CMS Manual System

Pub 100-06 Medicare Financial Management

Transmittal 95

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: APRIL 28, 2006

Change Request 4334

NOTE: This instruction is being re-issued as a correction to correct the issue date that appears in the manual instruction. The issue date has been corrected and this instruction will maintain the same transmittal number. All other information remains the same.

SUBJECT: Chapter 7, Internal Control Requirements Update

I. SUMMARY OF CHANGES: This document updates the Internal Control Objectives and changes the Certification Package for Internal Controls (CPIC) due date to August 1. Also, see below for additional Internal Control edits and clarifications.

NEW/REVISED MATERIAL
EFFECTIVE DATE: May 30, 2006
IMPLEMENTATION DATE: May 30, 2006

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

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

R/N/D	Chapter / Section / SubSection / Title
R	7/Table of Contents
R	7/10/Introduction
R	7/10.1/Authority
R	7/10.1.4/OMB Circular A - 123
R	7/20.1/Risk Assessment
N	7/20.1.1/Risk Analysis Chart
R	7/20.2/Internal Control Objectives
R	7/20.2.1/FY2006 Medicare Control Objectives

R	7/20.3/Policies and Procedures
R	7/20.4/Control Activities
R	7/20.5/Testing Methods
R	7/20.6/Documentation and Working Papers
R	7/30.1/ Requirements
R	7/30.2/Certification Statement
R	7/30.3/Executive Summary
R	7/30.4/CPIC Report of Material Weaknesses
R	7/30.5/CPIC Report of Reportable Conditions
R	7/30.6/Definitions of Reportable Conditions and Material Weaknesses
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	7/40.6/Entering Data into the Initial or Quarterly CAP Report
N	7/50/List of FY 2006 Medicare Control Objectives

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirement

Pub. 100-06	Transmittal: 95	Date: April 28, 2006	Change Request 4334

NOTE: This instruction is being re-issued as a correction to correct the issue date that appears in the manual instruction. The issue date has been corrected and this instruction will maintain the same transmittal number. All other information remains the same.

SUBJECT: Chapter 7, Internal Control Requirements Update

I. GENERAL INFORMATION

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

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

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4334.1	Medicare contractors shall prepare a separate assurance statement on the effectiveness of internal control over financial reporting.	X	X	X	X					
4334.2	Medicare contractors should use the New Risk Analysis Chart as a tool for selecting the high-risk activities within their organization.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4334.3	Medicare contractors shall have written policies and procedures regarding their overall CPIC process. See section 30.1.	X	X	X	X					
4334.4	Medicare contractors shall submit all electronic CPIC Reports on or before August 1, 2006. The CPIC Reporting period is September 1, 2005 through June 30, 2006. Medicare contractors shall submit an update for the period July through September to report subsequently identified material weakness. See section 30.1 for detailed guidelines.	X	X	X	X					
4334.5	The Medicare contractor shall not submit a hard copy report if it has the capability to insert electronic signatures.	X	X	X	X					
4334.6	The total number of material weaknesses shall be reported under column one: CMS Finding Number. The type of finding shall be reported in Column nine: Original Source of Findings See section 30.6. The Repeat/Duplicate finding number shall not be recognized. This column was deleted from the Example Report of Material Weaknesses.	X	X	X	X					
4334.7	The Medicare contractor shall report the total number of reportable conditions in the CPIC Executive Summary. See section 30.6.	X	X	X	X					
4334.8	The Medicare contractor shall report all material weaknesses and/or SAS 70 findings on the Report of Material Weaknesses. See section 30.7.	X	X	X	X					
4334.9	The Medicare contractors shall not submit the original hardcopy of the Initial and Quarterly CAP reports that have been signed by the VP and submitted from the VP's email.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4334.10	The Medicare contractor shall implement the CMS control objectives at section 50.	X	X	X	X					
4334.11	The Statement on Auditing Standards Number 70 (SAS 70) previously called a review, shall be called a SAS 70 *audit.*	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
N/A										

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: May 30, 2006 **Implementation Date:** May 30, 2006 **Pre-Implementation Contact(s):** Ellen L. McNeill, 410-786-7911 or Paul Konka, 410-786-7842. **Post-Implementation Contact(s):** Same	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Financial Management Manual
Chapter 7 - Internal Control Requirements

Table of Contents
(Rev. 95, 04-28-06)

10 - Introduction

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

10.1 - Authority

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

10.1.4 - OMB Circular A-123

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

20.1 - Risk Assessment

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

- Direction for what areas should get priority attention from management due to the nature, sensitivity and importance of the area's operations;

- A preliminary judgment from managers about the adequacy of existing internal control policies and procedures to minimize or detect problems; and

- An early indication of where potential internal control weaknesses exist that should be corrected.

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

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

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

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

- Who - List who is involved and state their roles and responsibilities.

- Where - List the geographical location(s) for which the certification applies. For multi-site contractors, review and explain the roles for all sites, i.e., do they do their own risk assessment and control objective testing.

- What – Describe the risk factors and the risk assessment process.

- When - List when the risk assessment process was completed.

- Why – Prioritize the risk areas to ensure that high-risk *control* objectives are reviewed first.

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

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

Step 1 - Segment Operations

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

Step 2 - Prioritize Risk and Exposure Factors

Identify the primary risks and exposure factors that could jeopardize the achievement of the goals and objectives of the unit as well as the organization's ability to achieve the objectives of reliable financial reporting, safeguarding of assets, and compliance with budget, laws, regulations and instructions. Risk and exposure factors can arise due to both internal and external circumstances. Document the definitions and methodology of the risk and exposure factors used in the risk assessment process.

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

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

Assign a score to each cell based on the methodology predetermined. *Retain notes to support scoring of key risk factors such as "prior audits" and factors that are scored very high or very low. This will assist CMS in evaluating the reasonableness of your risk assessment results.* Total the scores for each line item *(control objective)*. The higher scores for each line item will prioritize the risk areas for consideration to be reviewed to support the CPIC. *If a high risk control objective is included in a current year Type II*

SAS 70 audit, rely on the SAS 70 testing and document this as the rationale for excluding it from testing.

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

20.1.1- Risk Analysis Chart

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

This chart is provided to assist Medicare contractors in selecting the high-risk activities within their organization.

HIGH RISK FACTORS	***MEDIUM RISK FACTORS***	***LOW RISK FACTORS***
❖ *Recent audit findings showing material weaknesses related internal control processes.*	❖ *Potential program weaknesses related to violation of privacy issues.*	❖ *Areas where CAPs have already been implemented.*
❖ *Areas affected by significant changes in laws, regulations, special requirements or instructions.*	❖ *Areas with high visibility.*	❖ *Areas with low visibility; routine program operations.*
❖ *Areas where policies and procedures regarding internal control over financial reporting are not well documented.*	❖ *Areas where due dates are often not met or responses to correspondence are late.*	❖ *Areas where workers are meeting routine program operations and performance targets and attitudes and staff motivations are high.*
❖ *Areas of significant financial vulnerabilities (e. g., new accounting or regulatory guidelines).*	❖ *Areas with consistent complaints or inquiry.*	❖ *Areas that undergo frequent financial audits/reviews by external parties (e.g., CFO, SAS 70, CPIC, etc.).*
❖ *Areas where guidelines have varied interpretations and/or areas being restructured.* ❖ *Areas with new contract*	❖ *Areas where recent policy changes were implemented.* ❖ *Areas with reorganization*	❖ *Areas that managers perform periodic reviews to ensure that work assignments are*

activities.	*activities.*	*performed consistently, and accurately.*
❖ *Areas where objectives of the corporate mission could be in jeopardy if not properly implemented.*	❖ *Areas where there is a breakdown in communication with corporate, regional, state or satellite offices, etc.*	❖ *Work activities are being phased out.*
❖ *Areas lacking performance measures or monitoring.*	❖ *Areas with new or problematic performance measures.*	❖ *Areas with established and validated performance measures.*

Scoring Criteria Guidelines:

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

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

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

20.2 - Internal Control Objectives

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

1. Operations - relating to effective and efficient use of the organization's resources.
2. Financial *Reporting*-- relating to preparation of reliable financial statements.
3. Compliance - relating to the organization's compliance with applicable laws and regulations.

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

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

control activities (see *section* 20.4 Control Activities) used as well as testing (see *section* 20.5 Testing Methods) that supports the control objectives.

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

20.2.1 – FY *2006* Medicare Control Objectives

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

The complete list of CMS control objectives has been moved to section 50. If you completed your risk assessment prior to issuance of the current year CMS control objectives, you should ensure that any new or revised control objectives are assessed and the risk matrix is updated. In addition, you should create or update the control activities supporting any new or revised control objectives as appropriate (see 20.4 Control Activities).

20.3 – Policies and Procedures

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

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

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

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

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

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

An example of a policy is, “an agency shall establish physical control to secure and safeguard vulnerable assets”. The specific control activities, *or procedures,* which support this policy may include: all doors to the facility have locks, the locks only have one key, all keys are held by security guards, security guards are stationed at every door.

20.4 - Control Activities

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

Control activities are the specific activities performed to support management's directives and help ensure that actions are taken to address risks. The control activities should be effective and efficient in accomplishing the Medicare contractor’s control objectives.

Control activities occur at all levels and functions of the Medicare contractor’s operation. The Medicare contractor should update the control activities to support the current control objectives annually and create or adjust internal controls as appropriate.

Control activities may be either manual or automated, which could include:

- *Top-level reviews of actual performance;*
- *Reviews by management at the transactional or application level;*
- *Management of human capital;*
- *Controls over information processing;*
- *Physical controls over vulnerable assets;*
- *Establishment and review of performance measures and indicators;*
- *Segregation of duties;*
- *Proper execution of transactions and events;*
- *Accurate and timely recording of transactions and events;*
- *Access restrictions to and accountability for resources and records, and*
- *Appropriate documentation and testing of transactions and internal control.*

Effective and efficient control activities are expected to provide reasonable assurance of achieving control objectives relating to the reliability of the operation, financial reporting and compliance with laws and regulations. Achievement of the control objectives depends on how activities within the organization's control are performed.

Medicare contractors shall have written policies and procedures to address all control objectives, and to update them on a timely basis as needed. Testing of the policies and procedures provides a basis from which to verify if control objectives are being met.

20.5 - Testing Methods

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

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

Step 1: Select the policies or procedures to be tested

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

Step 2: Select test methods

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

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

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

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

Step 3: Determine how much testing is needed

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

1. Breadth: Breadth of the sample assures that the testing covers all bases and is a representative cross section of the universe being tested. This will provide confidence that the sample will lead to a conclusion about the situation as a whole.
2. Size: Size is the number of items sampled. The size should be large enough to allow a conclusion that the findings have not happened by chance and provide confidence in the conclusion. The size of the sample should not be so large that testing becomes too costly. *When* selecting the size of the sample consider:
    a. Experience: Reducing the size of the sample when controls have operated satisfactorily in the past and no major changes have occurred.
    b. Margin of Error: Increase the size of the sample when only a small margin of error is acceptable.
    c. Importance: Increase the size of the sample when an important resource is at stake.
    d. Type: Increase the size of the sample when the control to be tested requires judgment calls. Decrease the size of the sample when the control is routine.

Step 4: Plan data collection

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

Step 5: Conduct the tests

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

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

20.6 - Documentation and Working Papers

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

The Medicare contractor shall document through its working papers the process it employed to support its internal control certification. This documentation shall include working papers so that a CMS reviewer can conclude that the Risk Assessment process as described in section 20.1 follows or exceeds these guidelines, and that the Control Activities (section 20.3) identified to support the high risk control objectives selected for review are current and clearly stated. Finally the CPIC documentation shall demonstrate how the Testing Methods employed comply with the general parameters as described in section 20.4 for the purpose of Control Activity validation.

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

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

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

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

- The objectives, scope, methodology, and the results of the review.
- Proper support for findings, judgments and/or conclusions, and to document the nature and scope of the work conducted.

- Sufficient information so that supplementary oral explanations are not required.
- Adequate indexing and cross-referencing, and summaries and lead schedules, as appropriate.
- Date and signature by the preparer and reviewer.
- Evidence of supervisory review of the work.
- Proper heading should be given to the basic content of the working papers.

30.1 – Requirements

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

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

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

The CPIC represents a summary of your internal control environment for the period *September 1, 2005 through June 30, 2006 (the CPIC period)*, as certified by your organization. *It should include an explicit conclusion as to whether the internal controls over financial reporting are effective. All findings (material weaknesses) that were identified during this period shall be included in the CPIC submission.* You should consider the results of final reports issued from internal and external audits and reviews, such as GAO and OIG audits as well as CFO Act audits, consultant reviews, management

control reviews, CPE engagements, SAS 70 *audits*, and other similar activities. These findings should be disclosed as material weaknesses or reportable conditions based upon the definitions provided in section 30.6. *Medicare contractors shall submit an update for the period July 1 through September 30 to report subsequently identified material weaknesses. The update shall be no more than a one page summary of the material weakness and the proposed corrective action. A CAP shall be completed in accordance to the guidelines shown at section 40.1. If no additional material weaknesses have been identified, submit the following: "No material weaknesses have been identified during the period July 1 through September 30, 2006; therefore no additional material weaknesses have been reported". Send the update report from the VP or CFO email box to internalcontrol@cms.hhs.gov by October 5.*

Electronic CPIC reports should be received by CMS on or before *August 1, 2006. The Medicare contractor is not required to submit a hard copy report if it has the capability to insert electronic signatures. Where applicable, the CPIC hard copy report should be post marked on or before August 1, 2006. The CPIC shall include:*

- A Certification Statement *(including an assurance statement on the effectiveness of internal controls over financial reporting as of June 30, 2006;*
- An Executive Summary;
- A description of your risk assessment process. This should include a matrix to illustrate the prioritization of risk and exposure factors and a narrative or flowchart that outlines the risk assessment process (see *section* 20.1 for more details regarding the risk assessment), and
- A CPIC Report of Material Weaknesses.

Note: A hardcopy of the CPIC package is not required, if the Medicare contractor has electronic signature capability. If electronic signature capability is not available, please send the hardcopies to:

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

An electronic version of all documents submitted as part of your CPIC submission shall be sent to CMS at internalcontrols@cms.hhs.gov as Microsoft Excel or Word files. Electronic copies should also be sent to your Associate Regional Administrator for Financial Management, your CFO/SAS 70 Coordinator, your Consortium Contractor Management Officer (CCMO), and Contract Manager. The file names for all electronic

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

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

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

30.2 - Certification Statement

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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. *The CPIC is due August 1, 2006, and shall cover the period from September 1, 2005 through June 30, 2006.*

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 (Medicare Chief Financial Officer and Vice President for Medicare) of (contractor name), we are writing to provide certification of reasonable assurance *for the period September 1, 2005, through June 30, 2006* 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 certification of reasonable assurance that (contractor name) has effective internal controls over financial reporting in compliance with revised OMB Circular A-123.*

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

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

If material weaknesses have been identified, use the following language: "Material weaknesses have been reported to you and the appropriate regional office. The respective Corrective Action Plans have been forwarded to your office." If no material weaknesses were identified, use the following language: "No material weaknesses have been identified during our review; therefore no material weaknesses have been reported." We have also included a description of our risk assessment analysis and our CPIC Report of Material Weaknesses. This letter and its attachments summarize the results of our review.

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

Sincerely,

(Medicare Chief Financial Officer Signature)

(Vice President for Medicare Signature)

30.3 - Executive Summary

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

A. The contractor identification numbers;

B. The geographical locations for which the certification applies;

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

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

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

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

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

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

I. The total number of reportable conditions reported in the CPIC Report of Reportable Conditions; and

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

30.4 - CPIC- Report of Material Weaknesses

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

The CPIC Report of Material Weaknesses *shall include all material weaknesses identified during the period September 1, 2005 through June 30, 2006. This report shall be updated as new findings are identified. It shall* be prepared as a spreadsheet and include the following columns of information:

1. The CMS Finding Number. *The Medicare contractor shall use the CMS finding number assigned in the final audit report for all external findings. Assign a CMS finding number to all internally-identified material weaknesses. This shall be done as soon as the determination is made that the finding is a material weakness.* -The CMS Finding Numbers can be found in section 40.3. Note: *The first section of the CMS finding number will identify the 3 or 4 letter abbreviation of the Medicare contractor.* The second section of *the* CMS finding number will identify the *CPIC reporting period*, i.e. for the CPIC due on August 1, 2006, *internally-identified* material weaknesses will be assigned "*06* " Additionally, all *internally-identified* material weaknesses will be identified with a "C" in the third section of the CMS finding number. Material weaknesses should be numbered sequentially beginning with "001". Information related to each material weakness should be on only one row of the spreadsheet; the "wrap text" function in Excel should be utilized.

   Note: Repeat/Duplicate is no longer recognized. This column has been deleted from the Example Report of Material Weaknesses.

2. The control objective numbers impacted (from *section 50*). Each material weakness *shall* have at least one control objective associated with it. However, a material weakness could have more than one control objective associated with it.

If more than one control objective is impacted by the material weakness, the finding *shall* be listed only once with multiple control objectives listed with it. You need to prioritize the control objectives impacted by each finding and limit them to no more than five. Additionally, the current list of control objectives from *section 50* should be used (i.e., *FY 2006* control objective*s* should be referenced for the FY *2006* CPIC submission).

3. A summary of the material weakness.

4. The corrective action plan (CAP).

5. Target completion date for the CAP.

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

7. The date the material weakness was identified.

8. The date the initial CAP was submitted to CMS as instructed in *section* 30.7.

9. The original source of the finding. If the original source is a Contractor Performance Evaluation review, you shall include the report date and site location of the review. *If the original source is a CPIC, identify the material weakness as either FMFIA or financial reporting (FR). See section 30.6.*

EXAMPLE REPORT OF MATERIAL WEAKNESSES
Medicare Contractor XYZ
CPIC Report of Material Weaknesses
Reporting Period 2006

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

CMS Finding Number	Control Objective (s) Impacted	Summary of the Material Weakness	Corrective Action Plan (CAP)	Target Completion Date	Actual Completion Date	Date Identified	Date Initial CAP Submitted to CMS	Original Source of Finding
XYZ-*06*-C-001	J.3	There is one individual who opens Medicare checks and records them in the cash receipts log. This indicates inadequate separation of duties for this process.	Duties of opening mail and logging in cash receipts are being assigned to separate individuals.	03/15/*2006*	03/15/*2006*	02/03/*2006*	02/27/*2006*	Internal Review
XYZ-*06*-C-002	J.2	There is no integrated general ledger accounting system to adequately track all Medicare financial data	The services of a consulting firm have been obtained to develop an integrated general ledger system for reporting Medicare financial data.	04/30/2006		02/20/*2006*	02/27/*2006*	Internal Review
XYZ-*06*-*S*-001	A.1	No Entity Wide Security Plan	Create an entity Wide Security Plan	6/30/*2006*		03/01/*2006*	03/10/*2006*	SAS 70 *Audit*

For CPIC material weakness submit CAPs in accordance with section 40.1.

NOTE: If you have received a CAP closing letter on a material weakness you previously reported, include a copy of the closing letter as part of the CPIC submission. Even if a CAP closing letter has been received, if the material weakness was originally identified during the *period covered by the CPIC*, it shall be reported on your CPIC Report of Material Weaknesses.

30.5 - CPIC- Report of Reportable Conditions

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

The CPIC Report of Reportable Conditions SHOULD NOT be submitted as part of the annual CPIC submission. *However, you are required to report in the Executive Summary the number of reportable conditions identified during the period covered by the CPIC.* The CPIC Report of Reportable Conditions should be prepared as a spreadsheet and include the following columns of information:

1. The original source of the finding.

2. The control objective numbers impacted (from *section 50*).

3. A summary of the reportable condition including when the condition was observed *and if a corrective action plan was implemented* (or the status if not corrected).

Each reportable condition should be listed and the total number of reportable conditions should be included. *The* Medicare contractors are required to prepare and maintain this report internally *and update this report as new reportable conditions are identified.* It should be available for review by CMS central and/or regional office staff. When reportable conditions are identified, you shall evaluate internal corrective actions for each of the reportable conditions and you should correct each *problem.* While you are required to document, track, and correct problems identified as reportable conditions, no CAP is required to be submitted to CMS.

30.6 - Definitions of Reportable Conditions and Material Weaknesses

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

Contractors *shall* identify Reportable Conditions and/or Material Weaknesses in their CPIC. These terms are defined as follows:

REPORTABLE CONDITION:

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

- *Financial Reporting – A control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report external financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the entity's financial statements, or other significant financial reports, that is more than inconsequential will not be prevented or deleted.*

MATERIAL WEAKNESS:

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

- *Financial reporting – Reportable condition, or combination of reportable conditions, that results in more than a remote likelihood that a material misstatement of the financial statements, or other significant financial reports, will not be prevented or detected.*

DEFINITION OF CONTROL DEFICIENCY:

- *A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis.*

30.7 - Material Weaknesses Identified During the *Reporting Period*

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

The evaluation of your internal control environment should be an ongoing process throughout the fiscal year. It should not be a once-a-year event, which occurs prior to submission of your annual CPIC. *The identification and reporting of material weaknesses should not wait until the end of the CPIC reporting period.* During *the reporting period*, if material weaknesses are identified, send an electronic *Initial CAP report within 45 days of identifying the problem,* via E-mail, to CAPS@cms.hhs.gov and internalcontrols@cms.hhs.gov., *(see section 40.5)*. Within that same time frame you are required to provide written notification, to your Associate Regional Administrator for Financial Management.

After the submission of your CPIC report on or before *August 1,* you are required to resubmit all material weaknesses *included in your CPIC* using the Initial CAP Report found in *section 40.4 by September 15, 2006.*

40 - Corrective Action Plans

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

The CMS has established policies and procedures to ensure that the Medicare contractors have appropriate CAPs *for addressing findings, or material weaknesses identified through the following audits/reviews:*

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

2. SAS 70 *audit* (including Novations);

3. Submission of a CPIC;

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

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

6. Financial reviews conducted by the GAO;

7. CMS' 1522 workgroup reviews; and

8. CMS' CPIC workgroup reviews.

Administrative cost audits, provider audits conducted by the OIG, *Medicare contractor initiated systems security annual compliance audits, and system penetration tests* are excluded from these procedures. The word "findings" will refer to various audit findings including deficiencies, and material weaknesses depending on the type of *audit/*review*s* performed.

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

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

Upon completion of any of the *audit/*reviews noted *in section 40,* with the exception of the CPIC, the Medicare contractor will receive a final report from the auditors noting all findings identified during their *audit*/review. Within 45 calendar days of the date of the report, the Medicare contractor is required to submit an initial CAP report, using the

Initial CAP report format from section 40.5. *For* SAS 70 and the AR AUP reports, initial CAPS are due within 45 calendar days of *the* electronic receipt *date* of the final report *since these* reports are dated with the final day of fieldwork, not the date of issuance. *Specifically for SAS 70 audits, CAPs are required for findings noted in the opinion letter only (section I), not those reported in section III of the SAS 70 Report.*

The initial CAP report shall address all newly identified and reported findings that have been assigned a finding number either by the auditor (i.e., SAS 70 audit) or by the Medicare contractor (i.e., CPIC). The CAP should summarize the procedures that have been or will be implemented to correct the finding. Upon receipt of the initial CAP reports, the Internal Control Team will send the reports to the appropriate CMS business owner for review of the CAP. Business owners may either approve the CAP as submitted, or may request additional information to be included in the CAP. All business owner comments shall be provided to the Medicare contractors before the due date of the next quarterly CAP report. Responses to the CMS business owner comments on the initial CAPs shall be included in the next Quarterly CAP Report due after the date of receipt of the comments.

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

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

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

Submit Initial and Quarterly CAP reports electronically from the Vice President's (VP) email to the CMS email: CAPS@cms.hhs.gov. *Medicare c*ontractors are required to furnish an electronic copy of the CAP report to their CMS Associate Regional Administrator for Financial Management, CCMO, and the designated Regional Office CFO/*SAS 70* coordinator.

Note: Medicare contractors are NOT required to submit the original hardcopy of the Initial and Quarterly CAP reports that have been signed by the VP and submitted from the VP's email.

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

40.2 - Corrective Action Plan (CAP) Reports

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

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

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

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

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

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

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

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

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

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

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

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

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

40.3 - CMS Finding Numbers

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

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

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

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

Choose one from the following list:

- *C – CPIC (your annual self certification package);*
- *E - CFO EDP audit;*
- *F - CFO Financial audit;*

- *G - GAO review (financial reviews);*
- *M – CMS' CPIC workgroup reviews;*
- *N – SAS 70 Novation;*
- *O - OIG review HHS/OIG/IT controls assessment;*
- *P – CMS' 1522 workgroup reviews;*
- *R - AR AUP review;*
- *S – SAS 70 audit; and*
- *V – CFO related NVA/ST*

D. The last three digits are three numbers assigned sequentially to each individual finding beginning with 0 01, 0 02, 0 03, etc. For example, for material weaknesses reported in a CPIC for FY 2005, CMS Finding Numbers for AdminaStar Federal, Inc. would be ASF- 05 C-0 01, ASF- 05 C-0 02, ASF- 05 C-0 03, etc.

Contractor Abbreviations

Anthem Health Plans of Maine Inc. (d.b.a. Associated Hospital Service)	*AHS*
Blue Cross and Blue Shield of Alabama (d.b.a. Cahaba Government Benefit Administrators)	*ALA*
Anthem Health Plans of New Hampshire, Inc. (d.b.a. Anthem Blue Cross and Blue Shield of New Hampshire)	*ANT*
Arkansas Blue Cross and Blue Shield	*ARK*
Blue Cross and Blue Shield of Arizona, Inc.	*ARZ*
AdminaStar Federal Inc.	*ASF*
AdminaStar Federal Inc. , DMERC	*ASFD*
Connecticut General Life Insurance Company (CGLIC), a CIGNA Company	*CIG*
Cooperativa de Seguros de Vida de Puerto Rico	*COP*
Empire Healthchoice Assurance, Inc. (d.b.a. Empire Medicare Services)	*EMP*
First Coast Service Options, Inc.	*FCSO*
Blue Cross and Blue Shield of Georgia, Inc.	*GEO*
Group Health Incorporated	*GHI*

Group Health Service of Oklahoma, Inc. (d.b.a. Blue Cross and Blue Shield of Oklahoma)	*GHO*
Highmark Inc. (d.b.a. HGSAdministrators)	*HGSA*
Healthnow New York, Inc.	*HLN*
Healthnow New York, Inc. DMERC	*HLND*
Blue Cross and Blue Shield of Kansas, Inc.	*KAN*
Blue Cross and Blue Shield of Montana, Inc.	*MNT*
Mutual of Omaha Insurance Company	*MUT*
Blue Cross and Blue Shield of Nebraska	*NEB*
National Heritage Insurance Company	*NHIC*
Noridian Mutual Insurance Company	*NOR*
Blue Cross and Blue Shield of South Carolina (d.b.a. Palmetto GBA Government Benefits Administrators)	*PGBA*
Blue Cross and Blue Shield of Tennessee (d.b.a. Riverbend Government Benefits Administrator)	*RGBA*
Triple S, Inc.	*SSS*
TrailBlazer Health Enterprises, LLC	*THE*
Blue Cross and Blue Shield of Mississippi (d.b.a. Trispan Health Services)	*TRI*
United Government Services, LLC	*UGS*
Highmark Inc. (d.b.a. Veritus Medicare Services)	*VRT*
Wisconsin Physicians Service Insurance Corporation	*WPS*
Blue Cross and Blue Shield of Wyoming	*WYG*

40.4 - Initial CAP Report

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

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

The contractor shall use the Initial CAP Report, as an Excel spreadsheet and add their data following the steps below. The format of the spreadsheet should not be altered. Additionally, this electronic file should be labeled Initial CAP Report, should be identified using the contractor abbreviations found in section 40.3, and should include the submission date. For example, Blue Cross and Blue Shield of Arizona would name this file "ARZ Initial CAP Report 103002.xls".

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

40.5 - Quarterly CAP Report

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

The contractor *shall* use the Quarterly CAP Report, as an Excel spreadsheet and add their data accordingly, without making changes to the format. Additionally, this electronic file shall be labeled Quarterly CAP Report, should be identified using the contractor abbreviations found in section 40.3, and shall include the submission date. For example, Blue Cross and Blue Shield of Arizona would name this file "ARZ Quarterly CAP Report 103002.xls".

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

40.6 – Entering Data into the Initial or Quarterly CAP Report

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

Overview

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

Launching the Spreadsheet Application

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

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

Entering Data

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

Header data elements:

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

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

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

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

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

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

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

VP for Medicare Operations Signature – *Medicare contractors are NOT required to submit the original hardcopy of the Initial and Quarterly CAP reports that have been signed by the VP and submitted from the VP's email.* A signature is not required to be completed on the electronic version of the spreadsheet; however, an original signed hard copy shall be sent to CMS for each Initial CAP Report submission and all Quarterly CAP Report updates.

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

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

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

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

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

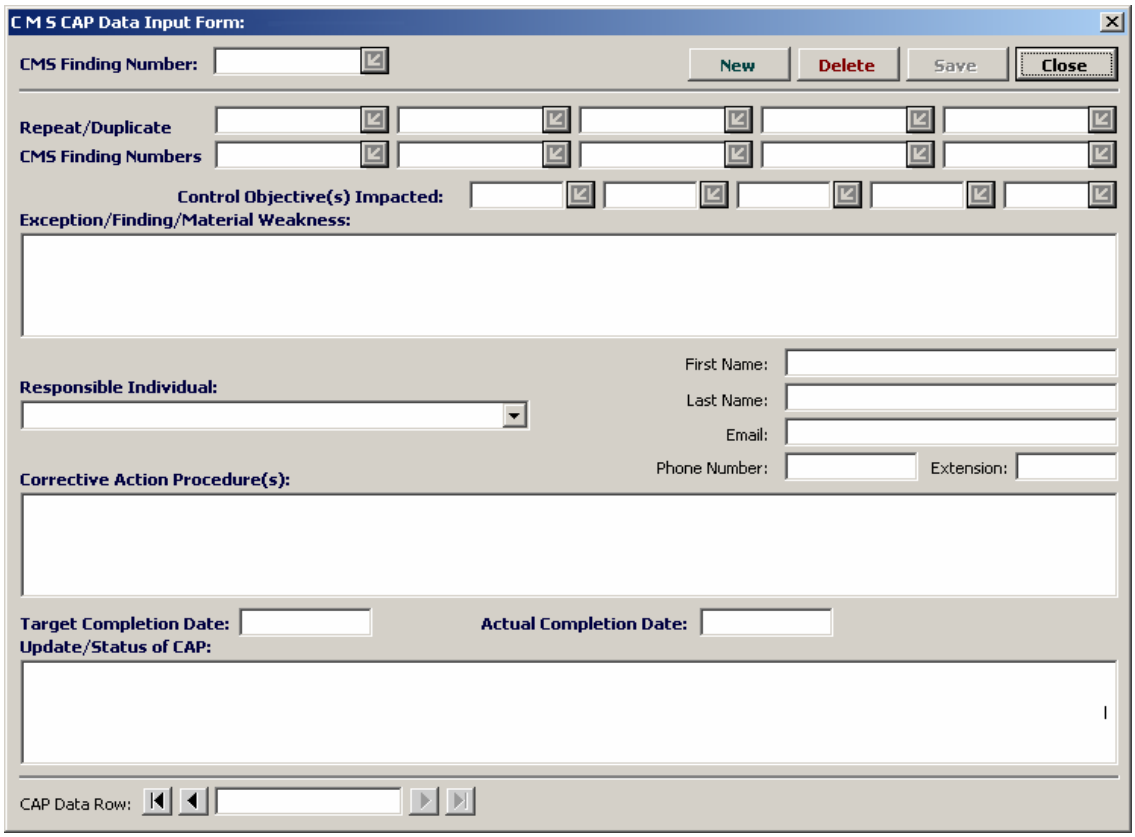

Figure 1: CMS CAP Data Input Form

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

CMS Finding Number components:

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

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

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

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

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

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

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

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

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

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

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

NOTE: If more than one control objective has been entered and deletions are necessary,

you shall click the Clear button and delete the objectives in the reverse order of entry.

For example, the last control objective entered shall be the first control objective deleted.

Use the tab key or the mouse pointer to move to the next cell, which is the Exception/Finding/Material Weakness box in the Data Input Form. Enter text exactly as it appears in the auditor's final report. Do not paraphrase. This field is limited to 1024 characters. Any additional information will be truncated. This is a required field.

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

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

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

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

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

The last field is the Update/Status field. Use this field to provide updates to corrective action procedures or to indicate that no changes have been made since the last reporting cycle. If a notation is made indicating that a CAP is complete, you shall ensure that an Actual Completion Date has been provided. This field is limited to 1024 characters. Any additional information will be truncated. This is a required field for the Quarterly CAP report.

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

Once the information is saved, which is indicated by the Save button being grayed out, you may either press the Close button or the New button. If you press the Close button, you will be returned to the spreadsheet application form. The data entered into the Data Input Form will now appear in the Excel spreadsheet. However, you may press the New button to remain in the Data Input Form and continue to enter additional findings.

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

Editing Existing CAP Data

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

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

Saving Files

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

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

Section 50 – List of FY 2006 Medicare Control Objectives

(Rev. 95, Issued: 04-28-06; Effective/Implementation Dates: 05-30-06)

Control Number	***Control Objective: Controls provide reasonable assurance that…***
A	***Information Systems***
A.1	*An entity-wide security program has been documented, approved and monitored by management in accordance with the CMS Business Partners Systems Security Manual (BPSSM) and includes requirements to assess security risks periodically, establish a security management structure and clearly assign security responsibilities, implement effective security-related personnel policies, monitor the security program's effectiveness and ensure security officer training and employee security awareness.*
A.2	*Security related personnel policies are implemented that include performance of background investigations and contacting references, include confidentiality agreements with employees (regular, contractual and temporary) and include termination and transfer procedures that require exit interviews, return of property, such as keys and ID cards, notification to security management of terminations, removal of access to systems and escorting of terminated employees out of the facility.*
A.3	*Information resources are classified (risk-ranked) according to their criticality/sensitivity and are periodically formally reviewed.*
A.4	*Access to computerized applications, 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.

A.8	*A System Development Life Cycle methodology is documented and in use and includes planning for and costs for security requirements in systems.*
A.9	*Change management policies and procedures exist that include documented testing and approval of changes for regular and emergency changes and restrictions on the use of public domain and personal software.*
A.10	*Access to program libraries is properly restricted and movement of programs among libraries is controlled.*
A.11	*Adequate segregation of duties exists between various functions within Medicare operations and is supported by appropriately authorized and documented policies.*
A.12	*Activities of employees should be controlled via formal operating procedures that include monitoring of employee activities by management with documentation maintained to provide evidence of management's monitoring and review process.*
A.13	*A regular risk assessment of the criticality and sensitivity of computer operations, including all network components, IT platforms and critical applications has been established and updated annually. The assessment includes identification of threats, known system vulnerabilities, system flaws, or weaknesses that could be exploited by threat sources.*
A.14	*A centralized risk management focal point for IT risk assessment has been established that includes promotion awareness programs, processes and procedures to mitigate risks and monitoring processes to assess the effectiveness of risk mitigation programs.*
A.15	*A risk assessment and systems security plan has been documented, approved, and monitored by management in accordance with the CMS Risk Assessment and Systems Security Plan Methodologies.*
A.16	*Regularly scheduled processes required to support the Medicare Contractor's continuity of operations (data, facilities or equipment) are performed.*
A.17	*A corrective action management process is in place that includes planning, implementing, evaluating, and fully documenting remedial action addressing findings noted from all security audits and reviews*

of IT systems, components and operations.

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

fraudulent and abusive practices and, in accordance with CMS instructions, to deter such practices. Any such apparent fraudulent or abusive practices as are identified are documented and reported in accordance with CMS instructions. (Maintainer Only)

C ***Appeals***

C.1 *Medicare Part A and Part B redeterminations are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines. Part B claims processed by Fiscal Intermediaries (FIs) follow the Part B appeals process redeterminations.*

C.2 *Medicare Part B redeterminations and hearings processed by carriers based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines.*

C.3 *Qualified Independent Contractor (QIC) request for cases are handled in compliance with CMS time frames.*

C.4 *Effectuations are processed as directed by CMS guidelines.*

C.5 *Contractor communications are clear and in compliance with CMS' instructions to include specific communications such as acknowledgement letters, decision letters, and information on additional appeal rights, etc.*

D ***Beneficiary/Provider Services***

D.1 *Personally identifiable health information, which is used and disclosed in accordance with the Privacy Act, is handled properly. (Internet Only Manual (IOM) Chapter 2-20.1.8-Beneficiary Customer Service).*

D.2 *Beneficiary and Provider written inquiries are retained and handled accurately, appropriately, and in a timely manner. (IOM Chapter 2-20.2 – Written Inquiries).*

D.3 *Telephone inquiries are answered timely, accurately, and appropriately. (IOM Chapter 2-20.1 Telephone Inquiries).*

E ***Benefit Integrity (BI)***

If BI work has been transitioned to the PSCs and you are no longer responsible for this function, do not include it in your CPIC submission.

E.1	*An independent BI unit that is responsible for detecting and deterring potential fraud should be developed and maintained.*
E.2	*Written procedures exist for BI unit personnel to use for the detection and review of potentially fraudulent situations. Also, written instructions exist detailing procedures for interaction between Program Safeguard Contractors (PSCs), Medicare contractor BI units, and the following contractor units: Medical Review, Overpayment Recovery, Medicare Secondary Payer, Correspondence, and Appeals, Provider Enrollment, Provider/Beneficiary Services and Audit/Reimbursement.*
E.3	*Reactive and proactive techniques in the detection and development of potential fraud cases are used especially in the area of data analysis.*
E.4	*Appropriate safeguard and administrative actions are taken when fraud is suspected which should include payment suspension, and payment recovery of overpayments, provider education, referral to OIG, and denials of claims.*
E.5	*Management supports the networking and sharing of information on potential fraud cases across all appropriate program integrity areas and law enforcement officials.*
E.6	*Procedures established for handling BI unit activities are compliant with the current Program Integrity Manual (PIM) instructions.*
E.7	*Procedures are in place and appropriate action is taken by BI unit personnel to educate other contractor units within Medicare on detecting and referring potential fraud situations. Procedures exist to ensure that other areas within the contractor's organization are alerted to procedural and programmatic weaknesses.*
E.8	*Information gathered by and furnished to the BI unit is maintained in a secure environment, kept confidential and the privacy of all parties protected.*
E.9	*Information compiled for direct and indirect reporting to CMS is clearly documented and can be traced to its original source.*
E.10	*Data residing within any automated Case Control system (e.g., Fraud Investigation Database (FID)) is entered timely and is complete and accurate. Staff is proficient in use of the system.*
E.11	*Inventory is properly controlled and monitored.*
E.12	*Necessary documentation regarding actions taken and final*

	disposition is properly executed and maintained.
E.13	*Requests for assistance from law enforcement agencies are responded to in a timely fashion.*
E.14	*Report requirements are met in an accurate and timely manner.*
E.15	*Notifications required by CMS are performed in a timely fashion and in accordance with CMS guidelines.*
E.16	*Provider amounts due are properly recorded and all subsequent transactions are properly accounted for and recorded.*
E.17	*Restricted and National Medicare Fraud Alerts are appropriately handled.*
E.18	*Regular communication takes place with the OIG on referred or pending cases and the contractor is taking appropriate administrative actions after consultation with OIG.*
E.19	*An established quality improvement program exists.*
E.20	*Contractors have incorporated fraud & abuse training into operations.*
F	***Medical Review (MR) and Local Provider Education and Training (LPET) If MR/LPET work has been transitioned to the PSCs and you are no longer responsible for this function, do not include it in your CPIC submission.***
F.1	*Contractor shall utilize the Progressive Corrective Action (PCA) process, in accordance with the Program Integrity Manual (PIM)) and CMS instructions, to drive medical review (MR) activity (i.e., data analysis, claims review, local policy development, and education).*
F.2	*Contractor shall use the PIM and Budget Performance Request (BPR) guidelines, data analysis and prior year MR results, Quarterly Strategy Analysis findings, and Comprehensive Error Rate Testing (CERT) results to develop and update the combined MR/LPET strategy document. The MR/LPET Strategy document shall address site-specific problems, prioritization of problems, funding, and workload and shall be targeted toward the goal of reducing the paid claims and provider compliance error rate. All work performed by the MR unit shall be identified in the MR/LPET Strategy and targeted based on the contractor's prioritized problem list.*
F.3	*Contractor shall perform data analysis throughout the fiscal year*

(FY) to identify potential problems such as aberrant billing practices, potential areas of over utilization, and changes in patterns of care over time. Current data from a variety of sources shall be used for data analysis. [Data shall include CMS and other national sources, including CERT. Other examples of data sources include contractor's internal databases, specialty data analysis contractors (e.g., Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)) and Program Safeguard Contractor (PSCs), Medicare contractors with similar geographic or size qualities, OIG reports, GAO reports, enrollment data, fraud alerts, and other available sources.]

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

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

F.6 *Contractor shall budget and perform the MR and LPET workloads throughout the FY as established in the MR/LPET strategy. Contractor shall report workload volume and associated costs, calculated in accordance with the approved cost allocation plan, accurately and timely in the monthly MR Interim Expenditure Reports (IERs). Variances between budgeted and actual volume 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.*

F.7 *Contractor shall be capable of identifying the status of each individual claim subjected to medical review at any time and all claims shall be processed timely for closure in accordance with PIM instructions.*

F.8 *Contractor shall effectively comply with all of the MR/LPET requirements of the Joint Operating Agreement with the PSCs.*

F.9 *The contractor LPET program shall utilize effective multifaceted educational activities utilizing various formats, conducted throughout the fiscal year, to address existing program vulnerabilities or*

emerging problems identified during the MR process.

F.10 *Contractor shall utilize post-LPET intervention data analysis findings to evaluate LPET training and intervention effectiveness.*

F.11 *Contractor shall implement and utilize Provider Tracking System (PTS) to track all provider contacts and ensure effective follow-up in accordance with PIM guidelines.*

F.12 *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 Benefit Integrity/PSC, Appeals, Audits, Provider Communication (PCOM), and inquiries.*

F.13 *Contractor shall apply quality assurance processes to all elements of the MR/LPET Strategy and to all aspects of program management, data analysis, edit effectiveness, problem identification, and claim adjudication.*

G ***Medicare Secondary Payer (MSP)***

G.1 *Internal quality controls are established and maintained that ensure timely and accurate processing of secondary claims submitted 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 CWF automatic notice in an automated fashion.*

**6800 edit codes can be located at: http://www.cms.hhs.gov/manuals/downloads/msp105c06.pdf at Publication # 100-05 (Medicare Secondary Payer Manual) in Chapter 6 (Medicare Secondary Payer CWF Processes).*
*** "I" records are located at:*
http://www.cms.hhs.gov/manuals/downloads/msp105c05.pdf

G.2 *Audit trails for MSP recoveries (receivables) are maintained. This should also include the contractor's ability to create a complete audit trail if cases are housed or maintained electronically. An audit trail should contain detail to support all accounting transactions as a result of establishing, reconciling and resolving a receivable. For example, an audit trail should establish the identification and creation of the debt through to its resolution including the source of the receivable, reason(s) for adjustment(s), referral to Treasury, and*

collection of the debt. All correspondence specific to a case should be accessible and in date order.

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

**The ECRS user guide is located at: www.cms.hhs.gov/manuals/downloads/msp105c5_att1.pdf at Publication #100-5 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 (BPR) 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 have quality assurance measures in place to ensure accuracy in the implementation of any CMS directive.*

G.6 *Contractors shall provide evidence that the results from quality assurance checks are documented to identify errors and training venues implemented to prevent the reoccurrence of these errors.*

H ***Administrative***

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

H.2 *Procurements are awarded and administered in accordance with the Medicare Agreement/Contract, CMS regulations, CMS general instructions and the Federal Acquisition Regulation.*

H.3 *Incoming and outgoing mail shall be properly handled in accordance with published time frames, security guidelines, and in the most cost*

effective and efficient manner.

H.4 *Medicare management structure provides for efficient contract performance and is consistent with business practices.*

H.5 *Records shall be retained according to guidelines established by CMS and other Federal agencies.*

H.6 *Internal controls provide reasonable assurance that certain regularly scheduled processes required to support the Medicare contractor's continuity of operations in the event of a catastrophic loss of relevant, distinguishable Medicare business unit facilities are performed as scheduled.*

I ***Provider Audit***

I.1 *Interim, tentative and PIP payments to Medicare providers are established, monitored and adjusted, if necessary, in a timely and accurate manner in accordance with CMS general instructions and provider payment files are updated in a timely and accurate manner. Adjustments to interim payments shall be made to insure 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 a timely and accurate manner.*

1.3 *Provider Cost Reports are properly submitted and accepted in accordance with CMS' general instructions. Appropriate program policies and instructions are followed in situations where the provider did not file a cost report. Cost report submission information is timely and properly forwarded to the proper CMS Systems.*

I.4 *Desk review procedures and performance are documented and are sufficient to obtain an accurate review of the submitted cost report. Documentation is established and maintained to identify situations requiring a limited desk review or a full desk review.*

I.5 *Notices of Program Reimbursement (NPR) are issued accurately and timely to providers and include all related documentation (e.g. an audit adjustment report, copy of the final settled cost report).*

I.6 *Inputs to mandated reports and systems regarding provider audit, settlement, and reimbursement performance (System Tracking for*

Audit and Reimbursement, Contractor Auditing and Settlement Report, etc.) 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 field audit or settled without audit based on audit plans that adhere to CMS guidelines and instructions.*
I.12	*The contractor's field 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, CMS audit and reimbursement policies, and other audit related instructions are timely and accurately communicated to all appropriate audit staff.*
I.14	*The contractor's audit staff maintains its necessary knowledge and skills by completing continuing education and training (CET) required by CMS instructions, and documentation is maintained to support compliance by each staff member.*
I.15	*Supervisory reviews of the audit and settlement process are conducted and the policies and procedures for these reviews are communicated to all supervisors in accordance with CMS program instructions.*

I.16 *All cost reports where fraud is suspected shall be referred to the Payment Safeguard Contractor (PSC) Benefit Integrity Unit in accordance with CMS and contractor instructions.*

I.17 *The contractor has processes and procedures in place to document that supervisory reviews by provider audit department management were completed on all provider audit CAPs from the establishment of the CAPs to the implementation and validation of the CAPs.*

J ***Financial***

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

- *Cost Report Settlement Process;*
- *Contractor Financial Reports:*
    - *Statement of Financial Position (CMS-H750A/B),*
    - *Status of Accounts Receivable (CMS-751A/B),*
    - *Status of Debt – Currently Not Collectible (CNC) (CMS –C751 A/B),*
    - *Status of Medicare Secondary Payer Accounts Receivable (CMS-M751A/B),*
    - *Status of Medicare Secondary Payer Debt-Currently Not Collectible (CMS-MC751A/B),*
    - *Reconcile to the Regional Office (RO) Status of Accounts Receivable (CMS-R751A/B) and RO Status of MSP Accounts Receivable (CMS-RM751A/B),*
    - *Reconcile the accounts receivable balance and activity to the Provider Overpayment Reporting (POR) System and the Physician Supplier Overpayment Reporting (PSOR) system,*
    - *HIGLAS-CMS Balance Sheets and Income Statements,*
    - *HIGLAS-CMS Treasury Report on Receivables*

(TROR),

- *HIGLAS-CMS CNC Eligibility,*
- *HIGLAS-CMS MSP Recovery GHP/Non-GHP Receivables,*
- *Reconcile the HIGLAS accounts receivable balance and activity to the following reports/registers:*

  CMS Beginning Balance Report,

  CMS Transaction Register,

  CMS Applied Collection Register,

  CMS Adjustment Register,

  CMS AR Overpayments Report,

  CMS Interest and Late Charges,

  CMS AR Balance Detail,

  CMS Written-Off/CNC,

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

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

J.2 *Financial transactions are valid and approved by authorized personnel in accordance with management and CMS' policies.*

J.3 *Recorded and processed transactions are correctly classified, maintained, summarized and reconciled. In addition, transactions shall be properly supported.*

J.4 *Segregation of duties exists within the areas of disbursement and collection (i.e., there shall be separate authorization, record keeping,*

and custody).

J.5 *All assets, including cash and accounts receivable should exist and be properly valued and demanded accounts receivable should be properly aged. Accounts receivable should be correctly recorded in the books/records of the contractor.*

J.6 *All liabilities, including accounts payables should exist and be properly valued. Accounts payable should be correctly recorded in the books/records of the contractor.*

J.7 *Contractor Financial Reports are accurate, signed/certified by authorized individuals and presented timely to CMS in accordance with Publication (Pub) 100-06 of the Medicare Financial Management Manual, Chapter 5, Financial Reporting, Section 230.*

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

K ***Debt Referral (MSP and Non-MSP)***

K.1 *Procedures are documented and followed to identify a debt eligible for referral to Treasury for cross servicing and Treasury Offset Program (TOP) prior to the debt becoming 180 days delinquent. These procedures are written and available for review. For MSP debt, see Internet Only Manual (IOM), Pub 100-05, MSP Manual, Chapter 7, Contractor MSP Recovery Rules. For Non-MSP debt, see Publication 100-06, Chapter 4, Section 70.*

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 also updated to reflect any changes to the eligibility status of the debt. Procedures are in place to handle undeliverable letters. For MSP, use the references in K.1 and the Debt Collection System (DCS) User Guide. For Non-MSP debt use Publication 100-06, Chapter 4, Section 70 and the DCS User Guide.*

K.4 *Eligible delinquent debt is input to the DCS accurately to ensure data agrees with data in contractor internal systems and the POR/PSOR system, if applicable, and timely in accordance with CMS instructions. Note: Medicare contractors using HIGLAS, forward eligible delinquent debt file to CMS CO for download to DCS.*

Use the references in K.1 and DCS User Guide.

K.5 *Medicare contractor initiated recalls and adjustments are entered into 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 these debts in DCS are in place and are being followed. - The MSP instructions are in Pub 100-5, Chapter 7. The Non-MSP instructions are in, Pub 100-06, Chapter 4, Section 70, and DCS User Guide.*

Note: Medicare contractors using HIGLAS, forward eligible delinquent debt file to CMS CO for download to DCS.
Use the references in K.1 and DCS User Guide.

K.6 *Contractor has procedures in place to ensure that Medicare contractor collection information is input to DCS in accordance with CMS instructions. The MSP instructions are in Pub 100-5, Chapter 7. The Non-MSP instructions are in Publication 100-06, Chapter 4, Section 70 which provided Medicare contractors full access to updating DCS.*

K.7 *Treasury Action forms for MSP debts are researched and resolved timely within 30 days in accordance with CMS instructions. See IOM, Pub 100-05, MSP Manual, Chapter 7, Contractor MSP Recovery Rules.*

L ***Non-MSP Debt Collection***

L.1 *Demand letters initiate the collection of a provider debt as well as inform the provider of the existence of the debt, their appeal rights with respect to the debt, and the ramifications if the debt is not paid or an agreement is not reached within a specified time period. In addition to the content of the demand letter, the demand letter shall be issued, printed and mailed timely.*

L.2 *Extended Repayment Plans (ERPs) shall be analyzed for approval or denial. A supervisor, in accordance with CMS instructions, reviews all ERPs. This includes monitoring all approved ERPs, the complete financial analysis of the provider's application, and the referral to CMS when necessary.*

L.3 *Interest is applied correctly and timely in accordance with CMS instructions. When necessary, interest adjustments are calculated correctly and processed and applied in a timely manner.*

L.4 *Bankruptcy cases are handled in accordance with CMS instructions and instructions given by the Office of General Counsel (OGC). An*

audit trail of the overpayment shall exist before and after the bankruptcy filing to ensure that Medicare's best interest can be represented by OGC.

L.5 *Provider debt is collected timely, completely, and accurately with an appropriate audit trail of all collection activity and attempts of collection activity. This audit trail supports the amount of the provider debt.*

L.6 *All appropriate entries to CMS' POR/PSOR (Refer to Joint Signature Memorandum 06233), HIGLAS and contractor internal systems are made timely and accurately and reconciled among the relevant CMS systems. Discrepancies are corrected and an audit trail is maintained.*

L.7 *Timely review and processing of all 838 Credit Balance Reports. Ensure that all reported credit balances are collected and properly processed in accordance with CMS instructions.*

L.8 *All overpayments, which meet the thresholds established in the Financial Management Manual, regardless of where they are determined, (Claims Processing, PSC/BI, Overpayments, Audit and Reimbursement…) are demanded and collection efforts are pursued. Medicare contractors are not responsible for the demand and collection efforts for the demand and collection efforts of overpayments identified through the Recovery Audit Contractor Demonstration.*

L.9 *For overpayments subject to the limitation on recoupment of Section 935 of the Medicare Modernization Act (MMA), recoupment is stopped when, a valid and timely first level appeal (redetermination) is received and when a valid and timely 2nd level appeal (Qualified Independent Contractor (QIC) reconsideration) is received. Section 935 directs CMS to stop recoupment of an overpayment where a provider or supplier has appealed to the QIC until the QIC reconsideration decision. This does not apply to Part A cost report overpayments. Interest continues to accrue.*

M ***Provider Enrollment***

M.1 *Review the CMS 855 enrollment applications and take appropriate action in accordance with CMS guidelines in the Program Integrity Manual (PIM), Chapter 10.*

M.2 *Enrollment applications are processed accurately and timely. This includes reviewing all names listed on the application against the Medicare Exclusion Database of OIG sanctioned individuals and*

organizations and the General Service Administration debarment list. (Note: this information is currently part of the QNet Summary report.) Contractors are also required to verify: social security numbers, tax identification numbers, practice locations and "pay to" addresses, including reviewing of the contractor's electronic funds transfer application to verify that the bank account being used meets CMS payment to bank requirements. Documentation verifying that these tasks were performed shall be in accordance with Section 25, Chapter 10 of the PIM.

M.3 *Provider enrollment files are kept in a secure environment in accordance with Section 24, Chapter 10 of the PIM.*

M.4 *Reassignments of benefits are made in accordance with Section 30.2 of the Medicare Claims Processing Manual and Section 7, Chapter 10 of the PIM.* ***(Carriers only)***

M.5 *Billing arrangements are in accordance with Section 30.2 of Medicare Claims Processing Manual.*

M.6 *The Unique Physicians Identification Number Registry is updated accurately and timely in accordance with Section 1005 of the MCM.* ***(Carriers only)***

M.7 *All information on CMS 855 Enrollment Applications shall be put into the Provider Enrollment Chain and Ownership System (PECOS) in accordance with the PECOS Users manual.*

M.8 *Personnel are trained in all aspects of Provider Enrollment as instructed in the PIM Section 2.2.*