
Program Memorandum Intermediaries/Carriers

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal AB-01-174

Date: DECEMBER 6, 2001

CHANGE REQUEST 1942

SUBJECT: The Certification Package for Internal Controls for Fiscal Year (FY) Ending September 30, 2002

This Program Memorandum (PM) provides instructions for the contractors for preparing FY 2002 certification packages and related materials. The key requirements and deadlines are summarized below in question and answer format.

1. Why do I have to prepare a Certification Package for Internal Controls?

The Certification Package for Internal Controls (CPIC) is essential to the audit of CMS's financial statements by the Office of Inspector General (OIG) and to provide CMS with knowledge and assurance that the contractors are complying with CMS instructions and directions. You are expected to certify your compliance with the Federal Managers' Financial Integrity Act (FMFIA) and Chief Financial Officers (CFO) Act by incorporating internal control standards into your operations. These standards can be found in the General Accounting Office's (GAO) "Standards for Internal Control in the Federal Government" as revised November 1999.

Recent Statement of Auditing Standards Number 70 (SAS-70s) continue to identify problems with documentation and substantiation of the financial data essential for CMS's preparation of its financial statements. All contractors have previously been made aware of their responsibilities to maintain accurate accounting records with supporting documentation, and to perform a reconciliation of all account balances. This expectation continues to remain a priority to CMS for FY 2002.

In addition, by signing this certification, you are in compliance with the requirements of §3.3 of the Business Partners Systems Security Manual (CMS-Pub 84).

2. What is required of me?

You are required to submit to CMS your CPIC, which includes your risk assessment, certification statement, executive summary, and CPIC Reports of Material Weakness(es) and Reportable Condition(s), by October 15, 2002.

We remind you of the importance of maintaining the appropriate and necessary documents to support any assertions and conclusions made during the self-assessment process. In your workpapers, 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.

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

3. What is required in the risk assessment?

Every organization faces a variety of risks from external and internal sources that must be assessed. Risk assessment is the identification and analysis of relevant risks to the achievement of established control objectives. You are required to perform a yearly risk assessment, prior to conducting your reviews, to ensure that the most critical areas are evaluated. We have included, as Exhibit 1, a list of control objectives. **Note that the list of control objectives for FY 2002 has changed significantly since the objectives for FY 2001 were published.** You will see that some of the control objectives have been deleted, combined, or simply updated to improve their usefulness. The numbering system for the FY 2002 control objectives has been changed to correlate with the new objectives. Changes to the control objectives listed in Exhibit 1 have been bolded for easier identification. The control objectives listed in Exhibit 1 are intended to be a minimum set of control objectives for consideration and are to serve as a guide during your risk assessment process. We expect that you will add to this list as you conduct your risk assessment.

When performing your yearly risk assessment, you are to consider all results from internal (management) and external reviews including GAO, OIG, CFO audit, Contractor Performance Evaluation (CPE), and results of your own and/or CMS-sponsored SAS-70 reviews. Any of these efforts could impact your risk assessment and preparation of your certification statement. Your risk assessment process must provide sufficient documentation to fully explain the reasoning behind and the planned testing methodology for each selected area. A description of your risk assessment process (which explains the steps and areas considered) must be included in your CPIC.

NOTE: CMS considers financial management to be a critical risk area. Therefore, we require that you include the financial management control objectives in your CPIC. (See sections **K, M, N, and O** in Exhibit 1.) If you believe, based upon your risk assessment that you should not review these areas, you must document this in your CPIC.

4. What is required in the certification statement?

You are required to provide a certification statement to CMS pertaining to your internal controls. Exhibit 2 contains a generic FY 2002 certification statement. This statement should be included as part of your CPIC. The statement is to be signed jointly by your Chief Financial Officer and Vice President for Medicare and is due by October 15, 2002.

5. What is required in the executive summary?

An executive summary should be included in your CPIC. This summary should provide, at a minimum:

- a. The contractor identification numbers;
- b. Geographical locations for which the certification applies;
- c. The functional areas selected for review;
- d. The time period during which the reviews were conducted;
- e. A brief summary of the review results, time estimate for when any deficiency will be corrected;
- f. The name and title of the person(s) who conducted the review;
- g. The location and custodian of the working papers; and
- h. The name, telephone number, and E-mail 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.

6. What is required in the CPIC reports of material weakness(es) and reportable condition(s)?

Within these reports, you are asked to identify reportable conditions and material weaknesses. Keep in mind that while you are required to document, track, and correct problems identified as reportable conditions, no corrective action plan (CAP) is required. **With a material weakness, however, you**

are required to provide written notification, as well as a CAP, to your regional office within 30 calendar days of identifying the problem. The CAPs will be reviewed and approved by the appropriate business owner(s) within CMS. Within that same time frame you are also required to send an electronic copy, via E-mail, to internalcontrols@cms.hhs.gov and provide a hard copy of the CAP to the Office of Financial Management at the address listed under Question 9.

After CMS has completed its review and approval process, you are required to include all current CPIC material weakness CAPs into the internal control quarterly CAP report that already includes CAPs from the SAS-70 reviews. The internal control quarterly report will be submitted electronically to internalcontrols@cms.hhs.gov.

Note that you must reference the control number that corresponds to the control objective affected by the material weakness or reportable condition when filling out the CPIC reports. (See Exhibit 3.) Each finding should be categorized as either a material weakness or a reportable condition. These terms are defined below and examples of each have also been provided. In your CPIC Reports of Material Weakness(es) and Reportable Condition(s) you must also identify the status of the CAP for each material weakness. An electronic version of this report must be sent to CMS at internalcontrols@cms.hhs.gov in Microsoft Excel 97 or other compatible software program.

The CPIC represents an annual summary of your internal control environment for the current FY as certified by your organization. All SAS-70 exceptions identified during the fiscal year must be reflected in your CPIC report. Each exception should be classified as a material weakness. There is no need to duplicate the SAS-70 exception(s) already identified in the internal control quarterly CAP report.

7. How is a reportable condition defined?

A **REPORTABLE CONDITION** exists when your internal controls are adequate in design and operation and reasonable assurance can be provided that the intent of the control objective is met, but deficiencies were found during the review that require correction. It is necessary for contractors to track and correct the problem, but no CAP need be submitted to CMS. You should, however, inform CMS when the condition was observed and corrected (or the status if not corrected), and include information on any dollar impact on the Medicare Trust Fund.

EXAMPLES:

1. Access controls are in place within the data centers; however, during the review it was found that particular employee passwords were openly displayed. (Control Objective B.3 - physical access to Medicare facilities and systems is appropriately authorized, documented, and access violations monitored and followed-up.)
2. While controls are in place, isolated incidents occurred where some supporting documentation for the CMS 1522 report could not be located. (Control Objective N.5 - The contractor must provide CMS with contractor financial reports that are appropriately and adequately supported, documented, accumulated, completed, reviewed, formally approved and presented timely to CMS.)

8. How is a material weakness defined?

A **MATERIAL WEAKNESS** exists when the contractor fails to meet a control objective. This may be due to a significant deficiency in the design and/or operation of internal control policies and procedures. Because of these shortfalls in internal controls, the contractor cannot provide reasonable assurance that the intent of the control objective is being met. Contractors should, however, inform CMS when the condition was observed and corrected (or the status if not corrected), and include information on any dollar impact on the Medicare Trust Fund.

With a material weakness, you are required to provide a CAP, to your regional office within 30 calendar days of identifying the problem. Within that same time frame you are also required to send an electronic copy, via E-mail, to internalcontrols@cms.hhs.gov and provide a hard copy of the CAP to the Office of Financial Management at the address listed under Question 9.

EXAMPLES:

1. No controls are in place for access to data. Employees within certain data centers were found to share the same password. (Control Objective B.3 - Physical access to Medicare facilities and systems is appropriately authorized, documented, and access violations monitored and followed-up.)
2. Formal processes for developing supporting documentation for value of outstanding Medicare payment checks for inclusion in CMS 1522 report were not implemented and related documentation could not be located to support estimates used for the period reviewed. (Control Objective N.5 - The contractor must provide CMS with contractor financial reports that are appropriately and adequately supported, documented, accumulated, completed, reviewed, formally approved and presented timely to CMS.)

9. Where do I send my CPIC package?

Your CPIC package should be sent to the Office of Financial Management at the address listed below. A hard copy should also be forwarded to your regional office.

Ms. A. Michelle Snyder
 Chief Financial Officer
 Office of Financial Management
 Attn: Internal Controls Team
 Centers for Medicare & Medicaid Services
 7500 Security Boulevard, C3-13-17
 Baltimore, MD 21244-1850

Also, an electronic copy of the documents included in your CPIC package (in a format compatible with Microsoft Office 97) should be sent to internalcontrols@cms.hhs.gov by October 15, 2002.

10. What about next year's CPIC?

The CMS intends that the certification process will continue on a yearly basis and that it will be updated to reflect new or changed processes.

Additionally, CMS is in the process of producing an official internal control manual. In this manual, we intend to provide more detailed guidance on the supporting documentation for your CPIC including your risk assessment and proper documentation of your policies and procedures.

3 Attachments

The *effective date* for this PM is October 1, 2001.

The *implementation date* for this PM is December 6, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after December 3, 2002.

If you have any questions, contact Patty Gould on (410) 786-6441 or William Karantzalis on (410) 786-3361.

Exhibit 1

FY 2002 Medicare Control Objectives

Control Number	Control Objective <i>Controls provide reasonable assurance that...</i>
A	Systems: Entity-Wide Security Program
A.1	An entity-wide security program has been documented, approved, is monitored by management, and is in accordance with CMS guidelines.
A.2	Appropriately designated and authorized security personnel are in place.
A.3	Security related personnel policies are implemented and effective.
B	Systems: Access Controls
B.1	Information resources are classified (risk-ranked) according to their criticality/sensitivity and are periodically formally reviewed.
B.2	Access to computerized applications, systems software, and Medicare data is appropriately authorized, documented, and monitored.
B.3	Physical access to Medicare facilities and systems is appropriately authorized, documented, and access violations monitored and followed-up.
C	Systems: Application Software Development and Change Control
C.1	Medicare application and related systems software development and maintenance activities are authorized, documented, tested, and approved.
D	Systems: Segregation of Duties
D.1	Adequate segregation of duties exists between various functions within Medicare operations and is supported by appropriately authorized and documented policies.
D.2	Personnel activities are controlled using approved formal operating procedures and supervision/review of the use of these procedures.
E	Systems: Service Continuity
E.1	A regular assessment of the criticality and sensitivity of computerized operations and related supporting resources is performed.
E.2	A documented and approved comprehensive contingency plan has been developed, is periodically tested, and is updated as necessary.
F	Claims Processing
F.1	System capabilities and documentation are accessible in the Medicare claims processing system to track a claim from receipt to final resolution.
F.2	Data scheduled for processing is valid and errors are rejected.
F.3	Claims are processed accurately and in a timely manner in accordance with CMS guidelines.
F.4	Claims are reopened when necessary and in accordance with CMS guidelines.
F.5	Claim payments are properly calculated and duplicate claims are identified prior to payment.
F.6	Claims are properly aged from the actual receipt date to the actual date of payment in compliance with legislative mandates.
F.7	Personnel are trained to detect and deter fraudulent and abusive practices.
G	Appeals
G.1	Medicare Part A reconsiderations, Part A reviews, and Part A hearings are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines.
G.2	Medicare Part B reviews and hearings are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines.
G.3	Administrative Law Judge (ALJ) cases are handled in compliance with legislatively mandated time frames.
G.4	Medicare appeals activities are carried out in order of priority as directed by CMS guidelines.
H	Beneficiary/Provider Services
H.1	Enroll providers in the Medicare Participation Program and issue provider numbers in accordance with CMS guidelines (Part B only).
H.2	Methodologies are established as approved by CMS to educate providers and beneficiaries in Medicare coverage, payment, and billing processes. Safeguards are in place to ensure Medicare information in provider bulletins is accurate and timely.
H.3	Personally identifiable health information, which is used and disclosed in accordance with the Privacy Act, is handled properly.
H.4	Safeguards are established in the Provider Enrollment Process to prevent sanctioned providers from receiving Medicare payment.
H.5	Beneficiary and provider written and walk-in inquiries are handled accurately, appropriately, and in a timely manner.
H.6	Telephone inquiries are answered timely, accurately, and appropriately.
I	Fraud and Abuse-Benefit Integrity (BI)
I.1	An independent BI unit that is responsible for detecting and deterring potential fraud should be developed and maintained.
I.2	Written procedures exist for BI unit personnel to use for the detection and review of potentially fraudulent situations.

I.3	Reactive and proactive techniques in the detection and development of potential fraud cases are used especially in the area of data analysis.
I.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 .
I.5	Management supports the networking and sharing of information on fraud cases across all program integrity areas, as well as the regional Medicare Fraud Information Specialist (MFIS), and other law enforcement officials.
I.6	Written instructions exist detailing procedures for interaction between the BI unit and the following contractor units: Medical Review, Overpayment Recovery , Medicare Secondary Payer, Correspondence, Appeals, Provider Enrollment, Provider/Beneficiary Services and Audit/Reimbursement.
I.7	Procedures established for handling BI unit activities are compliant with the current Program Integrity Manual (PIM) instructions.
I.8	Procedures are in place and appropriate action 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.
I.9	Information gathered by and furnished to the BI unit is maintained in a secure environment, kept confidential and the privacy of all parties protected.
I.10	Information compiled for direct and indirect reporting to CMS is clearly documented and can be traced to its original source.
I.11	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.
I.12	Inventory is properly controlled and monitored.
I.13	Necessary documentation regarding actions taken and final disposition is properly executed and maintained.
I.14	Requests for assistance from law enforcement agencies are responded to in a timely fashion.
I.15	Report requirements are met in an accurate and timely manner.
I.16	Notifications required by CMS are performed in a timely fashion and in accordance with CMS guidelines.
I.17	Provider amounts due are properly recorded and all subsequent transactions are properly accounted for and recorded.
I.18	Restricted and National Medicare Fraud Alerts are appropriately handled.
I.19	Regular communication takes place with the OIG on referred or pending cases and the contractor is taking appropriate administrative actions after consultation with OIG.
I.20	An established quality improvement program exists.
I.21	Contractors have incorporated fraud & abuse training into operations.
J	Medical Review (MR)
J.1	Data analysis is performed to identify aberrant billing practices , potential areas of over utilization, and changes in patterns of care overtime (trends) by providers and services that present financial risks through incorrect payments to the Medicare Program.
J.2	Data is used from CMS, the contractors internal databases, specialty data analysis contractors (e.g. Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) and Program Safeguard Contractor (PSCs)), and other sources available to the contractors to identify targets for focused reviews.
J.3	Edits developed as a result of data analysis are effective in detecting inappropriate claims.
J.4	Medical Review is automated to the greatest extent possible.
J.5	Appropriate medical expertise is applied during the MR process.
J.6	Workload is accomplished in conformance with the current FY medical review strategy.
J.7	Current MR/Progressive Corrective Action (PCA), CMS issued instructions are used to verify that services on claims billed are covered and medically necessary.
J.8	The status of cases can be identified at any time and are closed timely.
J.9	The Medicare claims experience of all providers in the service area is monitored to acquire relevant statistical data on these claims and their specialty groups.
J.10	Providers are notified timely of any new or modified CMS guidelines and are educated on appropriate billing practices.
J.11	Provider contact resulting from the MR process is in compliance with the PCA and other Program Integrity Manual instructions relating to communication and education.
J.12	The Medicare contractor's management supports the internal networking and sharing of information on MR activities, potential fraud cases, audits, and MSP.
J.13	A quality improvement program ensures accuracy of Medical Review decisions.
K	Medicare Secondary Payer (MSP)
K.1	MSP provisions are performed in accordance with current manual requirements.
K.2	Claims involving multiple payers are processed correctly; i.e., when Medicare is primary, claims are paid as primary.
K.3	Procedures and training materials are created and utilized to ensure consistency with all CMS applicable directives, regulations, etc., and compliance with the MSP provisions for the Internal Revenue Service/Social Security Administration/CMS Data Match Recoveries project should exist.
K.4	The contractor should document procedures that facilitate compliant treatment of MSP Data Match and Routine Recovery cases generated by the contractor when the third-party payer or the employer

	responds to any demand letter.
K.5	Clear audit trails for MSP recoveries (receivables) are maintained.
K.6	Timely reporting of required MSP reports exists.
K.7	Correspondence is issued to the appropriate parties in cases where other party primary liability is suspected.
K.8	Contractors should seek recovery of mistaken or conditional primary payments made in MSP situations in accordance with all CMS instructions.
K.9	Contractors are in compliance with CMS directives regarding debt referral as stated in the Debt Collection Improvement Act (DCIA).
L	Administrative
L.1	Employees must 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.
L.2	Procurements must be awarded and administered in accordance with the Medicare Agreement/Contract, CMS regulations, CMS general instructions and the Federal Acquisition Regulation.
L.3	Incoming and outgoing mail must be properly handled in accordance with published time frames, security guidelines, and in the most cost effective and efficient manner.
L.4	Medicare management structure provides for efficient contract performance and is consistent with business practices.
L.5	Records must be retained according to guidelines established by CMS and other Federal agencies.
L.6	Business continuity plans must be in place, the plans must be tested periodically, and must cover relevant, distinguishable Medicare business units.
M	Provider Audit and Reimbursement
M.1	An internal quality control process should be established and maintained to ensure that audit work (full and limited audits and focused reviews) 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.
M.2	Information received by CMS or obtained by the contractor from other sources to establish a new provider, process a change of ownership for an existing provider, terminate a provider, or process a change of intermediary are identified, recorded, and processed in a timely and accurate manner.
M.3	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 that provider payment files are updated in a timely and accurate manner . Adjustments to interim payments should be made to insure that payments approximate final program liability within established ranges. Payment records are adequately protected.
M.4	Provider Cost Reports are properly submitted and accepted in accordance with CMS's general instructions and that cost report information is properly forwarded to the proper CMS system.
M.5	Desk review activity should be properly performed to obtain a fair and accurate review of the submitted cost report . Methods should be established and maintained to identify provider situations requiring a limited desk review, a complete desk review or a problem resolution .
M.6	Final settlement includes all adjustments to the cost report and that accurate and timely Notices of Program Reimbursement (NPR) including all related documentation are issued to the providers .
M.7	Provider cost reports are reopened and settled in accordance with CMS program policy .
M.8	Provider exception requests are handled in accordance with all relevant regulations such as the TEFRA Target Limits .
M.9	Provider appeals (including both the Provider Reimbursement Review Board (PRRB) and Intermediary Appeals) are handled appropriately and that all jurisdictional questions are addressed and all timeframes for submission are observed.
M.10	Information captured to update the Provider Statistical and Reimbursement Report (PSRR) is obtained and related reports are distributed to providers and internally reconciled with paid claims files.
M.11	Inputs to mandated reports regarding provider audit, settlement, and reimbursement performance (STAR, CASR, etc.) are accurate and in compliance with program instructions.
N	Financial Transactions for Medicare accounts receivable, payables, expenses, and administrative costs must be recorded and reported timely and accurately, and financial reporting must 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 should focus on the following areas: ? ? Cost Report Settlement Process; ? Contractor Financial Reports: <ul style="list-style-type: none"> ◆ Statement of Financial Position (CMS-H750A/B), ◆ Status of Accounts Receivable (CMS-751A/B), ◆ Status of Medicare Secondary Payer Accounts Receivable (CMS-M751A/B), ◆ Status of Debt-Currently Not Collectible (CMS-C751A/B) ◆ Status of Medicare Secondary Payer Debt-Currently Not Collectible (CMS-MC751A/B) ◆ Reconcile to the Regional Office Status of Accounts Receivable (CMS-R751A/B) and Regional Office Status of Medicare Secondary Payer Accounts Receivable (CMS-

	<p>RM751A/B),</p> <ul style="list-style-type: none"> ◆ Reconcile the accounts receivable balance and activity to the Provider Overpayment Reporting (POR) System and the Physician Supplier Overpayment Reporting (PSOR) system. ? Monthly Contractor Financial Report (CMS 1522) and Contractor Draws on Letter of Credit (CMS 1521), ? Reconciliation of Cash Balances and Cash Receipts.
N.1	Appropriately authorized personnel, in accordance with CMS' policies, approve recorded and processed transactions. In addition, Medicare contractor management and CMS policies should be consistently applied.
N.2	Recorded and processed transactions are appropriately classified, maintained, summarized, and reconciled. In addition, all transactions must be adequately supported.
N.3	Adequate segregation of duties exist within the areas of disbursement and collection (i.e., there should be separate authorization, record keeping, and custody).
N.4	Accounts receivable should exist, be valued, and aged on an appropriate basis and should be correctly recorded in the books and records of the contractor.
N.5	The contractor must provide CMS with Contractor Financial Reports that are appropriately and adequately supported, documented, accumulated, completed, reviewed, formally approved and presented timely to CMS .
N.6	Financial transactions received are valid and are appropriately supported , valued, recorded, and reported.
N.7	Banking information relevant to Medicare processing is accurately stated and conforms to the tripartite agreement.
N.8	Budget Performance Requirements are achieved per criteria established by CMS and that exceptions are appropriately negotiated.
O	Debt Collection
O.1	Documented procedures are used to collect provider debt timely and maintain appropriate audit trails of the collection activity that supports the amounts reported.
O.2	All appropriate entries to CMS' POR/PSOR and DCS systems are made timely and accurately and reconciled among the relevant CMS systems.
O.3	The correct debt balance is reported and reconciled to all relevant CMS systems the contractor is responsible for maintaining and updating. Discrepancies are corrected and an audit trail is maintained.
O.4	All debts are appropriately aged and related reports are reconciled to monitor CNC classification, status and follow up.

Exhibit 2

Ms. A. Michelle Snyder
Chief Financial Officer
Office of Financial Management
Attn: Internal Controls Team
Centers for Medicare & Medicaid Services
7500 Security Boulevard, C3-13-17
Baltimore, MD 21244-1850

Dear Ms. Snyder:

As (Medicare Chief Financial Officer, Vice President for Medicare, or appropriate equivalent) of (contractor name), I am writing to provide certification of reasonable assurance 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 my operations.

I am cognizant of the importance of internal controls. I 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, I have included an assessment and testing of the programmatic, administrative, and financial controls for the Medicare program operations.

In the enclosures to this letter, I have provided an executive summary that identifies: A) The contractor identification numbers; B) The geographical locations for which the certification applies; C) The functional areas selected for review; D) The time period during which the reviews were conducted; E) A brief summary of the review results (including a time estimate for when the deficiency will be corrected); F) The name and title of the person(s) who conducted the review; G) The location and custodian of the working papers for the review; and H) The name, telephone number, and email address of a contact person. Material weaknesses have been reported to you and the appropriate regional office. The respective Corrective Action Plans have been forwarded to your office. I have also included a description of our risk assessment analysis and Certification Package for Internal Controls Report of Material Weakness(es) and Reportable Condition(s). This letter and its attachments summarize the results of our review.

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

Sincerely,

(Medicare Chief Financial Officer Signature)

(Vice President for Medicare Signature)

