff-28(b)(3)(C)).
- (5) Subrecipient administrative expenses include usual and recognized overhead activities, including those that are reimbursed through

approved indirect cost rates; 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)).

- b. 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 RWHAP Part B, with priority given to activities related to providing therapeutics (42 USC 300ff-26(g)). To assess whether a state or subrecipient is giving priority to activities related to providing therapeutics, the state (or subrecipient) should be able to demonstrate, that, before undertaking any type of activities other than ADAP purchases for medications or insurance that are allowed under paragraph 1.a. above, it (1) has no waiting list for ADAP services; (2) the ADAP formulary includes the required classes of HIV antiretroviral medications and opportunistic infection-related medications; and (3) the financial eligibility to access the ADAP is established at no less than 200 percent of the federal poverty level (the poverty guidelines are available at <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines> and are also published each year in the *Federal Register*).
- c. Rebates may be used for allowable RWHAP Part B services that exceed the recipient's RWHAP Part B implementation work plan. Rebates are not part of the recipient's RWHAP Part B award, and, therefore, are not subject to the 10 percent administrative cost cap, the planning and evaluation cost cap, clinical quality management cost cap, nor to the requirement to spend 75 percent on core medical services (see III.G.3.b and h, "Matching, Level of Effort, and Earmarking – Earmarking" below). Rebates can be used to meet both a recipient's state matching and maintenance of effort (MOE) requirements (42 USC 300ff-26(g) and Policy Clarification Notice #15-04 Utilization and Reporting of Pharmaceutical Rebates, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-04-pharmaceutical-rebates.pdf>).

2. *Activities Unallowed*

- a. 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)).
- b. Funds may not be used to make cash payments to intended recipients of RWHAP services. Where direct provision of the service is not possible or effective; store gift cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Recipients are advised to administer voucher

and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards (42 USC 300ff-28(b)(6)) and Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds, Policy Clarification Notice #16-02, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf>).

- c. 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/territory 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)).
- d. Funds may not be used for inpatient hospital services, or nursing home or other long-term care facilities (42 USC 300ff-24(c)(3)).
- e. 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/territory under Title XIX of the Social Security Act (Medicaid) (42 USC 300ff-25(b)).
- f. 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).
- g. Funds may not be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug (Consolidated Appropriations Act (Pub. L. No. 114-113), 2016, Division H, Title V, Section 520 and subsequent appropriations, as applicable). Other elements of syringe services programs may be allowable if in compliance with applicable HHS and HRSA-specific guidance.
- h. ADAP rebates cannot be shared with other entities including, but not limited to, RWHAP Part A recipients, high-risk insurance pools, Marketplace plans, Medicaid, or any other state or federal program (42 USC 300ff-31(b)).
- i. International travel.

E. Eligibility**1. Eligibility for Individuals**

- a. To be eligible to receive assistance in the form of therapeutics, an individual must have a medical diagnosis of HIV and be (1) a low-income individual (as defined by the state), and (2) a resident of the state (as defined by the state) (42 USC 300ff-26(b)).

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

A state must use Emerging Communities funding in the geographic area specified as an Emerging Community, as defined in 42 USC 300ff-30(d)—a metropolitan area for which there has been reported to and confirmed by the Centers for Disease Control and Prevention a cumulative total of at least 500, but fewer than 1,000, cases of AIDS during the most recent period of five calendar years for which such data are available (42 USC 300ff-32(b)(1) and 300ff-30).

3. Eligibility for Subrecipients

- a. To receive funding from the state under a consortium agreement, an applicant consortium must agree to provide, directly or through agreements with other service providers, essential health services, and essential 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)(5)) to meet identified service needs following a consultation process (42 USC 300ff-23(c)(2)).
- b. 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 one percent of the aggregate number of national cases of HIV/AIDS in the two-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 Nonfederal Matching	Ratio of Nonfederal to Federal Expenditures
First	16 2/3	\$1 nonfederal/\$5 Federal
Second	20	\$1 nonfederal/\$4 Federal
Third	25	\$1 nonfederal/\$3 Federal
Fourth and subsequent	33 1/3	\$1 nonfederal/\$2 Federal

- b. All recipients are subject to a matching requirement for ADAP supplemental funds in an amount equal to \$1 for every \$4 of federal funds (42 USC 300ff-28(a)(2)(F)(ii)(III)). Those recipients that are required to match the base formula funds may request and receive a waiver from this additional matching requirement.

2. Level of Effort

2.1 Level of Effort – *Maintenance of Effort*

The state/territory will maintain HIV-related activities at a level that is equal to not less than the level of such expenditures by the state/territory for the one-year period preceding the fiscal year for which the state/territory is applying for RWHAP Part B funds (42 USC 300ff-27(b)(7)(E)).

2.2 Level of Effort – *Supplement Not Supplant*

Funds awarded under a grant must supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved (42 USC 300ff-22(d)(2)(B)).

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 amounts received under the grant for administration (42 USC 300ff-28(b)(3)(A)).
- c. A state may not use more than a total of 15 percent of the amounts received for the combined costs for administration and planning and evaluation (42 USC 300ff-28(b)(4)). States and territories that receive a minimum allotment (between \$50,000 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 subrecipients may not exceed 10 percent of the total amount of grant funds sub awarded by the state (without regard to whether particular entities

spend more than 10 percent for such purposes) (42 USC 300ff-28(b)(3)(B)).

- e. Unless waived by the secretary, for the purpose of providing health and support services to women, youth, infants, and children with HIV, 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 RWHAP 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-22(e)). This information is provided to the state by HRSA with reporting requirements (i.e., annual progress report) as listed on the Notice of Award (NoA). Recipients demonstrate compliance with the WICY expenditure requirement in their annual progress report and may request a waiver as part of the annual progress report.
- 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 specific amount for ADAP will be provided in the grant agreement. Of the specific amount 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 clinical 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, planning and evaluation, and a clinical quality management program shall be used to provide core medical services to eligible people with HIV (including services regarding the co-occurring conditions of those individuals) (42 USC 300ff-22(b)).

J. Program Income

1. The NoA provides guidance on the use of program income. Generally, the addition method is used for this program; program income may also be used to satisfy all or part of the state matching requirements. Program income must be used for activities described in III.A.1, “Activities Allowed.”
2. The terms and conditions of award under the RWHAP Part B regarding program income do not apply to drug rebates. Rather, drug rebates must be used as specified in III.A.1.b and c, “Activities Allowed or Unallowed – Activities Allowed.”

M. Subrecipient Monitoring

1. HHS Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR Part 75) requires pass-through entities: (1) to evaluate each subrecipient’s risk of noncompliance in order to determine the appropriate monitoring level; (2) monitor the activities of subrecipient organizations to ensure that the subaward is in compliance with applicable federal statutes and regulations and terms of the subaward; and (3) verify that subrecipients are audited as required under this guidance. Specifically, the grantee must conduct monitoring activities in accordance with sections 75.351 through 75.353 of Subpart D of 45 CFR Part 75.
2. Recipients must ensure that all requirements imposed by the federal government are passed down to subrecipients so that the HHS award is used in accordance with federal statutes, regulations, and the terms and conditions of the award.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 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 the Ryan White HIV/AIDS Program (RWHAP) Part C Early Intervention Services (EIS) is to provide outpatient, high-quality, early intervention services and primary care related to the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

II. PROGRAM PROCEDURES

The Department of Health and Human Services (HHS) administers the RWHAP Part C EIS through the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB). Grants are awarded to public and nonprofit private entities, including federally qualified health centers under Section 1905(1)(2)(B) of the Social Security Act (42 USC 1396d (1)(2)(B)).

Grants also are awarded to (1) grantees under Section 1001 (regarding family planning) other than states, (2) comprehensive hemophilia diagnostic and treatment centers, (3) rural health clinics, (4) health facilities operated by or pursuant to a contract with the Indian Health Service, (5) community-based organizations, clinics, hospitals, and other health facilities that provide early intervention services to those people with HIV, or (6) nonprofit private entities that provide comprehensive primary care services to populations at risk for HIV/AIDS, including faith-based and community-based organizations. 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 RWHAP Part C EIS enables provision of a comprehensive primary health care and support services in an outpatient setting, including (1) HIV counseling and testing, (2) periodic medical evaluation, clinical, and diagnostic services, (3) provision of therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising with HIV/AIDS; and (4) referrals to appropriate providers of health care and support services. RWHAP Part C EIS recipients work with their community and public health partners to improve outcomes across the HIV care continuum so that individuals diagnosed with HIV are linked and engaged in care and started on antiretroviral therapy (ART) as early as possible.

Minority AIDS Initiative (MAI) funds are provided to recipients based on the percentage of the RWHAP Part C EIS populations served within racial/ethnic minority communities.

Services may be provided directly by the recipient or through contractual agreements with other service providers/subrecipients.

Source of Governing Requirements

The RWHAP Part C EIS is authorized under sections 2651–2667 of Title XXVI of the Public Health Service (PHS) Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Pub. L. No. 111-87) and is codified at 42 USC 300ff-51 through 300ff-67. The MAI is authorized under Section 2693(b)(2)(C) of the Public Health Service Act (42 USC 300ff-121(b)(2)(C)).

The RWHAP Part C EIS has no specific program regulations.

Availability of Other Program Information

Further information about the RWHAP Part C EIS is available at <https://ryanwhite.hrsa.gov/>.

Additional information on allowable uses of funds under the RWHAP Part C EIS is contained in policy notices and standards found at <https://ryanwhite.hrsa.gov/grants/policy-notice>.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	N	Y	Y	Y	Y	N	N

A. Activities Allowed or Unallowed**1. *Activities Allowed***

- a. Funds may be used for counseling (whether or not associated with HIV 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 clinical and diagnostic services regarding HIV/AIDS and periodic medical evaluations of individuals with HIV. Funds also may be used for providing therapeutic measures for preventing and treating the deterioration of the immune system and related conditions (including STD, hepatitis C, and tuberculosis) (42 USC 300ff- 51(e)(1)(D) and (E)).
- c. Funds may be used to refer people with HIV to providers of health and support services, as appropriate. This includes recipients of funding under the RWHAP Part A and Part B for the provision of health and support services; biomedical research facilities of institutions of higher education that offer experimental treatment for such disease; community-based organizations or other entities that provide such treatment; and, in the case of pregnant women, recipients of funding under RWHAP Part D (42 USC 300ff-51(e)(1)(C) and -51(e)(2)(A-C)).
- d. At least 75 percent of funds must be used for core medical services for an individual with HIV, including the co-occurring conditions of the individual. Core medical services encompass the following services: (1) outpatient and ambulatory health services; (2) AIDS Drug Assistance Program treatments defined under 42 USC 300ff-26; (3) AIDS pharmaceutical assistance; (4) oral healthcare; (5) early intervention services described in 42 USC 300ff-51(e); (6) health insurance premium and cost sharing assistance for low-income individuals in accordance with 42 USC 300ff-15; (7) home health care; (8) medical nutrition therapy; (9) hospice services; (10) home and community-based health services as defined under 42 USC 300ff-14(c); (11) mental health services; (12) substance abuse outpatient care; and (13) medical case management, including treatment adherence services (42 USC 300ff-51(b)(1)(A) and 51(c)).
- e. Funds may be used to pay the costs of providing support services that are needed for people with HIV to achieve their medical outcomes. These services include, but are not limited to, outreach services, nonmedical case management, medical transportation, translation, and referrals for healthcare and support services. Support services are subject to approval of the secretary of HHS or designee (42 USC 300ff-51(b)(1)(B) and 51(d)).

- f. Funds may be used for the establishment of a clinical quality management program to assess the extent to which medical services that are provided to patients are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infections, and, as applicable, 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-64 (g)(5)). Policy Clarification Notice #15-02, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-02-cqm.pdf>.
- g. Funds may be used for administrative expenses; no more than 10 percent on 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. Funds may not be used to fund AIDS programs or to develop materials, designed to promote or encourage, directly, intravenous drug abuse or sexual activity, whether homosexual or heterosexual (42 USC 300ff-84).
- d. Funds may not be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug (Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113), Division H, Title V, Section 520, and subsequent appropriations, as applicable). Other elements of syringe services programs may be allowable if in compliance with applicable HHS and HRSA-specific guidance.
- 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)).
- f. Funds may not be used to purchase or improve land or to purchase, construct, or make permanent improvement to any building (42 USC 300ff-64(g)(1)).
- g. Payments for clinical research.

- h. Payments for nursing home care.
- i. Pre-Exposure Prophylaxis (PrEP) or Post-Exposure Prophylaxis (nPEP) medications or medical services. As outlined in the June 22, 2016 RWHAP and PrEP program letter, the RWHAP legislation provides grant funds to be used for the care and treatment of People Living with HIV/AIDS (PLWH), thus prohibiting the use of RWHAP funds for PrEP medications or related medical services, such as physician visits and laboratory costs. However, RWHAP Part C recipients and subrecipients may provide prevention counseling and information, which should be part of a comprehensive PrEP program.
- j. International travel.
- k. Funds may not be used to make cash payments to intended recipients of RWHAP services (42 USC 300ff-28(b)(6) and Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds, Policy Clarification Notice #16-02, <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf>).

B. Allowable Costs/Cost Principles

Costs charged to federal funds under this program must comply with the cost principles at 45 CFR Part 75, Subpart E, and any other requirements or restrictions on the use of federal funding.

J. Program Income

The Notice of Award provides guidance on the use of program income. The additional method is used for RWHAP Part C EIS. Program income must be used for activities described in III.A.1, “Activities Allowed.”

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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES**ASSISTANCE LISTING 93.958 BLOCK GRANTS FOR COMMUNITY MENTAL HEALTH SERVICES****I. PROGRAM OBJECTIVES**

The objective of the Community Mental Health Services Block Grant (MHBG) 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 ensure 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

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. MHBG-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; (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); (4) collecting and reporting an estimate of the incidence and prevalence in the state of serious mental illness among adults and serious emotional disturbance among children; and (5) staffing and training for mental health services providers necessary to implement the state plan.

MHBG 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.

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. The 45 CFR Part 96 provides regulations for the general administrative requirements for the covered block grant programs. These regulations are in lieu of the general administrative requirements included in 45 CFR Part 75 (the HHS implementation of 2 CFR Part 200). Section 75.202 and sections 75.351 through 75.353 of Subpart D, and Subpart F of 45 CFR 75 are applicable to the MHBG. In addition, states are to administer the MHBG program according to the plans that they submitted to SAMHSA.

States are to use the fiscal policies that apply to their own funds in administering MHBG. Procedures must be adequate to ensure 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 MHBG program, within very broad federal guidelines. States must administer their MHBG 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 nonrecurring 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 nonrecurring expense exclusion.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status Discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	Y	Y	N	N	Y	Y	N

A. Activities Allowed or Unallowed

1. *Activities Allowed*

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. Twenty-four-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. *Activities Unallowed*

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 nonfederal funds as a condition for the receipt of federal funding; or
- e. Provide financial assistance to any entity other than a public or nonprofit 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

State cost principles requirements apply to MHBG (45 CFR section 96.30). As discussed in Appendix I to this Supplement, “Federal Programs Excluded from the A-102 Common Rule and Portions of 2 CFR Part 200,” MHBG is exempt from the provisions of OMB cost principles.

C. Cash Management

SAMHSA will make payments at such times and in such amounts to each state from its awards in advance or by way of reimbursement in accordance with 31 USC 6503(a) and Treasury Circular No. 1075 (31 CFR Part 205) (45 CFR section 96.12).

G. Matching, Level of Effort, Earmarking

1. Matching

Not Applicable

2. Level of Effort

2.1 Level of Effort – *Maintenance of Effort*

- a. The state shall for each fiscal year maintain aggregate state expenditures for community mental health services 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 nonrecurring 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

- a. 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)).
- b. A state shall expend not less than 10 percent of grant funds for carrying out evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. Evidence-based programs are interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, that promote individual-level or population-level outcomes. Different evidence-based programs are available at: <https://www.samhsa.gov/resource-search/ebp>. In lieu of expending 10 percent of the amount received for a fiscal year, a state may elect to expend not less than 20 percent of such amount by the end of the succeeding fiscal year (42 USC 300x-9c).
- c. A state shall expend 5 percent of grant funds for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses (SMI) and children with serious mental and emotional disturbances (SED). SAMHSA guidance related to the 5 percent set-aside is available at: <https://www.samhsa.gov/sites/default/files/mhbg-crisis-set-aside-guidance.pdf> Definitions for SMI and SED can be found at: <https://www.samhsa.gov/sites/default/files/federal-register-notice-58-96-definitions.pdf> A state’s expenditures must be for core crisis care elements, such as: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or statewide crisis call centers coordinating in real time (P.L. 116-260 and MHBG document entitled, *Guidance for the Revision of the FY 2020-2021 for the Mental Health Block Grant Application for the New Crisis Services 5% Set-Aside*).

H. Period of Performance

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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

M. Subrecipient Monitoring

The state must conduct monitoring activities in accordance with sections 75.351 through 75.353 of Subpart D of 45 CFR 75.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSISTANCE LISTING 93.959 BLOCK GRANTS FOR PREVENTION AND TREATMENT OF SUBSTANCE ABUSE

I. PROGRAM OBJECTIVES

The objective of the Substance Abuse Prevention and Treatment Block Grant (SABG) 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 SABG is the primary tool the federal government uses to fund state SA prevention and treatment programs. While the SABG 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

The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division of the Department of Health and Human Services (HHS), administers the SABG 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 US Virgin Islands, and the Red Lake Band of Chippewa Indians. The states generally subaward funds for the provision of services to public and nonprofit organizations. Service providers may include for-profit organizations, but for-profits may not receive financial assistance.

Examples of SABG activities are:

1. *Alcohol Treatment and Rehabilitation* – Direct services to patients experiencing primary problems for alcohol, such as community outreach, detoxification, outpatient counseling, residential rehabilitation, hospital based care (not inpatient hospital services), abuse monitoring, vocational counseling, case management, central intake, and program administration.
2. *Drug Treatment and Rehabilitation* – Direct services to patients experiencing primary problems with illicit 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.
3. *Primary Prevention Activities* – Education, counseling, and other activities designed to reduce the risk of substance abuse.

The SABG 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 SABG 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. SABG statutory “set asides” were established to fund programs targeting special populations, such as services for substance using pregnant women and women with dependent children, and, in certain “designated states,” for screening for human immunodeficiency virus (HIV).

The 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-21-66) 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.

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-21-67). The implementing regulations are published at 45 CFR Part 96. Those regulations include general administrative requirements for the covered block grant programs in 45 CFR sections 96.46 through 96.120. Specific SABG requirements are included in 45 CFR sections 96.121 through 96.137. Section 75.202 and sections 75.351 through 75.353 of Subpart D, and Subpart F of 45 CFR 75 are applicable to the SABG. With the exceptions noted, 45 CFR 75.101(d) exempts SABG from the general administrative requirements of 45 CFR Part 75.

States are to administer their SABG programs according to the plan that they submitted to SAMHSA. States are to use the fiscal policies that apply to their own funds in administering the SABG. 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 nonrecurring 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 nonrecurring expense exclusion.

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	Y	Y	N	N	Y	Y	N

A. Activities Allowed or Unallowed

1. *Activities Allowed*

- a. SABG funds may be expended to provide for a wide range of activities to prevent and treat substance abuse and may be expended to deal with the abuse of alcohol, the use or abuse of illicit drugs, the abuse of licit drugs, and the use or abuse of tobacco products as identified in the Overview section above (sections 1921 to 1954 of the PHS Act, 42 USC 300x-21–300x-35; 58 FR 17062 No. 60, March 1993).
- b. The state may use grant funds 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 \$4,000 (45 CFR section 96.129).

2. *Activities Unallowed*

- a. 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)).
- b. 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)).
- c. 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)).
- d. The state shall not use grant funds to satisfy any requirement for the expenditure of nonfederal funds as a condition for the receipt of federal funding (42 USC 300x-31(a); 45 CFR section 96.135(a)(4)).
- e. Grant funds may not be used to provide financial assistance (i.e., a subgrant) to any entity other than a public or nonprofit 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)).
- f. The state shall not expend grant funds to purchase sterile needles or syringes for the hypodermic injection of any illegal drug, provided that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant state or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the state or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with state and local law (42 USC

300ee-5; 45 CFR section 96.135 (a)(6); and Pub. L. No. 114-113, Division H, Title V, Section 520).

- g. Grant funds may not be used to enforce state laws regarding sale of tobacco products to individuals under the age of 18, except that grant funds may be expended from the primary prevention set-aside of SABG 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)).
- h. 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 specified in Appendix I to this Supplement, “Federal Programs Excluded from the A-102 Common Rule and Portions of 2 CFR Part 200,” SABG is exempt from the provisions of the OMB cost principles. State cost principles requirements apply to SABG.

C. Cash Management

SAMHSA will make payments at such times and in such amounts to each state from its awards in advance or by way of reimbursement in accordance with section 203 of the Intergovernmental Cooperation Act (42 USC 4213) and Treasury Circular No. 1075 (31 CFR Part 205) (45 CFR section 96.12).

G. Matching, Level of Effort, Earmarking

1. Matching

Not Applicable

2. Level of Effort

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. Section 8002(c)(3) of the 21st Century Cures Act (Pub. L. No. 114-255 repealed section 1924(d) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 USC 300x-24(d)). State and jurisdictions are no longer required to demonstrate compliance with the maintenance of effort requirement regarding tuberculosis and human immunodeficiency virus.

2.2 Level of Effort – *Supplement Not Supplant*

- a. The Block Grant will not be used to supplant state funding of alcohol and other drug prevention and treatment programs (45 CFR section 96.123(a)(10)).

3. Earmarking

- a. The state shall expend not less than 20 percent of SABG 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 (i.e., any state whose cases of Acquired Immunodeficiency Syndrome (AIDS) is 10 or more per 100,000 individuals (as indicated by the number of such cases reported to and confirmed by the Centers for Disease Control and Prevention for the most recent calendar year for which data are available)), 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 (EIS HIV) 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 sections 96.128(a)(1), (b), and (d)). Note: The applicable percentage is based on the percent change in a current year allotment to the base year

allotment under the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant. Any “designated state” whose percentage change in allotment is greater than 5 percent is required to obligate and expend 5 percent of the SABG allotment for the applicable federal fiscal year (FFY) to establish one or more projects designed to provide EIS HIV at the site(s) at which individuals are receiving SA treatment.

In FFY 2011, SAMHSA amended the EIS HIV program policy to allow states that were previously considered a “designated state” during any of the three prior FFYs for which a state was applying for a grant and whose AIDS case rates dropped below the AIDS case rate threshold, to opt to continue to set aside 5 percent of the award amount for EIS HIV. Such states are authorized to obligate and expend 5 percent of SABG funds for EIS HIV in accordance with section 1924(b)(4) and 45 CFR section 96.128(a)(2).

- 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 Performance

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. Special Reporting for Federal Funding Accountability and Transparency Act

See Part 3.L for audit guidance.

M. Subrecipient Monitoring

The state must conduct monitoring activities in accordance with sections 75.351 through 75.353 of Subpart D of 45 CFR 75.

IV. OTHER INFORMATION

As described in Part 4, Social Services Block Grant (SSBG) program (Assistance Listing 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**ASSISTANCE LISTING 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 ensure 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 16 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

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 pre-established 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 nonprofit 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 75 (the HHS implementation of 2 CFR Part 200).

Availability of Other Program Information

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

III. COMPLIANCE REQUIREMENTS

In developing the audit procedures to test compliance with the requirements for this federal program, the auditor must determine, from the following summary (also included in Part 2, “Matrix of Compliance Requirements”), which of the 12 types of compliance requirements have been identified as subject to the audit (noted with a “Y” in the summary matrix below), and then determine which of the compliance requirements that are subject to the audit are likely to have a direct and material effect on the federal program at the auditee. For each such compliance requirement subject to the audit, the auditor must use Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and this program supplement (which includes any program-specific requirements) to perform the audit. When a compliance requirement is shown in the summary below as “N,” it has been identified as not being subject to the audit. Auditors are not expected to test requirements that have been noted with an “N.” See the Safe Harbor Status discussion in Part 1 for additional information.

A	B	C	E	F	G	H	I	J	L	M	N
Activities Allowed or Unallowed	Allowable Costs/Cost Principles	Cash Management	Eligibility	Equipment and Real Property Management	Matching, Level of Effort, Earmarking	Period Of Performance	Procurement and Suspension and Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	N	Y	Y	N	N	Y	N	N

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 nonprofit 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

The MCH Block Grant program is exempt from the provisions of the OMB cost principles. State cost principles requirements apply to the MCH Block Grant program.

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

For every four dollars of federal funds expended, States must match three dollars of nonfederal funds (42 USC 703(a)).

2. Level of Effort**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 Performance

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)).

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

Maternal and Child Health Services Block Grant 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:

1. *Form 2* – MCH Budget/Expenditure Details
 - 4:3 Match: For both the budget for the application year and the expenditure for the reporting year on Form 2, the 4:3 match is in place (comparing Line 1, Federal Allocation, with Line 7, Total State Match). If the match is not met for expenditures, a note is provided explaining the discrepancy.
 - 30% Preventative and Primary Services: For both the budget for the application year and the expenditure for the reporting year on Form 2, 30% of federal funding is allocated to preventive and primary services for children (Line 1A). If the percentage is not met for expenditures, a note is provided explaining the discrepancy.
 - 30% Children with Special Care Need: For both the budget for the application year and the expenditure for the reporting year on Form 2, 30% of federal funding is allocated to children with special health care needs (Line 1B). If the percentage is not met for expenditures, a note is provided explaining the discrepancy.
 - 10% Title V Admin Costs: For both the budget for the application year and the expenditure for the reporting year on Form 2, no more than 10% of federal funding is allocated to Title V administrative costs

(Line 1C). If the percentage is exceeded for expenditures, a note is provided explaining the discrepancy.

- **State Match \neq State MOE:** For both the budget for the application year and expenditure for the reporting year on Form 2, the Total State Match (Line 7) is equal to or more than the State FY 1989 Maintenance of Effort Amount (Line 7A). If the amount is not met for expenditures, a note is provided explaining the discrepancy.
- **Form 4 – Number and Percentage of Newborns and Others Screened, Cases Confirmed and Treated**
- **Newborn Screening:** For the annual report year on Form 4, the number of newborns screened is broken out by the aggregate total number of newborns receiving at least one valid screen, the aggregate total number of out-of-range results, the aggregate total number of confirmed cases, and the aggregate total number of referred for treatment.

5. *Form 5a – Count of Individuals Served By Title V*

- **Individuals Served by Title V for Direct and Enabling Service:** For the annual report year on Form 5a, the count of individuals served by Title V are broken out by the types of individuals served (Pregnant Women, Infants, Children, Children with Special Health Care Needs, and All Others) and by Primary Source of Coverage.

6. *Form 5b – Total Percentage of Populations Served by Title V*

- **Populations served by Title V by Levels of Service:** For the annual report year on Form 5b, the count of individuals served by Title V are broken out by the types of individuals served by percentage (Pregnant Women, Infants, Children, Children with Special Health Care Needs, and All Others).

7. *Form 6 – Deliveries and Infants Served by Title V and Entitled to Benefits under Title XIX*

- **Deliveries and Infants Served by Title V and Entitled to Benefits under Title XIX:** For the annual report year on Form 6, the total number of deliveries and infants served by Title V and eligible for Title XIX are broken out by race and ethnicity.

4. **Special Reporting for Federal Funding Accountability and Transparency Act**

See Part 3.L for audit guidance.

IV. OTHER INFORMATION

Federal funds from other block grant programs (e.g., Social Services Block Grant (Assistance Listing 93.667) and Preventive Health and Health Services Block Grant (Assistance Listing 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.