CMS Medicare Manual System
Pub. 100-6 Financial Management

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

Transmittal 11 **Date: SEPTEMBER 27, 2002**

CHANGE REQUEST 2287

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
7	40 40.1 Attachment A		

NEW/REVISED MATERIAL - EFFECTIVE DATE: September 27, 2002
IMPLEMENTATION DATE: September 27, 2002

40 – Corrective Action Plans – this section was revised to specifically exclude the submission of corrective action plans for findings related to a Contractor Performance Evaluation.

40.1 – Submission, Review, and Approval of Corrective Action Plans – this section was revised to address findings from a Contractor Performance Evaluation, clarify reporting requirements when reporting global findings, and to correct the email address as to where to submit corrective action plans.

Attachment A – Universal Corrective Action Plan Report – Universal Corrective Action Plan Report – one spelling error was corrected (contract person name was corrected to contact person name)**.**

Medicare contractors only: these instructions should be implemented within your current operating budget.

40 - Corrective Action Plans (Rev. 11, 09-27-02)

For fiscal year (FY) 1999, CMS received its first unqualified audit opinion on its financial statements. Since then, the goal has been to maintain that unqualified opinion. Therefore, CMS has continued to make financial management improvements that will improve internal controls over the corrective action plan (CAP) process. The annual Chief Financial Officer (CFO) audit as well as various other types of reviews has helped to identify operational weaknesses that limits CMS's ability to effectively manage the Medicare program. Correcting these findings is critical if we are to demonstrate our commitment to improving financial management and internal controls.

The CMS has established policies and procedures to ensure that the Medicare contractors have appropriate CAPs for addressing findings, exceptions or material weaknesses identified through a:

1. CFO financial or electronic data processing (EDP) audit;
2. Statement of Auditing Standards (SAS)-70 review;
3. Submission of a Certification Package of Internal Controls (CPIC);
4. Account receivable (AR) advisory review; and
5. Other financial management audits and reviews performed by certified public accounting (CPA) firms, the Office of Inspector General, and the General Accounting Office (GAO).

Administrative cost and provider audits conducted by the OIG are excluded from these procedures. *Additionally, CAPs for CPE findings should not be included on the quarterly CAP report. However, if a finding's original source was a CPE finding and the contractor's analysis determines it should be considered a material weakness, it must be reported on the CPIC Report of Material Weaknesses as part of the CPIC submission.* Throughout the remainder of these instructions, the word "findings" will refer to various audit findings including exceptions and material weaknesses depending on the type of review performed.

A new Universal CAP Report, prepared in Microsoft Excel, will be used to report on all open CAPs for all fiscal years. There should only be one report submitted by Medicare contractors for all CAPs related to the findings listed above. Because of a character limitation within Excel, CAPs will need to be summarized. If there has been no change in a CAP since the previous report, simply list the current date along with a comment of "no change" in the Update/Status of CAP column.

40.1 - Submission, Review, and Approval of Corrective Action Plans (Rev. 11, 09-27-02)

Upon completion of any of the reviews noted above, with the exception of the CPIC, the Medicare contractor will receive a final report from the auditors or advisors noting all findings identified during their review. Within 45 days of the date of the report, the Medicare contractor is required to submit an initial CAP report, *using the universal CAP format*, that addresses all of the reported findings which is certified by the Vice President (VP) of Medicare Operations. The CMS will no longer send a letter to the contractors requesting the submission of a CAP; however, CMS will continue to request a CAP from the system maintainers. *The universal CAP report must also include corrective actions addressing findings identified in the annual CPIC, except when the finding's original source was a CPE finding.*

If the auditors or advisors classify any finding as a "recommendation", the Medicare contractor is not required to provide a CAP to address the recommendation. However, if

the Medicare contractor revises current operating policies and procedures to implement the recommendation, those changes must be reported on the universal CAP report as well. Recommendations are not assigned a CMS finding number, therefore, the Medicare contractor must identify the recommendation as such by entering the word "Recommendation" in the CMS finding number column of the CAP report.

Similarly, if the auditors or advisors classify any finding as a "global finding", the Medicare contractor is required to provide a CAP that reports the status of *any requests submitted to system maintainers for system changes, program enhancements, or modifications needed or already implemented to correct system limitations and findings.* The Medicare contractors must also include information regarding the priority of the request by the impacted user group and the contractor's efforts taken to get the programming request addressed by your systems maintainer.

A quarterly universal CAP report updating the status of the Medicare contractor's initial CAP is due within 30 days following the end of each quarter (i.e., January 30, April 30, July 30, and October 30). The quarterly universal CAP report should address all open findings, as well as continue to report information on all findings reported as completed by the Medicare contractor, until CMS sends the Medicare contractor a standard closeout letter indicating which findings are officially closed. After the Medicare contractor receives the closeout letter, they may discontinue reporting on those findings in future quarterly CAP submissions. Separate CAP reports are not required for findings identified in prior fiscal years. Instead, all findings, regardless of the year identified, should be included in the single universal CAP report.

To facilitate the timely submission of the CAP, CMS established an Internet e-mail address, *CAPS@cms.hhs.gov* Medicare contractors to electronically submit all universal CAP reports. Since Medicare contractors must consolidate all CAPs into one universal CAP report, Medicare contractors will no longer electronically submit SAS-70 or CPIC CAPs to the e-mail box, internalcontrols@cms.hhs.gov. Contractors are required to furnish a copy of the CAP to its CMS Consortium Administrator, Regional Administrator, Associate Regional Administrator for Financial Management, Consortium Contractor Management Officer, and the designated Regional Office CFO coordinator. Contractors are also required to submit a hard copy of the universal CAP report that has been certified by the VP of Medicare Operations to:

The Centers for Medicare & Medicaid Services
Attention: Chief Financial Officer
7500 Security Blvd. - C3-13-08
Baltimore, MD 21244

The CMS will review each CAP report submission to determine if the Medicare contractor adequately addressed each finding. The CMS will respond to the contractor within 45 days either approving the CAP, rejecting the CAP or requesting a revised CAP for any finding that was not adequately addressed by annotating this information on the CAP. Quarterly updates will also be reviewed; however, CMS will not respond to the CAP 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.

Attachment A - Universal Corrective Action Plan Report

UNIVERSAL CORRECTIVE ACTION PLAN REPORT

Contact Name/Number:		ABC Contractor, Number 00897						
Date of Submission:		3/31/2002						
Contact Person Name:		Joe Smith						
Contact Person Email:		joe_smith@abc.com						
Contact Person Phone #:		999-555-1212						
VP of Medicare Operations Name:								
VP of Medicare Operations Signature:		_____						
CMS Finding Number	**Source of Finding**	**Control Objective(s) Impacted**	**Exception/ Finding/ Material Weakness**	**Responsible Individual (Name, Email Address, and Phone Number**	**Corrective Action Procedure(s)**	**Target Completion Date**	**Actual Completion Date**	**Update/ Status of CAP**
ABC-02-C-001	CFO Audit, CPIC, SAS-70, AR, etc.	110	The financial statements…	Jane doe, jane_doe@abc.com, 999-555-1234	Procedures for …	12/30/2001	11/28/2001	