CMS Guidance Document	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Executive Guidance Number 0071	**Date: September 21, 2007**
Planned Web Site Address http://www.cms.hhs.gov/manuals/	**Release planned: October 5, 2007**

PROGRAM AREA: Financial Reporting

SUBJECT: Chapter 7, Internal Control Requirement Update

APPLIES TO: Contractors

SUMMARY OF DOCUMENT: This document updates the CMS Control Objectives and provides guidelines and clarifications for Internal Control Over Financial Reporting. It also provides edits in the sections as shown below.

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)
STATUS: R=REVISED, N=NEW, D=DELETED.

Status	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/Table of Contents
R	7/10 - Introduction
R	7/10.1.2 - FMFIA and the CMS Medicare Contractor Contract
R	7/10.1.4 - OMB Circular A-123
R	7/10.2.3 - Standards for Internal Control
R	7/10.2.3.1 - Control Environment
R	7/10.2.3.2 - Risk Assessment
R	7/10.2.3.3 - Control Activities
R	7/10.2.3.4 - Information and Communication
R	7/10.2.3.5 - Monitoring
R	7/20.1 - Risk Assessment
R	7/20.2 - Internal Control Objectives
R	7/20.2.1 - Medicare Control Objectives
R	7/20.4 - Testing Methods
R	7/30.1 - CPIC Requirements
R	7/30.1.1 - OMB Circular A-123 and Internal Control Over Financial Reporting

R	7/30.2 - Certification Statement
R	7/30.3 - Executive Summary
R	7/30.4 CPIC - Report of Material Weaknesses
R	7/30.5 CPIC - Report of Internal Control Deficiencies
R	7/30.6 - Definitions of Control Deficiency, Reportable Condition, Significant Deficiency and Material Weakness
R	7/30.7 - Material Weaknesses Identified During the Reporting Period
R	7/40 - Corrective Action Plans
R	7/40.1 - Submission, Review, and Approval of Corrective Action Plans
R	7/40.2 - Corrective Action Plan (CAP) Reports
R	7/40.3 - CMS Finding Numbers
R	7/40.4 - Initial CAP Report
R	7/40.5 - Quarterly CAP Report
R	7/50 - List of Medicare Control Objectives

III. CLEARANCES:

Clearance & Point of Contact (POC)	Name/Telephone/Component
Senior Official Clearance	Tim Hill, Director and Chief Financial Officer, OFM, 410) 786-5448
Agency POC	Ellen McNeil, OFM/AMG/DDRO, (410) 786-7911

IV. TYPE (Check appropriate boxes for type of guidance)

	Audit Guide
X	**Change Request**
	HPMS
	Joint Signature Memorandum/Technical Director Letter
	Manual Transmittal/Non-Change Request
	State Medicaid Director Letters
	Other

V. STATUTORY OR REGULATORY AUTHORITY:
The Federal Manager's Financial Integrity Act of 1982 (FMFIA)

Attachment - Business Requirements

Pub. 100-06	Transmittal:	Date:	Change Request: 5701

SUBJECT: Chapter 7, Internal Control Requirements Update

EFFECTIVE DATE: October 1, 2007

IMPLEMENTATION DATE: 30 days from issuance

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 HHS/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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5701.1	Medicare contractors shall administer the Medicare program under the Social Security Act, and the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). (see section 10)	X	X	X	X		X					
5701.2	Medicare contractors shall be evaluated by CMS on administrative service performance of the Social Security Act, and the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). (see section 10.1.2)	X	X	X	X		X					
5701.3	Medicare contractors shall identify, capture, and communicate pertinent information in a form and time frame that enables employees to	X	X	X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	carry out their responsibilities. (see section 10.2.3.4)											
5701.4	Medicare contractors shall submit the annual CPIC report to CMS within fifteen business days after June 30. The CPIC reporting period is October 1 through June 30. The updated CPIC report shall be submitted from the VP or CFO email box to: internalcontrols@cms.hhs.gov within five business days after September 30. The updated CPIC reporting period is July 1 through September 30. (see section 30.1)	X	X	X	X		X					
5701.5	Medicare contractors shall submit electronic versions of all documents (including updates) as part of your CPIC to CMS at internalcontrols@cms.hhs.gov as Microsoft Excel or Word files. (see section 30.1)	X	X	X	X		X					
5701.6	Medicare contractors shall leverage existing internal and external audits/reviews being performed when conducting its assessment of internal control over financial reporting. (see section 30.1.1)	X	X	X	X		X					
5701.7	Medicare contractors shall consider the results of audits/reviews in order to identify gaps between current control activities and the documentation. The control objectives of A, F, G, I, J, K and L shall be considered if applicable. (see Plan and Scope the Evaluation, section 30.1.1)	X	X	X	X		X					
5701.8	Medicare contractors shall use the results of a SAS 70 audit for the statement of assurance combined with other audits and reviews as appropriate. (see Plan and Scope the Evaluation, 30.1.1)	X	X	X	X		X					
5701.9	Medicare contractors shall conduct additional testing for Circular A-123 as deemed necessary. (see Plan and Scope the Evaluation, 30.1.1.)	X	X	X	X		X					
5701.10	Medicare contractors shall update cycle memos for financial reporting, accounts receivable, accounts payable, and claims expense. (see section 30.1.1 Document Controls and Evaluate Design of Controls.)	X	X	X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5701.11	Medicare contractors shall test the effectiveness of internal control for both manual and automated controls. (see section 30.1.1 Test Operating Effectiveness)	X	X	X	X		X					
5701.12	Medicare contractors shall keep a report of control deficiencies, reportable conditions, and significant deficiencies. Medicare contractors shall update the report as new deficiencies are identified. Medicare contractors shall evaluate internal corrective actions for each deficiency and correct each problem. Medicare contractors are not required to submit a CAP to CMS for these deficiencies. Medicare contractors are required to report the number of deficiencies in the CPIC. (see sections 30.3 and 30.5)	X	X	X	X		X					
5701.13	Medicare contractors shall ensure that any new or revised control objectives are assessed and the risk matrix is updated. Medicare contractors shall implement the updated control objectives. (see sections 20.2.1 and 50)	X	X	X	X		X					

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

None

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.

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Ellen L. McNeill, 410-786-7911
Paul Konka, 410-786-7842

Post-Implementation Contact(s): Ellen L. McNeill, 410-786-7911
Paul Konka, 410-786-7842

VI. FUNDING

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

B. F*or Medicare Administrative Contractors (MAC)* uses only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.)

10 - Introduction

(Rev.)

This chapter provides guidelines and policies to the Medicare 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 Medicare 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.

10.1.2 - FMFIA and the CMS Medicare Contractor Contract

(Rev.)

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 Modernization Act of 2003 (MMA),* Medicare contractors *shall* be evaluated by CMS on administrative service performance. The CMS evaluates Medicare contractor's performance by various internal and external reviews.

To further sensitize the Medicare contractors as to the importance of FMFIA compliance, CMS requires the Medicare 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 Medicare contractors to provide this assurance is the Certification Package for Internal Controls (CPIC). The CPIC includes a self-certification representation that the Medicare contractor's internal controls are in compliance with FMFIA expectations, that the Medicare contractor recognizes the importance of internal controls, and the Medicare contractor has provided required documentation in the package.

10.1.4 - OMB Circular A-123

(Rev.)

OMB Circular A-123, Management's Responsibility for Internal Control, December 21, 2004, provides specific requirements for assessing and reporting on internal controls. *The* Circular requires Federal agencies to prepare a separate assurance statement on the effectiveness of internal control over financial reporting. The Circular is issued under the authority of FMFIA and provides additional guidance. The Circular emphasizes that internal control should benefit rather than encumber management, and should make sense for each agency's operating structure and environment.

10.2.3 - Standards for Internal Control

(Rev.)

Internal control consists of five interrelated standards. The GAO "Standards for Internal Control in the Federal Government" describes these five standards:

A. Control environment;

B. Risk assessment;

C. Control activities;

D. Information and communication; and

E. Monitoring.

Each of these internal control standards plays an important role in the overall control environment of an organization. These standards define the minimum level of quality acceptable for internal control in government and provide the basis against which the internal control is to be evaluated.

While each internal control standard is an integral part of the management process and plays a specific role, it is the combination of these standards that establishes internal control in an organization. The control environment provides the discipline and atmosphere in which the organization conducts its activities and carr*ies* out its control responsibilities. It also serves as the foundation for the other standards. Within this environment, management conducts risk assessments to assess potential affect of internal and external risks in achieving the organization's objectives. Control activities are implemented to help ensure that management directives are carried out as planned. Relevant information is captured and communicated in a timely and effective manner throughout the organization on an ongoing basis. The organization's operations are continuously monitored as an integral part of the organization's performance evaluation.

10.2.3.1 - Control Environment

(Rev.)

Management and employees should establish and maintain an environment throughout the organization that sets a positive and supportive attitude toward internal control and conscientious management.

The control environment of an organization sets the tone of an organization, influencing the *internal* control consciousness of its people. It is the foundation for all other standards of internal control, providing discipline and structure. Control environment factors include the integrity, ethical values, and competence of the organization's people; management's philosophy and operating style; and the way management assigns authority and responsibility and organizes and develops its human resources.

10.2.3.2 - Risk Assessment

(Rev.)

Every organization faces a variety of risks from external and internal sources that must be assessed. A precondition to risk assessment is establishment of control objectives, linked at different levels and internally consistent.

Risk assessment is the identification and analysis of relevant risks to the achievement of established objectives. A key factor in the consideration of an internal control structure is the importance and risk associated with a program and its associated cost effectiveness. When determining whether a particular control objective should be established, the risk of failure and the potential affect must be considered along with the cost of establishing the control.

10.2.3.3 - Control Activities

(Rev.)

The control activities help ensure that management's directives are carried out. The control activities should be effective and efficient in accomplishing the organization's control objectives.

Control activities are the written activities used to support policies and procedures that help ensure management directives are carried out. Also see *s*ection 20.3, Policies and Procedures. They help ensure that necessary actions are taken to address potential risks that may affect the organization's objectives. Control activities occur throughout the organization, at all levels and in all functions. They include a range of activities as diverse as approvals, authorizations, verifications, reconciliation, performance reviews, security of assets, and segregation of duties. For examples of Non-Information Systems and Information Systems control activities, see GAO – Internal Control Management and Evaluation Tool at: www.gao.gov/new.items/d011008g.pdf.

10.2.3.4 - Information and Communication

(Rev.)

Information should be recorded and communicated to management and others within the entity who need it and in a form and within a time frame that enables them to carry out their internal control and other responsibilities.

Pertinent information *shall* be identified, captured, and communicated in a form and time frame that enables *employees* to carry out their responsibilities. Information systems produce reports containing operational, financial, and compliance related information that make it possible to control the organization. Information systems deal not only with internally generated data, but also information about external events, activities and conditions necessary for informed decision making and external reporting. Effective communication also must occur in a broader sense, flowing down, across, and up the organizational structure. All personnel must receive a clear message from top management that control responsibilities must be taken seriously. They must understand their own role in the internal control system, as well as how individual activities relate to the work of others. They must have a means of communicating significant information *throughout the organization*. The organization must also effectively communicate with external parties, such as customers, suppliers, state officials, and legislators.

10.2.3.5 - Monitoring

(Rev.)

Internal control monitoring should assess the quality of performance over time and ensure that the 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.

20.1 - Risk Assessment

(Rev.)

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 Medicare 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 Medicare 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, 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 and 1522 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 Medicare 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.
- 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.
- 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 Medicare 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 Medicare 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, *you may* rely on the SAS 70 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 Medicare 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). Medicare 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 Medicare Agreement/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.

20.2 - Internal Control Objectives

(Rev.)

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 Medicare 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 Medicare 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 – Medicare Control Objectives

(Rev.)

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).

20.4 - Testing Methods

(Rev.)

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 methods can be used to test the policies and procedures:

1. Document Analysis: a test method used to determine if the policies and procedures are effective by reviewing existing records, completed forms, or other documentation.

2. Observations: a test method used to determine if the policies and procedures are working by watching the performance of that control objective. Observation is often used when the reviewer wants to test how the control objective works for an entire cycle for the function or activity. In this case, the observer watches the performance of all of the steps and observes all involved personnel. For example, a reviewer may observe what happens to a check from the time it is received to the time it is entered into the log and secured in the office safe. A reviewer would record who took which steps, and which controls were used.

3. Interviews: a test method used to determine if the policy or procedure is working by eliciting information from the personnel who perform the control objective. Interviews should be used to supplement document analyses and/or observations. Interviews can provide valuable information about the operation of controls under many different situations.

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,* Reportable Conditions, *Significant Deficiencies, and* Material Weaknesses and should be considered for inclusion in the CPIC submission (see section 30.6).

30.1 – CPIC Requirements

(Rev.)

The Medicare 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 Medicare 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 Medicare contractor to provide assurances that internal controls are in place and to identify and correct any areas of weakness in its operations. Medicare 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.

Medicare contractors 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, and other similar activities. These findings should be *classified* as *control deficiencies*, reportable conditions, *significant deficiencies, or material weaknesses* based upon the definitions provided in section 30.6. Medicare contractors 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 Medicare 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, if the Medicare contractor has electronic signature capability. If electronic signature capability is not available, please send the 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 to your Associate Regional Administrator for Financial Management *and Fee for Service Operations*, CFO/SAS 70 Coordinator, Consortium Contractor Management Officer (CCMO) and/or the Project Officer of the Medicare Administrative Contractor (MAC). 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 Medicare 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 and Internal Control Over Financial Reporting *(Rev.)*

Medicare contractors 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 Medicare contractor shall leverage existing internal and external audits/reviews being performed (SAS 70, 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, F, G, I, J, K, and L shall be considered if applicable.

If a Medicare contractor has a SAS 70 audit 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 Medicare contractor shall conduct additional testing for Circular A-123 as deemed necessary. For example, if the SAS 70 audit report was unqualified (no findings in Section I (Opinion Letter)), then the Medicare contractor is not required to conduct additional testing. 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 Medicare contractor shall conduct additional testing on the findings identified in Section I and the exceptions identified in Section III. (See SAS 70 Reliance Examples chart). If other audits and reviews contradict the SAS 70 audit, 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.

At the process level, documentation shall be prepared in the form of a cycle memo*(s)* that demonstrates an understanding, from beginning to end, of the underlying processes and document flows involved in each major transaction cycle. Identify the key control activities that are relied upon to assure the relevant financial statement assertions are met. 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. For ineffective or partially effective key control activities, *indicate the following in the documentation:* (a) the identified vulnerability caused by the ineffective process, including a specific statement of risk and impact; (b) any existing mitigating/compensating controls that address the identified vulnerability; and (c) a corrective action plan to address the problem if not done so by the mitigating/compensating controls.

Key financial reporting cycle memos would include financial reporting, accounts receivable, accounts payable, and claims expense. Documentation of the controls will provide the foundation for subsequent work and will facilitate the review and evaluation of key controls. *Note: Medicare contractors may combine related cycles (e.g., accounts payable and claims expense).*

3) Test Operating Effectiveness

Testing of the operation of key controls shall be performed and documented *(refer to "Plan and Scope the Evaluation" (see above) as 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.

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).

5) Report on Internal Controls

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

> "… (Medicare contractor) has effective internal controls over financial reporting in compliance with OMB Circular A-123."

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

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

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

> "…(Medicare contractor) 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

"…(Medicare contractor) did not fully implement the requirements included in OMB Circular A-123 and therefore cannot provide assurance that its internal control over financial reporting was operating effectively."

This chart is provided to assist Medicare contractors in determining when to conduct testing.

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	No SAS 70	Unqualified	Not Required
2	No SAS 70	Unqualified	No SAS 70	Not Required
3	Unqualified	No SAS 70	No SAS 70	Not Required
4	Qualified	Unqualified	No SAS 70	Not Required
5	No SAS 70	No SAS 70	Qualified	Not Required
6	No SAS 70	Qualified	No SAS 70 and the Findings are Corrected and Validated by CMS (CAP Closure Letter Received)	Not Required
7	Unqualified	Qualified	No SAS 70 and the Findings are Corrected and Validated by CMS (CAP Closure Letter Received)	Not Required
8	Qualified	No SAS 70 and the Findings are Corrected and Validated by CMS (CAP Closure Letter Received)	No SAS 70	Not Required
9	Unqualified	Qualified	No SAS 70 and the Findings are NOT Corrected or Validated by CMS (No CAP Closure Letter)	Required
10	No SAS 70	Qualified	No SAS 70 and the Findings are NOT Corrected or Validated by CMS (No CAP Closure Letter)	Required
11	Qualified	No SAS 70 and the Findings are NOT Corrected or Validated by CMS (No CAP Closure Letter)	No SAS 70 and the Findings are NOT Corrected or Validated by CMS (No CAP Closure Letter)	Required

SAS 70 Unqualified Report - No Findings in Section I

SAS 70 Qualified Report - 1 or More Findings in Section I

***Note: Assumes other subsequent audits and reviews do not contradict the SAS 70 or contradictions have been corrected and validated.**

30.2 - Certification Statement

(Rev.)

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 *or the equivalent Senior Executive responsible for Medicare*. 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* (Medicare Chief Financial Officer and Vice President for Medicare) 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 [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 Medicare 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. 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,

(Medicare Chief Financial Officer Signature)

(Vice President for Medicare Signature)

30.3 - Executive Summary

(Rev.)

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;

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,* reportable conditions *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.)

The CPIC Report of Material Weaknesses shall include all *initial* material weaknesses 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 Medicare 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 material weaknesses. This shall be done as soon as the determination is made that the finding is a material weakness. Note: Information related to each material weakness should be on only one row of the spreadsheet; the "wrap text" function in Excel should be *used*.

2. *C*ontrol *O*bjective *I*mpacted (*see* section 50). Each material weakness shall have at least one control objective associated with it. However, a material weakness could have more than one control objective associated with it. If more than one control objective is impacted by the material weakness, the finding shall be listed only once with multiple control objectives listed with it. *P*rioritize 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. CAP target completion date.

6. Actual completion date for the CAP (if completed).

7. Date the material weakness was identified.

8. Date the initial CAP was submitted to CMS as instructed in section 30.7.

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 *your* CPIC, identify the material weakness as either FMFIA or financial reporting (FR). See section 30.6.

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

The total number of material weaknesses reported shall be included. Each material weakness shall be reported once for this total count, even if there is more than one control objective impacted by the material weakness.

(1) CMS Finding Number	(2) Control Objective (s) Impacted	(3) Summary of the Material Weakness	(4) Corrective Action Plan (CAP)	(5) CAP Target Completion Date	(6) Actual Completion Date	(7) Date Material Weakness Identified	(8) Date Initial CAP Submitted to CMS	(9) Original Source of Finding
XYZ-*08*-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.	*03/15/2008*	*03/15/2008*	*02/03/2008*	*02/27/2008*	Internal Review
XYZ-*08*-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.	*04/30/2008*		*02/20/2008*	*02/27/2008*	Internal Review
XYZ-*08*-S-001	A.1	No Entity Wide Security Plan	Create an entity Wide Security Plan	*6/30/2008*		*03/01/2008*	*03/10/2008*	SAS 70 Audit

30.5 - CPIC- Report of *Internal Control Deficiencies*
(Rev.)

The CPIC Report of Internal Control *Deficiencies shall include control deficiencies, reportable conditions, 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*, reportable conditions, *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, reportable condition, 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,* reportable condition*, 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*, reportable condition, *and significant deficiency shall* be listed and the total number of *control deficiencies,* reportable conditions, *and significant deficiencies shall* be included *in the report.* The Medicare 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 *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*, reportable conditions, *and significant deficiencies (and material weaknesses)*, no CAP is required to be submitted to CMS *for control deficiencies or reportable conditions (see section 40).*

30.6 - Definitions of *Control Deficiency,* Reportable Condition*,* Significant Deficiency*, and* Material Weakness
(Rev.)

These terms are defined as follows:

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.

REPORTABLE CONDITION:

FMFIA overall – A control deficiency, or combination of control deficiencies, that in management's judgment, should be communicated because they represent significant weaknesses in the design or operation of internal control that could adversely affect the organization's ability to meet its internal control objectives.

SIGNIFICANT DEFICIENCY:

Financial Reporting – *A control deficiency, or combination of control 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.*

MATERIAL WEAKNESS:

FMFIA overall – Reportable condition in which the Medicare contractor's CFO and VP of Medicare determine to be significant enough to report outside of the Medicare contractor.

Financial reporting – *Significant deficiency,* or combination of significant deficienc*ies*, that results in "more than remote" (*i.e., at least reasonably possible)* likelihood that a material misstatement of the financial statements will not be prevented or detected.

30.7 - Material Weaknesses Identified during the Reporting Period

(Rev.)

The evaluation of your internal control environment should be an ongoing process throughout the fiscal year. It should not be a once-a-year event, which occurs prior to submission of your annual CPIC. The identification and reporting of material weaknesses should not wait until the end of the CPIC reporting period. During the reporting period, if material weaknesses are identified, send an electronic Initial CAP report within 45 days of identifying the problem, via E-mail, to CAPS@cms.hhs.gov and internalcontrols@cms.hhs.gov. (see section 40.4). Within that same time frame you are required to provide written notification, to your Associate Regional Administrator for Financial Management *and Fee for Service Operations.*

40 - Corrective Action Plans

(Rev.)

The CMS conducts various financial management and electronic data processing (EDP) audit*s*/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 Medicare 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 Medicare 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 assessments.

Administrative cost audits, provider audits conducted by the OIG, Medicare contractor initiated systems security annual compliance audits, and system penetration tests are excluded from these procedures. *The word "finding" includes control deficiency, reportable condition, 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 OMB Circular A-123 assessments, CAPs to be submitted to CMS are required for significant deficiency and material weakness findings.*

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

(Rev.)

Upon completion of any of the audit*s*/reviews noted in section 40, with the exception of *the* CPIC, the Medicare 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 the report, the Medicare contractor is required to submit an initial CAP report, using the Initial CAP report format from section 40.5. For SAS 70 and the AR AUP reports, initial CAPS are due within 45 calendar days of the electronic receipt date of the final report since these reports are dated with the final day of fieldwork, not the date of issuance.

The initial CAP report shall address newly identified and reported findings that have been assigned a finding number either by the auditor (*e.g.,* SAS 70 audit) or by the Medicare 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 Medicare 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 Medicare 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 should address all open findings, as well as continue to report information on all findings reported as completed by the Medicare contractors until CMS sends the Medicare contractor a closeout letter indicating which findings are officially closed. After the Medicare 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. Medicare contractors are required to furnish an electronic copy of the CAP report*s* to their CMS Associate Regional Administrator for Financial Management and *Fee for Service Operations,* CCMO, and the designated Regional Office CFO/SAS 70 coordinator.

NOTE: If the electronic copy of the Initial and Quarterly CAP reports has the VP of Medicare 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.

Medicare contractors 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.)

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, 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 Medicare 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 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 Medicare 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 Medicare 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.)

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 type of review.

Choose one from the following list:

- *A - 123 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

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

Contractor Abbreviations

Cahaba Government Benefit Administrators (d.b.a. Alabama BCBS)	CAH
Chisholm Administrative Services (d.b.a. BCBS Oklahoma)	CAS
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
Blue Cross and Blue Shield of Georgia, Inc.	GEO
Group Health Incorporated	GHI
Healthnow New York, Inc.	HLN
Highmark Medicare Services	HMS
Mutual of Omaha Insurance Company	MUT
Blue Cross and Blue Shield of Nebraska	NEB
National Government Services, Inc.	*NGS*
National Government Services, Inc. DME MAC	*NGSD*
National Heritage Insurance Company	NHIC
National Heritage Insurance Company, DME MAC	NHICD
Noridian Mutual Insurance Company, A/B MAC	NOR
Noridian Mutual Insurance Company, DME MAC	NORD
Palmetto Government Benefits Administrators (d.b.a. Blue Cross and Blue Shield of South Carolina*)*	PGBA
Pinnacle Business Solutions, Inc. (d.b.a. Arkansas BC/BS)	PBSI
Riverbend Government Benefits Administrator (d.b.a. Blue Cross and Blue Shield of Tennessee)	RGBA
TrailBlazer Health Enterprises, LLC	THE
Triple S, Inc.	SSS
TriSpan Health Services (d.b.a. as BCBS Mississippi)	TRI
Wheatlands Administrative Services, Inc.	WAS
Wisconsin Physicians Service Insurance Corporation	WPS
Chickasaw Nation Industries, Inc. *(Medicare Secondary Payer Recovery Contractor)*	CNI
Retiree Drug Subsidy (ViPS) (Part D Contractor)	RDSV

40.4 - Initial CAP Report

(Rev.)

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, Wheatlands Administrative Services, Inc. (WAS) would name this file "WAS Initial CAP Report 10/30/06.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.)

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, Wheatlands Administrative Services, Inc. (WAS) would name this file "WAS Quarterly CAP Report 10/30/06.xls".

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

50 – List of Medicare Control Objectives

(Rev.)

Control Number	Control Objective: Controls provide reasonable assurance that…
A	**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 Medicare Contractor'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	**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	**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 cases 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	**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).
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).
D.3	Telephone inquiries are answered timely, accurately, and appropriately. (IOM Chapter 2-20.1 Telephone Inquiries).
E	***Complementary Credits***
E.1	*Contractors 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.*
E.2	*Contractors 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.*
F	**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 findings, 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., Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)) and PSCs, Medicare 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, or deleted 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.*

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 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

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 **Administrative**

H.1 All employees comply with applicable laws and regulations, a code of ethics and conflict of interest standards. Education and training programs are in place to ensure that employees understand their responsibilities.

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 Medicare contractor's continuity of operations in the event of a catastrophic loss of relevant, distinguishable Medicare business unit facilities are performed as scheduled.
I	**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 *en*sure 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 *R*eimbursement (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	**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.

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, *s*ection 230.

J.8 Banking information relevant to Medicare processing is accurately stated and conforms to the tripartite agreement.

K 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 100-5, MSP Manual, Chapter 7, Section 60. For Non-MSP debt, see IOM, Pub 100-6, Chapter 4, Section 70. For MSP and Non-MSP debt, see also Pub 100-6, 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	**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. Medicare contractors are not responsible for the demand and collection efforts 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	**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.