Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-00-75 **Date: AUGUST 11, 2000**

CHANGE REQUEST 1239

SUBJECT: The Internal Control Certification Statement Required by the Budget and Performance Requirements (BPR) for the Fiscal Year (FY) Ending September 30, 2000

The FY 2000 BPRs ask each contractor to demonstrate and certify they have acceptable internal controls. This requirement is essential to the certification process of HCFA's financial statements by the Office of Inspector General (OIG) and to provide HCFA with knowledge and assurance that the contractors are complying with HCFA instructions and directions. By September 1, 2000, each contractor is required to certify that it is in compliance with the Federal Managers' Financial Integrity Act (FMFIA) and Chief Financial Officers (CFO) Act requirements by incorporating internal control standards into its operations. These standards are specified in the General Accounting Office's (GAO) "Standards for Internal Control in the Federal Government" as revised November 1999 (a copy can be obtained from the GAO Web site- HTTP://www.gao.gov/special.pubs/ai00021p.pdf)

The following points are to be considered as you evaluate your internal controls for the FY 2000 certification statements:

- Reviews by the OIG and GAO continue to identify problems with documentation and substantiation of the financial data essential for the HCFA'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 perform reconciliations of all account balances. This expectation continues to remain a priority to HCFA for FY 2000.

- You are required to have and be able to identify documented policies and procedures for internal control standards. These policies and procedures should be in writing, be updated to reflect any changes in operations, and be operating effectively within your organization.

- You are required to perform a yearly risk assessment, prior to conducting your reviews, to ensure that the most critical areas and areas of greatest risk are evaluated. We have included a generic list of control objectives as Exhibit 1. These are intended to be a minimum set of control objectives, 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.

- In the performance of your yearly risk assessment, you are to consider all results from either internal or external reviews including recent GAO, OIG reviews (including CFO audit/reviews), Contractor Performance Evaluation (CPE) Reviews, and results of either your own or HCFA-sponsored SAS-70 reviews. Any of these efforts could impact the conduct of your risk assessment and preparation of your certification statement. Remember that this years risk assessment process is the first one to be conducted after HCFAs mandated 5-year review cycle. Your risk assessment process must provide sufficient documentation to fully explain the reasoning behind and the planned testing methodology for each selected area. **A copy of your risk assessment analysis must be included as an attachment with your certification statement**. In the near future, HCFA will send a letter to those Medicare contractors that have had HCFA-sponsored SAS-70 and Certification Statement Oversight reviews regarding how those contractors will report and follow-up on the results of those reviews.

- You are required to provide a certification statement to HCFA pertaining to your internal controls. Within the context of the certification, you are asked to identify Reportable Conditions and Material Weaknesses. These terms have been defined and are included as Exhibit 2. 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.** Within that same time frame you are also required to notify and provide a copy of the CAP to the Office of Financial Management at the address below.

- Beginning this year, HCFA is requiring an Executive Summary to be included with the certification statement. This summary should provide, at a minimum, the contractor identification numbers, geographical locations for which the certification applies, the areas selected for review, the dates the reviews were conducted, a brief summary of the review results, the name and title of the person(s) who conducted the review, the location and custodian of the working papers, any Reportable Conditions, any Material Weaknesses, and the status of any corrective action plans. Also, the summary should provide the name and telephone number of a contact person who can explain the risk assessment process, the certification review, the results and the status of any corrective action plans.

- Exhibit 3 contains a generic FY 2000 certification statement. If necessary, the statement should be modified to reflect actual findings and conditions found through your review. The statement is to be signed by a corporate officer and is due by September 1, 2000. The original statement should be sent to the address listed below, with a copy forwarded to your regional office.

  Ms. A. Michelle Snyder
  Director
  Office of Financial Management
  Health Care Financing Administration
  7500 Security Boulevard, C3-01-24
  Baltimore MD 21244-1850

The certification statement must include information on the status of any corrective actions, the effect on management controls and operating capacity, as well as the estimated dollar impact on the Medicare Trust Funds. Certification statements should also provide reasonable assurance that your organization is in compliance with FMFIA and the CFO Act requirements. A rationale for management controls, which are not implemented on the basis of a cost benefit analysis, should be also documented in your working papers prepared for this review.

We remind you of the importance of maintaining appropriate and necessary documents to support any assertions and conclusions made during the self-assessment process. Please understand that the documentation and rationales that support your certification statement, whether prepared internally or by an external organization, must be available for review and copying by HCFA and its authorized representatives. **If you are relying on the work of an external organization to support your certification statement, include a copy of their opinion and/or report with the submission of the certification statement.**

The *effective date* for this Program Memorandum (PM) is October 1, 1999.

The *implementation date* for this PM is September 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after June 30, 2001.

If you have any questions, contact Bill Karantzalis at 410-786-3361 or Tom Grieves at 410-786-3373.

Exhibit 1

FY 2000 SUGGESTED CONTROL OBJECTIVES

A. **Medicare Protocol Information Systems Objectives**

1. Entity-wide security program

   a) Periodically assesses risks.
   b) Document an entity-wide security program plan.
   c) Establish a security management structure and clearly assign security responsibilities.
   d) Implement effective security related personnel policies.
   e) Monitor the security program's effectiveness.

2. Access Controls

   a) Classify information resources according to their criticality and sensitivity.
   b) Maintain a current list of authorized users and their access authorization.
   c) Establish physical and technical access controls to prevent or detect unauthorized access.
   d) Monitor access, investigate apparent security violations, and take appropriate remedial action.

3. Application software development and change control

   a) Ensure that processing features and program modifications are properly authorized.
   b) Test and approve all new or newly revised software.
   c) Control software libraries.

4. Segregation of Duties

   a) Segregate incompatible duties and establish related policies.
   b) Establish access controls to enforce segregation of duties
   c) Control personnel activities through formal operating procedures, supervision, and review.

5. System Software

   a) Limit access to system software.
   b) Monitors access to and use of system software.
   c) Control system software changes.

6. Service Continuity

   a) Assess the criticality and sensitivity of computerized operations and identify supporting resources.
   b) Take steps to prevent and minimize potential damages and interruption.
   c) Develop and document a comprehensive contingency plan.
   d) Periodically test the contingency plan and adjust as appropriate

B. **Medicare Claims Processing Control Objectives**

1. Medicare Claims

   a) System capabilities and documentation are accessible in the Medicare claims processing system to track a claim from receipt to final resolution.
   b) Procedures are established to ensure that the data scheduled for processing is valid and errors are rejected.
   c) Controls and edits are in place to ensure claims are processed accurately and in a timely manner in accordance with HCFA guidelines.
   d) Claims are reopened when necessary and in accordance with HCFA guidelines.
   e) Claim payments are properly calculated and duplicate claims are identified prior to payment.
   f) Claims are properly aged from the actual receipt date to the actual date of payment in compliance with legislative mandates.
   g) Procedures are in place to train personnel to detect and deter fraudulent and abusive practices.

2. Appeals

   a) Medicare Part A reconsideration's and Part A reviews are processed based on HCFA instructions and completed within legislatively mandated time frames.
   b) Medicare Part B reviews and hearings are appropriately logged and tracked to meet HCFA guidelines.
   c) Medicare Part A reviews and hearings are processed based on HCFA instructions and completed within HCFA legislatively mandated time frames.
   d) Medicare Part B reviews and hearings are processed based on HCFA instructions and completed within legislatively mandated timeframes.
   e) Policies are in place to ensure Administrative Law Judge (ALJ) cases are handled in compliance with legislatively mandated time frames.

3. Beneficiary/Provider Services

   a) Beneficiary and provider written and walk-in inquiries are handled accurately, appropriately, and in a timely manner.
   b) Controls are in place to ensure telephone inquiries are answered timely, accurately, and appropriately.
   c) Information, which is releasable in accordance with the Privacy Act, is handled properly.
   d) A quality assurance program is in place to ensure Explanation of Medicare Benefits are properly generated (Part B only).
   e) Methodologies are established as approved by HCFA 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.
   f) Safeguards are established in the Provider Enrollment Process to prevent sanctioned providers from receiving Medicare payment.
   g) Enroll providers in the Medicare Participation Program and issue provider numbers in accordance with HCFA guidelines (Part B only).

C. **Payment Safeguards**

1. Fraud and Abuse

a) An independent fraud unit that is responsible for detecting and deterring potential fraud should be developed and maintained.

b) Written procedures should exist for fraud department personnel to use for the detection and review of potential fraud situations.

c) Reactive and proactive techniques in the detection and development of potential fraud cases should be used especially in the area of data analysis.

d) Procedures should exist to ensure appropriate safeguard actions are taken when fraud is suspected which should include suspension, recovery of overpayments, provider education, referral to OIG, and denials.

e) Management should support 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.

f) Written instructions should exist detailing procedures for interaction between the fraud unit and the following contractor units; Medical Review, Overpayment, Medicare Secondary Payer, Correspondence, Appeals, Provider Enrollment, Provider/Beneficiary Services and Audit.

g) All procedures established for handling fraud unit activities should be compliant with the current Medicare contract and all relevant Medicare Intermediary Manual (MIM) and Medicare Carrier Manual (MCM) sections, Budget Performance Requirements (BPR), Program Integrity Manual (PIM) and general instructions provided by HCFA.

h) Procedures should be in place and appropriate action taken for fraud unit personnel to educate other departments within Medicare on detecting and referring potential fraud situations. Procedures should exist to ensure that other areas within the contractor's organization are alerted to procedural and programmatic weaknesses.

i) All information gathered by and furnished to the fraud unit should be maintained in a secure environment, kept confidential and the privacy of all parties should be protected.

j) Ensure that information compiled for direct and indirect reporting to HCFA is clearly documented and can be traced to its original source.

k) Adequate controls should be in place within any automated Case Control system to ensure the data residing within this system is entered timely and is complete and accurate. Staff is proficient in use of the system.

l) Procedures should be in place to ensure that cases are appropriately identified and prioritized according to the guidelines established by HCFA.

m) Procedures should be in place to ensure that all inventory is properly controlled and monitored.

n) Procedures should be in place to ensure that all necessary documentation regarding actions taken and final disposition is properly executed and maintained.

o) Procedures should be in place to ensure that all requests for assistance from law enforcement agencies are responded to in a timely fashion.

p) Procedures should be in place to ensure that all report requirements are met in an accurate and timely manner.

q) Procedures should be in place to ensure that all notifications required by HCFA are performed in a timely fashion and in accordance with HCFA guidelines.

r) Procedures should be in place to ensure that all provider amounts due are properly recorded and all subsequent transactions are properly accounted for and recorded.

s) Procedures should be in place to ensure that all National Medicare Fraud Alerts are appropriately handled.

t) Procedures should be in place to ensure that regular communication takes place with the OIG on referred or pending cases.

2. Medical Review

a) Data Analysis to Support Focused Medical Reviews (FMR)

1) Controls/procedures should be in place to conduct data analysis to identify baseline practice patterns, aberrance's, potential areas of over utilization, patterns of non-covered care, and changes in utilization overtime (trends) by providers in aggregate, by specialty type or individually.

b) Local Medical Review Policies (LMRPs)

1) When LMRPs are developed, ensure that the policies are comprehensive and accurate to the particular item or service(s) and are not in conflict with national policy.

c) Prepayment Medical Review

1) Procedures should be in place to detect which HCFA; specified edit comparisons in the prepayment environment are producing the greatest savings or are the most frequently used.
2) Procedures should be in place so that when services are clearlynon-covered, denials for those items/services are automated whenever possible.
3) Procedures should be in place to ensure necessary medical expertise is applied during the MR process.
4) Controls/procedures should be in place to ensure current MR/FMR instructions are used to verify services billed are covered services, medically necessary, not excessive in nature, and are appropriately classified for payment and beneficiary liability purposes in accordance with current FY BPRs, as well as manual requirements.

d) Post Payment Medical Review

1) A procedure should be in place to ensure thorough comprehensive post payment medical reviews and/or coverage compliance reviews fully comply with manual requirements.
2) Procedures should be in place to ensure the status of post payment cases can be identified at any given point in time and are closed in a timely manner.
3) Controls/procedures should be in place to monitor the Medicare claims experience of all providers, individual and group physicians/suppliers in your service area to acquire statistical data on them and their specialty groups.
4) Procedures should be in place to ensure providers are notified in a timely manner of any new or modified HCFA guidelines and are educated on appropriate billing practices.
5) Procedures should be in place to ensure provider contact resulting from the MR process is in compliance with the Medicare Intermediary Manual and/or Medicare Carrier Manual.
6) Assure all quality of care issues are referred to the Professional Review Organization, OIG, or the regional office (Health Standards and Quality).
7) Controls/procedures should be in place to identify suppliers who bill for services not ordered by a physician or items not properly certified by a physician.

8) Controls/procedures should be in place showing how management supports the internal networking and sharing of information on MR activities, potential fraud cases, audit and MSP.
9) Procedures should be in place to ensure files contain proper documentation and are in compliance with HCFA, MIM and MCM requirements.

3. Medicare Secondary Payer (MSP)

a) Procedures that are consistent with all HCFA applicable directives, regulations, etc. should be in place to ensure that MSP provisions are performed in accordance with current FY BPRs, as well as manual requirements.
b) Contractors should follow HCFA guidelines to ensure that claims involving multiple payers are processed correctly; i.e., when Medicare is primary, claims are paid as primary.
c) Procedures that are consistent with all HCFA applicable directives, regulations, etc. should be in place to ensure compliance with the MSP provisions for the Internal Revenue Service/Social Security Administration/HCFA Data Match Recoveries project.
d) 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.
e) Procedures that are consistent with all HCFA applicable directives, regulations, etc. should be in place to ensure that clear audit trails for MSP recoveries (receivables) are maintained.
f) Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure the timely reporting of all required MSP reports.
g) Procedures that are consistent with all HCFA applicable directives, regulations, etc. should be in place to ensure that correspondence is issued to the appropriate parties in cases where other party primary liability is suspected.
h) Contractors should seek recovery of mistaken or conditional primary payments made in MSP situations in accordance with all HCFA instructions.

D. **Administrative Control Objectives**

1. Employees must comply with applicable laws and regulations regarding compliance issues, conflict of interest and code of ethics. Program compliance education and training programs are in place to ensure that employees understand their responsibilities.
2. Data being reported must be valid and free of errors before being submitted to HCFA or other reporting entities.
3. Reports shall be automated. If manual adjustments are made, appropriate documentation of the file must be made.
4. Procedures shall be in place to ensure that the integrity of the mail room receipt date is maintained.
5. Incoming and outgoing mail, both electronic, and paper must be properly handled in accordance with published time frames, security guidelines, and in the most cost effective and efficient manner.
6. Procurements must be awarded and administered in a consistent manner and in accordance with the Medicare contract and applicable FAR.
7. Appropriate levels of approval must be observed to ensure control and avoid potential legal issues.
8. Appropriate operating areas must ensure that instructions and critical tasks are implemented and maintained timely and accurately.
9. Medicare management structure must be conducive to efficient contract performance and prudent business practices.

10. Records must be retained according to guidelines established by HCFA and other Federal Agencies.

11. Operations must have business continuity plans and the plans must be tested periodically.

E. **Provider Audit and Reimbursement**

1. All information received by HCFA 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 should be identified, recorded, and processed in a timely manner.
2. Interim payments to Medicare providers should be established in a timely manner, and monitored in accordance with HCFA general instructions. Adjustments to interim payments should be made to insure that payments approximate final program liability within established ranges. Provider payment files should be updated in a timely manner when adjustments are made, and should be adequately protected.
3. Systems should be established and maintained to insure that all Provider cost Reports are submitted within the time frames stipulated by HCFA's general instructions. Once received, cost report information should be forwarded to the proper HCFA system. Controls should be established to trigger actions for cost reports that are not filed timely.
4. Desk Review activity should be properly scoped to obtain a fair and accurate review of reimbursed costs. Methods should be established and maintained to identify provider situations requiring either limited desk review or focused review. All tentative settlements based desk review activity should be made in a timely manner.
5. Audits of providers' records should be performed in accordance with HCFA instructions and in conjunction with Government Auditing Standards (GAS). The process should be managed through proper planning and budgeting. Objectives should be established to manage the process through proper working paper documentation, propose and communicate adjustments and to include the provider's responses. An internal quality control process (IQC) should be established to ensure the propriety of the audit process.
6. Control the settlement process by establishing procedures to include all adjustments to the cost report. Identify final program liability of the provider. Issue proper and timely Notices of Program Reimbursement (NPR) including all related documentation. All final settlements should be made in a timely manner.
7. Systems should be established to accurately identify, remit or collect payments to/from providers. These systems should have the ability to track such transactions on an ongoing basis, and reconcile them with a provider's final program liability. All overpayments should be identified and collected in a timely manner. Files should be maintained and reconciled to identify outstanding provider receivables/payables according to HCFA instructions on financial reports. Proper communication among the provider, the Medicare Contractor, and HCFA should be maintained.
8. The Medicare Contractor should establish and implement administrative procedures for the reopening of the Medicare cost report. All time frames regarding the conditions under which a cost report can be reopened should be included in the administrative procedures.
9. Procedures should be established and implemented for the processing of provider exception requests (such as End Stage Renal disease (ESRD) exceptions or Routine Cost Limit (RCL) exception requests) and other requests.
10. The Medicare Contractor must establish and implement administrative procedures for handling all provider appeals and adjustments. These controls should include both the Office of Hearings (OH) and Intermediary Appeals. The procedures should assure that all jurisdictional questions are addressed and all timeframes for submission are observed.

11. Procedures should be established and implemented to capture and update the Provider Statistical and Reimbursement Report (PSRR). Processes should be in place to distribute the report, as appropriate, to providers, and to internally reconcile the report with claims paid files.
12. Procedures should be established and implemented to assure that inputs to mandated reports regarding Provider Audit and Reimbursement performance (STAR, CASR, etc.) are accurate and in compliance with program instructions.

F. **Financial Control Objectives**

Transactions for Medicare benefit receivables, payables, expenses and administrative costs must be recorded and reported timely and accurately, and financial reporting must be completed in accordance with HCFA 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 (HCFA 750A and HCFA 750B),
  - Status of Accounts Receivable (HCFA 751A and HCFA 751B),
  - Status of Accounts Receivable Medicare Secondary Payer (HCFA 751A-MSP and HCFA 751B-MSP),
  - Reconcile to the Status of Accounts Receivable Regional Office (HCFA 751A-
  - Reconcile to the Provider Overpayment Reporting (POR) System and the Physician Supplier Overpayment Reporting (PSOR) system.
- Monthly Contractor Financial Report (HCFA 1522) and Contractor Draws on Letter of Credit (HCFA 1521),
- Reconciliation of Cash Balances and Cash Receipts.

1. All transactions recorded and processed through the accounting system should be approved by appropriate individuals in accordance with management's criteria and should meet HCFA's policies.
2. All transactions and related processing activities must be supported by appropriate detailed records, which are properly classified, maintained, accurately summarized and reconciled to account balances.
3. The contractor must provide for the segregation of duties for disbursement activities, collection activities, and activities related to assets.
4. The contractor must provide HCFA with Contractor Financial Reports that are properly accumulated and accurately represent their financial data within mandated timeframes. In addition, the contractor must properly review the documentation/reports and have documentation to support each line item.
5. The contractor should have an individual sign and certify all reports, and where applicable, provide reasonable assurance that the information in the reports is accurate.
6. All accounts receivables should exist and be valued on an appropriate basis and should be correctly recorded in the books and records of the contractor.
7. All banking information received from the bank must be accurate and conform to the tripartite agreement.
8. Budget Performance Requirements must be met or an exception negotiated with HCFA.

G. **Debt Collection**

1. Procedures that are consistent with all HCFA applicable directives, regulations, etc. should be in place to ensure that provider debt collection provisions are performed in accordance with current FY BPRs, as well as manual requirements.
2. Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure that all provider amounts due are timely collected and that clear audit trails for debt recoveries (receivables) are maintained.
3. Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure the proper recording and the timely reporting on the Provider Overpayment Reporting System and the Physician and Supplier Overpayment Report of all provider amounts due.
4. Controls/procedures should be in place showing how management supports the internal net working and sharing of information on debt collection activities.
5. Procedures should be in place to ensure that all provider amounts due (accounts receivables) are properly controlled and monitored.
6. Procedures should be placed to ensure that all necessary documentation regarding debt collection actions taken and final disposition are properly executed and maintained.

Exhibit 2

Definitions
Reportable Conditions and Material Weaknesses

Contractors are required to identify " Reportable Conditions" and "Material Weakness" in their certification letter. These terms are defined as follows:

- A **REPORTABLE CONDITION** exists when a contractor's internal controls are adequate and reasonable assurance can be provided that the intent of the control objective is met, but problems requiring correction have been identified during the review. It is necessary for contractors to track and correct the problem, but no Corrective Action Plan (CAP) need be submitted to the Health Care Financing Administration (HCFA). Contractors should, however, inform HCFA when the condition was observed and corrected (or the status if not corrected), and include information on any dollar impact on the Medicare Trust Funds.

- A **MATERIAL WEAKNESS** exists when the contractor fails to meet a control objective. This may be due to a significant deficiency in the contractor's internal controls that result from inadequate performance and/or policies and procedures. Because of these shortfalls in internal controls, the contractor cannot provide reasonable assurance that the intent of the control objective and/or that a contractual obligation is being met.

Contractors are required to provide written notification of all Material Weaknesses and a CAP to their Regional Administrator, as well as the Provider Audit Operations Branch (the address is contained in the letter, which accompanies this document) within 30 calendar days of the identification of the problem. Information in the certification statement must include the status of any corrective actions, the effect on internal controls, and operating capacity, as well as, the estimated dollar impact on the Medicare Trust Funds.

Exhibit 3

Ms. A. Michelle Snyder
Director
Office of Financial Management
Health Care Financing Administration
c/o Provider Audit Operations Branch
7500 Security Boulevard, C3-14-00
Baltimore, MD 21244-1850

Dear Ms Snyder:

As (Chief Executive Officer, Chief Financial Officer, 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 Comptroller General's "Standards For Internal Controls In the Federal Government" as required by the Federal Manager Financial Integrity Act and the Chief Financial Officers Act.

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 and executive summary that identifies: a) the name and title of the person(s) who reviewed our internal controls; b) the geographical locations for which the certification applies, c) the dates the reviews were conducted, d) a brief explanation of how the reviews were conducted, e) a summary of the results of the review, f) the name and title of the person(s) who conducted the review g) the areas reviewed; h) the location and custodian of the working papers for the review, i) Reportable Conditions; j) Material Weaknesses; k) the status of any corrective actions; and l) the contract identification numbers. Material Weaknesses have previously been reported to you and the appropriate regional office; the respective Corrective action Plans/Performance Improvement Plans have previously been forwarded to your office. I have also included a copy of our risk assessment analysis. This letter and its attachments summarize the results of our review.

I also understand that officials from the Health Care Financing Administration, 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;

(Official's Signature and Title)