CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 228	**Date: September 27, 2013**
	Change Request 8438

SUBJECT: Medicare Financial Management Manual, Chapter 7, Internal Controls

I. SUMMARY OF CHANGES: This document updates and provides clarification for Office of Management and Budget (OMB) A-123 and Internal Control over Financial Reporting.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 28, 2013

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/Table of Contents
R	7/30.8/Statement on Standards for Attestation Engagements (SSAE) Number 16, Reporting on Controls at Service Providers
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
D	7/40.6/Entering Data into the Initial or Quarterly CAP Report
R	7/50/List of CMS Contractor Control Objectives
R	7/60.2/Appendix 5 – Initial CAP Report Template

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 228	Date: September	Change Request: 8438

SUBJECT: Medicare Financial Management Manual, Chapter 7, Internal Controls

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 27, 2013

I. GENERAL INFORMATION

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

B. Policy: The CMS contract with 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

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8438.1	All MACs shall ensure that SSAE 16 Type II audits are in compliance with the AICPA standards and licensing regulations. MACs shall perform due diligence to obtain assurance and representations from the CPA firm that applicable state licensing regulations are followed and that relevant disclosures are provided. In addition, MACs shall complete the SSAE Checklist, which identifies the AICPA requirements of an SSAE 16 Type II audit report. MACs shall submit the SSAE 16 checklist along with the draft SSAE and Corrective Action Plan (CAP) Follow Up reports to the CMS Internal Control Team at Internalcontrols@cms.hhs.gov by June 15.	X	X		X								
8438.2	All contractors shall use the excel Initial CAP Report. The Initial CAP Report template will no longer be required to be submitted. The Internal Control Team developed an excel format that is	X	X		X	X	X						RRB-SMAC

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	identical to the template, without the macros and formulas. The excel Initial CAP Report will be distributed by and can be obtained from CAPS@cms.hhs.gov.												
8438.3	All MACs shall perform data analysis continuously. Data from a variety of sources must be used for data analysis. At a minimum, sources include: contractor internal data; CMS program vulnerability alerts such as Quarterly Vulnerability Technical Direction Letters that require corrective action reporting, FATHOM/PEPPER and other comparative billing reports; results from medical review studies performed by specialty MR or Program Integrity contractors; and other national or regional sources such as Office of Inspector General (OIG) reports, Government Accountability Office (GAO) reports, enrollment data, and fraud alerts.	X	X		X								
8438.4	All MACs shall effectively comply with all of the MR requirements of the Joint Operating Agreement (JOA) with the PSCs/ZPICs, RAs, and specialty medical review contractors.	X	X		X								
8438.5	All MACs shall institute a corrective action reporting process for claims-specific errors and vulnerabilities in accordance with Change Request 7241. Contractors shall submit either an interim reportable action or final reportable action for each vulnerability. An “interim reportable action” describes how a Medicare contractor is evaluating a vulnerability identified by an RA. A “final reportable action” describes how a Medicare contractor is addressing a vulnerability identified by an RA. All reportable actions shall be quantified with the volume amount identified. CMS must be notified if more than 90 days are required to report corrective actions.	X	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Eleanor Sheain, 410-786-8120 or Eleanor.Sheain@cms.hhs.gov, Ronald Dea, 410-786-1375 or Ronald.Dea@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets.

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

Medicare Financial Management Manual
Chapter 7 - Internal Control Requirements

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(Rev.228, Issued:,09-27-13)

Transmittals for Chapter 7

60.2 – List of Appendices:
Appendix 5 – Initial CAP Report Template

30.8 –Statement on Standards for Attestation Engagements (SSAE) Number 16, Reporting on Controls at Service Providers

(Rev.228, Issued: 09-27-13, Effective: 10-01-13, Implementation: 10-28-13)

NOTE: This section would only be applicable to MACs and DME MACs.
In lieu of receiving an A-123 Appendix A review, MACs/DME MACs are required to undergo a SSAE 16 Type II audit. The MAC/DME MAC shall contract with an independent certified public accounting (CPA) firm to perform this audit in accordance with the requirements below. The MAC/DME MAC shall follow its respective internal procurement process for contracting with the independent CPA firm or contact CMS Office of Acquisition and Grants Management for assistance.

To maintain independence in the appointment, compensation, and oversight of the audit work of the CPA firm, the MAC/DME MAC shall utilize its internal audit function, a board of directors, an audit committee, or an area external to the CFO's responsibilities. This requirement is similar to the requirements under the Sarbanes Oxley Act of 2002, Title III - Corporate Responsibility, Public Law 107-204-July 30, 2002. The CPA firm must have experience in SSAE 16 and/or SAS 70 Type II audits, Medicare operations and accounting and financial reporting. Key personnel shall have at least five years experience in Medicare operations with experience in American Institute of Certified Public Accountants (AICPA) consulting standards, and have a technical proficiency in internal controls and financial reporting. *MACs shall ensure that SSAE 16 Type II audits are in compliance with the AICPA standards and state licensing regulations.*

To ensure that the SSAE 16 Type II audit is complete and in compliance with AICPA Standards, MACs shall perform due diligence to obtain assurance and representations from the CPA firm that applicable state licensing regulations are followed and that relevant disclosures are provided. In addition, MACs shall complete the SSAE Checklist, which identifies the AICPA requirements of a SSAE 16 Type II audit report, including AICPA - SSAE 16, Reporting on Controls at a Service Organization, effective June 15, 2011, paragraph 7 - Complementary User Entity Controls. MACs shall submit the SSAE 16 Checklist along with the draft SSAE and Corrective Action Plan (CAP) Follow Up reports to the CMS Internal Control Team at Internalcontrols@cms.hhs.gov by June 15.

AB/DME MAC:

The objective of this checklist is to evaluate whether the SSAE 16 Type II Audit is in compliance with AICPA Standards, state licensing regulations and in accordance with Internet Only Manual, Publication 100-06, Medicare Financial Management Manual, Chapter 7, Internal Control Requirements. The MAC shall review the SSAE 16 Type II Audit Report and check "yes" or "no" for each requirement. If the requirement is not met, the MAC shall follow-up with the CPA firm and indicate in the comment section the action(s) for meeting the requirement. The MAC shall ensure these requirements are reflected in the final report. If the MAC has any questions or comments, please contact your COR and copy the CMS Internal Control Team at internalcontrols@cms.hhs.gov.

Type II Audit Requirements	Yes	No	Comments and Follow-up Action (s) as Required
I. SSAE 16 Type II Audit Report			
1. Does the title of the SSAE Report indicate it is for the period October 1, 2012 through March 31, 2013?			
2. Is the Independent Service Auditor's Report (Section I) signed and dated by the CPA firm and include the City/State of the issuing office?			
3. Are there any deficiencies identified in the SSAE 16 Report Auditors Opinion Section (Section I)?			
4. Did the CPA firm include a spreadsheet or table in Section I of the Report and include Finding Number, Description of the Finding, and Control Objective Number impacted?			
5. Were the appropriate control objectives tested? The initial audit for new MACs/DME MACs (which includes cases where outgoing MACs transition to a new MAC) must review all 12 or 13 applicable control objectives. Existing MACs/DME MACs must have the core 8 control objectives tested (see IOM Chapter 7, Section 30.8)			
6. Does the report include the following components? 1) Opinion, 2) Management's Assertion (placement may vary), 3) Description of System and Controls, 4) Control Objectives, Activities, Testing, and Results (including disclosure of sample sizes when exceptions are identified).			
7. Did the service auditor report on 3 elements of the system for the entire period covered by the report? 1) Fairness of presentation, 2) Suitability of design, and 3) Effectiveness of operation.			
II. Corrective Action Plan Report			
1. Is the Corrective Action Plan Report signed and dated by the CPA firm and include the City/State of the issuing office?			
2. Did the CPA firm include the specific procedures and testing performed to validate closure of each CAP reviewed?			
3. For each open CAP, did the CPA firm make a recommendation to close or to keep the CAP open?			
III. AICPA Standards			
1. Is the CPA firm in compliance with AICPA standards and state licensing regulations?			
2. Did the service auditor include User Control Considerations or UCCs in the final report? UCCs are controls that reside at the user organization (CMS). These controls are usually delineated in the SSAE 16 reports within their own report subsection and/or next to the control objectives they relate.			

IV. Overall Comments/Observations

V. Supervisory Review and Approval

This section is for Supervisory review, comment and approval.

Review Performed By: _____ Date:_____

CFO Signature: _____ Date:_____

The initial audit (for new MACs, which include cases where outgoing MACs transition to a new MAC) shall include all of the CMS Control Objective areas described in Section 50 of this IOM. In subsequent years, the control objectives for financial, MSP, non-MSP, information systems, debt referral, medical review, provider audit, and claims processing shall be audited. In addition, the contractor shall conduct a risk assessment regarding the remaining Control Objectives and have them audited if the risk assessment warrants such a conclusion. The scope of the audit begins October 1st of each fiscal year and ends no earlier than March 31 (6 months). Furthermore, subcontractors to the Contractor shall be included in the audit if the services they provide directly impact the financial statements of the MAC/DME MAC.

The MAC/DME MAC shall keep CMS informed of the progress of the SSAE 16 audit. This shall be performed as follows:

Entrance Conference - The CPA firm shall conduct an entrance conference with the MAC/DME MAC before the start of each engagement to discuss the scope, timeframe (including estimated fieldwork start and finish dates), and any other issues relating to the engagement. The MAC/DME MAC shall notify the individual Business Function Leads (BFLs), COR, and Technical Monitors (TMs) via email, as well as, the A-123 Technical Team (ATT) at internalcontrols@cms.hhs.gov of the date and time of the entrance conference at least five days prior to its occurrence. The BFLs, COR, TMs and ATT reserve the right to participate in the entrance conference on-site or by teleconference.

Status Meetings - The CPA firm shall conduct status meetings, at least bi-weekly, with the MAC/DME MAC. The status meetings shall include discussion of the activities performed during the period prior to the status meeting (including CAP Follow Up Review activities, if applicable), significant findings/potential issues identified thus far, and any concerns that may affect the completion of the work. The MAC/DME MAC shall notify the BFLs, COR, TMs and ATT of the dates and times of the status meetings at least five days prior to their occurrence. The MAC/DME MAC shall provide a copy of the written status report outlining activities performed during the period prior to the status meeting (including CAP Follow Up activities, if applicable), any significant findings/potential issues identified thus far, and any concerns that may affect the completion of the work. The BFLs, COR, TMs, and ATT reserve the right to participate in the status meetings on-site or by teleconference.

Exit Conference – The CPA firm shall conduct an exit conference with the MAC/DME MAC after the release of the draft SSAE 16 report to provide a summary of the review areas and the estimated final report issuance date. The scheduling of the final exit conference shall provide adequate time for the MAC/DME MAC to review the draft report. The MAC/DME MAC shall notify the BFLs, COR, TMs and ATT of the date and time of the exit conference at least five days prior to its occurrence. The BFLs, COR, TMs and ATT reserve the right to participate in the exit conference on-site or by teleconference.

The CPA firm(s) shall deliver to the contractor a matrix in the form of a Microsoft Excel spreadsheet or Microsoft Word table to report all SSAE 16 findings in Sections I and III/IV of the report. The matrix must include:

a. Finding Number (the CPA firm shall number the findings in accordance with Section 40.3)
b. Description of the Finding
c. Control Objective Number Impacted (limited to 5)

The CPA firm shall, if applicable, conduct Corrective Action Plan (CAP) Follow up Reviews for prior CAPs as part of the engagement. If or when the contractor has open prior year CAPs for the CPA firm to follow up on, the contractor may make recommendations to the CPA firm and/or check with CMS/OFM to verify what CAPs should be followed up on. Prior year CAPs are defined as any CAPs reported to CMS for any reviews/audits listed in Section 40. The CPA firm shall review the CAPs to ensure that corrective actions have been implemented and that the CAPs are operating effectively. The CPA firm shall make a recommendation to the Contractor whether or not to close the CAP or have it remain open. If testing is needed in addition to that performed for the required control objective areas, it shall be completed.

The CPA firm shall deliver a CAP Follow up Report to the Contractor. The report shall contain a Microsoft Excel spreadsheet or Microsoft Word table to report the status of all prior year CAPs. The matrix shall include:

a. Finding Number
b. Business Area
c. Description of the Finding
d. Corrective Action Plan
e. Verification/Testing Methodology
f. Correction Status
g. Recommendation

Copies of the draft SSAE 16 and CAP Follow Up reports shall be issued and provided to CMS by June 15th. These documents shall be submitted electronically to the CMS Internal Control Team at internalcontrols@cms.hhs.gov, as well as to the BFLs, COR, and TMs. The target date for CMS comments back to the contractor is one week subsequent to issuance of the draft reports. Copies of the final SSAE 16 and CAP Follow Up reports shall be issued and provided to CMS by July 1st. These documents shall be submitted electronically to the e-mail address and noted parties above, as well as in hardcopy to:

Centers for Medicare & Medicaid Services
Office of Financial Management
7500 Security Boulevard, Mailstop N3-11-17
Baltimore, MD 21244-1850
Attn: Internal Control Team

Work papers and supporting documentation shall be made available upon request to any party designated by CMS. The CMS reserves the right to request and review work papers resulting from SSAE 16 audits and CAP Follow Up Reviews.

40 - Corrective Action Plans

(Rev.228, Issued: 09-27-13, Effective: 10-01-13, Implementation: 10-28-13)

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

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

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

2. SSAE 16 audits;

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

4. Financial reviews conducted by the GAO;

5. CMS' 1522 and CMBRW workgroup reviews;

6. CMS' CPIC reviews; and

7. OMB Circular A-123 Appendix A reviews.

Administrative cost audits, provider audits conducted by the OIG, the contractor initiated systems security annual compliance audits, and system penetration tests are excluded from these procedures. The word "finding" includes control deficiency, significant deficiency, and material weakness. For SSAE 16 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/IV of the SSAE 16 report. Section III/IV findings are not required to be included on the Initial and Quarterly CAP Reports. Section III/IV findings shall be tracked internally and corrected. Contractors are required to prepare and maintain documentation to support the status and corrective actions taken on Section III/IV findings. It shall be available for review and submitted to CMS central and/or regional office, upon request. For A-123 Appendix A reviews, the contractor shall submit corrective action plans for all deficiencies: control deficiencies, significant deficiencies, and material weaknesses.

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

(Rev.228, Issued: 09-27-13, Effective: 10-01-13, Implementation: 10-28-13)

Upon completion of any of the audits/reviews noted in section 40, with the exception of the CPIC, the contractor will receive a final report from the auditors/reviewers noting all findings identified during their audit/review. Within 45 calendar days of the date of report issuance, the contractor is required to submit an Initial CAP Report, using the *excel Initial CAP Report. The Initial CAP Report template will no longer be required to be submitted. The Internal Control Team developed an excel format that is identical to the template, without the macros and formulas, found in section 60.2, Appendix 5. The excel Initial CAP Report can be obtained from CAPS@cms.hhs.gov.* For SSAE 16, CFO, and A-123 Appendix A reviews, initial CAPS are due within 45 calendar days of the electronic receipt date of the final report.

The Initial CAP Report shall address newly identified and reported findings that have been assigned a finding number either by the auditor/reviewer (e.g., SSAE 16 audit or A-123 Appendix A review) or by the contractor (i.e., CPIC). The CAP shall summarize the procedures that have been or will be implemented to correct the finding. Upon receipt of the Initial CAP Reports, the Internal Control Team will send the reports to the appropriate CMS business owner for review of the CAP. Business owners may either approve the CAP as submitted, or may request additional information to be included in the CAP. All business owner comments shall be provided to the contractors before the due date of the next Quarterly CAP Report. Responses to the CMS business owner comments on the initial CAPs shall be included in the next Quarterly CAP Report due after the date of receipt of the comments.

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

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

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

Submit Initial and Quarterly CAP Reports electronically to: CAPS@cms.hhs.gov. Contractors are required to furnish an electronic copy of the CAP reports to their CMS Associate Regional Administrator for Financial Management and Fee for Service Operations, and the designated Regional Office RO CFO

coordinator. MACs and DME MACs shall submit initial and quarterly CAPs to the CAPS@cms.hhs.gov mail box, and the MAC COTR. RDS and MSPRC shall submit initial and quarterly CAPs to the CAPS@cms.hhs.gov, and the central office COR.

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

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.228, Issued: 09-27-13, Effective: 10-01-13, Implementation: 10-28-13)

The Initial or Quarterly CAP Report shall include the data explained below using the *excel template*. Findings should be grouped by type of review (i.e. CFO, SSAE 16, A-123 Appendix A, CPIC, etc.). Definitions of CAP report data fields:

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

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

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

Control objective(s) impacted - Required only for SSAE 16 findings, A-123 Appendix A findings, and CPIC material weaknesses. This represents the control objective number(s) impacted by an identified finding. More than one control objective may be impacted for each finding but you need to prioritize and limit the control objectives impacted to no more than five.

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

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

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

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

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

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

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

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

40.3 - CMS Finding Numbers

(Rev.228, Issued: 09-27-13, Effective: 10-01-13, Implementation: 10-28-13)

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. Finding numbers ending with D & J are defined as follows:

- End letter “D” represents a DME MAC
- End letter “J” represents a A/B MAC

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

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

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

Review/Audit Type

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

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

- S - SSAE 16 audit;
- V - CFO related NVA/ST; and
- W – Regional Office Review

Table 1 - CONTRACTOR ABBREVIATIONS

Cahaba Government Benefit Administrators	CAH
Cahaba Government Benefit Administrators, *LLC* (J10 A/B MAC)	CAHJ
Commercial Repayment Center (CRC) (MSPRC)	*CRC*
CGS Administrators, LLC (J15 A/B MAC)	CGSJ
CGS Administrators, LLC, Durable Medical Equipment (DME) MAC *JC*	CGSD
First Coast Service Options, Inc. (J9 A/B MAC)	FCSOJ
Group Health Inc. (MSPRC)	GHI
National Government Services, Inc.	NGS
National Government Services, Inc. (*J6 and JK* A/B MAC)	NGSJ
National Government Services, Inc. DME MAC *JB*	NGSD
NHIC, Corp. (J14 A/B MAC)	NHICJ
NHIC, Corp. DME MAC *JA*	NHICD
Noridian *Healthcare Solutions*	NOR
Noridian *Healthcare Solutions* (J3 and JF A/B MAC)	NORJ
Noridian *Healthcare Solutions*, DME MAC JD	NORD
Noridian *Healthcare Solutions*, Pricing, Data Analysis, and Coding (PDAC)	NORP
Novitas Solutions, Inc. (J12 and JH A/B MAC)	NOVJ
Palmetto Government Benefits Administrators (J1 and J11 A/B MAC)	PGBAJ
Pinnacle Business Solutions, Inc.	PBSI
Railroad Retirement Board Specialty MAC (SMAC)	*RRBS*
Wisconsin Physicians Service Insurance Corporation	WPS
Wisconsin Physicians Service Insurance Corporation (J5 *and J8* A/B MAC)	WPSJ
Retiree Drug Subsidy (ViPS) (Part D Contractor)	RDSV
Retiree Drug Subsidy Contact Center (RDSCC)	RDSC

Table 2 - SHARED SYSTEM MAINTAINER ABBREVIATIONS

Common Working File	CWF
Fiscal Intermediary Shared (or Standard) System /Multi-Carrier System	FISS
Multi-Carrier System	MCS
Quality Software Single Testing Contract Services, Inc.	QSSI
Viable Information Processing Systems (ViPS)	VMS

Table 3 – DATA CENTER ABBREVIATIONS

CNI/MARTI & SMART	CNIMS
Companion Data Services (CDS) (EDC)	CDS
CMS Central Office (EDC, Baltimore Data Center)	BDC
DCCA (MBES)	MBES
HP Enterprise Services EDS –Plano, TX	MCS
HP Enterprise Services EDS – Tulsa, OK (EDC)	EDS
IBM – Boulder Colorado (HIGLAS)	IBM
ViPS/GHI (New York, NY)	ViPS

40.4 - Initial CAP Report

(Rev.228, Issued: 09-27-13, Effective: 10-01-13, Implementation: 10-28-13)

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 shown above, these findings shall also be reported using the CMS FISMA Controls Tracking System (CFACTS). A separate CAP report shall be submitted for each contractor, as listed in Section 40.3.

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

The Initial CAP Report format can be obtained from: CAPS@cms.hhs.gov.

50 – List of CMS Contractor Control Objectives

(Rev.228, Issued: 09-27-13, Effective: 10-01-13, Implementation: 10-28-13)

Control Number	**Control Objectives**
A - Control Number	**Control Objective - Information Systems**
A.1	An entity-wide security program has been documented, approved and monitored by

Control Number	Control Objectives
	management in accordance with the CMS Acceptable Risk Safeguards (ARS) and 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,

Control Number	Control Objectives
	known system vulnerabilities, system flaws, or weaknesses that could be exploited by threat sources.
A.14	A centralized risk management focal point for IT risk assessment has been established that includes promotion awareness programs, processes and procedures to mitigate risks and monitoring processes to assess the effectiveness of risk mitigation programs.
A.15	A risk assessment and systems security plan has been documented, approved, and monitored by management in accordance with the CMS Risk Assessment and Systems Security Plan Methodologies.
A.16	Regularly scheduled processes required to support the CMS 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 – Control Number	**Control Objective - Claims Processing**
B.1	The Medicare claims processing system tracks each claim from receipt to final resolution.
B.2	The system checks each claim, adjustment, and any other transaction for validity and, in accordance with CMS instructions, rejects such claims, adjustment, or other transaction failing such validity check. (Maintainer Only)
B.3	The system generates an audit trail with respect to each claim, adjustment, or other related transaction. Such audit trail shall include the results of each applicable claim edit. (Maintainer Only)
B.4	Each claim is adjudicated in accordance with CMS instructions which includes but is not limited to enhancing accuracy through a "Do Not Pay List".
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.

Control Number	Control Objectives
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.
C – Control Number	**Control Objective - Appeals**
C.1	Medicare Part A and Part B redeterminations processed by Fiscal Intermediaries and MACs are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines. (Does not pertain to MSPRC. Refer to C.3 for MSPRC control objective.)
C.2	Medicare Part B redeterminations processed by carriers and MACs are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines. (Does not pertain to MSPRC. Refer to C.3 for MSPRC control objective.)
C.3	Redeterminations processed by the MSPRC are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines.
C.4	Qualified Independent Contractor (QIC) request for case files are handled in compliance with CMS time frames.
C.5	Effectuations are processed as directed by CMS guidelines.
C.6	Contractor communications are clear and in compliance with CMS' instructions to include specific communications such as acknowledgement letters, decision letters, and information on additional appeal rights, etc.
D - Control Number	**Control Objective - Beneficiary/Provider Services**
D.1	Personally identifiable health information, which is used and disclosed in accordance with the Privacy Act, is handled properly. (Internet Only Manual (IOM) Chapter 2-20.1.8-Beneficiary Customer Service; IOM Pub. 100-9, Chapter 6-Provider Customer Service Program).
D.2	Beneficiary and Provider written inquiries are retained and handled accurately, appropriately, and in a timely manner. (IOM Chapter 2-20.2 – Written Inquiries; IOM Pub. 100-9, Chapter 6-Provider Customer Service Program).
D.3	Telephone inquiries are answered timely, accurately, and appropriately. (IOM Chapter 2-20.1 Telephone Inquiries; IOM Pub. 100-9, Chapter 6-Provider Customer Service Program).

Control Number	Control Objectives
E – Control Number	**Control Objective - Complementary Credits**
E.1	*Contractors* shall report cash received from the COBC for COBA crossover claims in the proper fiscal year in the CMS Analytical, Reporting, & Tracking system (CMS ART).
F – Control Number	**Control Objective - Medical Review (MR)**
F.1	Contractor shall use the P*rogram* I*ntegrity* M*anual* guidelines, data analysis (prior year and most current) and MR results including Strategy Analysis Report (SAR), and Comprehensive Error Rate Testing (CERT) results to develop and update the Medical Review Strategy (MRS). The problem-focused outcome-based MRS report shall address both provider and *service*-specific problems, and a prioritization of problems. The MRS shall focus its medical review activities toward the goal of reducing the *claims improper payment rate*. All work performed by the MR unit shall be identified in the MRS and targeted based on the contractor's prioritized problem list *or as directed by CMS.*
F.2	Contractor shall budget and perform the MR workloads throughout the year as established in the MR Strategy. MACs shall report workload volume, and costs associated with MR activities in CMS ARTs or as directed by the COR. *Until the MAC transition is complete*, FIs and Carriers (Legacy contractors) shall continue to 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). For FIs and carriers, 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 if variance amount is <$5,000. MACs shall explain any significant fluctuations in workload or costs in the Monthly Report and SAR.
F.3	Contractor shall perform data analysis continuously to identify potential problems such as aberrant billing practices, potential of over-utilization areas, and changes in patterns of care to target medical review activities *to reduce the claims improper payment rate*. Data from a variety of sources must be used for data analysis. *At a minimum, sources* include: *contractor internal data; CERT*, CMS *program vulnerability alerts such as Quarterly Vulnerability Technical Direction Letters that require corrective action reporting, FATHOM/PEPPER and other comparative billing reports; results from medical review studies performed by specialty MR or Program Integrity contractors; and other national or regional sources such as* Office of Inspector General (OIG) reports, Government Accountability Office (GAO) reports, enrollment data, *and* fraud alerts.
F.4	Contractor shall ensure that effective MR edits are developed and implemented as a result of data analysis findings and policies. The effectiveness of each MR edit shall be analyzed and measured by tracking the denial rate, appeals reversal rate, basis of

Control Number	Control Objectives
	the appeals reversal, and the dollar return on the cost of operationalizing the edit (savings), and success of edit towards billing behavior correction. MR edits shall be modified, deleted, or deactivated when they are determined to no longer be effective.
F.5	Contractor shall utilize the Progressive Corrective Action (PCA**)** process, in accordance with the PIM and CMS instructions, to drive MR activity (i.e., data analysis, claims review, medical review education local policy development).
F.6	Contractor shall be capable of identifying the status of each claim subjected to medical review at any time (and all claims must be processed timely for closure in accordance with PIM instructions).
F.7	Contractors shall develop, revise, and maintain local policies based on data analysis findings as outlined in their MRS to enhance provider/supplier decision-making to accurately bill claims. Local policies must be in the appropriate format in accordance with PIM guidelines.
F.8	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.9	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 and external organizations.
F.10	Contractor shall ensure that there is adequate internal networking and sharing of information, and appropriate collaborative actions are taken as a result, between MR and other business functions such as Appeals, Audits, POE, and inquiries and external organizations such as the ZPIC, RAs, and Quality Improvement Organizations (QIOs).
F.11	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.
F.12	Contractor shall effectively comply with all of the MR requirements of the Joint Operating Agreement (JOA) with the PSCs/ZPICs *and RAs.*
F.13	*Contractor shall institute a corrective action reporting process for claims-specific errors and vulnerabilities in accordance with Change Request 7241. Contractors shall submit either an interim reportable action or final reportable action for each vulnerability. An "interim reportable action" describes how a Medicare contractor is evaluating a vulnerability identified by a RA. A "final reportable action" describes how a Medicare contractor is addressing a vulnerability identified by a RA. All reportable actions shall be quantified with the volume amount identified. CMS must be notified if more than 90 days is required to report corrective actions.*
G – Control Number	**Control Objective - Medicare Secondary Payer (MSP)**
G.1	Internal quality controls are established and maintained that ensure timely and accurate processing of secondary claims submitted, including paper MSP claims, with a primary payer's explanation of benefits (EOB) or remittance advice (RA). This

Control Number	Control Objectives
	includes utilization of the MSPPAY module, resolving all MSP edits (including 6800 codes*), creation of "I"** records and resolving suspended claims. Contractor internal systems used to process MSP claims are updated via the Common Working File (CWF) automatic notice in an automated fashion. *6800 edit codes can be located at: http://www.cms.hhs.gov/manuals/downloads/msp105c06.pdf at Publication # 100-05 (Medicare Secondary Payer Manual) in Chapter 6 (Medicare Secondary Payer CWF Processes). ** "I" records are located at: http://www.cms.hhs.gov/manuals/downloads/msp105c05.pdf This control objective does not pertain to *GHI* or the CRC contractor.
G.2	Audit trails for MSP recoveries (receivables) are maintained. This should also include the contractor's ability to create a complete audit trail if cases are housed or maintained electronically. An audit trail should contain detail to support all accounting transactions as a result of establishing, reconciling and resolving a receivable. For example, an audit trail should establish the identification and creation of the debt through to its resolution including the source of the receivable, reason(s) for adjustment(s), referral to Treasury, and collection of the debt. All correspondence specific to a case should be accessible and in date order.
G.3	Contractors have processes and procedures in place to ensure compliance with all CMS instructions and directives relating to Phase III (MSP Investigations) of the Coordination of Benefits Contracts. This includes transmitting appropriate, timely and complete Electronic Correspondence Referral System (ECRS)*, CWF Assistance Requests and ECRS MSP inquiries as a result of the receipt of a phone call, correspondence, claim or unsolicited check/voluntary refund. All references must be maintained in an area accessible to MSP staff and must be available for CMS review. *The ECRS user guide is located at: http://www.cms.hhs.gov/manuals/downloads/msp105c05_att1.pdf at Publication #100-05 Medicare Secondary Payer Manual in Chapter 5 Contractor Prepayment Processing Requirements.
G.4	Contractors have processes in place to identify and track all incoming correspondence to ensure Budget and Performance Requirements (Title XVIII contractors)/Statement of Work (Medicare Administrative Contractors) task priority compliance and timely response and acknowledgement. These tracking mechanisms should include the ability to track ECRS submissions when awaiting a particular response/status from COBC, or if your ECRS submission may warrant further actions after COBC development/investigation (e.g., claims adjustments).
G.5	Contractors shall have quality assurance measures in place to ensure the accuracy of the implementation of any CMS directive. Contractors shall also provide evidence that the results from quality assurance checks are documented to identify errors and that training venues are implemented to prevent the reoccurrence of these errors.
H – Control Number	**Control Objective - Administrative**
H.1	Contractors shall have a written code of business ethics and conduct. To promote compliance with such code of business ethics and conduct and to ensure that all

Control Number	Control Objectives
	employees comply with applicable laws and regulations, contractors shall appoint a compliance officer, and have an employee business ethics and compliance training program and an internal control system that – 1. Are suitable to the size of the company and extent of its involvement in Government contracting; 2. Facilitate timely discovery and disclosure of improper conduct in connection with Government contracts; and 3. Ensure corrective measures are promptly instituted and carried out.
H.2	Procurements are awarded and administered in accordance with the Medicare Agreement/Contract, CMS regulations, CMS general instructions and the Federal Acquisition Regulation.
H.3	Incoming and outgoing mail shall be properly handled in accordance with published time frames, security guidelines, and in the most cost effective and efficient manner.
H.4	Medicare management structure provides for efficient contract performance and is consistent with business practices.
H.5	Records shall be retained according to guidelines established by CMS and other Federal agencies.
H.6	Internal controls provide reasonable assurance that certain regularly scheduled processes required to support the CMS contractor's continuity of operations in the event of a catastrophic loss of relevant, distinguishable Medicare business unit facilities are performed as scheduled.
I – Control Number	**Control Objective - Provider Audit**
I.1	Interim, tentative and PIP payments to Medicare providers are established, monitored and adjusted, if necessary, in a timely and accurate manner in accordance with CMS general instructions and provider payment files are updated in a timely and accurate manner. Adjustments to interim payments shall be made to ensure that payments approximate final program liability within established ranges. Payment records are adequately protected.
I.2	Information received by the contractor from CMS or obtained from other sources regarding new providers, change of ownership for an existing provider, termination of a provider, or a change of intermediary are identified, recorded, and processed in System Tracking for Audit and Reimbursement (STAR) in a timely and accurate manner and reflected in subsequent audit activities.
1.3	Provider Cost Reports are properly submitted and accepted in accordance with CMS' regulations, policies, and 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

Control Number	Control Objectives
	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

Control Number	Control Objectives
	audit CAPs from the establishment of the CAPs to the implementation and validation of the CAPs.
I.18	HITECH incentive payments for Medicare subsection (d) and critical access hospitals are calculated properly, in accordance with CMS' regulations, policies, and instructions. Data is properly entered into the FISS screens in order for the HITECH system to generate the incentive payments.

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

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

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

Control Number	Control Objectives
	CMS AR Balance Detail, CMS Written-Off/CNC, • Monthly Contractor Financial Report (CMS 1522) and Contractor Draws on Letter of Credit (CMS 1521), • Reconciliation of Cash Balances and Cash Receipts. • HIGLAS-CMS Trial Balance and General Ledger, • HIGLAS-CMS Cash Management Reports, • HIGLAS-CMS Accounts Payable Reports. • HIGLAS-Contractor's Monthly Bank Reconciliation Worksheet
J.1	Financial statements and reports should include all authorized transactions that occurred for the period reported.
J.2	Financial transactions are valid and approved by authorized personnel in accordance with management and CMS' policies.
J.3	Recorded and processed transactions are correctly classified, maintained, summarized and reconciled. In addition, transactions shall be properly supported.
J.4	Segregation of duties exists within the areas of disbursement and collection (i.e., there shall be separate authorization, record keeping, and custody).
J.5	All assets, including cash and accounts receivable should exist and be properly valued and demanded accounts receivable should be properly aged. Accounts receivable should be correctly recorded in the books/records of the contractor.
J.6	All liabilities, including accounts payables should exist and be properly valued. Accounts payable should be correctly recorded in the books/records of the contractor.
J.7	Contractor Financial Reports are accurate, signed/certified by authorized individuals and presented timely to CMS in accordance with Publication (Pub) 100-06 of the Medicare Financial Management Manual, Chapter 5, Financial Reporting, section 230 and/or the HIGLAS Certification Statement.
J.8	Banking information relevant to Medicare processing is accurately stated and conforms to the tripartite agreement.
K – Control Number	**Control Objective - Debt Referral (MSP and Non-MSP)**
K.1	Procedures are documented and followed to identify a debt eligible for referral to Treasury for cross servicing and Treasury Offset Program (TOP) prior to the debt becoming 180 days delinquent. These procedures are written and available for review. Debts eligible for referral and debts ineligible for referral are properly reported on the appropriate CMS Forms 751, Contractor Financial Reports, Status of Accounts Receivable, or the Treasury Report on Receivables and Debt Collection Activities Report. For MSP debt, see Internet Only Manual (IOM), Pub 100-05, MSP Manual, Chapter 7, Section 60. For Non-MSP debt, see IOM, Pub 100-06, Chapter 4,

Control Number	Control Objectives
	Section 70. Financial Reporting for MSP and Non-MSP debt, see also Pub 100-06, Chapter 5.
K.2	Intent to Refer letters (IRLs) for eligible debt are sent in a timely manner in accordance with CMS instructions. Use the MSP and Non-MSP references in K.1 to provide the timeframes for each type of debt.
K.3	Responses to the IRL letter are handled timely according to CMS instructions. Appropriate systems are updated to reflect any changes to the eligibility status of the debt and these statuses are properly reported on the financial reporting forms outlined in K.1. Procedures are in place to handle undeliverable letters. Use the references in K.1.
K.4	Eligible delinquent debt is input to the Debt Collection System (DCS) timely and accurately, including debt type, in accordance with CMS instructions. Use references in K.1.
K.5	Contractor initiated recalls, collections, and adjustments are entered timely and accurately 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. Internal systems and DCS are updated with refund/adjustment information as appropriate and Comments Screen in DCS is annotated, as appropriate.
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, including the Status Code and Comments Screen, and properly report the status and balance of the debt in the financial reporting forms outlined in K.l.
K.8	Contractor has procedures in place to ensure Returned to Agency (RTA) Spreadsheets are completed in accordance with CMS instructions and debts listed on the spreadsheet are properly reported on the financial reporting forms and the DCS in accordance with CMS instructions. Use references in K.1.
L – Control Number	**Control Objective - Non-MSP Debt Collection**
L.1	Demand letters initiate the collection of a provider debt as well as inform the provider of the existence of the debt, their appeal rights with respect to the debt, and the ramifications if the debt is not paid or an agreement is not reached within a specified time period. In addition to the content of the demand letter, the demand letter shall be issued, printed and mailed timely, in accordance with CMS instructions at Pub 100-06, chapters 3 and 4.
L.2	Extended Repayment Schedules (ERSs) shall be analyzed for approval or denial. A supervisor, in accordance with CMS instructions, reviews all ERSs. This includes monitoring all approved ERSs, the complete financial analysis of the provider's application, and the referral to CMS when necessary in accordance with CMS

Control Number	Control Objectives
	instructions at Pub 100-06, Chapters 3 and 4.
L.3	Interest is applied correctly and timely in accordance with CMS instructions. The interest rate is updated/changed in accordance with the notice of the new interest rate for Medicare Overpayments and Underpayments notification. When necessary, interest adjustments are calculated correctly and processed and applied in a timely manner in accordance with CMS instructions at Pub 100-06, Chapters 3 and 4.
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 in accordance with CMS instructions at Pub 100-06, Chapters 3 and 4.
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 in accordance with CMS instructions at Pub 100-06, Chapters 3 and 4.
L.6	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 in accordance with CMS instructions at Pub 100-06, Chapter 12.
L.7	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 in accordance with CMS instructions at Pub 100-06, Chapters 3 and 4.
L.8	For overpayments subject to the limitation on recoupment of section 935(f)(2) of the Medicare Modernization Act (MMA), recoupment is stopped when, a timely and valid first level appeal request (redetermination), or a second level (reconsideration) request is received from a provider or supplier on an overpayment subject to these limitations. During the appeal process, the contractor cannot recoup or demand the debt; however, the debt continues to age. Once both levels of appeal are completed and CMS prevails, collection activities, including demand letters and internal recoupment may resume within the timeframes set forth. Contractors will calculate the 935(f)(2) interest if the provider prevails (wholly (full) or partially favorable decision) at the ALJ or subsequent levels. This does not apply to Part A cost report overpayments. Interest continues to accrue: Refer to Publication 100.06 Chapter 3, section 200.
M – Control Number	**Control Objective - Provider Enrollment**
M.1	Review the Medicare enrollment applications (paper CMS-855 or Internet-based Provider Enrollment Chain and Ownership System enrollment application) and take appropriate action in accordance with CMS guidelines in the Publication 100-*0*8, Chapters 15 of the Program Integrity Manual (PIM).
M.2	Reassignments of benefits are made in accordance with *Publication 100-04,* section 30.2 of the Medicare Claims Processing Manual and *Publication 100-08, Chapter 15,*

Control Number	Control Objectives
	section *15.5.20*, of the PIM.
M.3	Billing arrangements are in accordance with *Publication 100-04, Chapter 1,* section 30.2 of the Medicare Claims Processing Manual.

60.2 List of Appendices

(Rev.228, Issued: 09-27-13, Effective: 10-01-13, Implementation: 10-28-13)

Appendix 1 - Key Contacts

Add key contacts for respective cycle memo contacts, especially for the key controls.

Appendix 2 – Flowcharts

Documenting transaction flows accurately is one of the most important steps in the assessment process, as it provides the foundation for all subsequent work. Thorough, well written documents and flowcharts can facilitate the review of key controls. Add flow charts for respective areas to reflect an understanding from beginning to end of the underlying processes. These would be the processes for initiating, authorizing, recording, processing, and reporting accounts and transactions that affect the operations for financial reports. The documentation should start with the collection and review of documentation that already exists. Some examples of existing documentation are:

- Policy and procedure manuals;
- Accounting manuals;
- Cycle memos;
- Memoranda;
- Flowcharts;
- Job descriptions, and
- Other.

Appendix 3 - Applicable Laws and Regulations

The first step in documenting internal controls is to identify significant provisions of laws and regulations that could have a direct and material effect on the processes described in the cycle memo. The following laws and regulations affect the Financial Reporting cycle. They are provided as examples. The CMS contractor can add or delete as necessary:

1. **OMB Circular A-123, Appendix A Management's Responsibility for Internal Control**

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

2. **Chief Financial Officers Act of 1990 (CFO Act)**

   Requires Federal agencies to prepare and have audited financial statements for many agency components and operations.

3. **Federal Managers' Financial Integrity Act (FMFIA)**

   Requires entities to provide assurance as to agency management control and agency compliance with Federal management system requirements by December 31 of each year.

4. **Federal Financial Management Improvement Act of 1996 (FFMIA)**

   Requires agencies to implement and maintain financial management systems that comply substantially with Federal financial management systems requirements, applicable Federal

accounting standards, and the United States Government Standard General Ledger at the transaction level.

Appendix 4 - Key Information Technology Systems and Repositories

For each cycle memo, the contractor should oversee the identification and documentation of application systems and systems processing environments. The structure should include processes such as computer operations and change management. It is critical that technology-based (automated) controls are assessed and key controls in the IT system design are identified. The CMS contractor relies on IT systems to process financial transactions and report the associated financial information. To support the assessment of ICOFR, the contractor should ensure that applicable IT system components, such as automated calculations, accumulations, interfaces, and reports are operating effectively. The CMS contractor shall show applicable key information technology systems as they relate to its respective operation.

Appendix 5 – Initial CAP Report Template

	QUARTERLY CORRECTIVE ACTION PLAN REPORT									
Contractor Name:										
Contractor Number:										
Date of Submission:										
Contact Person Name:										
Contact Person Email:										
Contact Person Phone#										
President and CEO Name:										
President and CEO Signature:										
CMS Finding Number	Repeat/Duplicate Finding Numbers	Control Objective(s) Impacted	Exception/Finding/Material Weakness	Responsible Individual Name	Responsible Individual Email Address	Responsible Individual Phone Number	Corrective Action Procedure(s)	Target Completion Date	Actual Completion Date	Update/Status of CAP