CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 150	**Date: April 2, 2009**
	Change Request 6249

Transmittal 147, issued on February 6, 2009is rescinded and replaced by Transmittal 150, dated April 2, 2009. Some of the information in Exhibits 2 and 3 was inadvertently cut off. This has now been corrected. All other information remains the same.

SUBJECT: Chapter 7 - Internal Control Requirements Update

I. SUMMARY OF CHANGES: This document updates the CMS Control Objectives and provides guidelines for the Office of Management and Budget (OMB) and Internal Control over Financial Reporting.

NEW / REVISED MATERIAL
**EFFECTIVE DATE: ***March 9, 2009
IMPLEMENTATION DATE: March 9, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	7/Table of Contents
R	7/10/Introduction
R	7/10.1 Authority
R	7/10.1.2 FMFIA and the CMS Contractor Contract
R	7/10.1.5/GAO Standards for Internal Controls in the Federal Government
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R	7/20 CMS Contraactor Internal Control Review Process
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R	7/30.1 CPIC Requirements
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R	7/40.3 CMS Finding Numbers
R	7/40.4 Initial CAP Report
R	7/40.5 Quarterly CAP Report
R	7/40.6 Entering Data into the Initial or Quarterly CAP Report
R	7/50 List of CMS Contractor Control Objectives
N	7/60 CMS Financial Reporting Cycle Memo
N	7/60.1 Financial Reporting Cycle Memo Inclusions
N	7/60.2 List of Appendices
N	7/60.2/Appendix 1 - Key Contacts
N	7/60.2/Appendix 2 - Flowcharts
N	7/60.2/Appendix 3 - Applicable Laws and Regulations
N	7/60.2/Appendix 4 - Key Information Technology Systems and Repositories
N	7/60.3 List of Exhibits
N	7/60.3/Exhibit 1 - Timeline for Preparation and Audit of CMS Financial Statements
N	7/60.3/Exhibit 2 - Financial Statement Crosswalk Excerpts
N	7/60.3/Exhibit 3 - Cost Allocation Percentages Excerpts

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-06	Transmittal: 150	Date: April 2, 2009	Change Request: 6249

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SUBJECT: Chapter 7, Internal Control Requirements Update

EFFECTIVE DATE: March 9, 2009

IMPLEMENTATION DATE: March 9, 2009

I. GENERAL INFORMATION

A. Background: The Federal Managers' Financial Integrity Act of 1982 (FMFIA) established internal control requirements that shall be met by Federal agencies. For CMS to meet the requirements of the FMFIA, Medicare contractors shall demonstrate that they comply with the FMFIA.

B. Policy: The CMS contract with its Medicare contractors includes an article titled FMFIA. In this article, the Medicare contractor agrees to cooperate with CMS in the development of procedures permitting CMS to comply with FMFIA, and other related standards prescribed by the Comptroller General of the United States. Under various provisions of the Social Security Act and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Medicare contractors are to be evaluated by CMS on administrative service performance. The CMS evaluates Medicare contractor's performance by various internal and external audits and reviews.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6249.1	The contractor shall submit one Certification Package for Internal Controls (CPIC) report for each type of contract, i.e., Title XVIII workload, MAC workload, DME MAC workload, Retiree Drug Subsidy (RDS) and Medicare Secondary Payer Recovery Contractor (MSPRC). See section 30.	X	X	X	X	X					RDS & MSPRC
6249.2	The contractor shall not submit a hardcopy of the CPIC if the CPIC is sent from the VP or CFO's email. See	X	X	X	X	X					RDS & MSPRC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	section 30.1										
6249.3	The RDS and the MSPRC contractors shall submit their electronic CPIC to the CMS Project Officer, and the previously required internalcontrols@cms.hhs.gov mail box. See section 30.1.										RDS & MSPRC
6249.4	The contractor shall submit corrective action plans for all deficiencies (control deficiencies, significant deficiencies, and material weaknesses) identified as a result of A-123 Appendix A reviews. See sections 30.1.1, item 4, and 40.	X	X	X	X	X					RDS & MSPRC
6249.5	MACs shall report complementary credits received from the Coordination of Benefit Contractor (COBC) for Coordination of Benefits Agreement crossover claims in the proper fiscal year in the CMS Analytical, Reporting, & Tracking system (CMS ART). The credit is applied properly on the ART report when it is reported in the fiscal year in which the claims being reimbursed were originally crossed to the COBC. See section 50, control objective E.1.	X	X	X	X	X					RDS
6249.6	Contractors shall have a written code of business ethics and conduct. To promote compliance with such code of business ethics and conduct, contractors shall have an employee business ethics and compliance training program and an internal control system that – 1. Are suitable to the size of the company and extent of its involvement in Government contracting; 2. Facilitate timely discovery and disclosure of improper conduct in connection with Government contracts; and 3. Ensure corrective measures are promptly instituted and carried out. See section 50, control objective H.1.	X	X	X	X	X					RDS & MSPRC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space: None.

V. CONTACTS

Pre-Implementation Contact(s): Ellen L. McNeill, 410-786-7911
Eleanor Sheain, 410-786-8120

Post-Implementation Contact(s): Same

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and

immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Financial Management Manual
Chapter 7 - Internal Control Requirements

Table of Contents

(Rev.150, 04-02-09)

10 - Introduction

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

This chapter provides guidelines and policies to the CMS contractors to enable them to strengthen their internal control procedures. The CMS contracts with companies to administer the Medicare program under the Social Security Act and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The contractors shall administer the Medicare program efficiently and economically to achieve the program objectives. Internal control is a major part of managing an organization. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud. In short, internal control helps government program managers achieve desired results through effective stewardship of public resources.

10.1 - Authority

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The Federal Managers' Financial Integrity Act of 1982 (FMFIA) establishes internal control requirements that shall be met by CMS. For CMS to meet the requirements of FMFIA, *CMS* contractors shall demonstrate that they comply with the FMFIA guidelines.

10.1.2 - FMFIA and the CMS Contractor Contract

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The CMS contract with its Medicare *Title XVIII* contractors includes an article titled FMFIA. In this article, the contractor agrees to cooperate with CMS in the development of procedures permitting CMS to comply with FMFIA and other related standards prescribed by the Comptroller General of the United States. *The Medicare Administrative Contractor (MAC) Statement of Work states that, "the contractor shall establish and maintain efficient and effective internal controls to perform the requirements of the contract in accordance with IOM Pub.* 100.06, Chapter 7". Under various provisions of the Social Security Act, and the Medicare Prescription Drug, Improvement Modernization Act of 2003 (MMA), contractors shall be evaluated by CMS on administrative service performance. The CMS evaluates contractor's performance by various internal and external reviews.

To further sensitize the contractors as to the importance of FMFIA compliance, CMS requires the contractors to annually provide assurance that internal controls are in place and to identify and correct any areas of weakness in their operations. The vehicle used by the contractors to provide this assurance is the Certification Package for Internal Controls (CPIC). The CPIC includes a self-certification representation that the contractor's internal controls are in compliance with FMFIA expectations, that the contractor recognizes the importance of internal controls, and the contractor has provided required documentation in the package.

10.1.5 - GAO Standards for Internal Controls in the Federal Government

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The FMFIA requires the Government Accountability Office (GAO) to issue standards for internal control in government. GAO's "Standards for Internal Controls in the Federal Government" were updated in November 1999. The standards provide the overall framework for establishing and maintaining internal control and for identifying and addressing major performance and management challenges as well as areas of greatest risk of fraud, waste, abuse, and mismanagement. These are the internal control standards that CMS and its contractors must follow.

10.2.1 - Definition and Objectives

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Internal controls are the checks and balances that ensure that operational objectives are carried out as planned in the most effective and efficient manner possible. We should not look upon these controls as separate specialized systems, but as integral parts of each system that management uses to accomplish the objectives of the Medicare program. In this regard internal controls are not just financial tools that safeguard assets, but are tools that are of vital importance to day-to-day programmatic and administrative operations as well. Internal control should be the first thought in CMS' oversight process. That is, can we be sure that there are adequate internal controls in place and operating effectively for the process we are evaluating?

Internal controls are an integral part of an organization's management to provide reasonable assurance that the following objectives are being achieved:

- Effectiveness and efficiency of operations;
- Reliability of financial reporting; and
- Compliance with applicable laws and regulations

Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud. In short, internal control, which is synonymous with management control, helps program managers achieve desired results through effective stewardship of resources.

10.2.3.5 - Monitoring

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Internal control monitoring should assess the quality of performance over time and ensure that the *observations and* findings of audits and other reviews are promptly resolved.

Internal control systems need to be monitored. Monitoring is a process that assesses the quality of the system's performance over time. Internal control should generally be designed to assure that ongoing monitoring occurs in the course of normal operations. This is accomplished through ongoing monitoring activities, separate evaluations, or a combination of the two. Ongoing monitoring includes regular management and supervisory activities, and other actions (such as periodic reviews, reconciliations, or comparison of data) personnel take in performing their duties. The scope and frequency of separate evaluations will depend primarily on an assessment of risks and the effectiveness of ongoing monitoring procedures.

20 - *CMS* Contractor Internal Control Review Process

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

20.1 - Risk Assessment

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Risk assessment identifies areas that should be reviewed to determine which components of an organization's operation present the highest probability of waste, loss, or misappropriation. The risk assessment process is the identification, measurement, prioritization and mitigation of risks. This process is intended to provide the contractors with:

- Direction for what areas should get priority attention from management due to the nature, sensitivity and importance of the area's operations;
- A preliminary judgment from managers about the adequacy of existing internal control policies and procedures to minimize or detect problems; and
- An early indication of where potential internal control weaknesses exist that should be corrected.

The CMS requires contractors to perform an annual risk assessment, to identify the most critical areas and areas of greatest risk to be subjected to a review. Operational managers with knowledge and experience in their particular business area shall perform risk assessments. Outside sources can assist with this process, but should not be solely relied upon (e.g., Internal Audit departments, Statement on Auditing Standards Number 70 (SAS 70) audit, *OMB Circular A-123 Appendix A reviews,* etc.).

When performing your yearly risk assessment, you are to consider all results from final reports issued during the fiscal year from internal and external reviews including GAO, OIG, CFO audit, Contractor Performance Evaluation (CPE), CPIC, 1522 reviews, *A-123 Appendix A reviews* and results of your own or CMS-sponsored SAS 70 audits. Any of these findings could impact your risk assessment and preparation of your certification statement. Your risk assessment process shall provide sufficient documentation to fully explain the reasoning behind and the planned testing methodology for each selected area.

The contractor shall submit a description of the risk assessment process to CMS as an attachment with the annual CPIC and maintain sufficient documentation to support the risk assessment process. Examples of sufficient documentation are meeting agendas, meeting notes or minutes, and emails. The documentation should be readily available for CMS review.

Below are the elements to include in the description or methodology of your risk assessment process:

- Who - List who is involved and state their roles and responsibilities.
- Where - List the geographical location(s) for which the certification applies. For multi-site contractors, review and explain the roles for all sites, i.e., do they do their own risk assessment and control objective testing. Describe the certification process for geographical locations.
- What – Describe the risk factors and the risk assessment process.
- When - List when the risk assessment process was completed.
- Why – Prioritize control objectives based upon their level of risk while ensuring high risk areas are reviewed in accordance with the scoring criteria guidelines in section 20.1.

  NOTE: *The MAC Statement of Work may also include requirements regarding review of CMS control objectives.*

- How – Describe the scoring methodology and provide a description and definition for each risk and exposure factor. Include specific value ranges used in your scoring methodology.

The contractor is encouraged to exceed the risk assessment approach provided below based on its unique operations. The risk assessment process shall at a minimum include the following and shall be submitted as part of the CPIC package:

Step 1 - Segment Operations

Segment the contractor’s operation into common operational areas of activity that can be evaluated. List the primary components of the unit with consideration to the business purpose, objectives, or goals of the auditable unit. Limit the list to the primary activities designed to achieve the goals and objectives of the auditable unit. Include the CMS control objectives applicable to each auditable unit.

Step 2 - Prioritize Risk and Exposure Factors

Identify the primary risks and exposure factors that could jeopardize the achievement of the goals and objectives of the unit as well as the organization's ability to achieve the objectives of reliable financial reporting, safeguarding of assets, and compliance with budget, laws,

regulations and instructions. Risk and exposure factors can arise due to both internal and external circumstances. Document the definitions and methodology of the risk and exposure factors used in the risk assessment process.

Step 3 – Create a Matrix to Illustrate the Prioritization of Risk and Exposure Factors

Create a matrix listing on the left axis by operational areas of activity (see step 1 above). The top axis should list all the risk and exposure factors of concern and determine the weight each column should have. Some columns may weigh more than other columns. Develop a scoring methodology and provide a description and definitions of this methodology used for each risk or exposure factor. This methodology can use an absolute ranking or relative risk identification. Absolute ranking would assign predefined quantifiable measures such as dollars, volume, or some other factor in ranges that would equate to a ranking score such as high, medium or low. Relative risk ranking involves identifying the risk and exposure factors into natural clusters by definition and assigning values to these clusters. Include a legend with the score ranges representing high-risk, medium-risk, and low-risk on the risk matrix.

Assign a score to each cell based on the methodology predetermined. Retain notes to support scoring of key risk factors such as "prior audits" and factors that are scored very high or very low. This will assist CMS in evaluating the reasonableness of your risk assessment results. Total the scores for each line item (control objective). The higher scores for each line item will prioritize the risk areas for consideration to be reviewed to support the CPIC. If a high risk control objective is included in a current year Type II SAS 70 audit *or A-123 Appendix A review, you may rely on the SAS 70 audit or A-123 Appendix A review* testing and document this as the rationale for excluding it from testing.

The CMS considers system security to be a critical risk area. Therefore, contractors shall include control objective A.1 in your CPIC each year. All contractors are required to certify their system security compliance. Contractors shall verify that a system's security features meet CMS' Core Security Requirements as defined by the Business Partners Systems Security Manual (BPSSM). Contractors should write a few paragraphs to self-certify that their organization has successfully completed all required security activities including the security self-assessment of their Medicare IT systems and associated software in accordance with the terms of their Contract. See section 3.3 of the BPSSM, which can be found at www.cms.hhs.gov/it/security for more details. Also, include the results of the testing of A.1 in the Executive Summary. See section 30.3.

20.1.1- Risk Analysis Chart

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Table 1 -- **This chart is provided to assist contractors in selecting the high-risk activities within their organization. There are 3 columns that gives directions on how to rank operational areas for potential risk.**

HIGH RISK FACTORS (1)	**MEDIUM RISK FACTORS (2)**	**LOW RISK FACTORS (3)**
Recent *review or audit observations* or findings showing material weaknesses related to internal control processes.	Potential program weaknesses related to violation of privacy issues.	Areas where CAPs have already been implemented.
Areas affected by significant changes in laws, regulations, special requirements or instructions.	Areas with high visibility.	Areas with low visibility; routine program operations.
Areas where policies and procedures regarding internal control over financial reporting are not well documented.	Areas where due dates are often not met or responses to correspondence are late.	Areas where workers are meeting routine program operations and performance targets and attitudes and staff motivations are high.
Areas of significant financial vulnerabilities (e. g., new accounting or regulatory guidelines).	Areas with consistent complaints or inquiry. *Areas where there are no written policies and procedures.*	Areas that undergo frequent financial audits/ reviews by external parties (e.g., CFO, SAS 70, *A-123 Appendix A,* CPIC, etc.).
Areas where guidelines have varied interpretations and/or areas being restructured.	Areas where recent policy changes were implemented.	Areas that managers perform periodic reviews to ensure that work assignments are performed consistently, and accurately.
Areas with new contract activities.	Areas with reorganization activities.	
Areas where objectives of the corporate mission could be in jeopardy if not properly implemented.	Areas where there is a breakdown in communication with corporate, regional, state or satellite offices, etc.	Work activities are being phased out.
Areas lacking performance measures or monitoring.	Areas with new or problematic performance measures.	Areas with established and validated performance

HIGH RISK FACTORS (1)	MEDIUM RISK FACTORS (2)	LOW RISK FACTORS (3)

measures.

Scoring Criteria Guidelines:

High: If an activity has two or more high risk rating factors, review annually.

Medium: If an activity has two or more medium risk factors, review biannually.

Low: Low activities can be reviewed within a 5-year timeframe or at manager's discretion that should be balanced with costs and resources.

20.2 - Internal Control Objectives

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Internal control objectives are established to identify risk and vulnerabilities. Control objectives may be set for an entity as a whole, or be targeted to specific activities within the entity. Generally, objectives fall into three categories:

1. Operations - relating to effective and efficient use of the organization's resources.

2. Financial Reporting - relating to preparation of reliable financial statements.

3. Compliance - relating to the organization's compliance with applicable laws and regulations.

An acceptable internal control system can be expected to provide reasonable assurance of achieving objectives relating to the reliability of operations, financial reporting and compliance. Achievement of those objectives depends on how activities within the organization's control are performed.

Section 50 lists the minimum set of control objectives. The contractor may add to the CMS control objective list. For the respective operational areas selected for review in Step 2 of the Risk Assessment discussion, cross-reference the high risk operational areas to CMS' or the contractor's unique control objectives on a work sheet. Some control objectives will apply to more than one operational area selected for review. The control objectives identified in this step shall be validated by documentation of the control activities (see section 10.2.3.3) used as well as testing (see section 20.4) that supports the control objectives.

Reminder: Excessive control is costly and counterproductive. Too little control presents undue risk. There should be a conscious effort made to achieve an appropriate balance.

20.2.1 – *CMS Contractor* Control Objectives

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The complete list of control objectives is in section 50. If you completed your risk assessment prior to issuance of the current year CMS control objectives, you should ensure that any new or revised control objectives are assessed and the risk matrix is updated. In addition, you should create or update the control activities supporting any new or revised control objectives as appropriate (see section 10.2.3.3).

20.3 – Policies and Procedures

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Policies and procedures are a set of established guidelines or rules for conducting the affairs of a business. Good policies:

- Are written in clear, concise, and simple language. They are updated as necessary, signed and dated.
- Address what the guideline or rule is; not how to implement the guideline or rule.
- Are readily available and properly communicated to staff.

Procedures are a set of steps in a plan intended to influence and determine decisions and actions. Good procedures are tied to policies and:

- Are written in clear, concise, and simple language.
- Are tied to the policy.
- Are developed and implemented with the user in mind.
- Are readily available and properly communicated to staff.

*C*ontractors shall have written policies and procedures to achieve their control objectives. These policies and procedures shall be updated in a timely manner to reflect changes in CMS instructions or your internal operations.

*C*ontractors shall demonstrate and document that its policies and procedures are actually being used as designed and are effectively and efficiently meeting the control objective, as described in section 50. Evaluation and testing of the effectiveness of controls are important in determining if the major areas of risk have been properly mitigated.

An example of a policy is, “an agency shall establish physical control to secure and safeguard vulnerable assets”. The specific control activities, or procedures, which support this policy may

include: all doors to the facility have locks, the locks only have one key, all keys are held by security guards, security guards are stationed at every door.

20.4 - Testing Methods

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Testing the policies and procedures involves ensuring that the documented policies and procedures are actually being used as designed and are effective to meet a control objective. Evaluating and testing the effectiveness of policies and procedures is important to determine if the major areas of risks have been properly mitigated and provide reasonable assurance that the control objective is met.

Testing and evaluating the policies and procedures consists of five steps:

Step 1: Select the policies or procedures to be tested

It is both impractical and unnecessary to test all policies and procedures. The policies and procedures to be tested are those that primarily contribute to the achievement of the control objectives. A policy or procedure may be eliminated from testing when it does not meet the control objective to be tested due to being poorly designed, unnecessary or duplicative, or not performed in a timely manner. However, if this justification is invoked, other policies and procedures should be tested to validate meeting the control objective. Another justification for testing elimination is due to the cost of testing the policy or procedure exceeds the value of the control objective to be tested. If a policy or procedure is eliminated from testing, the reasoning should be documented.

Step 2: Select test methods

Once the policies and procedures to be tested are determined, test methods shall be determined. A combination of tests can be used depending on risk or type of activity. The following *would be considered acceptable tests:*

1. *Inquiry: Asking responsible personnel if certain controls are functioning as intended (e.g., "Do you reconcile your activity or do you review a certain report each month?").*

2. *Inspection: Analyzing evidence of a given control procedure (e.g., searching for signatures of a reviewing official or reviewing past reconciliations).*

3. *Observation: Observing actual controls in operation (e.g., observing a physical inventory or watching a reconciliation occur).*

4. *Re-performance: Conducting a given control procedure more than once (e.g., recalculating an estimate or re-performing a reconciliation).*

Observation and inquiry are less persuasive forms of evidence than inspection and re-performance.

Step 3: Determine how much testing is needed

The next sub-step is to determine the extent of the testing efforts. In most cases, it is unrealistic to observe each policy and procedure or to review 100 percent of all records. Instead, policies and procedures are tested by observing a selected number of controls performed or by reviewing a portion of the existing records. This selection process is called sampling. A representative sample provides confidence that the findings are not by chance by taking into account the factors of breadth and size.

1. Breadth: Breadth of the sample assures that the testing covers all bases and is a representative cross section of the universe being tested. This will provide confidence that the sample will lead to a conclusion about the situation as a whole.

2. Size: Size is the number of items sampled. The size should be large enough to allow a conclusion that the findings have not happened by chance and provide confidence in the conclusion. The size of the sample should not be so large that testing becomes too costly. When selecting the size of the sample consider:

    a. Experience: Reducing the size of the sample when controls have operated satisfactorily in the past and no major changes have occurred.

    b. Margin of Error: Increase the size of the sample when only a small margin of error is acceptable.

    c. Importance: Increase the size of the sample when an important resource is at stake.

    d. Type: Increase the size of the sample when the control to be tested requires judgment calls. Decrease the size of the sample when the control is routine.

Step 4: Plan data collection

The sampling plan gives an idea of the "who, where, what, when, why, and how" (see section 20.1) aspect of the tests to be conducted. A data collection plan can be used to determine how the test results will be recorded. The accurate recording of test results is an extremely important part of the test documentation. Planning data collection prior to beginning the testing can be very helpful to ensure the information collected will provide conclusive data from which to evaluate the controls.

Step 5: Conduct the tests

The final step of testing and evaluating controls consists of actually effectuating the testing protocol and documenting the results.

At the conclusion of the testing, the results are analyzed and evaluated. Evaluating involves reviewing the information collected and making an overall judgment on the adequacy of the internal control system as a whole. Deficient areas are to be categorized into Control Deficiencies, Significant Deficiencies, and Material Weaknesses and should be considered for inclusion in the CPIC submission (see section 30.6).

20.5 - Documentation and Working Papers

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The contractor shall document through its working papers the process it employed to support its internal control certification. This documentation shall include working papers so that a CMS reviewer can conclude that the Risk Assessment process as described in section 20.1 follows or exceeds these guidelines, and that the Control Activities (section 10.2.3.3) identified to support the high risk control objectives selected for review are current and clearly stated. Finally, the CPIC documentation shall demonstrate how the Testing Methods employed comply with the general parameters as described in section 20.4 for the purpose of Control Activity validation.

Working papers contain evidence accumulated throughout the review to support the work performed, the results of the review, including findings made, the judgment and/or conclusion of the reviewers. They are the records kept by the reviewer of the procedures applied, the tests performed, the information obtained, and the pertinent judgment and/or conclusions reached in the review process. Examples of working papers are review programs, analyses, memoranda, letters of confirmation and representation, abstracts of documents, and schedules or commentaries prepared or obtained by the reviewer. Working papers may be in the form of data stored on tapes, film, or other media.

General Content of Working Papers - Working papers should ordinarily include documentation showing that:

- The work has been adequately planned and supervised.
- The review evidence obtained, the reviewing procedures applied, and the testing performed has provided sufficient, competent evidential matter to support the reviewer's judgments and/or conclusions.

Format of Working Papers - Working paper requirements should ensure that the working papers follow certain standards. As a whole, a good set of working papers should contain the following:

- The objectives, scope, methodology, and the results of the review.
- Proper support for findings, judgments and/or conclusions, and to document the nature and scope of the work conducted.
- Sufficient information so that supplementary oral explanations are not required.

- Adequate indexing and cross-referencing, and summaries and lead schedules, as appropriate.
- Date and signature by the preparer and reviewer.
- Evidence of supervisory review of the work.
- Proper heading should be given to the basic content of the working papers.

30 - Certification Package for Internal Controls (CPIC)

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The contractor shall submit one CPIC report for each type of contract, i.e., Title XVIII workload, MAC workload, DME MAC workload, Retiree Drug Subsidy (RDS), and Medicare Secondary Payer Recovery (MSPRC) workloads.

30.1 – CPIC Requirements

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The contractor self-certification process provides CMS with assurance that contractors are in compliance with the FMFIA, OMB Circular A-123, and CFO Act of 1990 by incorporating internal control standards into their operations. The contractor self-certification process supports the audit of CMS' financial statements by the Office of Inspector General (OIG) and the CMS Administrator's FMFIA assurance statement.

This compliance is achieved by an annual self-certification statement and has been known as a CPIC. Through these self-certification statements, CMS has required each contractor to provide assurances that internal controls are in place and to identify and correct any areas of weakness in its operations. Contractors are expected to evaluate the effectiveness of their operations against CMS' control objectives discussed above. The control objectives represent the minimum expectations for contractor performance in the area of internal controls.

*C*ontractors shall have written policies and procedures regarding their overall CPIC process and the preparation of the annual CPIC submission. They shall also have written policies and procedures that discuss the handling of potential internal control deficiencies identified by employees and managers in the course of their daily operations. This should include the process for reporting issues upward through the appropriate levels of management, tracking them to completion of any necessary corrective actions, and considering them for inclusion in the CPIC submission.

The CPIC represents a summary of your internal control environment for the period October 1 through June 30 (the CPIC period), as certified by your organization. It shall include an explicit conclusion as to whether the internal controls over financial reporting are effective (see section 30.1.1). All material weaknesses that were identified during this period shall be included in the

CPIC submission. You should consider the results of final reports issued from internal and external audits and reviews, such as GAO and OIG audits as well as CFO Act audits, consultant reviews, management control reviews, CPE reviews, SAS 70 audits, *A-123 Appendix A reviews* and other similar activities. These findings should be classified as control deficiencies, significant deficiencies, or material weaknesses based upon the definitions provided in section 30.6. *C*ontractors shall submit an update for the period July 1 through September 30 to report subsequently identified material weaknesses. The update shall be no more than a one page summary of the material weakness (es) and the proposed corrective action. A CAP shall be completed in accordance to the guidelines shown at section 40.1. If no additional material weaknesses have been identified, submit the following: "No material weaknesses have been identified during the period July 1 through September 30; therefore no additional material weaknesses have been reported". Send the update report from the VP or CFO email box to internalcontrols@cms.hhs.gov within five business days after September 30.

Electronic CPIC reports shall be received by CMS within fifteen business days after June 30. The contractor is not required to submit a hard copy report if it has the capability to insert electronic signatures. Where applicable, the CPIC hard copy report shall be post marked within fifteen business days after June 30.
The CPIC shall include:

- A Certification Statement (including an assurance statement on the effectiveness of internal controls over financial reporting as of June 30);
- An Executive Summary;
- A description of your risk assessment process. This should include a matrix to illustrate the prioritization of risk and exposure factors and a narrative or flowchart that outlines the risk assessment process (see section 20.1 for more details regarding the risk assessment), and
- A CPIC Report of Material Weaknesses.

NOTE: A hardcopy of the CPIC package is not required *to be sent to CMS if the VP of Operations has electronic signature, or if the CPIC is sent from the VP of Operations' email or the CFO's email. If these capabilities are not available, please send the signed hardcopies to:*

Chief Financial Officer
Office of Financial Management
Attn: Accounting Management Group, N3-11-17
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

An electronic version of all documents (including updates) submitted as part of your CPIC submission shall be sent to CMS at internalcontrols@cms.hhs.gov as Microsoft Excel or Word files. Electronic copies shall also be sent as follows:

- Title XVIII contractors shall send to the Associate Regional Administrator (ARA) for Financial Management and Fee for Service Operations, CFO/SAS 70 Coordinator, and the Consortium Contractor Management Officer (CCMO)

- MACs shall send to the ARA for Financial Management and Fee for Service Operations, CFO/SAS 70 Coordinator, CCMO, and the Project Officer of the MAC.

- *RDS and MSPRC shall send to the CMS Project Officer*

The file names for all electronic files submitted, as part of your CPIC package should begin with the three or four letter abbreviation assigned to each contractor in section 40.3. Additionally, in the subject line of your email submission, you shall include the corporate name of the entity submitting the CPIC.

Maintain the appropriate and necessary documents to support any assertions and conclusions made during the self-assessment process. In your working papers, you are required to document the respective policies and procedures for each control objective reviewed. These policies and procedures should be in writing, be updated to reflect any changes in operations, and be operating effectively and efficiently within your organization.

The supporting documentation and rationale for your certification statement, whether prepared internally or by an external organization, shall be available for review and copying by CMS and its authorized representatives.

30.1.1 - OMB Circular A-123, *Appendix A:* Internal Controls Over Financial Reporting

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

CMS contractors, including *MSPRC and RDS*, shall use the five steps below to assess the effectiveness of its internal control over financial reporting. Documentation shall occur within each of the basic steps, whether documenting the assessment methodology during the planning phase or documenting key processes and test results during the evaluation and testing steps.

1) Plan and Scope the Evaluation

During this phase, the *CMS* contractor shall leverage existing internal and external audits/reviews being performed (SAS 70 *audits, A-123 Appendix A Internal Control Reviews*, CPIC, 912 Evaluations, Federal Information Security Management (FISMA), Contractor Performance Evaluations (CPE), etc.) when conducting its assessment of internal control over financial reporting. Management shall consider the results of these audits/reviews in order to identify gaps between current control activities and the documentation of them. The control objectives of A, *B,* F, G, I, J, K, and L shall be considered, if applicable.

If a *CMS* contractor *had* a SAS 70 audit *or an A-123 Appendix A Internal Control Review* in the current or past two fiscal years, it shall be used as a basis for the statement of assurance combined with other audits and reviews as appropriate. The contractor shall conduct additional testing for Circular A-123 as deemed necessary *(see A-123 Appendix A Internal Control Review/SAS 70 Reliance Examples chart). For example, if the A-123 Appendix A assurance statement was unqualified, then the contractor is not required to conduct additional testing. Similarly,* if the SAS 70 audit report was unqualified (no findings in Section I (Opinion Letter)), then the contractor is not required to conduct additional testing. *However, if the previous year's A-123 Appendix A assurance statement is qualified, then the contractor shall conduct additional testing on the control deficiencies identified. Similarly,* if Section I of the prior year's SAS 70 audit report is qualified (one or more findings that have not been corrected and validated), then the contractor shall conduct additional testing on the findings identified in Section I and the exceptions identified in Section III (See *A-123 Appendix A Internal Control Review/*SAS 70 Reliance Examples chart). If other audits and reviews contradict the SAS 70 audit *or A-123 Appendix A Internal Control Review*, then that contradiction shall be addressed via testing if the issue has not already been corrected and validated.

2) Document Controls and Evaluate Design of Controls

This step begins with the documentation and evaluation of entity-level controls. Consideration must be given to the five standards of internal control (control environment, risk assessment, control activities, information and communication, and monitoring) (see section 10.2.3 – Standards for Internal Control) that can have a pervasive effect on the risk of error or fraud, and will aid in determining the nature and extent of internal control testing that may be required at the transaction or process level. The GAO issued an internal control evaluation tool (www.gao.gov/new.items/d011008g.pdf) to assess the effectiveness of internal control and identify important aspects of control in need of improvement. This tool shall be used in conducting your assessment.

Contractors shall prepare cycle memos for financial reporting, accounts receivable, accounts payable, and claims expense (Note: *C*ontractors may combine related cycles (e.g., accounts payable and claims expense). *These major transaction cycles relate to significant line items on the financial reports. Cycle memos should identify the key control activities that are relied upon to assure the relevant financial statement assertions are met:*

- ***Existence and Occurrence:*** *All reported transactions actually occurred during the reporting period and all assets and liabilities exist as of the reporting date. Recorded transactions represent economic events that actually occurred during a stated period of time.*

- ***Rights and Obligations:*** *The entity legally owns all its assets collectively and all liabilities are legal obligations of the entity. Assets and liabilities reported on the Balance Sheet are bona fide rights and obligations of the entity as of that point in time.*

- ***Completeness:*** *All assets, liabilities, and transactions that should be reported have been included, and no unauthorized transactions or balances are included. All transactions*

during a specific period should have been recorded in that period. No unrecorded assets, liabilities, transactions or omitted disclosures.

- ***Valuation or Allocation:*** *Assets, liabilities, revenue, and expenses have been included in the financial statements at appropriate amounts. Where applicable, all costs have been properly allocated. Assets and liabilities are recorded at appropriate amounts in accordance with relevant accounting principles.*

- ***Presentation and Disclosure:*** *The financial report is presented in the proper form and any required disclosures are present. Financial statement items are properly described, classified and fairly presented.*

Not all assertions will be significant to all accounts. A single key control will often not cover all assertions; which may necessitate several key controls to support the selected assertions for each line item. However, each assertion is applicable to every major transaction cycle and all associated assertions must be covered to avoid any control gaps.

Documenting transaction flows accurately is one of the most important steps in the assessment process, as it provides a foundation for the A-123 assessment. Thorough, well-written documents and flowcharts can facilitate the review of key controls. The documentation should reflect an understanding, from beginning to end, of the underlying processes and document flows involved in each major transaction cycle. This would include the procedures for initiating, authorizing, recording, processing, and reporting accounts and transactions that affect the financial reports. The cycle memo shall include Information Technology (IT) key control activities pertinent to the transaction cycle.

The documentation should start with the collection and review of documentation that already exists. The following are examples of existing documentation that could be used:

- *Existing policy and procedure manuals;*
- *Existing forms and documents;*
- *Documentation from independent auditors and the OIG;*
- *Risk assessments;*
- *Accounting manuals;*
- *Memoranda;*
- *Flowcharts;*
- *Job descriptions;*
- *Decision tables;*
- *Procedural write-ups; and/or*
- *Self-assessment reports.*

Interviews should be conducted with personnel who have knowledge of the relevant operations to validate that manuals, policies, forms, and documents are accurate and being applied.

A major transaction cycle narrative is a written summary of the transaction process. For each major transaction cycle, the narrative describes:

- *The initiation point;*
- *The processing type (e.g., automated versus manual, preventative versus detective);*
- *The completion point;*
- *Other data characteristics, such as source; receipt; processing; and transmission;*
- *Key activities/class of transactions within the process;*
- *Controls in place to mitigate the risk of financial statement errors;*
- *Supervisor/manager review; process and calculations performed in preparation of financial reporting; and process outputs;*
- *Use of computer application controls and controls over spreadsheets used in the preparation of financial reporting;*
- *Identification of errors; types of errors found; reporting errors; and resolving errors; and*
- *Ability of personnel to override the process or controls.*

Within the cycle memo, the key controls should be clearly identified by highlighting, bolding, or underlining. Contractors are responsible for reviewing and updating cycle memos to keep them current.

Control activities are the specific policies, procedures, and activities that are established to manage or mitigate risks. Key controls are those controls designed to meet the control objectives and support management's financial statement assertions. In other words, they are the controls that management relies upon to prevent and detect material errors and misstatements. For each key control activity, state: (a) the frequency of performance; (b) the specific steps performed; (c) how exceptions are resolved; and (d) how the performance of the control activity and related results/disposition are documented.

Examples of control activities that may be identified include:

- *Top-level reviews of actual performance;*
  - *Compare major achievements to plans, goals, and objectives*
- *Reviews by management at the functional or actual level;*
  - *Compare actual performance to planned or expected results*
- *Management of human capital;*
  - *Match skills to organizational goals*
  - *Manage staff to ensure internal control objectives are achieved*
- *Controls over information processing;*
  - *Edit checks of data*
  - *Control totals on data files*
  - *Access controls*
  - *Review of audit logs*
  - *Change controls*
  - *Disaster recovery*
- *Physical controls over vulnerable assets;*
  - *Access controls to equipment or other assets*
  - *Periodic inventory of assets and reconciliation to control records*

- *Establishment and review of performance measures and indicators;*
  - *Relationship monitoring of data*
- *Segregation of duties;*
- *Proper execution of transactions and events*
  - *Communicating names of authorizing officials*
  - *Proper signatures and authorizations*
- *Accurate and timely recording of transactions and events*
  - *Interfaces to record transactions*
  - *Regular review of financial reports*
- *Access restrictions to and accountability for resources and records; and*
  - *Periodic reviews of resources and job functions*
- *Appropriate documentation of transactions and internal control.*
  - *Clear documentation*
  - *Readily available for examination*
  - *Documentation should be included in management directives, policies, or operating manuals*

To document management's understanding of major transaction cycles, management should use a combination of the following:

- *Narratives;*
- *Flowcharts; and*
- *Control matrices.*

To illustrate this process, we have provided the CMS Financial Reporting cycle memo as an example (See Section 60 – CMS Financial Reporting Cycle Memo).

3) Test Operating Effectiveness

Testing of the operation of key controls shall be performed and documented (refer to "Plan and Scope the Evaluation" (above) *as well as the chart below with regard* to testing applicability), to determine whether the control is operating effectively, partially effectively, or not effectively. Testing shall address both manual and automated controls. Ideally, testing should be performed throughout the year. The results of testing completed prior to June 30th will form the basis of the June 30th assurance statement. As testing continues into the fourth quarter, the results of that testing, along with any items corrected since the June 30th assurance statement will be considered in the September 30th assurance statement update. The chart below is provided to assist contractors in determining when to conduct testing.

A-123 Appendix A Internal Control Review/SAS 70 Reliance Examples

Scenario	Prior Fiscal Year 2	Prior Fiscal Year 1	Current Fiscal Year	Additional Testing Required or Not Required*
1	No SAS 70/*A-123 Appendix A Review*	No SAS 70/*A-123 Appendix A Review*	Unqualified	Not Required
2	No SAS 70/*A-123 Appendix A Review*	Unqualified	No SAS 70/*A-123 Appendix A Review*	Not Required
3	Unqualified	No SAS 70/*A-123 Appendix A Review*	No SAS 70/*A-123 Appendix A Review*	Not Required
4	Qualified	Unqualified	No SAS 70/*A-123 Appendix A Review*	Not Required
5	No SAS 70/*A-123 Appendix A Review*	No SAS 70/*A-123 Appendix A Review*	Qualified	Not Required
6	No SAS 70/*A-123 Appendix A Review*	Qualified	No SAS 70/*A-123 Appendix A Review* and the Findings are Corrected and Validated by CMS (CAP Closure Letter Received)	Not Required
7	Unqualified	Qualified	No SAS 70/*A-123 Appendix A Review* and the Findings are Corrected and Validated by CMS (CAP Closure Letter Received)	Not Required
8	Qualified	No SAS 70/*A-123 Appendix A Review* and the Findings are Corrected and Validated by CMS (CAP Closure Letter Received)	No SAS 70/*A-123 Appendix A Review*	Not Required
9	Unqualified	Qualified	No SAS 70/*A-123 Appendix A Review* and the Findings are NOT Corrected or Validated by CMS (No CAP Closure Letter)	Required

10	**No SAS 70*/A-123 Appendix A Review***	**Qualified**	**No SAS 70*/A-123 Appendix A Review* and the Findings are NOT Corrected or Validated by CMS (No CAP Closure Letter)**	**Required**
11	**Qualified**	**No SAS 70*/A-123 Appendix A Review* and the Findings are NOT Corrected or Validated by CMS (No CAP Closure Letter)**	**No SAS 70*/A-123 Appendix A Review* and the Findings are NOT Corrected or Validated by CMS (No CAP Closure Letter)**	**Required**

Unqualified Report

SAS 70: **No Findings in Section I**

A-123 Appendix A Internal Control Review: No material weaknesses were noted

Qualified Report

SAS 70: 1 or More Findings in Section I

A-123 Appendix A Internal Control Review: Material weaknesses were noted, but were not pervasive

Note: Assumes other subsequent audits and reviews do not contradict the SAS 70/A-123 Appendix A Review* or contradictions have been corrected and validated.

4) Identify and Correct Deficiencies

If design or operating deficiencies are noted, the potential impact of control gaps or deficiencies on financial reporting shall be discussed with management. The magnitude or significance of the deficiency will determine if it should be categorized as a control deficiency, a significant deficiency, or a material weakness (see section 30.6).

Corrective action plans (CAPs) shall be created and implemented to remediate identified deficiencies (see section 40). *The contractor shall submit corrective action plans for all deficiencies (control deficiencies, significant deficiencies and material weaknesses) identified as a result of A-123 Appendix A reviews.*

5) Report on Internal Controls

The culmination of the contractor's assessment will be the assurance statement regarding its internal control over financial reporting. The statement will be one of three types:

1) Unqualified Statement of Assurance

Each contractor shall submit, as part of the CPIC report, an assurance statement for internal controls over financial reporting stating:

> "… (*C*ontractor) has effective internal controls over financial reporting in compliance with OMB Circular A-123, *Appendix A."*

Note: *The contractor's statement of assurance should be unqualified if this is consistent with the A-123 Appendix A Internal Control Review statement per the CPA firm report (augmented by internal reviews, if necessary). Similarly, if the* SAS 70 audit (augmented by internal reviews, if necessary) did not result in any findings or material weaknesses, then an unqualified statement of assurance would be applicable.

2) Qualified Statement of Assurance

Each contractor shall submit, as part of the CPIC report, an assurance statement for internal controls over financial reporting stating:

> "…(*C*ontractor) has effective internal controls over financial reporting in compliance with OMB Circular A-123, *Appendix A,* except for the material weakness(es) identified in the attached Report of Material Weaknesses."

Note: *The contractor's statement of assurance should be qualified if this is consistent with the A-123 Appendix A Internal Control Review statement per the CPA firm report (augmented by internal reviews, if necessary). Similarly,* if a SAS 70 audit and internal reviews in the current year disclosed either findings or a material weakness, then a qualified statement of assurance (see above) or a statement of no assurance (see below) would be issued, depending on the

pervasiveness of the findings or material weakness. The results of work performed in other control-related activities may also be used to support your assertion as to the effectiveness of internal controls.

3) Statement of No Assurance

Each contractor shall submit, as part of the CPIC report, an assurance statement for internal controls over financial reporting stating:

> "…(*C*ontractor) is unable to provide assurance that its internal control over financial reporting was operating effectively due to the material weakness(es) identified in the attached Report of Material Weaknesses."
>
> or
>
> "…(*C*ontractor) did not fully implement the requirements included in OMB Circular A-123*, Appendix A* and therefore cannot provide assurance that its internal control over financial reporting was operating effectively."

30.2 - Certification Statement

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Provide a certification statement to CMS pertaining to your internal controls. Listed below is a generic certification statement. This statement should be included as part of your CPIC. The statement is to be signed jointly by your Medicare CFO and Vice President (VP) for Medicare*, RDS or MSPRC* or the equivalent Senior Executive responsible for Medicare*, RDS or MSPRC*. The CPIC is due within fifteen business days after June 30 and shall cover the period from October 1 through June 30. An updated assurance statement for the period July 1 through September 30 is due to CMS within five business days after September 30. Your certification statement should follow this outline:

Chief Financial Officer
Office of Financial Management
Attn: Accounting Management Group, N3-11-17
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Chief Financial Officer:

As the (Chief Financial Officer and Vice President of (contractor name), we are writing to provide certification of reasonable assurance for the period October 1 through June 30 that (contractor name) internal controls are in compliance with the Federal Managers' Financial Integrity Act (FMFIA) and Chief Financial Officers (CFO) Act by incorporating internal control standards into our operations. We are also providing an unqualified [or qualified] statement of

assurance that (contractor name) has effective internal controls over financial reporting in compliance with revised OMB Circular A-123, *Appendix A* [except for the material weaknesses identified in the attached Report of Material Weaknesses].

We are cognizant of the importance of internal controls. We have taken the necessary actions to assure that an evaluation of the system of internal controls and the inherent risks have been conducted and documented in a conscientious and thorough manner. Accordingly, we have included an assessment and testing of the programmatic, administrative, and financial controls for the (*type of program*) operations.

In the enclosures to this letter, we have provided an executive summary that identifies a list of the minimum requirements. *(See section 30.3 Executive Summary for the list of minimum requirements to be provided in your CPIC.)*

If material weaknesses have been identified, use the following language: "Material weaknesses have been reported to you and the appropriate regional office, *and/or Project Officer.* The respective Corrective Action Plans have been forwarded to your office." *If no material weaknesses were identified, use the following language:* "No material weaknesses have been identified during our review; therefore no material weaknesses have been reported."

We have included a description of our risk assessment analysis and our CPIC Report of Material Weaknesses. This letter and attachments summarize the results of our review.

We also understand that officials from the Centers for Medicare & Medicaid Services, Office of Inspector General, Government Accountability Office, or any other appropriate Government agency have authority to request and review the working papers from our evaluation.

Sincerely,

(Chief Financial Officer Signature)

(Vice President for *(type of program)* Signature)

30.3 - Executive Summary

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

An executive summary shall be included in your CPIC, and at a minimum provide:

A. The contractor identification numbers;

B. The geographical locations for which the certification applies - *include all locations for the contractor line of business;*

C. A list of the control objectives selected for internal review;

D. The specific time period during which each of the reviews were conducted;

E. The name and title of the person(s) who conducted the review;

F. The location and custodian of the working papers for the review;

G. The name, telephone number, and email address of a contact person who can explain the risk assessment process, the certification review, the results, and the status of any corrective action plans;

H. The total number of material weaknesses reported in the CPIC Report of Material Weaknesses;

I. The total number of control deficiencies and significant deficiencies reported in the CPIC Report of Internal Control Deficiencies; and

J. A list of all other internal and external reviews conducted during the CPIC reporting period. The list should include the type of review, who conducted the review, dates conducted, functional areas reviewed, and the number of findings in each area. (Do not include the certification reviews already listed in 'C' above.)

30.4 - CPIC- Report of Material Weaknesses

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The CPIC Report of Material Weaknesses (MW) shall include all initial MW identified during the CPIC period and not yet corrected and approved by a CAP closing letter. This report shall be updated as new findings are identified. It shall be prepared as a spreadsheet and include the following columns of information:

1. CMS Finding Number. The contractor shall use the CMS finding number assigned in the final audit report for all external findings. Assign a CMS finding number (see section 40.3) to all internally-identified MWs. This shall be done as soon as the determination is made that the finding is a MW. Note: Information related to each MW should be on only one row of the spreadsheet; the "wrap text" function in Excel should be used.

2. Control Objective Impacted (see section 50). Each MW shall have at least one control objective associated with it. However, a MW could have more than one control objective associated with it. If more than one control objective is impacted by the MW, the finding shall be listed only once with multiple control objectives listed with it. Prioritize the control objectives impacted by each finding and limit them to no more than five.

3. Summary of the material weakness.

4. Corrective action plan (CAP).

5. Date the MW was first identified at the contractor level.

6. Date initial CAP submitted to CMS.

7. CAP target completion date.

8. Actual completion date.

9. Original source of the finding. If the original source is a Contractor Performance Evaluation review, you shall include the report date and site location of the review. If the original source *is an internal control review to support your CPIC certification,* identify the MW either FMFIA or financial reporting (FR). See section 30.6.

EXAMPLE REPORT OF MATERIAL WEAKNESSES
CMS Contractor XYZ
CPIC Report of Material Weaknesses
Reporting Period FY XXXX

(1) CMS Finding Number	(2) Control Objective (s) Impacted	(3) Summary of the MW	(4) Corrective Action Plan (CAP)	(5) Date MW Identified at the contractor level	(6) Date Initial CAP Submitted to CMS	(7) CAP Target Completion Date	(8) Actual Completion Date	(9) Original Source of Finding
XYZ-*XX*-C-001	J.4	One individual opens Medicare checks and records them in the cash receipts log. This indicates inadequate separation of duties for this process.	Duties of opening mail and logging in cash receipts are being assigned to separate individuals.	02/03/20*XX*	02/27/20*XX*	03/15/20*XX*	03/15/20*XX*	Internal Review
XYZ-*XX*-C-002	J.3	There is no integrated general ledger accounting system to adequately track all Medicare financial data	The services of a consulting firm have been obtained to develop an integrated general ledger system for reporting Medicare financial data.	02/20/20*XX*	02/27/20*XX*	04/30/20*XX*	To be determined	Internal Review
XYZ-*XX*-S-001	A.1	No Entity Wide Security Plan	Create an entity Wide Security Plan	03/01/20*XX*	03/10/20*XX*	6/30/20*XX*	To be determined	SAS 70 Audit

30.5 - CPIC Report of Internal Control Deficiencies

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The CPIC Report of Internal Control Deficiencies *is an internal report and it* shall include control deficiencies and significant deficiencies. The CPIC report of Internal Control Deficiencies shall not be submitted as part of the annual CPIC submission. However, you are required to report in the Executive Summary the number of control deficiencies and significant deficiencies identified during the period covered by the CPIC. The CPIC Report of Internal Control Deficiencies should be prepared as a spreadsheet and include the following columns of information:

1. The original source of the finding.

2. The type of control deficiency (control deficiency or significant deficiency).

3. Whether it is a design deficiency or operating deficiency.

4. The control objective numbers impacted (from section 50).

5. The corrective action plan.

6. A summary of the control deficiency and significant deficiencies including when the condition was observed and if a corrective action plan was implemented (or the status if not corrected).

Each control deficiency and significant deficiency shall be listed, and the total number of control deficiencies and significant deficiencies shall be included in the report. The contractors are required to prepare and maintain this report internally and update this report as new control deficiencies are identified. It shall be available for review by CMS central and/or regional office staff. When CPIC control deficiencies are identified, evaluate internal corrective actions for each of the deficiencies and correct each problem. While you are required to document, track, and correct problems identified as control deficiencies, significant deficiencies and material weaknesses, CPIC CAPs are not required to be submitted to CMS for control deficiencies and significant deficiencies.

30.6 - Definitions of Control Deficiency, Significant Deficiency, and Material Weakness

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The terms below are *definitions and reporting classifications for FMFIA and A-123 Internal Controls over Financial Reporting:*

CONTROL DEFICIENCY:

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. *A design deficiency exists when a control necessary to meet the control objective is missing or an existing control is not properly designed, so that even if the control operates as designed the control objective is not always met. An operation deficiency exists when a properly designed control does not operate as designed or when the person performing the control is not qualified or properly skilled to perform the control effectively.*

SIGNIFICANT DEFICIENCY:

A deficiency in internal control or combination of deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is "more than remote" (i.e., at least reasonably possible) likelihood that a misstatement of the entity's financial statements that is more than inconsequential will not be prevented or detected. *(Formerly Reportable Condition)*

MATERIAL WEAKNESS:

A material weakness is a significant deficiency, or a combination of significant deficiencies, that results in a "more than remote" (i.e., at least reasonably possible) likelihood that a material misstatement of the financial statements, or other significant financial reports, will not be prevented or detected.

The term "remote" is defined in the Statements of Federal Financial Standards No. 5, Accounting for Liabilities of the Federal Government, as the chance of the future event or events occurring is slight. Therefore, the likelihood of an event is "more than remote" when it is at least reasonably possible.

40 - Corrective Action Plans

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The CMS conducts various financial management and electronic data processing (EDP) audits/reviews performed by the OIG, GAO, independent CPA firms, and the CMS central office (CO) and regional office (RO) staff to provide reasonable assurance that contractors have developed and implemented internal controls. The results of these audits/reviews indicate whether the contractors' internal controls are operating as designed. Correcting these deficiencies is essential to improving financial management and internal control. Therefore, audit resolution remains a top priority at CMS.

The CMS has established policies and procedures to ensure that the contractors have appropriate CAPs for addressing findings identified through the following:

1.CFO financial or electronic data processing (EDP) audits related to annual CFO Financial Statement audits, which may include network vulnerability assessment/security testing (NVA/ST);

2.SAS 70 audits;

3.CPICs;

4.Accounts receivable (AR) Agreed Upon Procedures (AUP) reviews;

5.Health & Human Services (HHS), OIG Information Technology (IT) Controls Assessments;

6.Financial reviews conducted by the GAO;

7.CMS' 1522 workgroup reviews;

8.CMS' CPIC reviews; and

9.OMB Circular A-123 *Appendix A reviews.*

Administrative cost audits, provider audits conducted by the OIG, *the* contractor initiated systems security annual compliance audits, and system penetration tests are excluded from these procedures. The word "finding" includes control deficiency, significant deficiency, and material weakness. For SAS 70 audits, CAPs to be submitted to CMS are required for findings noted in the opinion letter only (section I), not those reported in section III of the SAS 70 Report. *For A-123 Appendix A reviews, the contractor shall submit corrective action plans for all deficiencies: control deficiencies, significant deficiencies, and material weaknesses.*

40.1 - Submission, Review, and Approval of Corrective Action Plans

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Upon completion of any of the audits/reviews noted in section 40, with the exception of the CPIC, the contractor will receive a final report from the auditors/reviewers noting all findings identified during their audit/review. Within 45 calendar days of the date of report *issuance,* the contractor is required to submit an initial CAP report, using the Initial CAP report format from section 40.5. For SAS 70*, A-123 Appendix A reviews,* and the AR AUP reports, initial CAPS are due within 45 calendar days of the electronic receipt date of the final report.

The initial CAP report shall address newly identified and reported findings that have been assigned a finding number either by the auditor*/reviewer* (e.g., SAS 70 audit *or A-123 Appendix A review)* or by the contractor (i.e., CPIC). The CAP shall summarize the procedures that have been or will be implemented to correct the finding. Upon receipt of the initial CAP reports, the Internal Control Team will send the reports to the appropriate CMS business owner for review of the CAP. Business owners may either approve the CAP as submitted, or may request additional information to be included in the CAP. All business owner comments shall be provided to the

contractors before the due date of the next quarterly CAP report. Responses to the CMS business owner comments on the initial CAPs shall be included in the next Quarterly CAP Report due after the date of receipt of the comments.

After an initial CAP has been submitted, the CAP shall be merged onto the Quarterly CAP using the report format in section 40.6. This report will contain all findings and CAPs previously submitted to CMS and provide updates to the actions taken to resolve the findings. If there has been no change in a specific CAP since the submission of the previous CAP report, note the date along with a comment of "no change" in the Update/Status column of that CAP.

The quarterly updates will also be reviewed; however, CMS will not respond to the quarterly updates unless the CAP indicates that the contractor is not making adequate progress on implementing the CAP or has made significant changes to target completion dates.

The Quarterly CAP report is due within 30 days following the end of each quarter. Therefore, all electronic and hardcopy CAP reports should be received by CMS on or before January 30, April 30, July 30, and October 30 annually. The Quarterly CAP report *shall* address all open findings, as well as continue to report information on all findings reported as completed by the contractors until CMS sends the contractor a closeout letter indicating which findings are officially closed. After the contractor receives the closeout letter, the CAP shall be removed from the Quarterly CAP report.

Submit Initial and Quarterly CAP reports electronically to: CAPS@cms.hhs.gov. *C*ontractors are required to furnish an electronic copy of the CAP reports to their CMS Associate Regional Administrator for Financial Management and Fee for Service Operations, CCMO, and the designated Regional Office CFO/SAS 70 coordinator. *MACs shall submit initial and quarterly CAPs to the CAPS@cms.hhs.gov mail box, and the MAC Project Officer. RDS and MSPRC shall submit initial and quarterly CAPs to the CAPS@cms.hhs.gov, and the central office Project Officer.*

NOTE: If the electronic copy of the Initial and Quarterly CAP reports has the VP of Operations electronic signature or is sent from the VP of Medicare Operations email or the CFO's email, then a hardcopy is not required to be sent to CMS. Otherwise, a hardcopy is required.

*C*ontractors shall maintain and have available for review backup documentation to support implementation of each CAP. This will facilitate the validation of CAPS by CMS or its agents.

40.2 - Corrective Action Plan (CAP) Reports

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The Initial or Quarterly CAP report shall include the data explained below using the format provided in section 40.4 and section 40.5. Findings should be grouped by type of review (i.e. CFO, SAS 70, *A-123 Appendix A*, AR AUP, CPIC, etc.). Definitions of CAP report data fields:

CMS finding number - The finding number assigned by the auditor/reviewer (or assigned by the contractor if it is a CPIC material weakness) and noted in final reports to identify and track contractor findings. See section 40.3, for the finding number methodology used by the auditors.

Repeat CMS Finding Numbers – If a finding is repeated or duplicated in subsequent years or reported in more than one type of review, provide all other CMS finding numbers for that issue. Repeat finding numbers listed for a particular finding shall be an identical issue, not a related or similar issue and have been identified as a repeat by the auditors in their audit report.

Findings with a repeat finding number shall only be listed once on the CAP report. The CMS finding number column will be populated with the primary finding number. The primary finding number is the finding number that was identified first. If in subsequent audit/reviews, the same finding is identified by the auditors, the auditors will assign a finding number applicable to the type of audit/review being conducted, and also note in the audit report that it is a repeat finding of a prior audit. The auditor should also note the repeat finding number so that the findings can be easily linked.

Control objective(s) impacted - Required only for SAS 70 findings, *A-123 Appendix A findings,* and CPIC material weaknesses. This represents the control objective number(s) impacted by an identified finding. More than one control objective may be impacted for each finding but you need to prioritize and limit the control objectives impacted to no more than five.

Finding/material weakness - A detailed description of the finding as identified by the auditor/reviewer in their final report or the material weakness as reported in the CPIC.

Responsible individual name – The name of an individual that can provide information on the resolution of the CAP, and is responsible for ensuring that the finding is resolved.

Responsible individual email - The email address of an individual that can provide information on the resolution of the CAP, and is responsible for ensuring that the finding is resolved.

Responsible individual phone number, is the phone number of an individual that can provide information on the resolution of the CAP and is responsible for ensuring that the finding is resolved.

Corrective action procedure(s) - The detailed actions that the contractor will take or has taken to resolve the finding. If the procedures have more than one step, all steps shall be included in one cell. Additionally, if the steps have multiple target and actual completion dates, include these in the Update/status of CAP column.

Target completion date - The date the contractor expects the final step of the corrective action procedure to be fully implemented.

Actual completion date - The date all steps of the corrective action procedure are considered by the contractor to be complete and the contractor has resolved the finding.

Update/status of CAP - Subsequent actions taken by the contractor to implement the initial CAP. If there are more than five control objectives impacted, add them to this field. If there has been no change in a specific CAP since the previous report, simply list the current date along with a comment of "no change" in the Update/Status of CAP column.

40.3 - CMS Finding Numbers

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The CMS Finding Numbers should be assigned using the following instructions. Each section of digits should be separated by a dash.

A. The first three, four, or five digits are letters, which identify the name of the contractor. Each contractor is assigned a unique set of letters listed below.

B. The second two digits are the last two numbers of the year of the review.

C. The next one digit is a letter to identify the review*/audit type*.

D. The last three digits are three numbers assigned sequentially to each finding type beginning with 001.

Review/Audit Type

Findings resulting from the following types of audits or reviews should be reported using the Initial and Quarterly CAP Reports. Choose one from the following list:

- A - *A*-123 *Appendix A* non-IT self-assessment
- C - CPIC (your annual self certification package);
- E - CFO EDP audit;
- F - CFO Financial audit;
- G - GAO review (financial reviews);
- I – A-123 IT (EDP) Self Assessment
- M - CMS' CPIC reviews;
- N - SAS 70 Novation;
- O - OIG review HHS/OIG/IT controls assessment;
- P - CMS' 1522 reviews;

- R - AR AUP review;
- S - SAS 70 audit; and
- V - CFO related NVA/ST
- *W – Regional Office Review*

Table 2 -CONTRACTOR ABBREVIATIONS

Cahaba Government Benefit Administrators (d.b.a. Alabama BCBS)	CAH
CIGNA Health Care	CIG
CIGNA Health Care, Durable Medical Equipment (DME) MAC	CIGD
Cooperativa de Seguros de Vida de Puerto Rico	COP
First Coast Service Options, Inc.	FCSO
First Coast Service Options, Inc.	*FCSOJ*
Blue Cross and Blue Shield of Georgia, Inc.	GEO
Highmark Medicare Services	*HMSJ*
National Government Services, Inc.	NGS
National Government Services, Inc.	*NGSJ*
National Government Services, Inc. DME MAC	NGSD
National Heritage Insurance Company	NHIC
National Heritage Insurance Company, DME MAC	NHICD
Noridian Mutual Insurance Company	NOR
Noridian Mutual Insurance Company	*NORJ*
Noridian Mutual Insurance Company, DME MAC	NORD
Palmetto Government Benefits Administrators	PGBA
Palmetto Government Benefits Administrators	*PGBAJ*
Pinnacle Business Solutions, Inc.	PBSI
Riverbend Government Benefits Administrator (d.b.a. Blue Cross and Blue Shield of Tennessee)	RGBA
TrailBlazer Health Enterprises, LLC	THE
TrailBlazer Health Enterprisess, LLC	*THEJ*
Triple S, Inc.	SSS
TriSpan Health Services (d.b.a. as BCBS Mississippi)	TRI
Wisconsin Physicians Service Insurance Corporation	WPS
Wisconsin Physicians Service Insurance Corporation	*WPSJ*
Chickasaw Nation Industries, Inc. (Medicare Secondary Payer Recovery Contractor)	CNI
Retiree Drug Subsidy (ViPS) (Part D Contractor)	RDSV

Table 3 - SHARED SYSTEM MAINTAINER ABBREVIATIONS

Common Working File	*CWF*
Fiscal Intermediary Shared (or Standard) System /Multi-Carrier System	*FISS*
Multi-Carrier System	*MCS*
Viable Information Processing Systems (ViPS)	*VMS*

40.4 - Initial CAP Report

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

All initial CAPs shall be reported on the Initial CAP Report. After this initial submission, CAPs shall be merged onto the Quarterly CAP report. All CAPs, for the reviews noted in section 40, shall be consolidated onto one Quarterly CAP Report. However, if you have findings for an affiliated data center or system maintainer, these findings shall be reported on a separate CAP report, and not with reported contractor findings. Specifically, if the three or four letter abbreviation listed in section 40.3 is not the same for all findings, a separate CAP report is required for each set of findings associated with that abbreviation code.

The contractor shall use the Initial CAP Report, as an Excel spreadsheet and add their data following the steps below. The format of the spreadsheet should not be altered. Additionally, this electronic file should be labeled Initial CAP Report, should be identified using the contractor abbreviations found in section 40.3, and should include the submission date. For example, *Wisconsin Physicians Service Insurance Corporation* (W*P*S) would name this file "W*P*S Initial CAP Report 10/30/XX.xls".

The initial CAP Report format will be distributed by and can be obtained from: CAPS@cms.hhs.gov.

40.5 - Quarterly CAP Report

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The contractor shall use the Quarterly CAP Report, as an Excel spreadsheet and add their data accordingly, without making changes to the format. Additionally, this electronic file shall be labeled Quarterly CAP Report, should be identified using the contractor abbreviations found in section 40.3, and shall include the submission date. For example, *Wisconsin Physicians Service Insurance Corporation (WPS)* would name this file "W*P*S Quarterly CAP Report 10/30/XX.xls".

The Quarterly CAP Report format will be distributed by and can be obtained from: CAPS@cms.hhs.gov.

40.6 – Entering Data into the Initial or Quarterly CAP Report

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Overview

The CMS spreadsheet application form assists the contractors to enter data quickly and easily into the CAP report. The application features drop down lists, reducing the amount of manually entered data, and has the ability to detect errors as each data element of information is entered. It also provides specific help features to assist in correcting detected errors.

Launching the Spreadsheet Application

Locate the file and double click on it to start Microsoft Excel and load the spreadsheet application. Or manually open Excel and use the 'File' – Open menu command to select and open the file, which also loads the spreadsheet application.

When opening the file, a Dialogue Box pops up. You shall click on Enable Macros. This will allow the spreadsheet to function properly and provide assistance in entering data and check for errors.

Entering Data

The first ten rows of the Initial or Quarterly CAP report are considered to be the header of the spreadsheet and contain eight data elements (rows 2 through 9). The data elements are Contractor Name, Contractor Number, Date of Submission, Contact Person Name, Contact Person Email, Contact Person Phone Number, and Vice President (VP) for Medicare Operations Name, and VP for Medicare Operations Signature.

Header data elements:

Contractor Name – Position your cursor in cell B2 of the spreadsheet. A dialogue box will appear. Click on the [arrow] on the right side of the CMS Contractor Name dialogue box to invoke the Pull Down Menu of contractor names. Select the appropriate name. After the name is selected, the cursor will automatically move to the next field: Contactor Number.

Contractor Number – Enter your contractor number(s). The number cannot exceed 5 digits and if less than 5 digits are entered, leading zeros will automatically be entered. If more than 1 contractor number is entered, separate the numbers with a comma (,). Maintainers and Data Centers are not required to enter a contractor number, thus this field shall be left blank. A flyover help box is provided to ensure the proper format is followed.

Date of Submission – Enter the date in the format of mm/dd/yyyy that the CAP report will be submitted to CMS. A flyover help box is provided to ensure the proper format is followed.

Contact Person's Name – Enter the first and last name of the person that may be contacted regarding any questions on the submission of the CAP report.

Contact Person's Email– Enter the email address of the contact person. The email address shall be properly formatted with a '@' sign.

Contact Person's Phone # - Enter the contact person's phone number (i.e., 410-786-5555, ext.123456). The phone number may have an extension of up to 6 digits. A flyover help box is provided to ensure that the proper format is followed.

VP for Medicare Operations Name – Enter the first and last name of the Vice President of Medicare Operations.

VP for Medicare Operations Signature – Insert electronic signature if capable.

NOTE: If incomplete information is entered or is not entered in the proper format, an error message will be displayed after each data entry indicating that the information is invalid. The application will not allow you to continue until all errors in the header are corrected. Also, you may use the function 7 (F7) key to enable spell check.

Row 11 provides the name of each column in the Detail section of the spreadsheet. The cells in this row may not be changed.

Proceed to cell A12 to begin to enter data in the Detail section of the spreadsheet.

To enter data, click the Edit Data button in the header section.

A dialogue box containing the 'CMS CAP Data Input' form will appear to allow information to be entered in the appropriate data fields. See Figure 1. All edits shall be performed in this input form. Edits performed directly into a cell when not in this form cannot be saved.

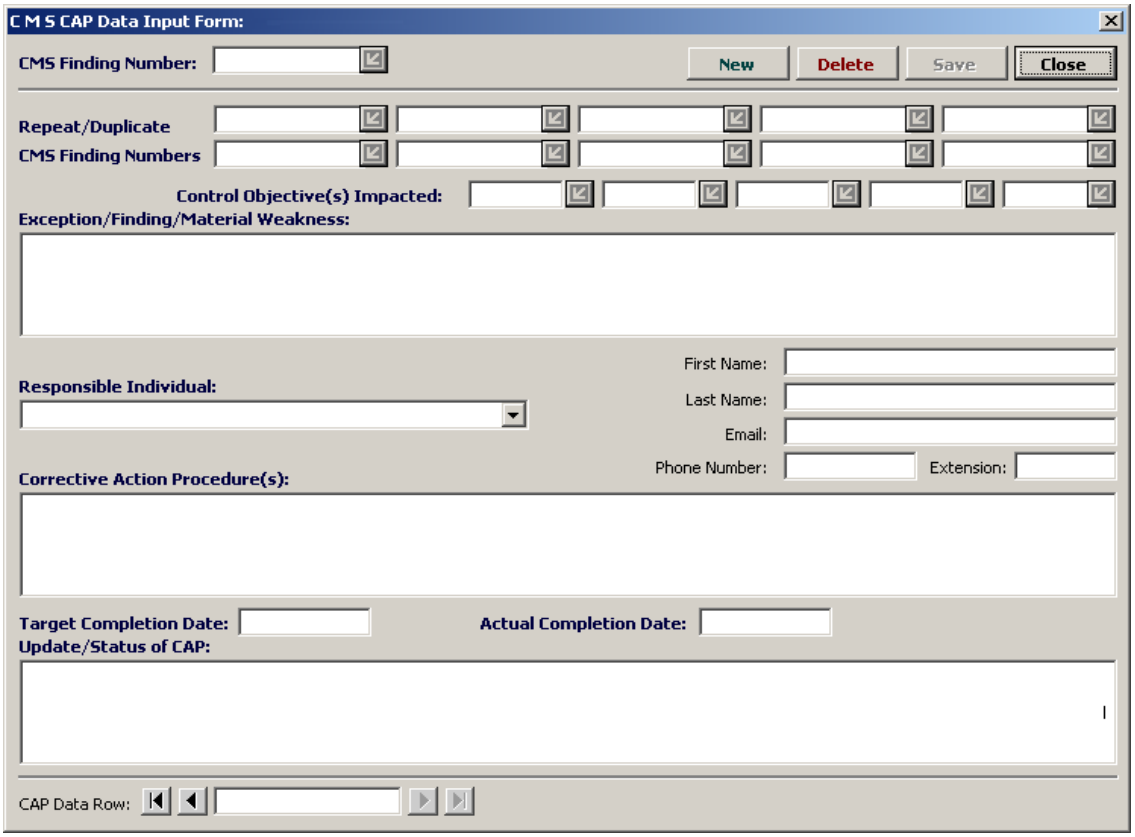

Table 4: CMS CAP Data Input Form

Figure 1—The CMS CAP data input form is a print screen of the initial CAP reporting template. There is a description for each data field such as provider number, contractor name, number and finding number, etc.

Click on the [arrow] to the right of the CMS finding number to open the next dialogue box containing the components of the CMS finding number. All components are required.

CMS Finding Number components:

Contractor abbreviation – The abbreviation will automatically be populated based on the Contractor Name entered in row 2 of the Header and as a result, will be grayed out. In order to change the abbreviation, the Contractor Name will have to be changed in the Header.

NOTE: Since the contractor abbreviation will always link to the contractor name, Initial and Quarterly CAP reports can no longer combine findings that originated at your contractor location, your data center and/or those applicable to your maintainer system in one report. Separate reports using the spreadsheet application form shall be completed for contractor, data center, and maintainer findings.

Year of Review – Enter the last 2 digits of the applicable fiscal year (FY) that the review was conducted.

Type of Review – Press on the [arrow] on the right side of the Type of Review dialogue box to invoke the Pull Down Menu of review types. Select the review applicable to the reported finding.

Sequential Numbering of Finding – Press on the up or down [arrows] to the right side of the Sequential Numbering of Finding dialogue box to enter the finding number as reported by the auditors in their final report.

When all components have been entered, click on the Save & Close button. Press the Clear button to delete entered data if corrections are necessary. After corrections are completed, click on the Save & Close button.

Use the tab key or the mouse pointer to move to the next box, which is the Repeat/Duplicate Finding Number. If appropriate, press on the first [arrow] on the right side of the Repeat/Duplicate Finding Number to open the next dialogue box containing the components of the first Repeat/Duplicate Finding Number. Press subsequent [arrows] to enter additional repeat findings. The application allows a total of ten repeat/duplicate finding numbers to be entered.

When all components of the Repeat/Duplicate Finding Number have been entered, click on the Save & Close button. Press the Clear button to delete entered data if corrections are necessary. After corrections are completed, click on the Save & Close button.

Use the tab key or the mouse pointer to move to the next cell, which is the Control Objective(s) Impacted. If the Type of Review entered in CMS Finding Number dialogue box was either C for CPIC submissions, N for Novation SAS 70 audits, or S for SAS 70 audits, this field will be activated and control objectives need to be entered. All other Types of Reviews/audits will disable this field and as a result, will be grayed out.

Press on the [arrow] on the right side of the Control Objective(s) Impacted dialogue box to open the Control Objectives Impacted selection box. Based on the FY entered as part of the CMS Finding Number, the Control Objective Impacted selection screen will provide a Pull Down Menu of the control objectives effective in that FY. Select the appropriate control objective from the list.

After each control objective has been entered, click on the Save & Close button. Press the Clear button to delete entered data if corrections are necessary. After corrections are completed, click on the Save & Close button. Repeat outlined steps until all applicable control objectives have been entered. The application allows a maximum of five control objectives to be entered. If more than 5 control objectives are impacted for a given finding, add the additional control objectives impacted to the Update/Status of CAP portion of the spreadsheet.

NOTE: If more than one control objective has been entered and deletions are necessary, you shall click the Clear button and delete the objectives in the reverse order of entry. For example, the last control objective entered shall be the first control objective deleted.
Use the tab key or the mouse pointer to move to the next cell, which is the Exception/Finding/Material Weakness box in the Data Input Form. Enter text exactly as it

appears in the auditor's final report. Do not paraphrase. This field is limited to 1024 characters. Any additional information will be truncated. This is a required field.

Continue to use the tab key or the mouse pointer to move to the next few cells, which provide information on the Responsible Individual of the finding. Enter the first and last name of the Responsible Individual, their email address which shall be properly formatted with the '@' sign, and their phone number in the format of xxx-xxx-xxxx and shall not include parenthesis (i.e. 410-786-5555, ext.123456). The phone number may have an extension of up to 6 digits. Only one name, email address and phone number may be entered. These are required fields.

After the information is first entered into the individual fields, the information will be merged and displayed in a drop down list under the Responsible Individual title on the left of the screen. This information can then be used for subsequent CAPs without reentering the details.

The next box contains the Corrective Action Procedures. Enter the procedures that have or will be implemented to address the finding. This field is limited to 1024 characters. Any additional information will be truncated. This is a required field.

Press the tab key or the mouse pointer to the Target Completion Date entry area. Enter the date that the finding is expected to be resolved using the format mm/dd/yyyy. This is a required field that shall be completed for all findings and only allows one date with no text. If a finding is considered to be 'global', enter 02/22/2222. This date will act as an indicator to CMS that the finding is global and assist in easily identifying all findings.

Enter an Actual Completion Date using the format mm/dd/yyyy to indicate when the CAP was implemented. This field shall include only one date with no text. If the CAP has not been completed, leave this field blank.

The last field is the Update/Status field. Use this field to provide updates to corrective action procedures or to indicate that no changes have been made since the last reporting cycle. If a notation is made indicating that a CAP *has been implemented,* you shall ensure that an Actual Completion Date has been provided. This field is limited to 1024 characters. Any additional information will be truncated. This is a required field for the Quarterly CAP report. *Contractors shall note in the comment section that you are requesting closure of the CAP. The CMS will validate that the finding has been corrected. The CMS central office shall provide a formal CAP closure letter to give notice that the CAP has been closed and may be removed from the Quarterly CAP Report.*

Once you have filled in all the data fields, press the Save button on the top right hand corner. If you have failed to properly enter data in any of the fields, an error message should have already been displayed to indicate the fields where invalid data was entered. Therefore, all errors should have been corrected prior to saving the information.

Once the information is saved, which is indicated by the Save button being grayed out, you may either press the Close button or the New button. If you press the Close button, you will be returned to the spreadsheet application form. The data entered into the Data Input Form will

now appear in the Excel spreadsheet. However, you may press the New button to remain in the Data Input Form and continue to enter additional findings.

NOTE: We recommend that entries be saved after completing the Data Input Form for each finding to prevent the loss of any data.

Editing Existing CAP Data

On the bottom left of the CMS CAP Data Input Form, there is a control bar (CAP Data Row) that lets you scroll through the completed rows while remaining in the Data Input Form. By clicking on the left or right arrows, you can scroll through the entries and make any changes that are needed. Remember, you shall press the Save button after any changes are made.

The application does not allow you to edit any data unless you are in the Data Input Form. If you try to manually enter or edit any information directly in the spreadsheet, the changes will not save because the data is protected. If changes are needed to existing data, position the cursor in any field in the row where the change is needed and click on the Edit Data button in the Data Input Form.

Saving Files

To save the completed spreadsheet application form, press the Save As button at the top of the form. This button automatically creates a file name that incorporates user and date information that allows for easy tracking of spreadsheets and their different versions.

The format for the file includes: Contractor Abbreviation, Report Name and Date (i.e. AHS Quarterly CAP Report 123101.xls). Please do not change the recommended file name that the application creates.

50 - LIST OF CMS CONTRACTOR CONTROL OBJECTIVES

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Control Number	Control Objectives
A - *Control Number*	***Control Objective* - Information Systems**
A.1	An entity-wide security program has been documented, approved and monitored by management in accordance with the CMS Business Partners Systems Security Manual (BPSSM) and includes requirements to assess security risks periodically, establish a security management structure and clearly assign security responsibilities, implement effective security-related personnel policies, monitor the security program's effectiveness and ensure security officer training and employee security awareness.
A.2	Security related personnel policies are implemented that include performance of background investigations and contacting references, include confidentiality agreements with employees (regular, contractual and temporary) and include termination and transfer procedures that require exit interviews, return of property, such as keys and ID cards, notification to security management of terminations, removal of access to systems and escorting of terminated employees out of the facility.
A.3	Information resources are classified (risk-ranked) according to their criticality/sensitivity and are periodically formally reviewed.
A.4	Access to significant computerized applications (such as claims processing), accounting systems, systems software, and Medicare data are appropriately authorized, documented and monitored and includes approval by resource owners, procedures to control emergency and temporary access and procedures to share and properly dispose of data.
A.5	Security policies and procedures include controls to ensure the security of platform configurations and to ensure proper patch management of operating systems.
A.6	Physical access by all employees, including visitors, to Medicare facilities, data centers and systems is appropriately authorized, documented, and access violations are monitored and investigated.
A.7	Medicare application and related systems software development and

maintenance activities are authorized, documented, tested, and approved. Application level controls must ensure completeness, accuracy, and authorization.

A.8 A System Development Life Cycle methodology is documented and in use and includes planning for and costs for security requirements in systems.

A.9 Change management policies and procedures exist that include documented testing and approval of changes for regular and emergency changes and restrictions on the use of public domain and personal software.

A.10 Access to program libraries is properly restricted and movement of programs among libraries is controlled.

A.11 Adequate segregation of duties exists between various functions within Medicare operations and is supported by appropriately authorized and documented policies.

A.12 Activities of employees should be controlled via formal operating procedures that include monitoring of employee activities by management with documentation maintained to provide evidence of management's monitoring and review process.

A.13 A regular risk assessment of the criticality and sensitivity of computer operations, including all network components, IT platforms and critical applications has been established and updated annually. The assessment includes identification of threats, known system vulnerabilities, system flaws, or weaknesses that could be exploited by threat sources.

A.14 A centralized risk management focal point for IT risk assessment has been established that includes promotion awareness programs, processes and procedures to mitigate risks and monitoring processes to assess the effectiveness of risk mitigation programs.

A.15 A risk assessment and systems security plan has been documented, approved, and monitored by management in accordance with the CMS Risk Assessment and Systems Security Plan Methodologies.

A.16 Regularly scheduled processes required to support the *CMS c*ontractor's continuity of operations (data, facilities or equipment) are performed.

A.17 A corrective action management process is in place that includes planning, implementing, evaluating, and fully documenting remedial action addressing findings noted from all security audits and reviews of

	IT systems, components and operations.
A.18	Management has processes to monitor systems and the network for unusual activity, and/or intrusion attempts.
A.19	Management procedures are in place to ensure proper action in response to unusual activity, intrusion attempts and actual intrusions.
A.20	Management processes and procedures include reporting of intrusions attempts and intrusions in accordance with the Federal Information Security Management Act (FISMA).
B – *Control Number*	***Control Objective*** **- Claims Processing**
B.1	The Medicare claims processing system tracks each claim from receipt to final resolution.
B.2	The system checks each claim, adjustment, and any other transaction for validity and, in accordance with CMS instructions, rejects such claims, adjustment, or other transaction failing such validity check. (Maintainer Only)
B.3	The system generates an audit trail with respect to each claim, adjustment, or other related transaction. Such audit trail shall include the results of each applicable claim edit. (Maintainer Only)
B.4	Each claim is adjudicated in accordance with CMS instructions.
B.5	Claims are reopened in accordance with CMS guidelines and readjudicated in accordance with CMS instructions.
B.6	Claim payment amounts are calculated in accordance with CMS instruction. Fee schedules are properly received, logged, and changed in the system and monitored, and applied in accordance with CMS instructions. Reasonable costs and reasonable charges are received, logged, and changed in the system, monitored, and applied in accordance with CMS instructions.
B.7	The system shall identify and deny duplicate claims in accordance with CMS instructions. (Maintainer Only)
B.8	Claims are properly aged from the actual receipt date to the actual date of payment in compliance with CMS instructions.
B.9	The system shall detect apparent fraudulent or abusive practices in accordance with CMS instructions. Personnel are trained to detect fraudulent and abusive practices and, in accordance with CMS

	instructions, to deter such practices. Any such apparent fraudulent or abusive practices as are identified are documented and reported in accordance with CMS instructions. (Maintainer Only)
C – *Control Number*	***Control Objective* - Appeals**
C.1	Medicare Part A and Part B redeterminations are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines. Part B claims processed by Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs) follow the Part B appeals process redeterminations
C.2	Medicare Part B redeterminations are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines.
C.3	Qualified Independent Contractor (QIC) request for case *files* are handled in compliance with CMS time frames.
C.4	Effectuations are processed as directed by CMS guidelines.
C.5	Contractor communications are clear and in compliance with CMS' instructions to include specific communications such as acknowledgement letters, decision letters, and information on additional appeal rights, etc.
D - *Control Number*	***Control Objective* - Beneficiary/Provider Services**
D.1	Personally identifiable health information, which is used and disclosed in accordance with the Privacy Act, is handled properly. (Internet Only Manual (IOM) Chapter 2-20.1.8-Beneficiary Customer Service; *IOM Pub. 100-9, Chapter 6-Provider Customer Service Program).*
D.2	Beneficiary and Provider written inquiries are retained and handled accurately, appropriately, and in a timely manner. (IOM Chapter 2-20.2 – Written Inquiries; *IOM Pub. 100-9, Chapter 6-Provider Customer Service Program).*
D.3	Telephone inquiries are answered timely, accurately, and appropriately. (IOM Chapter 2-20.1 Telephone Inquiries; *IOM Pub. 100-9, Chapter 6-Provider Customer Service Program).*
E – *Control Number*	***Control Objective* - Complementary Credits**
E.1	*Legacy c*ontractors shall report complementary credits received from the Coordination of Benefits Contractor (COBC) for Coordination of

Benefits Agreement (COBA) crossover claims in the proper fiscal year on their Interim Expenditure Reports (IERs). The credit is applied properly on the IER report when it is reported in the fiscal year in which the claims being reimbursed were originally crossed to the COBC.

MACs shall report complementary credits received from the COBC for COBA crossover claims in the proper fiscal year in the CMS Analytical, Reporting, & Tracking system (CMS ART). The credit is applied properly on the ART report when it is reported in the fiscal year in which the claims being reimbursed were originally crossed to the COBC.

E.2

*Legacy c*ontractors shall properly report their COBC accrual amounts on their monthly IER reports. These accruals shall be reported in the proper fiscal year (based on when the claims were crossed to the COBC), and shall be adjusted downward based upon (1) the details of the COBC Detailed Error Report; and (2) the information contained on the contractor's remittance advice that accompanies each reimbursement for crossover claims.

MACs will not be using the accrual accounting method for this line item based on a future change request.

F – *Control Number*

***Control Objective* - Medical Review (MR) -- If MR work has been transitioned to the Program Safeguard Contractors (PSCs) and you are no longer responsible for this function; do not include it in your CPIC submission.**

F.1

Contractor shall utilize the Progressive Corrective Action (PCA**)** process, in accordance with the Program Integrity Manual (PIM) and CMS instructions, to drive medical review (MR) activity (i.e., data analysis, claims review, local policy development).

F.2

Contractor shall use the PIM and Budget Performance Request (BPR) guidelines, data analysis and prior year MR results, applicable Strategy Analysis *Report (SAR)*, and Comprehensive Error Rate Testing (CERT) results to develop and update the MR strategy document. The MR Strategy document shall address site-specific problems, prioritization of problems, funding, and workload and shall be targeted toward the goal of reducing the paid claims and provider compliance error rate. All work performed by the MR unit shall be identified in the MR Strategy and targeted based on the contractor's prioritized problem list.

F.3 Contractor shall perform data analysis continuously throughout the fiscal year (FY) to identify potential problems such as aberrant billing submissions, potential areas of over utilization, and changes in patterns of care over time. Data from a variety of sources must be used for data analysis. [Examples of data sources could include: CMS and other national sources, contractor's internal databases, specialty data analysis contractors (e.g., *the Pricing, Data Analysis and Coding (PDAC contractor)* and PSCs, *CMS* contractors with similar geographic or size qualities, Office of Inspector General (OIG) reports, Government Accountability Office (GAO) reports, enrollment data, fraud alerts, and other available sources.]

F.4 Contractors shall develop, revise, and maintain local policies as based on data analysis findings and as outlined in their MR Strategy. Local policies must be in the appropriate format (see www.cms.hhs.gov/coverage) in accordance with PIM guidelines.

F.5 Contractor shall ensure that effective MR edits are developed and implemented as a result of data analysis findings. The effectiveness of each MR edit shall be analyzed and measured by tracking the denial rate, appeals reversal rate, dollar return on the cost of operationalizing the edit, and billing behavior correction. MR edits shall be modified, deleted*, or deactivated* when they are determined to no longer be effective.

F.6 Contractor shall budget and perform the MR workloads throughout the FY as established in the MR strategy. Contractor shall report workload volume and associated costs, calculated in accordance with the approved cost allocation plan, accurately and timely in the monthly MR Interim Expenditure Reports (IERs). Variances between budgeted and actual workload volume (10 percent or greater) and costs (5 percent or greater) shall be adequately addressed by ensuring appropriate strategy revisions and budget adjustments are made and submitted to the RO in accordance with PIM instructions. Please note that a variance analysis may not be required for NOBA/IER if variance amount is <$5,000.

***Still required for FIs and Carriers. MAC contractors do not submit IERs.*

F.7 The MR unit shall effectively collaborate with Provider Outreach and Education (POE) by referring educational needs that will address existing program vulnerabilities and emerging problems identified during the MR process conducted throughout the fiscal year.

F.8 Contractor shall be capable of identifying the status of each individual

	claim subjected to medical review at any time (and all claims must be processed timely for closure in accordance with PIM instructions.)
F.9	Contractor shall effectively comply with all of the MR requirements of the Joint Operating Agreement (JOA) with the PSCs.
F.10	Contractor shall implement and utilize a Provider Tracking System (PTS) to track all informational provider contacts made by medical review and all educational referrals submitted to POE.
F.11	Contractor shall ensure that there is adequate internal networking and sharing of information, and appropriate collaborative actions are taken as a result, between Medical Review and other business functions such as Benefit Integrity/PSC, Appeals, Audits, POE, and inquiries.
F.12	Contractor shall apply quality assurance processes to all elements of the MR Strategy and to all aspects of program management, data analysis, edit effectiveness, problem identification, and claim adjudication.
G – *Control Number*	***Control Objective*** **- Medicare Secondary Payer (MSP)**
G.1	Internal quality controls are established and maintained that ensure timely and accurate processing of secondary claims submitted, including paper MSP claims, with a primary payer's explanation of benefits (EOB) or remittance advice (RA). This includes utilization of the MSPPAY module, resolving all MSP edits (including 6800 codes*), creation of "I"** records and resolving suspended claims. Contractor internal systems used to process MSP claims are updated via the Common Working File (CWF) automatic notice in an automated fashion. *6800 edit codes can be located at: http://www.cms.hhs.gov/manuals/downloads/msp105c06.pdf at Publication # 100-05 (Medicare Secondary Payer Manual) in Chapter 6 (Medicare Secondary Payer CWF Processes). ** "I" records are located at: http://www.cms.hhs.gov/manuals/downloads/msp105c05.pdf *This control objective does not pertain to the MSPRC contractor.*
G.2	Audit trails for MSP recoveries (receivables) are maintained. This should also include the contractor's ability to create a complete audit trail if cases are housed or maintained electronically. An audit trail should contain detail to support all accounting transactions as a result of establishing, reconciling and resolving a receivable. For example, an audit trail should establish the identification and creation of the debt through to its resolution including the source of the receivable, reason(s)

for adjustment(s), referral to Treasury, and collection of the debt.

All correspondence specific to a case should be accessible and in date order.

G.3 Contractors have processes and procedures in place to ensure compliance with all CMS instructions and directives relating to Phase III (MSP Investigations) of the Coordination of Benefits Contracts. This includes transmitting appropriate, timely and complete Electronic Correspondence Referral System (ECRS)*, CWF Assistance Requests and ECRS MSP inquiries as a result of the receipt of a phone call, correspondence, claim or unsolicited check/voluntary refund. All references must be maintained in an area accessible to MSP staff and must be available for CMS review.

*The ECRS user guide is located at: www.cms.hhs.gov/manuals/downloads/msp105c5_att1.pdf at Publication #100-05 Medicare Secondary Payer Manual in Chapter 5 Contractor Prepayment Processing Requirements.

G.4 Contractors have processes in place to identify and track all incoming correspondence to ensure Budget and Performance Requirements (Title XVIII contractors)/Statement of Work (Medicare Administrative Contractors) task priority compliance and timely response and acknowledgement. These tracking mechanisms should include the ability to track ECRS submissions when awaiting a particular response/status from COBC, or if your ECRS submission may warrant further actions after COBC development/investigation (e.g., claims adjustments).

G.5 Contractors shall have quality assurance measures in place to ensure the accuracy of the implementation of any CMS directive. Contractors shall also provide evidence that the results from quality assurance checks are documented to identify errors and that training venues are implemented to prevent the reoccurrence of these errors.

H – *Control Number* ***Control Objective*** **- Administrative**

H.1 *Contractors shall have a written code of business ethics and conduct. To promote compliance with such code of business ethics and conduct and to ensure that all employees comply with applicable laws and regulations, contractors shall have an employee business ethics and compliance training program and an internal control system that –*

1. Are suitable to the size of the company and extent of its involvement in Government contracting;

2. Facilitate timely discovery and disclosure of improper conduct in connection with Government contracts; and

3. Ensure corrective measures are promptly instituted and carried out.

H.2	Procurements are awarded and administered in accordance with the Medicare Agreement/Contract, CMS regulations, CMS general instructions and the Federal Acquisition Regulation.
H.3	Incoming and outgoing mail shall be properly handled in accordance with published time frames, security guidelines, and in the most cost effective and efficient manner.
H.4	Medicare management structure provides for efficient contract performance and is consistent with business practices.
H.5	Records shall be retained according to guidelines established by CMS and other Federal agencies.
H.6	Internal controls provide reasonable assurance that certain regularly scheduled processes required to support the *CMS* contractor's continuity of operations in the event of a catastrophic loss of relevant, distinguishable Medicare business unit facilities are performed as scheduled.

I – *Control Number*	***Control Objective* - Provider Audit**
I.1	Interim, tentative and PIP payments to Medicare providers are established, monitored and adjusted, if necessary, in a timely and accurate manner in accordance with CMS general instructions and provider payment files are updated in a timely and accurate manner. Adjustments to interim payments shall be made to ensure that payments approximate final program liability within established ranges. Payment records are adequately protected.
I.2	Information received by the contractor from CMS or obtained from other sources regarding new providers, change of ownership for an existing provider, termination of a provider, or a change of intermediary are identified, recorded, and processed in System Tracking for Audit and Reimbursement (STAR) in a timely and accurate manner and reflected in subsequent audit activities.
1.3	Provider Cost Reports are properly submitted and accepted in accordance with CMS' general instructions. Appropriate program policies and instructions are followed in situations where the provider

	did not file a cost report. Cost report submission information is timely and properly forwarded to the proper CMS Systems.
I.4	Desk review procedures and work performed are documented and are sufficient to obtain an accurate review of the submitted cost report. Documentation is established and maintained to identify situations requiring a limited desk review or a full desk review.
I.5	Notices of Program Reimbursement (NPR) are issued accurately and timely to providers and include all related documentation (e.g. an audit adjustment report, copy of the final settled cost report).
I.6	Inputs to mandated systems regarding provider audit, settlement, and reimbursement performance (STAR) are complete, accurate and in compliance with program instructions. Documentation supporting reports and inputs shall be maintained.
I.7	The contractor's cost report reopening process is conducted in accordance with CMS regulations and program policy.
I.8	Provider appeals (including both the Provider Reimbursement Review Board (PRRB) and Intermediary Appeals) are handled appropriately. Jurisdictional questions are addressed and PRRB timeframes for submission are observed.
I.9	The contractor's Provider Statistical and Reimbursement Report (PSRR) system is operated in accordance with CMS manuals and instructions. Related reports are distributed to providers in accordance with CMS manuals and instructions.
I.10	An internal quality control process has been established and is functioning in accordance with CMS instructions to ensure that audit work performed on providers' cost reports is accurate, meets CMS quality standards, and results in program payments to providers which are in accordance with Medicare law, regulations and program instructions.
I.11	Cost reports are scoped and selected for audit or settled without audit based on audit plans that adhere to CMS guidelines and instructions.
I.12	The contractor's audit process is conducted in accordance with CMS manual instructions and timelines, i.e., timeframes for issuance of the engagement letter, documentation requests, pre-exit and exit conferences, and settlement of the audited cost report.
I.13	Communications of audit programs, desk review programs, CMS audit and reimbursement policies, and other audit related instructions are

timely and accurately communicated to all appropriate audit staff.

I.14	The contractor's audit staff maintains its necessary knowledge and skills by completing continuing education and training (CET) required by CMS instructions, and documentation is maintained to support compliance by each staff member.
I.15	Supervisory reviews of the audit and settlement process are conducted and the policies and procedures for these reviews are communicated to all supervisors in accordance with CMS program instructions.
I.16	All cost reports where fraud is suspected shall be referred to the Payment Safeguard Contractor (PSC) Benefit Integrity Unit in accordance with CMS and contractor instructions.
I.17	The contractor has processes and procedures in place to document that supervisory reviews by provider audit department management were completed on all provider audit CAPs from the establishment of the CAPs to the implementation and validation of the CAPs.

J – Control Number	***Control Objective*** **- Financial**

Transactions for Medicare accounts receivable, payables, expenses shall be recorded and reported timely and accurately, and financial reporting shall be completed in accordance with CMS standards, Federal Acquisition Regulation (FAR), Financial Accounting Standards Advisory Board, Cost Accounting Standards, and Generally Accepted Accounting Principles (GAAP). For the following control objectives, the review shall focus on the following areas:

- Cost Report Settlement Process;
- Contractor Financial Reports:
    - Statement of Financial Position (CMS-H750A/B),
    - Status of Accounts Receivable (CMS-751A/B),
    - Status of Debt – Currently Not Collectible (CNC) (CMS –C751 A/B),
    - Status of Medicare Secondary Payer Accounts Receivable (CMS-M751A/B),
    - Status of Medicare Secondary Payer Debt-Currently Not Collectible (CMS-MC751A/B),
    - Reconcile the accounts receivable balance and activity to

the Provider Overpayment Reporting (POR) System and the Physician Supplier Overpayment Reporting (PSOR) system,

- HIGLAS-CMS Balance Sheets and Income Statements,
- HIGLAS-CMS Treasury Report on Receivables (TROR),
- HIGLAS-CMS CNC Eligibility,
- HIGLAS-CMS MSP Recovery GHP/Non-GHP Receivables,
- Reconcile the HIGLAS accounts receivable balance and activity to the following reports/registers:

  CMS Beginning Balance Report,

  CMS Transaction Register,

  CMS Applied Collection Register,

  CMS Adjustment Register,

  CMS AR Overpayments Report,

  CMS Interest and Late Charges,

  CMS AR Balance Detail,

  CMS Written-Off/CNC,

- Monthly Contractor Financial Report (CMS 1522) and Contractor Draws on Letter of Credit (CMS 1521),
- Reconciliation of Cash Balances and Cash Receipts.
- HIGLAS-CMS Trial Balance and General Ledger,
- HIGLAS-CMS Cash Management Reports,
- HIGLAS-CMS Accounts Payable Reports.
- *HIGLAS-Contractor's Monthly Bank Reconciliation Worksheet*

J.1 Financial statements and reports should include all authorized transactions that occurred for the period reported.

J.2 Financial transactions are valid and approved by authorized personnel in

	accordance with management and CMS' policies.
J.3	Recorded and processed transactions are correctly classified, maintained, summarized and reconciled. In addition, transactions shall be properly supported.
J.4	Segregation of duties exists within the areas of disbursement and collection (i.e., there shall be separate authorization, record keeping, and custody).
J.5	All assets, including cash and accounts receivable should exist and be properly valued and demanded accounts receivable should be properly aged. Accounts receivable should be correctly recorded in the books/records of the contractor.
J.6	All liabilities, including accounts payables should exist and be properly valued. Accounts payable should be correctly recorded in the books/records of the contractor.
J.7	Contractor Financial Reports are accurate, signed/certified by authorized individuals and presented timely to CMS in accordance with Publication (Pub) 100-06 of the Medicare Financial Management Manual, Chapter 5, Financial Reporting, section 230.
J.8	Banking information relevant to Medicare processing is accurately stated and conforms to the tripartite agreement.
K – *Control Number*	***Control Objective*** **- Debt Referral (MSP and Non-MSP)**
K.1	Procedures are documented and followed to identify a debt eligible for referral to Treasury for cross servicing and Treasury Offset Program (TOP) prior to the debt becoming 180 days delinquent. These procedures are written and available for review. Debts eligible for referral and debts ineligible for referral are properly reported on the appropriate CMS Forms 751, Contractor Financial Reports, Status of Accounts Receivable, or the Treasury Report on Receivables and Debt Collection Activities Report. For MSP debt, see Internet Only Manual (IOM), Pub 100-05, MSP Manual, Chapter 7, Section 60. For Non-MSP debt, see IOM, Pub 100-06, Chapter 4, Section 70. For MSP and Non-MSP debt, see also Pub 100-06, Chapter 5.
K.2	Intent to Refer letters (IRLs) for eligible debt are sent in a timely manner in accordance with CMS instructions. Use the MSP and Non-MSP references in K.1 to provide the timeframes for each type of debt.
K.3	Responses to the IRL letter are handled timely according to CMS instructions.- Appropriate systems are updated to reflect any changes to

	the eligibility status of the debt and these statuses are properly reported on the financial reporting forms outlined in K.1. Procedures are in place to handle undeliverable letters. Use the references in K.1.
K.4	Eligible delinquent debt is input to the Debt Collection System (DCS) timely and accurately in accordance with CMS instructions. Use references in K.1.
K.5	Contractor initiated recalls, collections, and adjustments are entered to DCS as appropriate, when there is a change to a debt that has been referred for cross servicing, in accordance with CMS instructions. Procedures to update these debts in DCS are in place and are being followed. Use the references in K.1.
K.6	Contractor has procedures in place to ensure that the Collection/Refund Spreadsheets are completed in accordance with CMS instructions. Use the references in K.1.
K.7	Treasury Cross-Servicing Dispute Resolution forms are researched, resolved, and responded to Treasury timely in accordance with CMS instructions. See references in K.1. Procedures are in place and are being followed to respond to these disputes/inquiries, update the DCS, and properly report the status and balance of the debt in the financial reporting forms outlined in K.l.
L – *Control Number*	**Control Objective - Non-MSP Debt Collection**
L.1	Demand letters initiate the collection of a provider debt as well as inform the provider of the existence of the debt, their appeal rights with respect to the debt, and the ramifications if the debt is not paid or an agreement is not reached within a specified time period. In addition to the content of the demand letter, the demand letter shall be issued, printed and mailed timely.
L.2	Extended Repayment Plans (ERPs) shall be analyzed for approval or denial. A supervisor, in accordance with CMS instructions, reviews all ERPs. This includes monitoring all approved ERPs, the complete financial analysis of the provider's application, and the referral to CMS when necessary.
L.3	Interest is applied correctly and timely in accordance with CMS instructions. When necessary, interest adjustments are calculated correctly and processed and applied in a timely manner.
L.4	Bankruptcy cases are handled in accordance with CMS instructions and instructions given by the Office of General Counsel (OGC). An audit trail of the overpayment shall exist before and after the bankruptcy

	filing to ensure that Medicare's best interest can be represented by OGC.
L.5	Provider debt is collected timely, completely, and accurately with an appropriate audit trail of all collection activity and attempts of collection activity. This audit trail supports the amount of the provider debt.
L.6	All appropriate entries to CMS' POR/PSOR (Refer to Joint Signature Memorandum 06233), HIGLAS and contractor internal systems are made timely and accurately and reconciled among the relevant CMS systems. Discrepancies are corrected and an audit trail is maintained.
L.7	Timely review and processing of all 838 Credit Balance Reports. Ensure that all reported credit balances are collected and properly processed in accordance with CMS instructions.
L.8	All overpayments, which meet the thresholds established in the Financial Management Manual, regardless of where they are determined, (Claims Processing, PSC/BI, Overpayments, Audit and Reimbursement…) are demanded and collection efforts are pursued. The *CMS* contractors are not responsible for the demand and collection efforts of overpayments identified through the Recovery Audit Contractor Demonstration.
L.9	For overpayments subject to the limitation on recoupment of section 935 of the Medicare Modernization Act (MMA), recoupment is stopped when, a valid and timely first level appeal (redetermination) is received and when a valid and timely 2nd level appeal (Qualified Independent Contractor (QIC) reconsideration) is received. Section 935 directs CMS to stop recoupment of an overpayment where a provider or supplier has appealed to the QIC until the QIC reconsideration decision. This does not apply to Part A cost report overpayments. Interest continues to accrue.
M – *Control Number*	***Control Objective* - Provider Enrollment**
M.1	Review the CMS 855 enrollment applications and take appropriate action in accordance with CMS guidelines in the Program Integrity Manual (PIM), Chapter 10.
M.2	Reassignments of benefits are made in accordance with section 30.2 of the Medicare Claims Processing Manual and section 7, Chapter 10 of the PIM.
M.3	Billing arrangements are in accordance with section 30.2 of Medicare Claims Processing Manual.

60 – CMS Financial Reporting Cycle Memo

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

60 .1 Financial Reporting Cycle Memo Inclusions

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The financial reporting cycle memo shall include the following sections in the, "Table of Contents":

Section I. Objective

The objective of this financial reporting cycle memo is to describe the financial statement preparation and reporting processes performed by the Office of Financial Management's (OFM) Accounting Management Group (AMG) of the Centers for Medicare & Medicaid Services (CMS). As the Office of Management and Budget (OMB) Circular A-123, Management's Responsibility for Internal Control, asserts, gaining an understanding of the financial reporting process fulfills a major control objective that provides "reasonable assurance regarding the reliability of financial reporting."

Section II. Introduction

The CMS is a separate stand-alone financial reporting entity of the Department of Health and Human Services (HHS). The financial statements are prepared to report the financial position and results of CMS' operations, as required by the Chief Financial Officers Act of 1990 (CFO Act), as amended by the Government Management Reform Act of 1994 (GMRA). The statements are prepared from CMS' general ledger and subsidiary reports and supplemented with financial data provided by the U.S. Treasury. The financial statements are prepared in accordance with accounting principles generally accepted in the United States for Federal entities and follows guidance provided by OMB, the Federal Accounting Standards Advisory Board (FASAB), the Government Accountability Office (GAO) and HHS. OMB Circular No. A-136, Financial Reporting Requirements, prescribes the form and content of Federal agency financial statements and notes.

The CMS financial statements are prepared based on accrual accounting. The principal financial statements consist of the following:

- *Consolidated Balance Sheet*
- *Consolidated Statement of Net Cost (SNC)*
- *Consolidated Statement of Changes in Net Position (SCNP)*
- *Combined Statement of Budgetary Resources (SBR)*
- *Statement of Social Insurance (SOSI)*
- *Accompanying Notes to the financial statements*

Supplementary financial statements include (location in the CMS Financial Report parentheses below):

- *Consolidating Balance Sheet (Other Accompanying Information)*
- *Consolidating Statement of Net Cost (Other Accompanying Information)*
- *Consolidating Statement of Changes in Net Position (Other Accompanying Information)*
- *Combining Statement of Budgetary Resources (Required Supplementary Information)*

These statements along with other information reflect the accounting activity and operations for CMS' Medicare, Medicaid, and State Children's Health Insurance (SCHIP) programs for the fiscal year (FY) ending September 30. Additionally, CMS uses the United States Standard General Ledger (USSGL) account structure, establishing sub-accounts where detail is warranted, and follows accounting policies and guidelines issued by HHS. These financial statements reflect both accrual and budgetary accounting transactions. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when incurred, without regard to the receipt or payment of cash. Budgetary accounting is designed to recognize the obligation of funds according to legal requirements, which, in many cases, is made prior to the occurrence of an accrual-based transaction. Budgetary accounting is essential for compliance with legal constraints and controls over the use of Federal funds. For reporting purposes, the HHS annual Performance and Accountability Report breaks out department activity by the budget function classifications of the U.S. Government Budget. Accordingly, HHS has asked its operating divisions to do the same. As a result, CMS' programs fall under two major budget functional classifications:

MEDICARE (570):

- *Hospital Insurance (HI), which also includes:*
  - *Health Care Fraud and Abuse Control (HCFAC)*
  - *Income Tax on Old Age and Survivors and Disability Insurance (OASDI)*
  - *Self-Employment Contribution Act Credits (SECA)*
- *Supplementary Medical Insurance (SMI), which also includes:*
  - *Medicare Modernization Act of 2003 - Part D*
- *Payments to Health Care Trust Funds (PTF) - allocated to HI and SMI*

***HEALTH (550)**:*

- *Medicaid*
- *SCHIP*
- *Clinical Laboratory Improvement Amendments (CLIA)*
- *Program Management (allocated to HI, SMI, Medicaid, SCHIP, and State Grants and Demonstrations*
- *All Others:*
- *Budget Clearing Account/Suspense*
  - *Miscellaneous Fines, Penalties, and Forfeitures (custodial)*
  - *Interest Receipts (custodial)*

- *General Fund Receipts (custodial)*

Note: In consolidating proprietary statements, CMS aggregates CLIA, State Grants and Demonstrations, and Suspense/custodial funds (balance sheet only) under "All Others". However, on the Combining SBR, "All Others" also includes HCFAC, Part D, and all of Program Management.

Section III. Interface With Other Cycles

The Financial Reporting cycle includes information from the point transactions are recorded in the Financial Accounting Control Systems (FACS) to the point that they are presented in the financial statements. The detailed processes and key control activities surrounding the recording of data in FACS that have a significant impact on the financial statements are discussed in detail in the following related cycle memos:

- ***Fund Balance With Treasury***
  Fund Balance With Treasury Line Item

  Treasury-Managed Trust Funds *Includes recording the receipt of funds from the HI and SMI trust funds, Investments and discussion of the Benefits Adjustment Letter.*

- ***Medicaid***
  Includes the transactions for recording and reporting advances to States through the Payment Management System (PMS). Also includes discussion on Medicaid Accounts Receivable (A/R).

- ***Entitlement Benefits Due and Payable - Medicaid/SCHIP***
  Entitlement Benefit Payments Due and Payable Line Item

- ***Entitlement Benefits Due and Payable - Medicare***
  Entitlement Benefit Payments Due and Payable Line Item

- ***Medicare***
  - *Medicare HI Statement of Net Cost Line Item*
  - *Medicare SMI Statement of Net Cost Line Item*
  - *Accounts Receivables, Net Line Item*

- ***Medicare Advantage***
  - *Medicare HI Statement of Net Cost Line Item*
  - *Medicare SMI Statement of Net Cost Line Item*
  - *Accounts Receivables, Net Line Item*

- ***Budget***
  - *Includes the receipt of warrants from Congressional appropriations. It also discusses preparation of the Report on Budget Execution and Budgetary Resources (SF-133) and the resulting Year-End Closing Statement (FMS 2108), which is referenced herein.*

- *Combined Statement of Budgetary Resources various Line Items*

- ***Statement of Social Insurance***
  Statement of Social Insurance

Section IV. Current Environment

This cycle memo focuses on the preparation of the financial statements that result from the accumulation, summarization, and adjustment of financial information. The Current Environment section is divided into the following major processes:

A) FACS
1) *System Processing*
2) *Closing*
3) *Monthly Reconciliations*

B) Annual Production and Presentation of the Financial Statements
1) *Description of financial statements*
2) *Preliminary processes*
3) *Processes for generating financial statements*
4) *Processes for generating notes to the financial statements*
5) *Review and validation of financial statements*

C) Internal Controls for Maintaining Compliance with Laws and Regulations

A) FACS

The Financial Reporting cycle includes information from the point transactions are recorded in FACS to the point they are presented in the financial statements. As previously noted, the detailed processes and key control activities surrounding the recording of data in FACS are discussed in detail in the related cycle memos indicated in the previous section, Interface With Other Cycles.

1) System Processing

FACS is the central accounting system in which all data used in the compilation of the financial statements ultimately resides (except for the Statement of Social Insurance). FACS encompasses the Core Financial Module (Core) and three subsystems: Accounts Payable Subsystem (AP), Accounts Receivable and Collections Subsystem (ARC), and Letter of Credit Subsystem (LOC). Each of these subsystems is discussed in the Medicare cycle memo.

FACS subsystems have direct access to tables of the Core. These tables allow the systems to perform automated validity checks using the Core data before processing transactions. FACS also receives batch files from various feeder systems such as the Automated Standard Application for Payments (ASAP).

Transactions are posted to the Core through on-line transaction entries into the systems or through batch file processing. On-line transactions and batch files entered into the Core utilize the main program called Online Transaction Processing Module (TPMN) to edit transactions and update the system records.

In order for a transaction to post to the Core, it must pass through various edits found within the system and meet all system defined criteria such as having a document key, adequate funding and a valid transaction code (TC). A transaction code is a three-digit code used to enter a financial transaction. A FACS transaction code table assigns the general ledger accounts to which the transaction will post based on the transaction code, common accounting number (CAN), object class, and fiscal year entered for the transaction. FACS has built-in processes for ensuring the accuracy of its transactions. For example, there are various attributes for TCs. These attributes determine, for example, whether the transaction is subject to fund control, requires an invoice number, or if a collection number is required. The system then validates the data elements entered with the transaction code against system tables and determines if the combination of data elements is valid.

Transactions that do not pass the inherent edit checks within FACS are sent to Suspense during batch processing. A daily suspense report (R602) is delivered to each division showing those items in Suspense. In the Generic (GN) screen, users have the option to post, re-suspend, or delete a record. Once the user determines the cause of the error, the user can fix the error and post the transaction. FACS records the user ID of the person making the correction, which provides an audit trail of the transaction. If the transaction is made in error, it can be deleted; however, it is possible for valid transactions to be deleted in error. While there is not a specific process to track accidental deletions, material errors are detected in the reconciliation process. Each division has its own procedures for managing transactions in Suspense. Transactions in Suspense typically do not stay there for more than a couple of days and the length of time to resolve the issues related to the transactions in Suspense vary depending on the nature of the issue. Outstanding items will show up during the reconciliation process within each area.

Once the transaction successfully processes through all the edits, the transaction is posted to the following areas: a document area to track the status of the document, a funding area to track the funding, the ledgers area to track the funds for a specific Internal Accounting Code (IAC)/Allotment/Allowance, a transaction ledger area where each individual transaction is stored to provide an audit trail, and finally to the general ledger for general ledger tracking.

2) Closing

Each day the Production Control Group, which is a Lockheed Martin contractor to CMS' Office of Information Systems (OIS), runs a standard set of jobs, which results in the generation of the R100 series of reports. Reports with a 100 series designation indicate daily reports. Reports generated by the FACR101 job, referred to as user reports, represent all the entries into FACS on the previous day. In general, FACS closes at 6:00 p.m. and the jobs process is initiated. At approximately 12:00 a.m., backup jobs are run. The user reports are

printed nightly as part of the overnight FACS processing. A user report is generated for each user who has posted entries that day. Only those users who input data the previous day will receive a user report. The Division of Accounting Systems (DAS) maintains a distribution list spreadsheet and the user reports are distributed throughout CMS according to this list. All users, who posted transactions the previous day, are responsible for validating their transactions using the user reports. A summary report is produced on a daily basis to reflect the individual user reports produced for a given day. A monthly summary report that shows user activity for a given month is provided to the Director of DAS, which is reviewed to monitor transaction volume for growth rate and unusual spikes to ensure that there is sufficient capacity in the database for archiving the transactions. This report includes the date, user name, and dollar amount, but does not include the general ledger account numbers. If an individual user anticipates a user report and does not receive one, then the user can either query the system to ensure the transactions are posted or request through the Director of DAS that another copy of the user report be produced. It is the responsibility of each division in AMG to compare the user report to the source documents to ensure accuracy of input data. Accordingly, each division has its own review procedures.

The monthly process is similar to the daily process with a few exceptions. Generally, on the second business day after the month end, a request to perform FACS monthly closing process is made by DAS on a Standard PC 20 form that is sent by e-mail to the Production Control Group. When FACS monthly closing process is complete, the Production Control Group notifies DAS via e-mail. Once FACS is closed, the 300 series reports, which are generated during the monthly closing process, are distributed throughout CMS to verify that all transactions were correctly posted to FACS. Reports with a 300 series designation indicate monthly reports.

3) Monthly Reconciliations

The monthly reconciliation process helps ensure the accuracy of the GL trial balance. The reconciliation process begins when all of the monthly transactions are coded into FACS and all month-end reports are distributed by DAS. All of the divisions within AMG except DDRO are responsible for the completion and review of their assigned reconciliations. Reconciliations are signed by the preparer, and then reviewed by the Division's Lead/Technical Advisor for accuracy and validity of the data. Upon approval, the Division's Lead/Technical Advisor signs the reconciliation, evidencing review ***(CMS-FR-AA-1).***

The DFRP uses an internal Excel workbook (G:\glrec03\Masater.xls), composed of individual spreadsheets for each IAC to ensure that the IACs with activity are reconciled. The Excel spreadsheets are compared to the General Ledger Summary Trial Balance by Appropriation (GL R306) to ensure that the IACs with activity are inclusive. The comparison is documented by the insertion of N/A (No Activity) or the addition of GL accounts when activity occurs and they are not listed ***(CMS-FR-AA-5)****. Each Director in AMG except DDRO completes and signs a reconciliation report to ensure that all reconciliations within their division have been completed* ***(CMS-FR-AA-2****). The divisions are required to submit their reconciliation report to the DFRP by the 25th day after the*

month ended to ensure that the reconciliations are performed and in a timely manner. The DFRP utilize the reconciliation reports to record the reconciliation's preparer, preparer's division and director, and date of preparation on the Excel spreadsheets. The DFRP utilizes the data from the internal Excel workbook to compile selected accounts as deemed by HHS on the OPDIV (Operating Division of HHS) Reconciliation Summary Report. HHS requires either, the date completed or, a check mark to document the completion of the reconciliation. The reconciliation summary report is reviewed and documented with initials of the Financial Reporting Technical Advisor and Director of DFRP to ensure completeness and accuracy of all reconciliations. ***(CMS-FR-AA-3)*** *The report is then faxed to the Assistant Secretary for Resources and Technology within HHS. The DFRP maintains the reports in their division files.*

B) Production and Presentation of the Financial Statements:

The CFO Act requires that Executive Branch agencies prepare audited financial statements for all trust funds, revolving funds, and accounts having substantial activity. Additionally, GMRA expanded the CFO Act by requiring annual audited financial statements. As a reporting entity of HHS (in accordance with OMB Bulletin No. 01-02, Appendix B), CMS is required to comply with the CFO Act and GMRA requirements.

The CMS is required to produce quarterly (interim) financial statements in addition to the annual September 30 statements and notes. Notes are also prepared for the quarter ending June 30 and are submitted to HHS and to the CFO Auditors. Interim and year-end statements and notes for the comparative prior year periods are also required unless waived by OMB guidance. Interim statements are due to OMB 21 days after the end of the quarter. The fiscal year-end report is due to OMB by November 15.

The DFRP prepares all required financial statements with the exception of the Statement of Social Insurance, which is prepared by Office of the Actuary (OACT). The CMS has automated the production of the principal and supplementary financial statements and certain accompanying notes in FACS. Each of these statements and the processes, key controls, and key control activities in place to provide reasonable assurance as to the presentation, accuracy, and completeness of the statements is presented in the section, Processes For Generating Financial Statements.

Generation of the financial statements begins with CMS performing the following:
(1) Reviewing general ledger trial balances for accuracy and completeness
(2) Updating financial reporting procedures and crosswalks as per official guidance
(3) Preparing and recording journal vouchers for pre-closing accruals or adjusting entries
(4) Posting Treasury Bureau of Public Debt trial balances into FACS
(5) Closing the accounting quarter- or year-end in FACS
(6) Preparing journal vouchers for post-closing adjusting entries ("adjustment screen")
(7) Preparing a schedule of CMS intragovernmental balances for Automated Financial Statement (AFS) eliminations
(8) Calculating Program Management cost allocation percentages at year-end

(9) Preparing the financial statements, notes, supplementary information, and the required supplementary stewardship information, including submission via AFS to HHS
(10) Performing comparative statement variance analyses
(11) Reviewing and validating the complete set of statements and notes before forwarding to Management for review and certification
(12) Posting at fiscal year-end "adjustment screen" or auditor adjustments into the FACS general ledger to produce a Pre-closing R506 general ledger; reproducing automated statements based on the updated FACS general ledger to compare to the final draft,; validating that coding entries were correct; posting closing entries (Post-close R506); and
(13) Preparing the financial statements, including the notes, other accompanying information, and the required supplementary information.

1) Description of Financial Statements

OMB Circular No. A-136 requires Federal entities to break out certain lines between earmarked and all other funds on the Balance Sheet and SCNP. The CMS has designated Medicare, which includes HI, SMI, PTF, and the allocated portions of Program Management as earmarked. Other CMS programs are designated as all other.

The principal financial statements are single-column consolidated or combined (SBR only). They represent the aggregate total of all CMS programs. Consolidated statements are "net of intra-CMS eliminations" (i.e., offsetting transactions between CMS programs, which overstate activity, are excluded from the total) whereas the Combined Statement of Budgetary Resources shows gross totals without eliminations. OMB Circular No. A-136 states, "in order to remain consistent with the aggregate of the account-level information presented on the SF-133 [Report on Budget Execution], consolidation of this statement is not appropriate." Therefore, the SBR is prepared on a combined (gross) basis and "line-by-line consolidation…is not permitted." The comparative prior year consolidated and combined statements are also presented on the face of the principal statements.

FASAB Statements of Federal Financial Accounting Standards (SFFAS) No. 4, Managerial Cost Accounting and Standards, provides that Federal entities classify their major programs based on the missions and outputs described in the entities' Government Performance Reform Act (GPRA) strategic and annual plans. Although FASAB's pronouncement applies primarily to the Statement of Net Cost, CMS has designated Medicare HI, SMI, Medicaid and SCHIP as "GPRA Programs" for all proprietary supplementary statements. "All Others" includes the rest of CMS' programs.

The supplementary statements display columns for each GPRA program and "All Others." They are either consolidating (individual columns footing to a "combined" subtotal, followed by an "eliminations" column, leading to a "consolidated" total) or combining (SBR gross totals by column with no eliminations involved). The Combining SBR is broken out differently than consolidating statements. Refer to the CMS financial statement crosswalks for a detailed breakout by IAC of supplementary columns.

a) ***Balance Sheet***

The balance sheet presents, as of a specific time, amounts of future economic benefits owned or managed by CMS (assets), amounts owed by CMS (liabilities), and amounts that comprise the difference (net position). The components of the balance sheet are:

Assets

Assets that CMS has the authority to use in its operations and assets that are held by CMS, but are not available for use. Material assets include:

> ***Fund Balances with Treasury,*** *funds with Treasury that are primarily available to pay current liabilities. (See Fund Balance with Treasury cycle memo for detailed discussion of the processes, key controls, and key control activities surrounding recording of the fund balances in the CMS financial accounting system, FACS).*
>
> ***Trust Fund Investments,*** *investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried on the books at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and is adjusted to include an accrual for interest earned from July 1 to September 30 (See Treasury-Managed Trust Funds cycle memo for detailed discussion of the processes, key controls and key control activities surrounding recording of the investment balances in the CMS financial accounting system, FACS).*
>
> ***Accounts Receivable, Net****, amounts owed to CMS by other Federal agencies (intragovernmental) and by the public. Amounts due are presented net of an allowance for uncollectible accounts. Typically, the HI trust fund records an intragovernmental account receivable from the Railroad Retirement Board. Medicare Secondary Payer (MSP) and Medicare Non-MSP-related transactions, as well as Medicare Part D overpayments, account for the bulk of the "public" accounts receivable. (See the Medicare cycle memo for detailed discussion of the processes, key controls and key control activities surrounding recording of public accounts receivable in the CMS financial accounting system, FACS).*

Liabilities

Liabilities represent amounts owed by CMS. A liability for Federal accounting purposes is a probable future outflow or other sacrifice of resources because of past transactions or events. Liabilities of CMS cannot be liquidated without legislation that provides resources to do so.

> ***Entitlement Benefits Due and Payable*** *is the major component of CMS' liability balance. (See the respective Entitlement Benefits Due and Payable cycle memos for Medicare and Medicaid and SCHIP for detailed discussion of the processes, key*

controls and key control activities surrounding the calculation and recording of this liability in FACS).

Net Position
The components of net position are classified as follows:

> ***Unexpended Appropriations*** *include the portion of the entity's appropriations represented by undelivered orders and unobligated balances. Unexpended appropriations attributable to earmarked funds (HI and SMI) are shown separately from all other funds.*
>
> ***Cumulative Results of Operations*** *show the net results of operations since inception of the programs; earmarked funds (HI and SMI) are shown separately from all other funds.*

b) ***Statement of Net Cost***

The Statement of Net Cost shows the actual net cost of CMS' operations for the period by program. The net cost represents the total costs of a program reduced by exchange (earned) revenues, which yields the residual amount to be borne by taxpayers. Note that DFRP does not prepare a SNC for Payments to the Health Care Trust Funds, as this appropriation incurs no costs, only expenditure transfers to HI and SMI, which are reported on the SCNP.

c) ***Statement of Changes In Net Position***

The Statement of Changes in Net Position reports the change in net position during the fiscal year that occurred in the two components of net position: Unexpended Appropriations and Cumulative Results of Operations. The SCNP shows beginning balances, prior period adjustments (if any), current year financing sources (i.e., appropriations received, transfers in and out), net cost of operations, and ending balances.

d) ***Statement of Budgetary Resources***

The Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the period. Budgetary statements are developed for each of the budgetary accounts. Consequently, for the supplementary SBR, annual Program Management is not cost-allocated but is combined with Program Management—No Year, and together, are aggregated with State Grants and Demonstrations and HCFAC under "All others." "Payments to the Trust Funds" and Medicare Part D are shown under a separate columns.

e) ***Statement of Social Insurance***

The Statement of Social Insurance examines the current and future sustainability of the HI and SMI programs by reporting long-range cash projections, the ratio of contributors to beneficiaries, the actuarial present value of future benefits, future contributions and tax income, and other factors. Before FY 2006, the SOSI appeared under Required Supplementary Stewardship Information (RSSI). Effective in FY 2006, FASAB reclassified the presentation of the SOSI to a principal financial statement with significant risk assumptions disclosed in notes. Any remaining information will be reported as Required Supplementary Information (RSI). The CMS' OACT prepares the SOSI.

2) Preliminary Processes

Each quarter, DFRP develops a detailed timeline of steps and responsible divisions required to produce the financial statements (See Exhibit 1) to ensure compliance with internal and external reporting requirements ***(CMS-FR-FR-1).*** *The CMS also receives a timeline from HHS, which includes due dates for certain deliverables, including but not limited to AFS submission and intragovernmental eliminations from the OPDIVs, which further ensures compliance with external reporting requirements* ***(CMS-FR-FR-2).***

Three primary accounting reports are integral to financial statement preparation: the General Ledger Trial Balance Reports (R306 and R406), the Allotment and Allowance Report (R307, which is used for allocations) and the Prior Year Post-close General Ledger Trial Balance (R506, which is used for verifying beginning balances). With few exceptions, the process for generating and validating the quarterly statements is the same as for the year-end statements. Following is the process for the generation of year-end statements. In instances where there is an exception with respect to the quarterly statements, it is indicated in a footnote to the section.

Note: For quarterly financial statements, only the 300-series reports are generated: R306 and R307. The 300-series reports indicate monthly reports and 500-series reports denote annual reports.

a) *Review the General Ledger*

Although not formally documented, DFRP reviews the R306 general ledger for any new or unusual items such as:

- *new IACs or accounts that must be added to the crosswalks,*
- *atypical dollar amounts for certain balances (i.e., SMI premium deferred revenues at twice the normal balance might indicate that there was no reversal of the prior month's accrual),*
- *abnormal balances (credit balances in "normal" debit accounts and vice versa) ,*
- *transactions coded with "blank" attributes instead of GOV or Non-GOV indicators,*
- *transactions coded as expenses that should be "expenditure transfer,", and*
- *outstanding obligations in trust funds when there should be none.*

The DFRP informs the division responsible for the anomaly so that corrective action can be taken. DFRP does not have a system for tracking and documenting the corrective action and there is not a specific deadline for the corrective action. Each division is responsible for tracking and documenting their own corrective action.

b) ***Update financial statement crosswalks***

The CMS financial reporting crosswalks correlate CMS' general ledger accounts to the corresponding financial statement line item. (See Exhibit 2) For example, the 1300-series accounts receivable (including allowances) roll into either intragovernmental or public net receivables on the balance sheet. The financial reporting crosswalks are maintained in an Excel workbook file (G:\DA\FS\200x\sglcw200xasofMMDD.xls) on the shared G drive. AMG personnel are granted access to the shared G drive upon employment. A request for access to the shared drive is made either by the CMS Access Administrator; or by the employee's supervisor to the CMS Action Desk, and a service request is prepared ***(CMS-FR-FR-3).*** *While access to the G drive restricted, specific files on the G drive are not password protected. There are separate worksheets for each financial statement, including allocations of Program Management and PTF and intra-CMS eliminations. Furthermore, there are detailed and summary versions. These crosswalks comply with Treasury's prototype crosswalk except where CMS has unique reporting requirements.*

Through meetings and correspondence, DFRP becomes aware of events that may require crosswalks to be updated. The following are examples of events that require crosswalks to be updated:

- *OMB changes the format to the financial statements;*
- *Treasury adds to or deletes accounts from the USSGL or revises its crosswalk to the statements [refer to the Treasury Financial Management Services (TFMS) www.fms.treas/gov for the latest versions);*
- *CMS implements a new program or discontinues a former one.*

The DFRP utilizes the same numbering scheme as the USSGL crosswalk (under 'Line No.') for CMS' crosswalk (under 'SGL#') and financial statements. As mentioned above, DFRP reviews the R306 to detect any new IAC or accounts. In addition, when there is a new IAC, DAS e-mails all divisions to notify them of the addition. Since DFRP is responsible for requesting the set up of any new accounts, they are aware ahead of time of any new accounts and update the crosswalks accordingly. When IACs and accounts are changed or added, they are manually bolded so they can be easily identified ***(CMS-FR-GL-1),*** *however there is no formal documentation process for reviewing the updated financial statement crosswalks. Once the crosswalks are updated, DFRP e-mails the Excel copy to DAS to update the automated financial statement program and/or parameters within FACS.*

To generate automated statements, DAS has established a report parameter and an extract parameter for each financial statement crosswalk. These parameters are referenced when executing the various financial statement jobs that extract financial data

and other related data from various FACS records. Upon receipt of the financial reporting crosswalks, DAS updates the corresponding parameter(s). Routine changes such as adding a new IAC to the financial statement parameters are not immediately tested. However, DAS runs a preliminary test version prior to running the quarterly statements to verify changes made throughout the quarter. In addition, changes that are more complex are tested and reviewed by DAS when the change is made. Testing consists of running the necessary job(s) for the affected parameter(s) and reviewing affected reports to ensure the change was successfully implemented. If there are any discrepancies, they are researched and corrected. Test datasets are created and maintained as a result of testing ***(CMS-FR-GL-2).*** *Once DAS is satisfied that the change has been successfully implemented, the affected divisions are notified that the change has been tested and verified.*

c) ***Posting Bureau of Public Debt (BPD) Trial Balances into FACS***

Treasury's BPD manages the HI and SMI trust funds on CMS' behalf. The BPD receives revenues and other financing sources—periodic transfers of Federal Insurance Contribution Act (FICA) taxes to HI from the Internal Revenue Service, SMI premiums and their Federal matching contributions called in daily by CMS, etc.—and invests these receipts in special U.S. Government securities. The BPD redeems these securities to make funds available for CMS' allocation accounts to reimburse Medicare contractors, the Social Security Administration for administrative charges incurred while performing services for Medicare, and for other purposes. All of BPD's activities are recorded on the appropriate agency's HI and SMI general ledgers and are reported on monthly balance sheets and income statements posted on the BPD website.

For reporting purposes, CMS consolidates its own HI and SMI activities with those of BPD to report single-entity HI and SMI trust funds. Offsetting receivables and payables between BPD and CMS are eliminated on CMS' consolidating balance sheet while offsetting transfers-in-and-out net to zero on the SCNP. Each quarter, DFRP manually records BPD's current general ledger trial balances into FACS and reverses the previous quarter's balances. The manual recording is documented with a JV and signed by the DFRP Director ***(CMS-FR-FR-4).*** *Separate IACs have been established for BPD's HI and SMI and are incorporated in the statement crosswalks. Refer to the Treasury-Managed Trust Funds cycle memo for details concerning the recording of BPD activity.*

d) ***Intragovernmental Balances and Eliminations***

Federal agencies are required to report "intragovernmental" activity separately from activity "with the public" in certain financial statements and notes. The balance sheet contains separate intragovernmental asset and liability sections that report fund balances with Treasury, accounts receivable and payable between Federal entities, and other activity. Some notes break out costs and revenues between those with Federal entities and those with the public. The Consolidated Intragovernmental Balances associates the balances with the Federal partners involved. When there are offsetting receivables and payables between two programs within a single reporting entity, the consolidating

balance sheet presents an "intra-entity Eliminations" column to show the deduction of the related balances in their respective lines. Transfers in-and-out between two agency programs typically cancel each other out so that there is usually no need for the eliminations column on the consolidating SCNP. CMS programs rarely have offsetting costs and revenues. Transactions between CMS and external Federal entities are not eliminated and carry over to the consolidated total. The DFRP has developed crosswalks that place specified account balances in the appropriate lines under the "intra-CMS Eliminations" columns.

Each quarter, DFRP prepares an Excel schedule of all intragovernmental balances. The DFRP must also enter intragovernmental balances into a separate AFS Excel file that links to the AFS financial statement templates, populating the intra-CMS columns. There are two sets of intragovernmental balances in AFS: "intra-HHS" for transactions among HHS OPDIVs and "Intragov" for transactions with external Federal agencies. A DFRP Accountant uses the R539 (revenues and expenses) and R540 (assets and liabilities) eliminations reports, which extract all FACS "GOV" balances and sorts them by IAC and Federal or HHS two-digit partner codes. The R306 is also used to prepare the Excel schedule of intragovernmental balances. In the AFS data-entry worksheets, the DFRP Accountant enters account balances (rounded to thousands) under the respective Federal agency or HHS Bureau. The amounts are entered first by Federal Agency type, Intra-HHS or Intra-Gov, then by governmental GL account. DFRP personnel have approximately one week to complete the preliminary and final Excel worksheets. When all amounts are entered, the totals from the reports (R539, R540, and R306) are compared against the Excel spreadsheets to verify that the amounts agree. Upon completion of the comparison, the DFRP Accountant initials and dates the reports and the spreadsheets ***(CMS-FR-FR-5).*** *When uploaded into the AFS financial statement file, the data automatically populates the Eliminations column as well as separate schedules of Intragovernmental assets, liabilities, revenues, and expenses. These schedules become the framework of CMS' published "Consolidated Intragovernmental Balances."*

e) ***Program Management Cost Allocations***

The AMG records CMS' administrative costs (payroll, travel, rent, Medicare contractor administrative costs, etc.) in the annual or multi-year Program Management appropriations. Nearly all of the funding for these accounts comes from monthly draws out of BPD's HI and SMI accounts. The rest of the funds arrive via interagency reimbursable agreements or occasionally through general fund warrants. For reporting purposes, however, Program Management line items (excluding any residual general fund-related balances) are allocated among HI, SMI, Part D, CLIA, and Other (Medicaid, SCHIP, State Grants, and Demonstrations) in the balance sheet, SNC, and SCNP. The CLIA activity is included under "All Other". Program Management, No Year 75 X 0511 (IAC 032) is not included with the other Program Management accounts to be allocated; as its funding comes mostly from user fees, although small amounts are drawn from BPD's HI and SMI. The budgetary statements (SBR and SOF) are not cost-allocated. The aggregate Program Management (including No Year) is reported under "All Other" in the Combining SBR as well as the Consolidating SOF.

Program Management costs are allocated as follows:

1. *The OFM's Division of Budget Management & Execution (DBME) employs various cost-allocating methodologies to determine how much of certain administrative costs should be charged to their appropriate programs. For example, Medicare contractor administrative costs are charged to HI, SMI, and Part D and are typically based on the number of claims processed.*

2. *The DBME develops cost allocation percentages for five major allotments in Program Management: State Survey and Certification, Research, Medicare Contractors, Federal Administration, and Revitalization. The costs of the allotments are allocated among HI, SMI, and General (which includes CLIA, Part D, Medicaid, SCHIP, State Grants, and Demonstrations). At the end of the fiscal year, DBME provides a memorandum to DFRP detailing the percentages to be used when allocating the five major allotments of Program Management, together with CLIA.*

3. *The DFRP maintains an Excel worksheet that converts DBME's table of five sets of cost percentages (one for each allotment) into a single weighted-average set to be entered into a table within FACS that is read by the automated financial statement program. The DFRP selects the prior year Excel file of the Cost Allocation worksheet (See Exhibit 3) as a template. The current year balances are entered into the corresponding cells and saved as a new file. The Excel worksheet is essentially a step-by-step process for computing the final single set of percentages as described below:*

   a) *Part I: Cost percentages are entered directly from the annual DBME memorandum. "General" percentages among Medicaid, SCHIP, and State Grants and Demonstrations are prorated by using the built-in formula in the footnote, "Detailed Breakout of General Fund Percentages."*

   b) *Part II: The Cumulative Obligations balances are entered from the final R307D report for the five Program Management allotments. HI/SMI/Medicaid/SCHIP/ State Grants and Demonstrations/Other columns are updated with the new current percentages from Part I. The worksheet prorates cumulative obligations for each allotment among the CMS programs.*

   c) *Part III: The worksheet calculates final weighted percentages by dividing each of CMS program's total obligations (subtotals from Part II) by the aggregate total cumulative obligations. The DFRP must ensure that the total of the resulting percentages equals 100 percent.*

The DFRP forwards the resulting worksheet to DAS via email. The DAS enters the current fiscal year percentages per the worksheet into a Miscellaneous Codes and

Description Table (Table 50) in FACS. These percentages are included on the allocation reports and are verified when running the allocation jobs ***(CMS-FR-FR-6).***

f) ***Pre-closing adjustments for Financial Statements after FACS is closed***

Pre-closing adjustments are typically the result of financial statement reviews and/or CFO Auditor proposals, and occur after FACS is closed for the fiscal period.

Note: For quarterly statements, many adjustments are entered as pre-closing adjustments in that they are not posted to FACS until the next period as part of the normal processing. An example of a quarterly adjustment of this type would be cash reconciliations. These adjustments are manually entered into the Adjustment screen and are memo entries, which will be reflected in the financial statements but are not immediately posted to FACS general ledger. The procedures for posting Pre-Closing adjustments are as follows.

Through a process of research by AMG and/or the CFO Auditors, adjustments are identified and DFRP is notified via e-mail. Upon receipt of the notice and the corresponding support for the adjustment, DFRP prepares a Journal Voucher (JV), which is attached to the supporting documentation. The JV is forwarded to the Division Director and/or the AMG Director for review and signature ***(CMS-FR-AA-8****). After approval, the JV is forwarded to DFRP for entry as a Pre-Closing adjustment. As previously indicated, this JV is not posted to the FACS general ledger at this time. The JV is annotated as "entered in the Adjustment Screen" and is filed with all other quarterly journal vouchers. To ensure that all pre-closing adjustments have been posted, report number TADJ, Treasury Adjustment Entry Report, is generated. This report details by user, GL account number, applicable fiscal year and amount, all entries that have been made into the Adjustment screen. The DFRP reviews the report line by line; and annotates (by check marks) that the TADJ matches the journal voucher* ***(CMS-FR-AA-9).***

Typically, these "adjustment screen" transactions are eventually posted into the FACS general ledger in mid-November, after the audit is completed. Queries are made of the posted entries and checked against the journal vouchers for accuracy ***(CMS-FR-AA-10).*** *At the same time, the corresponding TADJ entries are deleted to avoid duplication. This deletion is verified by visual inspection of a subsequent TADJ report, which should not include the deleted entries* ***(CMS-FR-AA-11).*** *The automated financial statements are run again to verify that they match the audited version of the automated statements and to ensure compliance with the requirement that all transactions be recorded in the FACS general ledger.*

3) Process for Generating Financial Statements

The financial statement automation process is driven by parameters. These parameters are a reflection of the financial statement crosswalks provided by DFRP.

There are two types of parameters for each financial statement, financial statement note, and allocation. One is the report parameter and the other is the extract parameter. The report parameter defines the formatting such as headings, titles, and rounding. In general, the report parameter defines how the financial statement will look. The extract parameter indicates the GL accounts and the associated amounts to be used for the financial statement. For example, within the extract parameter one can define whether to include a month-end or year-end amount for a specific account and whether to pick up the amount for current year, expired years, or current and expired years.

Upon request from DFRP, DAS runs all necessary jobs to produce the automated financial statements. Upon completion, DAS delivers a hard copy of all financial statements and reports to DFRP.

4) Process for Generating Notes to the Financial Statements

OMB Circular A-136 prescribes the form and content of the notes to the financial statements. Generally, CMS notes incorporate the language and formats utilized in the previous fiscal year and are updated with current balances and narrative. The CMS prepares Excel worksheets and gathers various source documents that support the detail tables in the notes. Although the majority of the financial information presented in the notes is derived from routine AMG postings to FACS, other CMS components and Federal agencies provide data. For example, Treasury's BPD financial statements and trial balances provide detail for numerous notes; the Department of Labor submits data regarding the Federal Employees Compensation Act; and HHS provides documentation for pension and other benefit expenses that are deemed imputed costs.

The entire notes section is contained in a single Word document (G:\DA\FS\200x\SEPT200x FS and NOTES\SEPT 200x NOTES\FY200xNOTESMMDD.doc). The note charts themselves are produced and saved in Excel (G:\DA\FS\200x\SEPT 200x FS and NOTES\SEPT 200x NOTES\FY200xNOTESchartsMMDD.xls) and are imported into the Word document under their respective note numbers. Narrative text is typed directly into the Word document. Several notes have been automated along with supporting detail based on the corresponding DFRP crosswalk for these notes.

Before the note tables are imported into the Word document, the tables must be footed and rounded manually to reconcile to the corresponding financial statement line items. The note package is also reviewed by the DFRP Accountant for accuracy, completeness, and validity and to ensure that the financial statement footnotes contain all required disclosures. The DFRP Accountant initials and dates the note package, evidencing performance of the review ***(CMS-FR-NS-1).***

For the first two quarters in the fiscal year, footnote spreadsheets are not completed because OMB does not require CMS to prepare notes for the interim (quarterly) financial statements. However, CMS usually prepares notes for the June statements because the CFO Auditors perform extensive testing on these statements. When notes are prepared,

the footnote spreadsheets are due approximately one week following the completion of the financial statements.

Reconciliation of Net Cost of Operations to Budget note (previously the Statement of Financing)

Effective FY 2007, OMB moved the Statement of Financing to the Notes section under the title, "Reconciliation of Net Cost of Operations to Budget." This note reconciles the proprietary and budgetary statements. Specifically, the note reconciles the net cost of operations to obligations incurred. Accrual-based measures used in the Statement of Net Cost differ from the obligated-based measures used in the Statement of Budgetary Resources. The note takes the obligations incurred as reported on the SBR, deducts obligations used that do not affect net cost (i.e., the acquisition of fixed assets), and adds current costs that do not use budgetary resources (i.e., depreciation and amortization expense) to arrive at net cost of operations as reported on the SNC. The note is prepared on a consolidated basis, except for the budgetary information used to calculate net obligations, which must be presented on a combined basis.

For this note, CMS has retained the format and crosswalk for the Statement of Financing. Only the title has changed. The note is automated and is produced in the principal and supplementary formats.

5) Review and Validation of Financial Statements

The DFRP reviews the financial statements, ensuring that beginning balances tie to the previous fiscal year's ending balances, certain balances reconcile between statements, principal and supplementary statements show identical consolidated and combined totals, and Program Management and PTF allocations flow correctly within the statements. Upon completion of this review, the DFRP Accountant and the Team Lead initial and date the financial statements package, evidencing that the reviews were performed (CMS-FR-FR-7). Upon verification, DFRP requests that DAS create Excel versions of the principal and supplementary statements and notes. Accordingly, DAS downloads the necessary data sets into text files, which are run through macros to create Excel spreadsheets. The DAS forwards the Excel files to DFRP.
The automated statements round principal and supplementary statements to millions. As a result, line or column totals may not foot across or down because individual line item balances are rounded totals while line or column totals are the rounded aggregated sums of each complete line or column. To ensure that the statements are mathematically accurate, DFRP will round certain balances up or down in the Excel file to compensate for these rounding differences. Whenever practical, this rounding is performed on immaterial line items. The individual files for each financial statement are copied onto separate worksheets within a single Excel workbook (G:\DA\FS\200x\SEPT 200x FS and NOTES\SEPT 200x FINANCIAL STATEMENTS\Sept200xFSMMDD.xls). From printed copies of these Excel files, DFRP completes checklists to verify that beginning balances carry forward from the prior fiscal year and that related current balances reconcile

between statements. Balances from notes are also reconciled to the corresponding financial statement line items. These validations are reviewed by the DFRP Director, who signs them, evidencing review ***(CMS-FR-FR-8).***

Once validated, DFRP prints the statements and notes from Excel and Word and provides a copy to the review management team, consisting of the Directors of AMG, DFRP and a Technical Advisor. The management team returns the package to DFRP and any recommended changes are communicated via email. The DFRP makes the recommended changes and resubmits the financial statements to the management team (CMS-FR-FR-9).

Note: With the exception of the June 30 quarterly statements, Notes to the Financial Statements are typically not distributed with the fianancial statements, except upon specific request.

Each quarter, once all draft financial statements and notes are reviewed and verified, the DFRP Director prepares a cover memorandum for the accompanying statements and submits the package for review and concurrence by the Chief Financial Officer and Director of OFM, the Deputy Director of OFM, the Director of AMG, and the Deputy Director of AMG (CMS-FR-FR-10). The memorandum contains the principal financial statements (AFS and CMS published versions), the supplemental financial statements (AFS and CMS published versions), the schedule of gross costs and exchange revenue, the schedule of intragovernmental partners, accompanying notes, and high-level trending documentation.

A meeting is scheduled including the Deputy Director and Director of AMG, at which time questions are raised and addressed and trending documentation is reviewed. Both the Deputy Director and Director of AMG sign the document concurring or not concurring with the recommendation ***(CMS-FR-FR-11).***

The financial statements are then forwarded to the Deputy Director of OFM and the Director of OFM, who review the financials for reasonableness and completeness. Signatures are obtained from both parties signifying they concur or do not concur with the recommendation ***(CMS-FR-FR-12).***

After obtaining concurrence from the CFO, a package of the following is provided to the Auditors for their review and comment:

- *draft financial statements and notes (including AFS, which would have already been uploaded to the Department to meet the 7 am due date imposed by the Department),*
- *BPD statements and trial balances,*
- *updated crosswalks,*
- *detailed breakout reports of statement line items (by IACs and account balances),*
- *journal vouchers,*
- *and the R306.*

The DFRP makes changes as appropriate per the CFO Auditors' comments. Depending on the significance of the Auditors' comments, the final draft may be resubmitted to the CFO auditors. In any event, the Auditors receive a final set of financial statements that correlate to what will be published in the CMS Financial Report.

The Word document and Excel files are delivered to Graphics for production of the CMS Financial Report. The report is distributed agency-wide, to HHS, Congress, OMB, the Office of Inspector General, the CFO Auditors, and is published on the CMS website. Like all other HHS OPDIVs, CMS must transmit its quarterly and year-end financial statements to HHS via the web-based "Automated Financial Statements" system (AFS). June and September notes must also be transmitted through AFS. OPDIVS enter general ledger balances into an Excel worksheet that feeds into the standard financial statement templates as well as templates for the U S Government Closing Package statements. On the OPDIV's behalf, HHS forwards the interim statements and Closing Packages to OMB. The HHS compiles the OPDIV submissions, including those from CMS into the department-wide annual Performance and Accountability Report (PAR).

Note: For quarterly statements, the report is not produced by Graphics or distributed agency-wide. Aside from distribution during the review process, HHS receives the quarterly reports via the AFS system. In addition to the quarterly statements, HHS receives the OPDIV Summary Report for the quarter via facsimile. Additionally, the OIG tpically receives the quarterly reports for March 31, and as requested.

Variance Analyses of Comparative Financial Statements

The DFRP prepares fluctuation analyses for current and prior period financial statements for the 2nd and 3rd quarters and year-end. In some cases, the CFO auditors have accepted responses to their own variance analysis due to the significant time it takes to complete the CMS variance document. The responses provided to the CFO auditors become the DFRP variance analysis for that period. . Upon request from DFRP, DAS downloads the necessary datasets into text files, which are run through macros to create the fluctuation analyses in Excel format. When dollar and percentage variances both exceed specific thresholds established by DFRP, the line is automatically flagged (CMS-FR-AA-12). Upon completion, DAS delivers soft copies via email to DFRP (G:\DA\FS\200x\SEPT 200x FS and NOTES\SEPT 200x FS TRENDING\). The DFRP researches and writes explanations for the highlighted variances and saves it to the G drive (G:\DA\FS\200x\Sept200xvariances.doc). The CFO auditors accept responses to their variance analysis instead of the explanations for the highlighted variances identified on the CMS variance document. The statements and explanations are reviewed by the Director of DFRP and are submitted to the CFO Auditors. The AFS statements include fluctuation analysis and are submitted to HHS. The AFS fluctuation analysis Excel files are located on the shared drive at G:\DA\FS\200x\AFS\SEP 0x\x-30-0x_Statements template.xls ***(CMS-FR-FR-13).*** *The AFS fluctuation analysis has different thresholds and may have lines requiring explanations not required by the CMS thresholds. The AFS explanations are due prior to the CMS variance document.*

Closing Entries

The financial reporting cycle essentially ends with the coding of final pre-closing adjustments followed by the closing entries. As mentioned previously, DFRP posts into FACS general ledger any adjustments that have not yet been entered. Afterward, an updated R506 is run and checked against the coding. Next, a complete set of automated statements is generated based on the updated FACS general ledger and compared to the original "Auditor" copy. These sets of financial statements must be identical ***(CMS-FR-FC-1)****. With the Pre-close R506 validated, DFRP closes the appropriate cash disbursements and collections, revenues and expenses, and budgetary accounts. Finally, a Post-close R506 is run, verified and documented* ***(CMS-FR-FC-2).***

C) Internal Controls for Maintaining Compliance with Laws and Regulations

The CMS established a Risk Management and Financial Oversight Committee consisting of high-level management that ensures there is cross-functional involvement in the monitoring of business activities to identify situations where accounting evaluation or decision-making may be necessary. The following are CMS policies and procedures to monitor overall compliance with applicable laws and regulations:

1) *Identify and document all laws and regulations applicable to CMS* ***(CMS-FR-FR-14)****. The CMS' Office of Legislation (OL) identifies new and revised requirements by working closely with Congressional committees on draft legislation.*

2) *Monitor changes in applicable laws and regulations and respond on a timely basis (CMS-FR-FR-15). The OL provides copies of new legislation to all CMS components, since all programs are generally affected by some provisions of the laws.*

3) *Establish policies and procedures for complying with specific laws and regulations; clearly document and communicate policies and procedures to appropriate personnel (CMS-FR-FR-16). Each CMS component is responsible for establishing policies and procedures to comply with laws and regulations.*

4) *Prospective changes in reporting and accounting policies must be detailed in a position paper drafted by components and signed by AMG management* ***(CMS-FR-FR-17)****. This "white paper" should describe and justify the changes and show their impact on financial reports, accounting transactions and any other aspect of AMG operations. The document must contain the following:*

a) *An opening paragraph that describes the proposed changes*
b) *Background discussing current practices (including any weakness, if any)*
c) *Authoritative sources behind the change (FASAB standard, OMB clarification, Treasury crosswalk changes, etc.)*
d) *Pro forma statements and notes (if applicable) showing the original version, the revised and the differences between the two (required for restatements)*

e) *Proposed financial statement narrative disclosing the change*
f) *Illustrative journal voucher for accounting changes showing proposed transactions*
g) *AMG Director's concurrence*

5) *Monitor events that trigger a change in reporting and/or accounting policy. Events are tracked by all DFRP Accountants and discussed during meetings to inform all parties involved* ***(CMS-FR-FR-18)****. The following are examples of events:*

a) *FASAB pronouncements: FASAB frequently issues new standards (i.e. accounting for internal-use software) that modify or create new reporting requirements.*
b) *Treasury crosswalk change- Treasury periodically updates the standard general ledger crosswalks to the financial statements, adding or deleting accounts or reclassifying accounts.*
c) *Treasury Financial Manuals: Treasury often publishes new guidelines for financial reporting (i.e. Trust Fund Accounting Guidelines)*
d) *OMB Circulars and Bulletins: OMB issues new guidance or revises current bulletins and circulars.*
e) *Prior Period Adjustments: FASAB has prescribed strict criteria (error corrections and changes in accounting principles) for reporting prior period adjustments.*
f) *New CMS programs: implementing new programs (i.e. Medicare Prescription Drug Card and Transitional Assistance payments) might require new accounts and raise reporting issues.*
g) *Changes to estimation methodologies: CMS might alter its methods for calculating certain accruals (i.e. interim Medicare fee-for-service liabilities).*
h) *Auditor recommendations: Auditors often propose changes to formats, as well as items to include or exclude in financial reports.*

****Bolded CMS finding numbers in parenthesis denote key controls for testing****.

60.2 List of Appendices
(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Appendix 1 - Key Contacts
(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Add key contacts for respective cycle memo contacts

Appendix 2 – Flowcharts
(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Add flow charts for respective area

Appendix 3 - Applicable Laws and Regulations
(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

The following laws and regulations affect the Financial Reporting cycle:

1. ***OMB Circular A-123, Management's Responsibility for Internal Control***
   OMB Circular No. A-123 defines management's responsibility for internal control in Federal agencies. Circular A-123 and the statute it implements, the Federal Managers' Financial Integrity Act of 1982, are at the center of the existing Federal requirements to improve internal controls.

2. ***Chief Financial Officers Act of 1990 (CFO Act)***
   Requires Federal agencies to prepare and have audited financial statements for many agency components and operations.

3. ***Federal Managers' Financial Integrity Act (FMFIA)***
   Requires entities to provide assurance as to agency management control and agency compliance with Federal management system requirements by December 31 of each year.

4. ***Federal Financial Management Improvement Act of 1996 (FFMIA)***
   Requires agencies to implement and maintain financial management systems that comply substantially with Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level.

5. ***Adjustments between appropriations, 31 USC 1534***
   An appropriation available to an agency may be charged during a fiscal year for 1) the benefit of another appropriation available to pay costs and 2) for the purpose of financing the procurement of materials and services of other activities and costs for which funds are available both in the financing appropriation so charged and in the benefiting appropriation, except that such expenses so financed shall be charged on a final basis as of the close of the fiscal year.

Appendix 4 - Key Information Technology Systems and Repositories
(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

- *Endeavor*
- *FACS - Financial Accounting Control System*
- *Shared Network Drive*

60.3 – List of Exhibits

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

Exhibit 1 – Timeline for Preparation and Audit of CMS Financial Statements

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

This exhibit is a Timeline for Preparation and audit of CMS FY 2006 Financial Statements, September 30, 2006. The timeline is developed to ensure compliance with internal and external reporting requirements. It has 4 columns: Column one shows a list of steps, column 2 shows the activities, column 3 shows the responsible Division and column 4 shows the due date.

List of Steps	*Column 2 – List of activities to be completed in preparation for the audit of financial statements.*	***Responsible Division***	***Due Date***
1	*FACTS I: Verify and submit Master Appropriation File – Window opens. Window closes 9/19 [127]*	*DFRP*	*8/28-9/19*
2	*Obtain FY 2006 allocation percentages from FSG*	*DFRP*	*9/5-9/30*
3	*Closing Package window opens*	*DFRP*	*9/11/06*
4	*Reverse BPD data from general ledger*	*DFRP*	*9/15-9/30*
5	*Record Imputed Costs for 4th quarter FY 2006*	*DFRP*	*9/15-9/30*
6	*SMI Transfer for Medicaid based on estimate for September, actuals through August*	*DFRP*	*9/15-9/30*
7	*Prepare 1151s between parent and allocation accounts for FY 2001 HCFAC to zero out allocation account based on ending balance of Treasury Query as of 8/31/06. Note: If there is any September activity for FY 01, 1151s will have to be done again in October to close out the accounts as of September 30.*	*DFRP*	*9/15-9/30*
8	***Appropriation breakdowns*** *for September 28 and prior (IPAC, Deposit Ticket, Debit Voucher, and TFCS documents) must be given to DPBC by* ***10:00 AM on September 29****.*	*DFRP, DAO, DAS, DPBC,DDRO*	*9/29/06*
9	***Journal Vouchers*** *for September 28 and prior activity must be*	*DFRP, DAO, DAS,*	*9/29/06*

	*given to DPBC by **10 AM on September 29.***	*DPBC,DDRO*	
10	*FACTS I ATB window opens*	*DFRP*	*9/29/06*
11	*System to be available on Saturday and Sunday 9/30 & 10/1. 6 a.m. to 6 p.m. (if necessary)*	*DFRP, DAO, DAS, DPBC*	*9/30-10/1*
12	*Obtain necessary logs for preparation of 224.*	*DPBC, DAO DFRP*	*10/2/06*
13	*Close September Preliminary accounting month. Include reversal of advance balance in Medicaid, reclassification of Undelivered – unpaid obligations to delivered – unpaid obligations. (no later than 1 p.m.) Provide 5 copies of R106 and 3 copies of R107D*	*DAS DFRP*	*10/3/06*
14	*Run 105 (to be used for cash package preparation) – O.T. required for cash package preparers.*	*DAS DFRP*	*10/3/06*
15	*Run September month-end reports as usual. (Need to let DAS know which reports DFRP needs to be printed and the time they need to be available on 10/5 after month-end runs to ensure cash packages are completed by COB 10/5, i.e. R106, R305, R306.)*	*DAS*	*10/3/06*
16	*Run R539/540*	*DAS*	*10/3/06*
17	*Submit 9/30 Statement of Transactions (SF-224)*	*DFRP*	*10/4/06*
18	*Obtain data from contractors and Prepare journal voucher to reclassify refunds as offsetting receipts for September activity and include on supplemental SF-224 to be submitted on 10/6.*	*DFRP*	*10/4/06*
19	*Obtain UFMS capitalization costs form OF [135]*	*DFRP*	*10/4/06*
20	*Obtain HIGLAS capitalization costs from HPO*	*DFRP*	*10/4/06*
21	*Provide BPD payable adjustments **NOTE: Provide RRB data, if available. In addition, adjust the BPD Transitional Assistance 1151 payable by the amount we plan to reduce CMS Transitional Assistance 1151 receivable.***	*DFRP*	*10/4/06*
22	*Month end reports to be distributed by COB on Wednesday, 10/4*	*DAS*	*10/4/06*
23	*October 2006 month opens for FY 2007 activity on Wednesday, 10/4.*	*DAS*	*10/4/06*
24	*Prepare and deliver 1st set of cash packages based on 10/3 trial balance*	*DFRP*	*10/4/06*

25	*Prepare journal voucher to adjust 2213 and 6400G accounts by amounts based on R306 and R301 run date of 10/4 to transfer the OPM liability from 2211 to 2213 for July, August, and September*	*DFRP*	*10/4/06*
26	*Prepare DOL and OPM confirmations for submission to Department [153]*	*DFRP*	*10/4-16*
27	*Prepare journal voucher for the reclassification of refunds to offsetting receipts, prepare letter to BPD to process 1151 on 10/6. (This transaction does not need to be on BPD's prelim statements, but will be included on financial statements. The adjustments will be included with our final adjustments to BPD on 10/12/06.)*	*DFRP*	*10/5/06*
28	*Obtain PMS, CDC, PSC and DOJ 224s*	*DFRP*	*10/5/06*
29	*Prepare 2-sided 1081 to return FY 01 Program Management fund to HI/SMI*	*DFRP*	*10/5/06*
30	*Prepare supplemental SF-224 as a result of 2-sided 1081 and JV to reclassify refunds to offsetting receipts.*	*DFRP*	*10/5/06*
31	*Obtain BPD statements – preliminary*	*DFRP*	*10/5/06*
32	*Open PRIOR MONTH 1 p.m. to 8 p.m. for cash differences including IDDA (formerly IOTV) cash coding based on PMS, CDC and PSC 224 data*	*DFRP, DAO, DAS, DPBC*	*10/5/06*
33	*Prepare and deliver 2nd set of cash packages based on 10/5/2006 R105 (a.m.)*	*DFRP*	*10/6/06*
34	*Obtain September actual data from Medicare Contractors to calculate the known pieces of the Medicare IBNR – Approved to Paid, Outstanding Checks and Periodic Interim Payments*	*DFRP*	*10/6/06*
35	*Open PRIOR MONTH 6 a.m. to 8 p.m. for cash differences including IDDA (formerly IOTV) cash coding based on PMS, CDC and PSC 224 data.* ***All cash coding to be completed by 6 p.m.*** ***DFRP to inform divisions when cash differences clear between 6 and 8 p.m. to ensure that any remaining cash differences are corrected before the 8 p.m. cutoff.*** ***Run R105 for cash reconciliation purposes after cash coding is complete for the day. In addition, inform DAS which R300 series reports are needed during the day.***	*DFRP, DAO, DAS, DPBC*	*10/6/06*
36	*Update and submit AFS for eliminations data based on 10/4/2006*	*DFRP*	*10/6/06*

	R539 /R540 [138]		
37	*Open PRIOR MONTH 6 a.m. to 6 p.m. for cash differences (if necessary) including IDDA (formerly IOTV) cash coding based on PMS, CDC and PSC 224 data, BPD HI/SMI trial balance, HIGLAS Medicare Contractor data coding, other coding, if necessary. Inform DAS which R300 series reports are needed during the day.* ***Note this is Saturday and OT or COMP Time will be needed***	*DFRP, DAO, DAS, DPBC*	*10/7/06*
38	*IFCS - Fiduciary investment confirmations window. [154]*	*DFRP*	*10/6-19*
39	*Obtain HIGLAS Medicare Contractor Data (to be coded 10/8 or 10/9)*	*DFRP*	*10/7/06*
40	*Code general fund activity into adjustment screen; use FY 2006 allocation percentages based on TC 220 query and R406 as of 10/4. Update allocation table with 2006 percentages.*	*DFRP DAS*	*10/7/06*
41	*Prepare spreadsheet for Medicare IBNR based on data received 10/6 and provide to OACT.* ***Note this is Saturday and OT or COMP Time will be needed***	*DFRP*	*10/7/06*
42	*Run 105 (for cash activity coded on 10/7/06) after all cash coding completed*	*DAS*	*10/7/06*
43	*Run R306, R406, R307D at a minimum after all cash coding and other coding completed on 10/7*	*DAS*	*10/7/06*
44	*Open PRIOR MONTH for posting point account closing of cash, cash differences including IDDA (formerly IOTV) cash coding based on PMS, CDC and PSC 224 data, BPD HI/SMI trial balance (if necessary), funding reductions in 960/961 except for IBNR CANS, other coding, if necessary.* ***System to remain open until 6 p.m. Note this is Sunday and OT or COMP Time will be needed***	*DFRP DAS*	*10/8/06*
45	*Run 105 (for cash activity coded on 10/8/06)* ***if necessary***	*DAS*	*10/8/06*
46	*Run requested September month-end report. (DFRP needs to let DAS know which reports DFRP needs to be printed and the time they need to be available after month-end runs to ensure we have the necessary reports to work with on Monday holiday.)*	*DAS DFRP*	*10/8/06*
47	*Open PRIOR MONTH* ***if necessary -*** *BPD HI/SMI trial balance (if necessary), other coding, if necessary.* ***System to remain open until 6 p.m. Note this is Monday and a Holiday - OT or COMP Time will be needed***	*DFRP DAS*	*10/9/06*

48	*Run 105 (for cash activity coded on 10/9/06)* ***if necessary***	*DAS*	*10/9/06*
49	*Run R539, R540*	*DAS*	*10/10/06*
50	*Run first set of statements (will not have Medicare IBNR or CAFM Medicare Accounts Receivable data)*	*DAS*	*10/10/06*
51	*Obtain non-HIGLAS Medicare Contractor Accounts Receivable Data*	*DFRP*	*10/10/06*
52	*Obtain Medicare IBNR from OACT and prepare JV for Medicare IBNR to code 10/12.*	*DFRP*	*10/11/06*
53	*Provide BPD e-mail informing them of RRB accrual information, expenditure and Non-expenditure accrual for Program Management, HCFAC and Benefit Payments (based on the IBNR obligation calculated on JV from previous step.*	*DFRP*	*10/11/06*
54	*Open PRIOR MONTH 6 a.m. to 8 p.m. for posting Medicare Accounts Receivable data and Medicare IBNR and closing of receipt accounts. Need to finalize general ledger no later than 5 p.m. so financial statements can be run.* *Journal Vouchers should be completed by 1:30 p.m. to ensure time for coding, review of coding and finalizing general ledger by 5 p.m.* ***ADJUSTMENTS AFTER THIS TIME WILL BE CONSIDERED ON TOP ADJUSTMENTS THAT WILL BE INCLUDED WITH AUDIT ADJUSTMENTS AT 10/31***	*DAS*	*10/12/06*
55	*Run revised September month-end reports. (Print R306, R307D, R406, R305 at a minimum) Reports should be stamped* ***"PRE-CLOSE"***	*DAS*	*10/12/06*
56	*Run R539, R540* ***if necessary***	*DAS*	*10/12/06*
57	*Run FINAL automated f/s (all statements) and automated footnotes. Keep System open until 8 p.m. (Comp time or overtime required.)*	*DAS*	*10/12/06*
58	*Agency verification of FACTS II and FMS 2108 accounts and balances*	*DFRP*	*10/13/06*
59	*Provide excel version of statements and notes by 12 noon*	*DAS* *DFRP*	*10/13/06*

60	*Round excel version of statements to millions*	*DFRP*	*10/13/06*
61	*Provide variance analysis once we have final statements*	*DAS*	*10/14/06*
62	*Prepare variance analysis.*	*DFRP*	*10/14-26*
63	*Review automated f/s and footnotes. Includes reviewing the reconciliation checklist for statements.* ***Note: OT and Comp Time required for Sat 10/14 and Sun 10/15***	*DFRP*	*10/13-15*
64	*Proofread and foot automated financial statements, reconcile notes to statements* ***Note: OT and Comp Time required for Sat 10/14 and Sun 10/15***	*DFRP*	*10/12-10/15*
65	*Update AFS statements and notes and flux analysis to be submitted after management review 10/16.* ***Note: OT and Comp Time required for Sat 10/14 and Sun 10/15***	*DFRP*	*10/14-10/15*
66	*Complete preparation of published version of financial statements and notes*	*DFRP*	*10/14-10/16*
67	*Management review of statements and notes*	*DFRP*	*10/16/06*
68	*Submit 4th quarter IRAS [155]*	*DFRP*	*10/16/06*
69	***Submit final financial statements and footnotes without CPA adjustments to CPA and Department (hardcopy and AFS). [151] AFS by 7 a.m.***	*DFRP*	*10/16/06*
70	*Update financial statement highlights with numbers*	*DFRP*	*10/15-10/16*
71	*Compare FACTS II data to SBR*	*DFRP*	*10/14-24*
72	*Provide supplemental information (RSSI, RSI and OAI) into AFS. (SOSI RSI information) [164]*	*DFRP,OACT*	*10/20/06*
73	*Receive final BPD adjusted trial balance (Need to confirm a date with BPD)*	*DFRP*	*10/15-28*
74	*FACTS II reconciliations of September data and update AFS if necessary [173] Note: window closes 10/26 @ 2p.m.*	*DFRP*	*10/24/06*
75	***Receive GL reconciliation checklists from DAS, DAO, DPBC, and DFRP (Completed checklists can be given directly to Anika Kearney N3-08-26)***	*DAS, DAO, DPBC, DFRP*	*10/31/06*
76	***Update adjustment screen for automated statements with final audit adjustments (if required)***	*DFRP*	*10/31/06*
77	*Run FINAL Automated f/s with audit adjustments (all statements) and automated footnotes. (if required)*	*DAS*	*11/1/06*
78	***Submission of final financial statements with all CPA***	*DFRP*	*11/1/06*

	adjustments to CPA, Department, and OMB (hardcopy). (if required) AFS to be updated 11/3 [180]		
79	*Submit final revised principal statements with footnotes and supplemental schedules with audit adjustments to PSC via AFS [182]*	*DFRP*	*11/3/06*
80	*The Department submits final closing package data into GFRS [192]*	*OF*	*11/6/06*
81	*Submit verification to OF attesting cash reconciliations have been completed, attesting SBR/SF133 reconciliations have been completed, and submit "OPDIV Reconciliation Summary Report – FY 2006" [200]*	*DFRP*	*11/9/06*
82	*Closing Package (GFRS) window closes*	*DFRP*	*11/17/06*
83	*OPEN PRIOR YEAR to code adjustments not previously coded into FACS but included on Financial Statements (If necessary)*	*DFRP DAS*	*11/15/06*
84	*Run updated automated f/s and Notes based on 11/15 and ensure it matches 11/01/06 Statements. (if necessary)*	*DFRP*	*11/15-24*
85	*FACTS II Revisions (if necessary)*	*DFRP*	*11/15-12/1*
86	*Prepare Closing entries*	*DFRP*	*11/16-27*
87	*OPEN PRIOR YEAR to post closing entries*	*DFRP*	*11/28/06*
88	*Run and print R506 and R506 version of R406. Reports should be stamped **"POST-CLOSE"***	*DAS DFRP*	*11/28/06*
89	*Code adjustments for FACTS I*	*DFRP DAS*	*11/15-30*
90	*Run FACTS 1 jobs.*	*DAS*	*11/15-30*
91	*FACTS 1 window closes*	*DFRP*	*11/30/06*
92	*Audit Party*	*ALL*	*TBD*

NOTE: (1) Bracketed number in the Activity column (for example, [120 & 122]) represent line items from the Department's FY 2006 timeline.
(2) All activities represent completed activities as of the date indicated.

Exhibit 2 - Financial Statement Crosswalk Excerpts

(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

This chart correlates CMS' general ledger accounts to the corresponding financial statement line items. This document is provided as an example only.

Department of Health and Human Services
Centers for Medicare & Medicaid Services
GROSS COST AND EXCHANGE REVENUE
For the Year Ended September 30, 200x
(in millions)

As of 10/14/06

Net Program/Activity Costs

	With the Public		***Consolidated***						
	Gross Cost			***Less: Exchange Revenue***			*Gross Cost*	*Less: Exchange Revenue*	***Net Cost of Operations***
	Combined	*Eliminations*	*Consolidated*	*Combined*	*Eliminations*	*Consolidated*			
GPRA Programs									
Medicare									*(Consolidated **GOV** Gross Cost - Consolidated **GOV** Exchange Revenue)* plus *(Consolidated **PUB** Gross Cost - Consolidated **PUB** Exchange Revenue)*
*HI (961,971,980-986, **989, 990**)*	*6101G 6800G*		*Combined + Eliminations*	*5200G*		*Combined + Eliminations*	*6101N 6710N 6720N*	*5200N 5901N*	
Prog Mgmt Alloc							*6800N 6900N - 6109N **6610N 7211N***	***5905N***	*IAC **849** only*
*SMI (960,970,962,963 987,988,991**)***	*6101G 6800G*			*5200G*			*6101N 6710N 6720N*	*5200N 5901N **5904N***	*IACs 833, **970** only*
Prog Mgmt Alloc							*6800N 6900N - 6109N **6610N 7211N***	***5905N***	*IACs 833, **835, 843,** 970 only*
Medicaid (030)	*6101G 6800G*			*5200G*			*6101N 6720N 6800N*		
Prog Mgmt Alloc									
*SCHIP (209,110-112, 114,127,129**,131**)***	*6101G 6800G*			*5200G*			*6101N 6800N*		
Prog Mgmt Alloc									
Subtotal	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*

Other Activities								
CLIA (032)	*6101G*			*5200G*			*6101N* *6710N* *6720N* ***6610N*** ***7211N***	*5200N* *5903N*
State Grants and Demonstrations (020, *034, 113, 126, 128,130,132,****133****,211)* ***Prog Mgmt Alloc***	*6101G*			*5200G*			*6101N* *6800N* *6710N*	***5312N***
Other IAC (019)	*6101G ***			*5200G*			*6101N*	*5200N* *5301N (IAC 019)* *5903N (IAC 019)*
Subtotal	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*	*SUM*
Program/Activity Totals (GPRA + Other Activities)									

IAC's 201 + 115 thru 119 Program Management Allocation

6101 G/N
6330 G/N
6400 G/N
6610 G/N
6710 G/N
6720 G/N
6730 G
6800 G/N
6850 G/N
7211
7600 G/N
7701N
-7702N
-7704

Exhibit 3 - Cost Allocation Percentages Excerpts
(Rev.150, Issued: 04-02-09, Effective: 03-09-09, Implementation: 03-09-09)

FINAL FY 2007 COST ALLOCATION PERCENTAGES

as of 10/05/07

***I. Division of Budget Management & Execution Memo** (9/20/2007):*

	HI	SMI	Part D	Medicaid	SCHIP	SGD	Other
Research	*32.3%*	*27.5%*	*1.4%*	*38.8%*	*0.00%*	*0.00%*	------
Medicare Contractors	*14.8%*	*73.0%*	*12.2%*	------	------	------	------
State Certification	*94.3%*	*5.7%*	------	------	------	------	------
Administrative Costs	*32.3%*	*23.7%*	*17.0%*	*24.27%*	*0.72%*	*0.11%*	*1.9%*
Revitalization	*14.8%*	*73.0%*	*12.2%*	------	------	------	------

Note: Part D Admin added to SMI below:

see below for detailed breakout of GF prorated %'s

II. TOTAL OBLIGATIONS (R307D) REPORT
(CURRENT YEAR IACs 201 and 117-121 ACTIVITY ONLY)

	ALLOT:	** TOTAL OBLIGATIONS	HI	SMI	MEDICAID	SCHIP	TWI	ALL OTHERS	Check Total
State Certification	***22***	*257,607,720*	*242,924,080*	*14,683,640*					*0*
Research	***29/30'S***	*57,316,955*	*18,513,376*	*16,564,600*	*22,238,978*	*0*	*0*		*0*
Medicare Contractors	***40/12(121)***	*1,998,234,844*	*295,738,757*	*1,702,496,087*					*0*
a) ***Administrative Costs***	***50/12(120)/99***	*816,752,829*	*263,811,164*	*332,418,402*	*198,225,912*	*5,880,620*	*898,428*	*15,518,304*	*0*
b) ***Revitalization***	***IACs 118, 120***	*22,119,062*	*3,273,621*	*18,845,441*					*0*
	Subtotals:	***3,152,031,409***	***824,260,998***	***2,085,008,169***	***220,464,890***	***5,880,620***	***898,428***	***15,518,304***	*0*

*** 10/05/2007 R307D*

a) Administrative costs include IAC's 118-121 (less their respective Revitalization allotments).

b) Revitalization comprises IAC's 118 and 120 Revitalization allotments only.

III. WEIGHTED COST %s	***TOTAL OBLIG. by PROGRAM***	***% OF TOTAL $***	
HI	*824,260,998*	***26.28%***	
SMI	*2,085,008,169*	***66.47%***	*round -.01*
MEDICAID	*220,464,890*	***7.03%***	
SCHIP	*5,880,620*	***0.19%***	
State Grants & Demos	*898,428*	***0.03%***	
TOTAL:	***3,136,513,106***	***1.00***	

Detailed Breakout of General Fund Percentages

RESEARCH *ALLOTMENT (per 9/30 memo attachment):*

	Obligations	*Prorated Share*	*Total GF Research Pct.*	*Prorated Research Pct.*
Medicaid	*23,898,179*	*100.00%*	*38.8%*	*38.8%*
SCHIP	*0*	*0.00%*	*38.8%*	*0.00%*
TWI	*0*	*0.00%*	*38.8%*	*0.00%*
Total	*23,898,179*			

ADMIN *ALLOTMENT (Cumulative Obligations from* ***R307D****: 2007 year-only):*

	*Cum Obligations ***	*Prorated Share*	*9/30 memo GF Admin Pct.*	*Prorated Admin Pct.*
Medicaid	*201,001,123,148*	*96.69%*	*25.1%*	*24.27%*
SCHIP (all IACs)	*5,940,729,994*	*2.86%*	*25.1%*	*0.72%*
State Grants (all IACs)	*929,734,216*	*0.45%*	*25.1%*	*0.11%*
Total	*207,871,587,358*			

***** 10/05/2007 R307D***