CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 256	**Date: October 16, 2015**
	Change Request 9320

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 Controls over Financial Reporting.

EFFECTIVE DATE: November 17, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 17, 2015

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/60.2/Appendix 5/CMS CAP Report Template
R	7/10.1.5/GAO Standards for Internal Controls in the Federal Government
R	7/30.2/Certification Statement
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 CMS Contractor Control Objectives
R	7/60.1/CMS Contractor Cycle Memo Outline
R	7/60.2/List of Appendices

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 256	Date: October 16, 2015	Change Request: 9320

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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 the Centers for Medicare and Medicaid Services (CMS) to meet 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. 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	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9320.1	All contractors shall provide written notification to your Associate Regional Administrator for Financial Management and Fee for Service Operations, RO CFO Coordinator, and the COR of the MAC. RDS and MSPCRC shall send to the CMS COR.	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC
9320.2	All contractors shall provide an Initial and Quarterly CAP Report including the data explained below using the excel template located in Section 60.2 Appendix 5 and 6, in addition to a Field Legend providing field completion instructions.	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC
9320.2.1	All contractors shall complete the following field from the CMS CAP Report Template:	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Contractor - The abbreviated name assigned to the Medicare Administrative Contractor (MAC), Shared System Maintainer (SSM), Data Center, RDS or MSPRC see tables 2, 3, and 4 in section 40.3.									
9320.2.2	All contractors shall complete the following field from the CMS CAP Report Template: Fiscal Year (XX) – The last two digits of the fiscal year reviewed/audited (e.g., FY 2016 would be entered as 16).	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC
9320.2.3	All contractors shall complete the following field from the CMS CAP Report Template: Review/Audit Type – Refer to Section 40.3 Table 1 to identify the code for the review or audit type performed.	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC
9320.2.4	All contractors shall complete the following field from the CMS CAP Report Template: CAP No. – Sequential three digit number (starting with 001) issued by the auditor/reviewer (or assigned by the contractor if it is a CPIC material weakness) for each finding type.	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC
9320.2.5	All contractors shall complete the following field from the CMS CAP Report Template: Jurisdiction Identifier – Applicable to MACs only-refer to Section 40.3 Table 2 for jurisdiction code.	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC
9320.2.6	All contractors shall complete the following field from the CMS CAP Report Template: Repeat Cap – Indicate if original CAP has any repeat CAPs (“Yes”/”No”).	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC
9320.2.7	All contractors shall complete the following field from the CMS CAP Report Template: CAP Description – A description of the planned remediation strategy to eliminate or mitigate the deficiency identified. The CAP should address the root cause of the deficiency.	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9320.2.8	All contractors shall complete the following field from the CMS CAP Report Template: Progress Milestones – Sequentially numbered specific action-oriented steps that facilitate the CAP progress for each deficiency being remediated. Progress milestones shall not change once established. Any revision to an original progress milestone shall be documented in the "2. CAP Description" column and considered an amendment to the original progress milestone. Any changes to the original CAP shall be submitted to CMS for approval by the Business Owner. All steps (milestones) shall be included in one cell.	X	X		X					BCRC, CDS, CRC, RRB-SMAC, STC
9320.2.9	All contractors shall complete the following field from the CMS CAP Report Template: Original Target Completion Date – A target completion date must be assigned to every CAP and progress milestone within the CAP to include (MM/DD/YYYY). The target date shall not change once it is recorded.	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC
9320.2.10	All contractors shall complete the following field from the CMS CAP Report Template: Revised Target Completion Date – If the original target completion date is revised; the revised date should be included in this column and the reason for the revision should be documented in column "2. CAP Description" (MM/DD/YYYY). Note all changes in the original target completion date shall be submitted to CMS for approval by the Business owner.	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC
9320.2.11	All contractors shall complete the following field from the CMS CAP Report Template: Actual Completion Date – An actual completion date shall be recorded for every CAP and progress milestone within the CAP to include (MM/DD/YYYY) the remediation of the deficiency was validated as effective.	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC
9320.2.12	All contractors shall complete the following field from the CMS CAP Report Template:	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CAP Status – A status reflecting the disposition of the CAP must be assigned and updated as necessary for each deficiency being remediated. Status options for deficiencies assessment include: i. Open – Remediation efforts are in progress and the target completion date has not passed; ii. Delayed – Remediation efforts are in progress after the original target completion date has passed. Explanations/justifications for delayed status must be documented in the CAP; iii. Closed – Pending – Verification and validation efforts have been completed and the CAP is awaiting closure by the issuing party (e.g., SSAE 16 Auditor, A-123 Assessor). iv. Closed – Validation and verification procedures demonstrate remediation efforts were adequately addressed, proven effective, and remediation efforts have been closed by issuing party; and v. Cancelled – Remediation efforts have ceased because the remediation was recorded inadvertently or erroneously, or it can be demonstrated that the remendiation effort is no longer relevant. Explanations/justifications for cancelled statuses must be documented in the CAP and approved by the Business Owner.									
9320.2.13	All contractors shall complete the following field from the CMS CAP Report Template: CAP Lead 1 - Individual responsible for managing corrective action efforts must be assigned and documented for each deficiency being remediated.	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC
9320.2.14	All contractors shall complete the following field from the CMS CAP Report Template: Executive Sponsor 1 – The senior executive official accountable for the deficiency and the associated CAP must be documented for each deficiency requiring a CAP.	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC
9320.2.15	All contractors shall complete the following field from	X	X		X					BCRC, CDC,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the CMS CAP Report Template: Root Cause Analysis (RCA) Methodology – RCA is the examination process used to determine the underlying events(s) that cause the deficiency; the approach technique used to uncover causes of problems. Also, RCA can be seen as the process utilized to help identify what, how, and why an event occurred so that steps can be taken to prevent future occurrences. RCA documentation should be available upon request from the CAP Lead and include the decision process used to determine the RCA approach, and all supporting documentation (e.g. walk through documentation, meeting minutes, various dates analysis, emails, etc.).									CRC, RRB-SMAC, STC
9320.2.16	All contractors shall complete the following field from the CMS CAP Report Template: Progress Milestone Status – Each progress milestone must have an assigned status reflecting its disposition. Status options for deficiencies include: i. Open – Remediation efforts are in progress and the target completion date has not passed; ii. Delayed – Remediation efforts are in progress and after the original target completion date has passed. Explanations/justifications for delayed status must be documented in the CAP; iii. Closed – Pending – Verification and validation efforts have been completed and the CAP is awaiting closure by the issuing party (e.g., SSAE 16 Auditor, A-123 Assessor); iv. Closed – Validation and verification procedures demonstrate remediation efforts were adequately addressed, proven effective, and remediation efforts have been closed by issuing party; and v. Cancelled – Remediation efforts have ceased because the remediation was recorded inadvertently or erroneously, or it can be demonstrated that the remendiation effort is no longer relevant. Explanations/justifications for cancelled statuses must be documented in the CAP and approved by the	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Business Owner.									
9320.3	All contractors 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; however, the column width and row height may be adjusted to accommodate data entry. 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 template can be found in Appendix 5.	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC
9320.4	All contractors shall use the Quarterly CAP Report as an Excel spreadsheet and add their data accordingly. Changes are only allowed to be made to the column width and row height to accommodate data entry. Additionally, this electronic file shall be labeled Quarterly CAP Report, should be identified using the contractor abbreviations found in section 40.3, and shall include the submission date. For example, Wisconsin Physicians Service Insurance Corporation (WPS) would name this file "WPS Quarterly CAP Report 10/30/XX.xls". The Quarterly CAP Report template can be found in Appendix 5.	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC
9320.5	All contractors shall follow Control Number 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 120 days delinquent. These procedures are written and available for review. Debts eligible for referral and debts ineligible for referral are properly reported on the appropriate CMS Forms 751, Contractor Financial Reports, Status of Accounts Receivable, or the Treasury Report on Receivables and Debt Collection Activities Report. For MSP debt, see Internet Only Manual (IOM), Pub 100-05, MSP Manual, Chapter 7, Section 60. For Non-MSP debt, see IOM, Pub 100-06, Chapter 4, Section 70. Financial Reporting for MSP and Non-MSP debt, see also Pub 100-06, Chapter 5; and previously issued CMS guidance via technical direction letter regarding MSP	X	X		X					BCRC, CDC, CRC, RRB-SMAC, STC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Duplicate Primary Payment (DPP) ARs following non-MSP financial activities and reporting on TROR.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		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, Jamie Burke, 4107866848 or jamie.burke@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Financial Management Manual

Chapter 7 - Internal Control Requirements

Table of Contents

(Rev.256, Issued: 10-16-15)

10.1.5 - GAO Standards for Internal Controls in the Federal Government

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

The FMFIA requires the Government Accountability Office (GAO) to issue standards for internal control in government. GAO's "Standards for Internal Controls in the Federal Government" were updated in *September 2014*. The standards provide the overall framework for establishing and maintaining internal control and for identifying and addressing major performance and management challenges as well as areas of greatest risk of fraud, waste, abuse, and mismanagement. These are the internal control standards that CMS and its contractors must follow.

30.2 - Certification Statement

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

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

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

Dear Chief Financial Officer:

As the (Chief Financial Officer and Vice President of (contractor name), we are writing to provide certification of reasonable assurance for the period October 1 through June 30 that (contractor name) internal controls are in compliance with the Federal Managers' Financial Integrity Act (FMFIA) and Chief Financial Officers (CFO) Act by incorporating internal control standards into our operations. We are also providing an unqualified [or qualified] statement of assurance that (contractor name) has effective internal controls over financial reporting in compliance with revised OMB Circular A-123, Appendix A [except for the SSAE 16 Section I finding(s) and/or material weakness(es) identified in the attached Report of Material Weaknesses].

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

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

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

We have included a description of our risk assessment analysis and our CPIC Report of Material Weaknesses. This letter and attachments summarize the results of our review.
We also understand that officials from the Centers for Medicare & Medicaid Services, Office of Inspector General, Government Accountability Office, or any other appropriate Government agency have authority to request and review the working papers from our evaluation.

Sincerely,

(Chief Financial Officer Signature)

(Vice President for (type of program) Signature

30.7 - Material Weaknesses Identified During the Reporting Period

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

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. (See section 40.4). Within that same time frame *MACs and DME MACs* are required to provide written notification, to your Associate Regional Administrator for Financial Management and Fee for Service Operations, RO CFO Coordinator, and the COR of the MAC or DME MAC. *RDS and MSPCRC shall send to the CMS COR.*

40 - Corrective Action Plans

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

The CMS conducts various financial management and *information technology (IT)* 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 *information technology (IT)* 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.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

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 electronic receipt of the final report, the contractor is required to submit an Initial CAP Report, using the excel Initial CAP Report. The Internal Control Team developed an excel format that is 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. When submitting the Initial CAP Report, the email subject line shall denote the following information: Initial CAP Report, IOM entity abbreviated name (see section 40.3, Table I), jurisdiction code, and reporting due date.

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). All entities shall submit an Initial CAP Report even if the entity has no new findings. If there are no findings, this should be annotated on the Initial CAP Report. 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 that have not been closed through an official CMS CAP closure letter and provide updates to the actions taken to resolve the findings. All entities shall submit a Quarterly CAP Report even if the entity has no CAPs. If there are no open CAPs, this must be annotated on the Quarterly CAP Report. Only one Quarterly CAP Report shall be submitted for each jurisdiction that shall include all FYs and review types, i.e., SSAE 16 audits, A-123 reviews, CFO audits, etc.

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. When submitting the Quarterly CAP report, the email subject line shall denote the following information: Quarterly CAP Report, IOM entity abbreviated name (see section 40.3, Table I), jurisdiction code, and reporting due date. The Quarterly CAP Report shall address all open findings, as well as continue to report information on all findings reported as *closed* 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 COR. 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.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

The Initial or Quarterly CAP Report shall include the data explained below using the excel template *located in Section 60.2 Appendix 5; in addition to a Field Legend providing field completion instructions*. 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:

A. Contractor - The *abbreviated name* assigned *to the Medicare Administrative Contractor (MAC), Shared System Maintainer (SSM), Data Center, RDS or MSPRC see tables 2, 3, and 4 in section 40.3.*

B. Fiscal Year (XX) – The last two digits of the fiscal year reviewed/audited (e.g., FY 2016 would be entered as 16).

C. Review/Audit Type – Refer to Section 40.3 Table 1 to identify the code for the review or audit type performed.

D. CAP No. – Sequential three digit number (starting with 001) issued by the auditor/reviewer (or assigned by the contractor if it is a CPIC material weakness) for each finding type.

E. Jurisdiction Identifier – Applicable to MACs only-refer to Section 40.3 Table 2 for jurisdiction code.

F. Repeat Cap – Indicate if original CAP has any repeat CAPs ("Yes"/"No").

G. CAP Repeat Number – For Quarterly CAP reporting, if a finding is repeated or duplicated in subsequent years or reported in more than one type of review, provide all other *CAP ID Nos.* 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. Repeat finding numbers shall only be reported in the *"CAP ID Number"* column in the Initial CAP Report for new repeat findings identified. For the Quarterly CAP Report, the *"CAP ID Number"* column will be populated with the primary (original) finding number only. The primary finding number is the finding number that was identified first. If in subsequent audit/*review*, 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 primary (original) finding number so that the findings can be easily linked.

H. 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. *Note the CMSR number should not be reported in this field.*

I. Deficiency Description - 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.

J. Deficiency Classification – This column is reserved for use by the CMS internal control team.

1. *CAP ID No. - This field represents the unique identification number assigned to each deficiency requiring a CAP (formula driven).*

2. *CAP Description – A description of the planned remediation strategy to eliminate or mitigate the deficiency identified. The CAP should address the root cause of the deficiency.*

3. *Progress Milestones – Sequentially numbered specific action-oriented steps that facilitates the CAP progress for each deficiency being remediated. Progress milestones shall not change once established. Any revision to an original progress milestone shall be documented in the "2. CAP Description" column and considered an amendment to the original progress milestone. Any changes to the original CAP shall be submitted to CMS for approval by the Business Owner. All steps (milestones) shall be included in one cell.*

4. *Original Target Completion Date – A target completion date must be assigned to every CAP and progress milestone within the CAP to include (MM/DD/YYYY). The target date shall not change once it is recorded.*

5. *Revised Target Completion Date – If the original target completion date is revised ; the revised date should be included in this column and the reason for the revision should be documented in column "2. CAP Description" (MM/DD/YYYY). Note all changes in the original target completion date shall be submitted to CMS for approval by the Business owner.*

6. *Actual Completion Date – An actual completion date shall be recorded for every CAP and progress milestone within the CAP to include (MM/DD/YYYY) the remediation of the deficiency was validated as effective.*
7. *CAP Status – A status reflecting the disposition of the CAP must be assigned and updated as necessary for each deficiency being remediated. Status options for deficiencies assessment include:*

    i. ***Open*** *– Remediation efforts are in progress and the target completion date has not passed;*

    ii. ***Delayed*** *– Remediation efforts are in progress after the original target completion date has passed. Explanations/justifications for delayed status must be documented in the CAP;*

    iii. ***Closed*** *–* ***Pending*** *– Verification and validation efforts have been completed and the CAP is awaiting closure by the issuing party (e.g., SSAE 16 Auditor, A-123 Assessor).*

    iv. ***Closed*** *– Validation and verification procedures demonstrate remediation efforts were adequately addressed, proven effective, and remediation efforts have been closed by issuing party; and*

    v. ***Cancelled*** *– Remediation efforts have ceased because the remediation was recorded inadvertently or erroneously, or it can be demonstrated that the remediation effort is no longer relevant. Explanations/justifications for cancelled statuses must be document in the CAP and approved by the Business Owner.*

8. *CAP Lead 1 - Individual responsible for managing corrective action efforts must be assigned and documented for each deficiency being remediated.*

9. *CAP Lead 2 – Not applicable to Medicare Contractors.*

10. *CAP Lead 3 – Not applicable to Medicare Contractors.*

11. *Executive Sponsor 1 – The senior executive official accountable for the deficiency and the associated CAP must be documented for each deficiency requiring a CAP.*

12. *Executive Sponsor 2 – Not applicable to Medicare Contractors.*

13. *Executive Sponsor 3 – Not applicable to Medicare Contractors.*

14. *Testing Document Reference – Not applicable to Medicare Contractors.*

15. *Sport/Prosight Identifier – Not applicable to Medicare Contractors.*

16. *Root Cause Analysis (RCA) Methodology – RCA is the examination process used to determine the underlying events(s) that cause the deficiency; the approach technique used to uncover causes of problems. Also, RCA can be seen as the process utilized to help identify what, how, and why an event occurred so that steps can be taken to prevent future occurrences. RCA documentation should be available upon request from the CAP Lead and include the decision process used to determine the RCA approach, and all supporting documentation (e.g. walk through documentation, meeting minutes, various dates analysis, emails, etc.).*

17. *Not for use by contractor*

18. *Progress Milestone Status – Each progress milestone must have an assigned status reflecting its disposition. Status options for deficiencies include:*

    i. ***Open*** *– Remediation efforts are in progress and the target completion date has not passed;*

    ii. ***Delayed*** *– Remediation efforts are in progress and after the original target completion date has passed. Explanations/justifications for delayed status must be documented in the CAP;*

    iii. ***Closed*** *–* ***Pending*** *– Verification and validation efforts have been completed and the CAP is awaiting closure by the issuing party (e.g., SSAE 16 Auditor, A-123 Assessor).;*

    iv. ***Closed*** *– Validation and verification procedures demonstrate remediation efforts were adequately addressed, proven effective, and remediation efforts have been closed by issuing party; and*

    v. ***Cancelled*** *– Remediation efforts have ceased because the remediation was recorded inadvertently or erroneously, or it can be demonstrated that the remediation effort is no longer relevant. Explanations/justifications for cancelled statuses must be document in the CAP and approved by the Business Owner.*

40.3 - CMS Finding Numbers

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

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.

Table 1 - **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;
- M - CMS’ CPIC reviews;
- 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 *2* - CONTRACTOR ABBREVIATIONS

Cahaba Government Benefit Administrators, LLC (*JJ* A/B MAC)	CAHJ
CGI Federal, Inc. (CGI) Commercial Repayment Center (CRC) *(MSPRC)*	CGI
CGS Administrators, LLC (J15 A/B MAC)	CGSJ
CGS Administrators, LLC, Durable Medical Equipment (DME) MAC JC	CGSD
First Coast Service Options, Inc. (JN A/B MAC)	FCSOJ
Group Health Inc. (GHI) Benefits Coordination and Recovery Center (BCRC) *(MSPRC)*	GHI
National Government Services, Inc. (J6 and JK A/B MAC)	NGSJ
National Government Services, Inc. DME MAC JB	NGSD
NHIC, Corp. DME MAC JA	NHICD
Noridian Healthcare Solutions (JE 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. (JH and JL A/B MAC)	NOVJ
Palmetto Government Benefits Administrators (*JM* A/B MAC)	PGBAJ
Provider Resources, Inc. (PRI) Workers' Compensation Review Contractor (WCRC) (MSPRC)	*PRI*
Railroad Retirement Board Specialty MAC (SMAC)	RRBS
Wisconsin Physicians Service Insurance Corporation (J5 and J8 A/B MAC)	WPSJ
Retiree Drug Subsidy (*GDIT*) (Part D Contractor)	RDSV
Retiree Drug Subsidy Contact Center (RDSCC)	RDSC

Table *3* - SHARED SYSTEM MAINTAINER ABBREVIATIONS

Common Working File	CWF
Data Computer Corporation of America	*DCCA*
Multi-Carrier System	MCS
General Dynamics Information Technology	*GDIT*

Table *4* – DATA CENTER ABBREVIATIONS

Companion Data Services (CDS) (*V*DC)	CDS
CMS Central Office (*V*DC, 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
General Dynamics Information Technology /GHI (New York, NY)	*GDIT*

40.4 - Initial CAP Report

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

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*; however, the column width and row height may be adjusted to accommodate data entry.* 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 *template* can be *found in Appendix 5*.

40.5 - Quarterly CAP Report

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

The contractor shall use the Quarterly CAP Report, as an Excel spreadsheet and add their data accordingly, *changes are only allowed to be made to the column width and row height to accommodate data entry*. Additionally, this electronic file shall be labeled Quarterly CAP Report, should be identified using the contractor abbreviations found in section 40.3, and shall include the submission date. For example, Wisconsin Physicians Service Insurance Corporation (WPS) would name this file "WPS Quarterly CAP Report 10/30/XX.xls".

The Quarterly CAP Report *template* can be *found in Appendix 5*.

50 – List of CMS Contractor Control Objectives

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

Control Number	Control Objectives
A - Control Number	**Control Objective - Information Systems**
A.1	An entity-wide security program has been documented, approved and monitored by management in accordance with the CMS 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 the classifications 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 system hardware 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

Control Number	Control Objectives
	include monitoring of employee system activities by management with documentation maintained to provide evidence of management's monitoring and review process.
A.13	A regular risk assessment of the criticality and sensitivity of computer operations, including all network components, IT platforms and critical applications has been established and updated annually. The assessment includes identification of threats, known system vulnerabilities, system flaws, or weaknesses that could be exploited by threat sources.
A.14	A centralized risk management focal point for IT risk assessment has been established that includes promotion awareness programs, processes and procedures to mitigate risks and monitoring processes to assess the effectiveness of risk mitigation programs.
A.15	A risk assessment and systems security plan has been documented, approved, and monitored by management in accordance with the CMS Risk Assessment and Systems Security Plan Methodologies.
A.16	Regularly scheduled processes required to support the CMS 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.

Control Number	Control Objectives
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.
C – Control Number	**Control Objective - Appeals**
C.1	Medicare Part A and Part B redeterminations processed by 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 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. 100-09, 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

Control Number	Control Objectives
	Chapter 2-20.1 Telephone Inquiries; IOM Pub. 100-09, Chapter 6-Provider Customer Service Program).
E – Control Number	**Control Objective - Complementary Credits**
E.1	Contractors shall report cash received from the BCRC for COBA crossover claims as the cash is received in the CMS Analytical, Reporting, & Tracking system (CMS ART).
	.
F – Control Number	**Control Objective - Medical Review (MR)**
F.1	Contractor shall use the Program Integrity Manual 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. 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; 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 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 Pub. 100-08 and CMS instructions, to drive MR activity (i.e., data analysis, claims review, medical review education, and local policy

Control Number	Control Objectives
	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 Pub. 100-08 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, Recovery Auditors, 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 Recovery Auditors.
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 Recovery Auditor. A “final reportable action” describes how a Medicare contractor is addressing a vulnerability identified by a Recovery Auditor. All reportable actions shall be quantified with the volume amount identified. The 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 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.

Control Number	Control Objectives
	*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 BCRC 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 an outstanding debt. 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 MSP Investigations by the Benefit Coordination & Recovery Center (BCRC). 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 Statement of Work (Medicare Administrative Contractors and other Medicare 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 BCRC, or if your ECRS submission may warrant further actions after BCRC 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 (for example, (but not limited to) A-123, CFO, SSAE 16, QASP, etc).
H – Control Number	**Control Objective - Administrative**
H.1	Contractors shall have a written code of business ethics and conduct. To promote compliance with such code of business ethics and conduct and to ensure that all employees comply with applicable laws and regulations, contractors shall appoint a

Control Number	Control Objectives
	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 review.

Control Number	Control Objectives
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

Control Number	Control Objectives
	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: o A/P Detail Schedule of Entitlement Payables Due & Payable-Refunds Payable (216006), o A/P Detail Schedule of Entitlement Payables Due & Payable-Top Offsets (216097), o A/P Detail Schedule of Entitlement Payables Due & Payable-Settlement Matching (216098), o A/P Detail Schedule of Entitlement Payables Due & Payable-Third Party Payer (216099), • 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

Control Number	Control Objectives
	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 120 days delinquent. These procedures are written and available for review. Debts eligible for referral and debts ineligible for referral are properly reported on the appropriate CMS Forms 751, Contractor Financial Reports, Status of Accounts Receivable, or the Treasury Report on Receivables and Debt Collection Activities Report. For MSP debt, see Internet Only Manual (IOM), Pub 100-05, MSP Manual, Chapter 7, Section 60. For Non-MSP debt, see IOM, Pub 100-06, Chapter 4, Section 70. Financial Reporting for MSP and Non-MSP debt, see also Pub 100-06, Chapter 5; and previously issued CMS guidance via technical direction letter regarding MSP Duplicate Primary Payment (DPP) ARs following non-MSP financial activities and reporting on TROR. *For DME MACs, see recently issued CMS Change Request regarding Data Act Treasury Referral Timeframe and Reporting.*
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

Control Number	Control Objectives
	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 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

Control Number	Control Objectives
	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 100-08, 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, 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.

60.1 - CMS Contractor Cycle Memo Outline

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

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

Section I. Objective

The objective of the cycle memo is to describe the preparation and reporting of financial processes performed by the CMS contractor.

Section II. Introduction

The purpose of the introduction is to provide sufficient background on the process. An example of an introduction would be: The CMS utilizes contractors to manage and administer the Medicare program. Medicare contractor financial reports provide a method of reporting financial activities by the contractors as required by the Chief Financial Officers (CFO) Act of 1990. The CMS contractors are required to maintain accounting records in accordance with government accounting principles and applicable government laws and regulations.

Section III. Interface with Other Cycles

The contractor shall show what cycle memos interface or relate to other cycle memos such as the accounts receivable, accounts payable, claims expense or other. Contractors may combine related cycles such as the accounts payable and claims expense.

Section IV. Current Environment

The purpose of the current environment is to describe the processes in place and to identify the controls within those processes. The Medicare contractor financial reporting environment should show that it has established and maintained an effective commitment to internal controls over financial reporting. Internal

controls shall be established and assessments shall be designed to provide reasonable assurance and confidence those obligations and costs are in compliance with applicable laws and regulations. Funds and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation. Revenues and expenditures applicable to the operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over assets.

60.2 List of Appendices

(Rev.256, Issued: 10-16-15 Effective: 11-17-15, Implementation: 11-17-15)

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, Management's Responsibility for Internal Control, Appendix A, *Internal Control Over Financial Reporting***

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

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

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

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

Requires entities to provide *annual* assurance as to agency management control and agency compliance with Federal management system requirements.

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 – *CMS* CAP Report Template