Department of Health and Human Services
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Medicare Administrative Contractors Did Not Consistently Meet Medicare Cost Report Oversight Requirements

REPORT HIGHLIGHTS

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Why OIG Did This Audit

- Medicare cost reports are a crucial component of the operation and oversight of the Medicare program.
- Cost reports are used to set future Medicare prospective payment rate and wage indexes and reimburse providers for the care that the facilities provide to Medicare enrollees.
- This audit examined whether individual Medicare Administrative Contractors (MACs) met Medicare cost report oversight requirements.

What OIG Found

MACs did not consistently meet Medicare cost report oversight requirements.

- For Federal fiscal years 2019–2021 (audit period), each of the 12 MAC jurisdictions failed to comply with the contract requirements for audit and reimbursement desk review and audit quality (AR-4) for at least 1 of the 3 years.
- CMS identified 287 total audit issues among all MAC jurisdictions during our period, including MACs not performing proper reviews; inadequate review of graduate medical education and indirect medical education reimbursement; improper review of allocation, grouping, or reclassification of charges to cost centers; improper calculation and reimbursement for nursing and allied health programs; and inadequate review of bad debts.
- MAC officials from selected jurisdictions suggested multiple causes for the findings including unclear guidance from CMS, limited feedback on the cost report reviews, inadequate training, and staffing and workload issues.
- CMS addressed some of these issues after our audit period.

What OIG Recommends

We made three recommendations to CMS to improve its efforts in ensuring that MACs meet their cost report oversight requirements, including increasing transparency about its processes and providing additional training.

CMS generally concurred with all three recommendations and has taken steps to address all of our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare cost reports are a crucial component of the operation and oversight of the Medicare program. Federal law requires Medicare-enrolled institutional providers, including hospitals and skilled nursing facilities, to submit annual cost reports to their Medicare administrative contractor (MAC). MACs, which contract with the Centers for Medicare & Medicaid Services (CMS) to process claims and cost reports, submit cost report-related information to CMS. These reports constitute a comprehensive financial accounting of the costs of providing services to people enrolled in Medicare. Cost reports have many different uses by CMS including to establish future Medicare prospective payment rates and wage indexes. In addition, MACs use cost reports to determine the final amount of Medicare program reimbursement due to providers for their cost reporting period (e.g., reimbursements for provider spending on medical education, uncompensated care, low-income patients, and high-cost Medicare cases). CMS oversees and evaluates MACs' performance of their contractual obligations to process cost reports.

The Office of Inspector General (OIG) has conducted a significant number of audits involving Medicare cost reports, predominately those submitted by hospitals. This work has led to billions of dollars in savings for the Medicare program through the implementation of our recommendations to adjust payment rates based on information gained from cost report audits (See Appendix B for a list of related OIG reports).

We performed this audit to determine whether the MACs had adequate oversight of the cost report process.

OBJECTIVE

Our objective was to determine whether individual MACs met Medicare cost report oversight requirements stated in the MAC contracts.

BACKGROUND

The Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient and therapy services. CMS administers the Medicare program.

Medicare Administrative Contractors

A MAC is a private health care insurer that has been awarded a contract covering a defined geographic area, or jurisdiction, to process Medicare Parts A and B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries. MACs serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. MACs perform many administrative activities, including processing and paying claims, enrolling providers in the Medicare program, and conducting desk reviews and audits of cost reports.

There are 12 MACs that process A/B claims for services from providers within a jurisdiction, including institutional providers, physicians, and other health care entities.[1]

Medicare Cost Reports

Certain institutional providers, such as hospitals, skilled nursing facilities, and home health agencies, are required to submit annual cost reports to their MAC. CMS uses the financial and statistical data reported in the cost reports to set Medicare payment rates and calculate reimbursements for provider spending on medical education, uncompensated care, low-income patients, and high-cost Medicare cases. The cost report contains a series of worksheets with information on facility characteristics, health care utilization, employee salary and wage data, facility costs and charges, and Medicare settlement data.

MAC Oversight of Medicare Cost Reports

Pursuant to their contracts with CMS, MACs must ensure that providers follow the cost reporting principles and policies that are contained within the Provider Reimbursement Manuals and the regulations at 42 CFR §§ 413.20 and 413.24. After acceptance of each cost report, MACs perform a tentative settlement. Then, the MACs conduct desk reviews of cost reports for all providers that file a Medicare cost report, with the exception of cost reports for providers that have low or no Medicare utilization.[2, 3] A desk review is an analysis of the provider's cost report to evaluate its adequacy and completeness and determine the accuracy and reasonableness of the data contained in the cost report. This process does not include detailed verification and is designed to identify issues that may warrant additional review. The purpose of the desk review is to determine whether the cost report can be settled without an audit or whether an audit is necessary.[4] In contrast, an audit is an examination of financial

[1] Our audit was limited to the review of the performance of A/B MACs and did not include DME MACs.

[2] Medicare Financial Management Manual (MFMM), chapter 8, § 20.1.

[3] MACs may use professional judgment to determine whether to review a Medicare provider with low or no utilization.

[4] MFMM, chapter 8, § 20.1.

transactions that tests the provider's compliance with the law, regulations, and Medicare manual instructions.

In selecting cost reports to audit, the MAC uses its professional judgment in determining which providers represent the greatest risk of incorrect payment.[5, 6] MACs perform audits in compliance with the Government Auditing Standards issued by the Comptroller General of the United States and use desk reviews and empirical knowledge of providers to define audit objectives and the scope and methodology to achieve those objectives.[7] In addition, MACs are required to ensure that the audit is conducted by staff that collectively has the knowledge and skills necessary for the audit.[8] These qualifications apply to the knowledge and skills of the contractor's organization as a whole and not necessarily to every individual auditor. Also, all audit work performed is subject to supervisory review to ensure audit quality.[9]

After conducting the desk review or audit, the MAC will settle the cost report (i.e., final settlement) and send a Notice of Amount of Program Reimbursement (NPR) to the provider and other parties, as appropriate, reflecting the MAC's final determination of the total amount of reimbursement due to the provider.[10]

CMS Oversight of MAC Cost Report Settlement Activities

According to section 1874A(b)(3) of the Social Security Act (the Act), CMS has developed specific performance requirements for MACs to carry out functions such as cost report settlement activities. As part of its MAC oversight, CMS developed the Quality Assurance Surveillance Plan (QASP), which provides a systematic approach to evaluate how well MACs are fulfilling contract requirements. CMS has a contractor perform the Audit and Reimbursement QASP evaluations for each MAC annually.[11, 12] The QASP measures the MAC's compliance with the contract requirements in several areas, including Audit and Reimbursement (AR), Claims Processing, and Provider Enrollment. During the QASP evaluations, CMS identifies issues at each MAC based on their provider cost report audits and reviews.

[5] MFMM, chapter 8, § 40.

[6] MACs consider the provider reimbursement amount, new component areas, provider ownership changes, and Sustainability Tracking Assessment and Rating System (STAR) data in determining which providers to audit.

[7] MFMM, chapter 8, §§ 30.1, 50.1, and 80.

[8] MFMM, chapter 8, § 80.1.

[9] MFMM, chapter 8, § 60.13.

[10] MFMM, chapter 8, § 90.

[11] The CMS contractor has been performing Audit and Reimbursement QASP evaluations at each MAC since March 1, 2018.

[12] Throughout this report "CMS" includes the QASP contractor when we are discussing the QASP evaluations.

Thirteen AR performance standards exist. The various QASP AR standards evaluate areas such as 1) desk review and audit quality, 2) cost report acceptability timeliness, and 3) NPR timeliness. See Appendix C for a list of all 13 AR performance standards.

CMS assigned each performance standard a numeric goal (performance threshold) that it used to determine whether the MAC adequately performed that standard. For example, the Federal fiscal year (FFY) 2021 performance threshold for one AR standard, Desk Review and Audit Quality (AR-4), was 95 percent.[13] To achieve the 95 percent performance threshold for AR-4, CMS established a weighted methodology that assigned points for seven categories. The seven categories include the following: accurate desk review used, uniform desk review modules accurately completed, audit program steps accurately completed, accurate and complete workpapers, accurate summary of issues, accurate NPR reimbursement, and accurate cost report. To determine whether a MAC achieved this 95 percent performance threshold, CMS selected for review a sample of cost reports settled by the MACs.

For each year during our audit period (FFYs 2019–2021), CMS selected 3 to 5 cost reports per MAC jurisdiction for QASP evaluations—totaling 123 across the 12 MAC jurisdictions—in which the NPR was issued during the contract year.

Another aspect of CMS oversight is the development of the uniform desk review (UDR) program used by MACs for conducting desk reviews.[14, 15] CMS, its contractor, and the MACs coordinate to develop the UDR. CMS and its contractor develop an initial UDR and provide that to MACs for final comments. After the MACs provide comments, CMS revises the UDR, if necessary, and releases it for use. The UDRs are subject to revision as change requests and Technical Direction's Letters (TDLs), which can vary by topic, are issued by CMS to the MACs.

In addition, CMS developed a Hospital and SNF audit program (the audit program) containing procedures designed to verify that the costs claimed by providers are allowable under Medicare and are properly classified in the cost report.[16] The audit program is used after the cost report is settled and desk review is completed. The audit program is not designed to be used in its

[13] Throughout the report, we will refer to Audit & Reimbursement Desk Review and Audit Quality as AR-4.

[14] During our audit period, the latest UDRs were issued to MACs on May 14, 2021, and were effective for cost reports ending October 31, 2020, and later.

[15] MFMM, chapter 8, §§ 20.2 and 170 (Exhibit 1); Hospital Full Professional Desk Review Program.

[16] The CMS Hospital and SNF audit program was developed in 1999. Throughout the report, we will refer to the CMS Hospital and SNF audit program as the audit program.

totality but with a limited scope of audit procedures that focus on deficiencies identified during desk reviews.

HOW WE CONDUCTED THIS AUDIT

Our audit covered CMS contracts with all 12 A/B MAC jurisdictions responsible for reviewing and settling provider cost reports. We focused on the QASP standard AR-4 and the issues identified by CMS on the annual QASP evaluations. We reviewed all CMS QASP evaluation reports issued to these MACs for FFYs 2019, 2020, and 2021 to identify the 287 CMS issues described in the Findings section below.

Based on the QASP results for our audit period, each of the 12 MAC jurisdictions failed to meet the 95 percent performance threshold for AR-4 for at least 1 of the 3 years in our audit period. We selected a non-statistical sample of six jurisdictions that failed to reach the AR-4 95 percent performance threshold in at least one year of our audit period for a more detailed review of their desk review and audit processes, provider selection for audit, workpaper documentation, and audit oversight and supervision. In addition, these six jurisdictions had numerous issues identified by CMS during the QASP reviews for each of the three years in our audit period.[17] We conducted interviews with MAC oversight personnel and obtained documentation from the six selected jurisdictions relating to internal controls, cost report documentation, audit processes, and oversight.

This report does not represent an overall assessment of the MAC cost settlement process.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix A for details on our scope and methodology.

FINDINGS

MACs did not consistently meet Medicare cost report oversight requirements stated in their contracts. Each of the 12 MAC jurisdictions failed to meet the 95 percent performance threshold for AR-4 for at least 1 of the 3 years in our audit period. CMS identified 287 total audit issues among all MAC jurisdictions in its QASP during this period.

MAC officials from the six sampled jurisdictions described several challenges that contributed to their failure to meet contract requirements. These challenges included difficulties recruiting and retaining audit staff with the experience necessary to review complex cost report

[17] Three separate MACs are responsible for the oversight of the six jurisdictions.

settlements and an increase in the number of desk reviews and audits that they must conduct each year.

In addition, MAC officials suggested several ways that CMS could make the QASP process more useful to the MACs in improving compliance with cost report oversight requirements, including providing more detailed feedback and guidance from CMS, incorporating revised change requests and TDLs into the UDR, and offering training tailored to individual MACs based on the challenges they face in their specific jurisdictions.

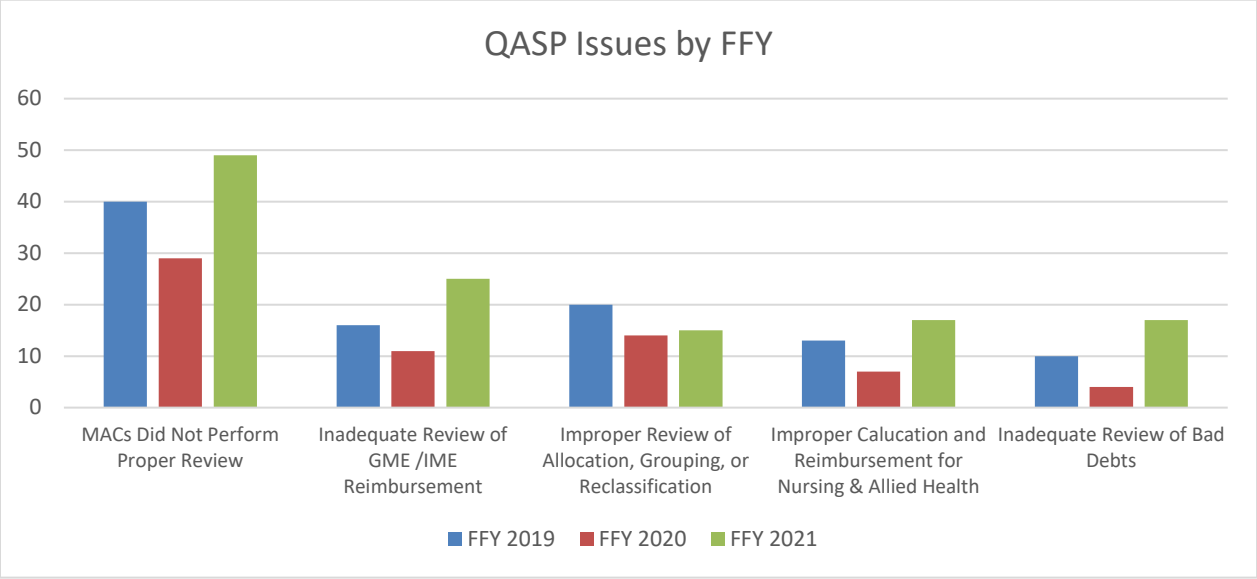
If CMS does not ensure that MACs meet contractual requirements for reviewing cost reports, providers may be incorrectly reimbursed. As noted in the sections below, CMS addressed some of these issues after our audit period.

MACs DID NOT CONSISTENTLY MEET MEDICARE COST REPORT OVERSIGHT REQUIREMENTS

Issues Identified by CMS in its QASP Reviews

Each of the 12 MAC jurisdictions failed to meet the 95 percent performance threshold for AR-4 for at least 1 year within our audit period. CMS identified 287 total audit issues among all MAC jurisdictions in its QASP during this period. For reporting purposes, we summarized the 287 audit issues into five major issue categories (see graphic below). The five categories are: (1) MACs did not perform proper review; (2) inadequate review of graduate medical education (GME) and indirect medical education (IME) reimbursement; (3) improper review of allocation, grouping, or reclassification of charges to cost centers; (4) improper calculation and reimbursement for nursing and allied health programs; and (5) inadequate review of bad debts.

Summary of QASP Audit Issues by Federal Fiscal Year



MACs Did Not Perform Proper Review

Proper reviews for MACs include ensuring there are no inaccuracies in paperwork, making necessary adjustments to cost reports, and confirming calculations of cost components. For the 3-year audit period, 118 out of the 287 (41 percent) issues identified across all MACs were for MACs that did not perform the proper review. The following are examples of issues in this category identified by CMS in its QASP evaluations:

- One MAC did not calculate the Hospital Acquired Condition program in the Provider Statistics and Reimbursement (PS&R) cost report settlement data, resulting in an overpayment of approximately $250,000.

- One MAC overstated organ acquisition days and did not properly allocate them when multiple organs were removed. This resulted in an estimated overpayment of more than $600,000.

Inadequate Review of Graduate Medical Education and Indirect Medical Education Reimbursement

GME costs are direct costs reimbursed by Medicare to teaching hospitals associated with training interns and residents. These direct costs include salaries paid to interns, residents, and teaching physicians, teaching materials, classrooms, and conferences. IME costs are additional patient care costs associated with the training of interns and residents.[18]

For the 3-year audit period, 52 out of the 287 (18 percent) issues identified across all MACs were for inadequate reviews of GME and IME reimbursement during cost report settlements. The following are examples of issues in this category identified by CMS in its QASP evaluations:

- One MAC used an incorrect GME update factor, resulting in a GME overpayment of $3,000.[19]

- One MAC had duplicate GME and IME resident full-time equivalent (FTE) counts. The MAC incorrectly stated that the provider did not have any prospective payment system (PPS)-excluded units. However, the provider had FTEs for an inpatient psychiatric facility and an inpatient rehab facility, both of which are PPS-excluded units. This issue could have resulted in erroneous payments totaling approximately $650,000 for duplicate FTEs in PPS and PPS-excluded units.

[18] IME costs are made to compensate teaching hospitals for the higher patient care costs and more complex cases that result from medical education.

[19] The GME update factor is a factor applied to the prior period's per-resident amount and used in determining the year's final settlement.

Improper Review of Allocation, Grouping, or Reclassification of Charges to Cost Centers

One of the fundamental requirements of the Medicare cost report is the proper grouping and reclassification of accounts to cost centers to match costs with charges, allocate overhead, and assign costs to non-reimbursable cost centers. When preparing the Medicare cost report, hospital providers must decide how to allocate Medicare charges to cost centers.[20] Specifically, hospital providers must allocate the revenue codes listed on the PS&R report to the various cost centers on the Medicare cost report.

For the 3-year audit period, 49 out of the 287 (17 percent) issues identified across all MACs were for improper reviews of allocation, grouping, or reclassification of charges to cost centers. The following are examples of issues in this category identified by CMS in its QASP evaluations:

- One MAC failed to account for physician and physician assistant salaries, resulting in an estimated cost reduction of approximately $1.8 million that would have significantly reduced the Medicare reimbursement to the hospital.

- One MAC allocated home office costs to the Adults and Pediatric cost center, but the costs should have been allocated to the Administrative and General cost center. In addition, those home office costs were allocated on a twelve-month period (October 1, 2014, to September 30, 2015) but should have been allocated based on the current year's cost report which was nine months (January 1, 2015, to September 30, 2015).

Improper Calculation and Reimbursement for Nursing and Allied Health Programs

Section 541 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113) provides for additional payments to hospitals for costs of nursing and allied health education associated with services to Medicare Advantage enrollees. Hospitals that operate approved nursing or allied health education programs and receive Medicare reasonable cost reimbursement for these programs would receive additional pass-through payments. Section 512 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554) changed the formula for determining the additional amounts to be paid to hospitals for Medicare Advantage nursing and allied health costs. Payments for nursing and allied health education net costs are determined on a reasonable cost basis, subject to conditions and limitations.[21]

For the 3-year audit period, 37 out of the 287 (13 percent) issues identified across all MACs were for improper calculations and reimbursements for nursing and allied health programs

[20] A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).

[21] Net cost refers to the total allowable educational costs that are directly related to approved educational activities less revenues received from tuition and student fees.

during cost report settlements. The following are examples of issues in this category identified by CMS in its QASP evaluations:

- One MAC erroneously included Title XIX Health Maintenance Organization (HMO) days and skilled nursing facility inpatient routine charges in the calculation of a proposed adjustment, resulting in an estimated overpayment of more than $250,000.[22]

- One MAC did not properly determine tuition income accounts associated with the allied health program. The MAC's review only included patient service revenues and did not support the review of other operating revenues to determine if tuition income was properly offset. Therefore, the MAC did not properly determine if there were any tuition income accounts associated with the allied health program.

Inadequate Review of Bad Debts

Under A/B, enrollees may be responsible for coinsurance and deductible amounts related to claims; however, some enrollees may not be able or willing to pay those outstanding amounts**.** Federal regulations state that Medicare reimburses providers 65 percent of Medicare deductible and coinsurance amounts that qualify as Medicare bad debts (42 CFR § 413.89). Bad debts are defined as amounts considered to be uncollectible from accounts and notes receivable that are created or acquired in providing services (Provider Reimbursement Manual–Part 1, CMS Pub. No. 15-1, section 302).

For the 3-year audit period, 31 out of the 287 (11 percent) issues identified across all MACs were for inadequate review of bad debts during cost report settlements. The following are examples of issues in this category identified by CMS in its QASP evaluation:

- One MAC's workpapers did not state that it reviewed the provider's policies and procedures for billing the State for deductible and coinsurance amounts. The audit program requires MACs to review the provider's policies and procedures for billing the State for the deductible and coinsurance amounts. If the provider does not have an ongoing billing system—or if there is a system in place but it has not been operated properly—the related bad debts for deductible and coinsurance amounts claimed under Medicare should be disallowed.

- Indigent accounts were not always disallowed.[23] One MAC selected a sample of patient files from the inpatient (IP) and outpatient (OP) bad debt listings. Based on the MAC's prior year's review of IP and OP bad debts, the contractor was aware that 100 percent

[22] Title XIX HMO days refers to the number of inpatient days spent by patients covered under a state's Medicaid program (Title XIX of the Social Security Act) who are enrolled in an HMO within that state's Medicaid plan.

[23] Indigent accounts apply to patients whose health insurance does not fully cover their medical expenses, and where the remaining costs would cause financial hardship, making them indigent if they were required to pay the full amount.

of indigent accounts had previously been disallowed. For the current year's IP and OP sampling testing sheets, the contractor combined traditional, indigent, and crossover bad debts into one IP and one OP sample. A combined sampling approach for all categories of IP and OP bad debts was deemed inappropriate as this methodology incorrectly reimbursed the provider for approximately $200,000 in Medicare indigent bad debts.

Factors at the CMS Level that Contributed to Non-Compliance with Cost Report Oversight Requirements

MAC oversight personnel from the six sampled jurisdictions suggested that CMS contributed to the MACs' failure to meet Medicare cost report oversight requirements in multiple ways, including unclear guidance from CMS, limited feedback on the results of the CMS QASP reviews, and inadequate training for specific challenges faced by individual MACs.

Unclear Guidance from CMS

CMS did not provide clear guidance to the MACs during our audit period for AR-4 performance standards. CMS provided the MACs with a program for conducting desk reviews. That program, called a UDR, is an analysis of the provider's cost report to determine its adequacy, completeness, and accuracy of the cost report data. The desk review results determine whether a cost report can be settled without a field audit or the extent to which a field audit is required. The MAC officials contended the UDR program instructions were vague and unclear and used general terminology. MAC oversight personnel indicated that these vague instructions are open to interpretation and MACs would find it more helpful to have more specific instructions.

The MAC officials stated that CMS's contracting officer representatives (CORs), responsible for monitoring MAC performance, should engage in ongoing discussions with the MACs during individual QASP reviews and respond to the MACs' corrective action plans (CAPs) and meeting requests.[24] The MACs explained that CMS does not provide much feedback following the CAP submission and typically just performs a closeout a few months after the QASP review. MACs also indicated that CMS would deny meeting requests on QASP reviews.

MAC oversight personnel also mentioned that the audit program is not updated with change requests or TDL updates. CMS issues changes through change requests and TDLs that take immediate effect, which makes it difficult for the MACs to transition to the new guidance without repeating previously completed work. In addition, MACs are not allotted additional resources (i.e., personnel) to account for these changes. According to the MACs, the review steps in these changes often contain vague and unclear instructions and tend to create various MAC interpretations that may not align with CMS's intent, which can lead to implementation

[24] CORs rely on subject matter experts that perform the QASP reviews to assist with these functions.

issues and ultimately result in QASP failures.[25] Also, the MACs said the number of change requests and the inability to predict when a change request will be sent hinder their ability to complete various work functions.

Limited Feedback on the CMS QASP Review Results

MAC oversight personnel expressed concern regarding CMS's limited feedback on the severity of the issues identified during the QASP reviews. CMS did not convey to the MACs which issues were more significant, and it would have been beneficial for MACs to have this information so they could focus on these issues when filing a CAP. Because of the limited information provided by CMS, the MACs were unable to adequately prioritize QASP-identified issues. The MACs stated if CMS provided more feedback, they would have been better able to reduce the QASP failure rate by having focused more on the higher-rated issues.

In addition, the MACs expressed concern regarding the limited information pertaining to the weighting and evaluation of scoring used by CMS in their QASP reviews to determine the MACs' performance percentage. MACs believed that additional feedback from CMS on the scoring of issues determined during the QASP reviews would allow them to focus on the more significant issues. In addition, MACs believed that depending on the weighting factor assigned to a particular error category, a minor issue could potentially have a major effect on the MACs' overall performance percentage, resulting in the failure to receive an award fee.

Inadequate MAC-Specific Training

During our audit period, CMS provided training related to cost report and reimbursement areas to the MACs through various methods.[26] However, the MACs indicated these were general trainings and did not address specific challenges faced by individual MACs. The MACs suggested CMS provide training that includes detailed case studies and best practices relevant to their jurisdictions so that MACs can implement additional controls to prevent recurrences of similar issues.

Factors at the MAC Level that Contributed to Non-Compliance with Cost Report Oversight Requirements

MAC oversight personnel from the six sampled jurisdictions suggested multiple causes for not consistently meeting Medicare cost report oversight requirements at the MAC level, including an increase in the number and complexity of audits and desk reviews. MAC officials said their

[25] We reviewed TDLs from CMS and agree that the instructions are unclear.

[26] Training modules developed by CMS are accessible through the online training library and are updated continuously. MAC personnel can access this system through their training coordinators. CMS also conducts an annual QASP overview webinar to explain issues identified from the prior year's QASP process. In addition, CMS and the MACs are part of the Technical Audit and Reimbursement Committee and Medicare AR Committee, which discuss technical and operational issues and policy areas.

personnel often found it challenging to complete complex cost report settlements on time because of staffing and workload issues. They said that newer staff members can be assigned to handle basic cost report audits, but complex cost report settlements require personnel with significant experience. In addition, MAC personnel indicated the expectation for the number of desk reviews and audits conducted each year has increased. Specifically, they cited the S-10 and wage index audits, which require them to dedicate a significant portion of staff to complete.[27, 28]

MAC officials acknowledged various failures leading to the specific issues cited by CMS in the QASP reviews during the audit period. However, the MACs indicated they had made several internal control improvements in response to previous QASP review issues, including an increase in automation for workpaper completion, additional review requirements for audit workpapers, revised standard working papers, and specialized training by subject matter experts on complex topics or new audit requirements. These controls help compensate for the limited staffing experience and should help improve the MACs' ability to meet their cost report oversight mission.

CMS Actions Taken After Our Audit Period

Since our audit period ended, CMS began a process to assist the MACs with their QASP concerns. CMS issued a TDL in May 2022 that included a process improvement initiative for AR performance on the MAC QASP.[29] From September 2022 through December 2022, CMS met with all A/B MACs and obtained the MACs' input on why they had been unable to meet QASP performance standards. After considering MAC feedback, CMS issued a TDL dated July 2023 implementing six changes, including two directly related to the QASP sample selection process:[30]

1) CMS doubled the sampling size for AR-4 and explained the items selected for QASP review were a combination of desk reviews and audits for providers whose cost reports had

[27] S-10 audits include a review of a provider's compliance with their own documented charity care and financial assistance policies as well as the Medicare Cost Report instructions, the completeness and accuracy of a provider's bad debts, reconciliation of a provider's financial accounting records with the bad debt amounts, and charity care amounts reported on Worksheet S-10.

[28] Wage index audits review A/B costs depending on general guidelines provided by CMS regarding appropriate supporting documentation. Each wage index audit can vary based on the provider's costs and hours related to A/B claimed on their cost report. Wage index audits occur annually between September and November.

[29] TDL-220383 Audit and Reimbursement Feedback Session (dated May 13, 2022).

[30] TDL-230464 Audit and Reimbursement QASP Feedback Session Follow-Up (dated July 10, 2023).

varying levels of complexity.[31] CMS asserts that this process improvement effort has led to greater transparency in the overall QASP process.

2) CMS adjusted the scoring for the AR-4 performance standard from an "all-or-nothing" disallowance to a partial disallowance based on a tiered weight system.[32]

In addition, CMS issued a TDL in July 2023 that included additional MAC training and a process to conduct routine feedback and training sessions tailored to individual MACs in addition to the broader annual feedback.

Had these new processes been in place during our audit period, some of the issues raised by the MACs might have been mitigated. However, as recently as June 2023, the MACs were still requesting that CMS increase its transparency on specifics relating to their QASP sample selection and content processes. In addition, CMS continues to use an outdated audit program. Because of these issues, the MACs said that the QASP failure rate may not reflect their performance across all cost settlements within a given review period. Improving its MAC evaluation process would give CMS a better picture of the MACs' overall performance in meeting requirements as stated in their contracts.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- provide MACs with a thorough explanation of the QASP results;
- update the audit program to incorporate revised change requests and TDLs so MACs can obtain a better understanding of CMS expectations and be evaluated on current requirements; and
- offer MACs additional training and guidance, based on the results of their QASP, and include best practices used by MACs.

[31] For example, desk reviews would be for providers whose cost reports did not contain many reimbursable components. On the other hand, audits would review providers with complex cost reports containing multiple reimbursable components.

[32] The tiered weight system scoring is based on a gradual scale, allowing partial points to be awarded based on the number of issues noted for each scoring category. For example, if an issue is noted in the accurate cost report category with no reimbursement impact, 19 of a possible 20 points are awarded. If an issue is noted in the accurate cost report category with a $5,000 or less reimbursement impact, 10 points are awarded. No points are awarded if an issue noted in the accurate cost report category has a greater than $5,000 reimbursement impact.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS generally concurred with all three recommendations and described steps it has taken to address them. Specifically, for the first recommendation, CMS indicated that it meets weekly with each individual MAC to go through a detailed report outlining QASP findings and results. Starting with the fiscal year 2024 QASP reviews, which began in October 2023, the QASP results are broken out into findings and observations before the MACs receive the evaluation reports. This allows the MACs to work to resolve more pressing issues noted during the QASP reviews.

For the second recommendation, CMS indicated that it is currently working to incorporate change requests and TDLs into the audit programs to give MACs a better understanding of CMS expectations of evaluation. CMS stated that it is also in the process of issuing a revised UDR that incorporates additional change requests or TDLs that have been issued since the latest version issued in 2021.

For the third recommendation, CMS said that it supports the MACs in their review of cost reports and has provided a UDR program that provides guidance to MACs on conducting desk reviews. CMS also stated that it provides various training methods to the MACs related to the cost report and reimbursement areas. CMS requested that OIG consider the first and third recommendations closed as implemented. If the steps CMS has detailed in its response are implemented, we believe the actions will address all our recommendations.

CMS's comments appear in Appendix D. CMS's technical comments are addressed in the final report.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered CMS contracts with all 12 A/B MAC jurisdictions responsible for reviewing and settling provider cost reports. We reviewed all CMS QASP AR-4 evaluation reports for these MACs for FFYs 2019, 2020, and 2021. Based on the QASP results for these evaluation periods, we selected a non-statistical sample of six jurisdictions that failed to reach the AR-4 95 percent performance threshold in at least one year of our audit period for a more detailed review of their internal controls, cost report documentation and audit processes, and oversight. In addition, these six jurisdictions had numerous issues identified by CMS during the QASP reviews for each of the three years in our audit period.

We focused our audit on the QASP AR-4 and the issues identified by CMS on the annual QASP evaluations. This report does not represent an overall assessment of the MACs' cost settlement process.

During our audit, we did not assess the overall internal control structure of CMS or the respective MACs. Rather, we limited our review to CMS's and the MAC's cost report review and oversight processes. To evaluate these internal controls, we:

- interviewed CMS officials regarding its oversight of MAC cost report audit and settlement;
- gathered CMS and MAC policies and procedures related to Medicare cost report reimbursement oversight;
- reviewed the audit program;
- reviewed CMS MAC contracts to determine what specific oversight actions those contracts assign to the MACs; and
- interviewed MAC oversight personnel for six jurisdictions and obtained supporting documentation regarding their cost report audit and settlement, including:
    - workpaper processes and related internal controls over desk reviews and audits;
    - auditor training and supervision related to their assignments;
    - MAC responses (i.e., rebuttals and CAPs) to CMS's QASP issues; and
    - obstacles encountered in meeting the CMS QASP AR-4 95 percent performance threshold.

We performed audit work from February 2022 to December 2024.

METHODOLOGY

To accomplish our objective, we took the following steps:

- reviewed applicable Federal laws, regulations, and guidance;
- completed an internal control assessment to document CMS's internal controls over MAC cost report audit and settlement;
- assessed the internal controls of MACs for six jurisdictions related to oversight, auditing, and settlement of Medicare hospital cost reports;
- aggregated the results of CMS's QASP AR-4 reviews for a 3-year evaluation period (FFYs 2019, 2020, and 2021) into five major issue categories, which included:
    - MACs did not perform proper review,
    - inadequate review of GME and IME reimbursement,
    - improper review of allocation, grouping, or reclassification of charges to cost centers,
    - improper calculation and reimbursement for nursing and allied health programs, and
    - inadequate review of bad debts;
- selected a non-statistical sample of six jurisdictions for review based on QASP AR-4 performance and other issues identified by CMS during the QASP review process;
- reviewed the audit processes of MACs for the six selected jurisdictions, including the following:
    - the basis on which Part A provider hospital cost reports are selected for audit;
    - audit processes for conducting desk reviews and audits;
    - working paper documentation for cost report desk reviews and audits, including:
        - sufficiency and competency of working papers,
        - qualifications of auditors assigned, and

        - adequacy of audit oversight and supervision;
    - use of subcontractors;
    - timeliness of desk review and audit completion;
    - controls related to QASP issues, CMS response, and MAC CAPs;
    - CMS oversight of the QASP performance standards including training and feedback; and
    - obstacles to the successful completion of MAC cost report desk reviews and audits;
- collaborated with CMS to gather information from their contractor assigned the responsibility for performing QASP evaluations to discuss:
    - the method of selecting cost reports for QASP review at each MAC,
    - the method for disseminating the results of those evaluations and responding to rebuttals,
    - the contractors' responsibilities for summarizing those results for the MAC community, and
    - the contractor's role in developing training for MAC personnel; and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers.	A-06-23-05001	9/11/2024
Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements To Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers.	A-06-22-05000	11/01/2023
Medicare Paid New Hospitals Three Times More for Their Capital Costs Than They Would Have Been Paid Under the Inpatient Prospective Payment System	A-07-19-02818	08/13/2021
Medicare Made $11.7 Million in Overpayments for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays	A-01-17-00508	05/01/2020
Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program	A-04-17-04058	08/30/2019
Some Hospitals in Medicare Jurisdiction F Claimed Residents as More Than One Full-Time Equivalent	A-02-15-01028	07/17/2017
Medicare Could Have Saved Billions at Critical Access Hospitals If Swing-Bed Services Were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates	A-05-12-00046	03/06/2015
Medicare Could Have Saved Millions if Organ Procurement Organizations Had Correctly Reported Procurement of Double Lungs as Two Organs	A-09-12-02085	12/31/2013

APPENDIX C: AUDIT AND REIMBURSEMENT PERFORMANCE STANDARDS[33]

Standard Number	Performance Standard Name	Performance Standard Language
AR-1	Late and Rejected Cost Reports: Payment Suspension	The MAC will suspend the payments at either 100% or a reduced rate if the provider requested and was approved for a reduction in the suspension rate and issue a demand letter for all interim and lump sum payments made for the applicable fiscal year if an acceptable cost report was not timely filed. The MAC will not remove the provider from suspension until a cost report is filed and determined acceptable.
AR-2	Cost Report Reopening Quality: Compliance and Accuracy	Cost report reopenings will be considered accurate when they comply with Medicare rules and regulations.
AR-3	STAR Database Maintenance[34]	STAR database is maintained accurately and timely when a CMS review indicates that it complies with the STAR manual.
AR-4	Desk Review and Audit Quality	Cost reports are settled accurately when a CMS review determines compliance with Medicare rules and regulations.
AR-6	Cost Report Acceptability Timeliness	The MAC is required to make a documentation of acceptability within 30 days of receipt of the provider's cost report.
AR-7	Tentative Settlement Timeliness	A tentative settlement is considered timely if completed within 60 days of acceptance of the cost report.[35]
AR-9	NPR Timeliness: Audits	The MAC shall issue the NPR and final adjustment report for cost reports that are audited in accordance with Internet-Only Manual (IOM) Pub. 100-06, Chapter 8, § 90.
AR-10	NPR Timeliness: No Audits	The MAC shall issue the NPR for cost reports that do not require an audit within 12 months of acceptance date of a cost

[33] These AR standards were effective during our audit period (FFY 2019–FFY 2021).

[34] For FFY 2021, the STAR Database Maintenance AR number was changed to AR-26.

[35] For FFY's 2019 and 2020, a tentative settlement is considered timely if completed within 60 days of acceptance of the cost report. For FFY 2021, a tentative settlement is considered timely if completed within 90 days of acceptance of the cost report.

		report in accordance with IOM Pub. 100-06, Chapter 8, § 90.
AR-11	Cost Report Reopenings: Timeliness	The MAC is required to issue a revised NPR for all reopened cost reports within 180 days of receipt of all information/documentation necessary to resolve the reopening issue(s) per IOM Pub Chapter 8, § 100.
AR-13	Cost Report Appeal Quality: Issue Resolution Accuracy	An issue resolution is considered accurate when a CMS review determines that the issues resolved and adjusted in the revised NPR were jurisdictionally valid in the appeal and the resolution was in compliance with Medicare Regulations and policy. This includes a reopening resulting from an appeal.
AR-16	Cost Report Outlier Reconciliation	A cost report shall be forwarded to CMS for an outlier reconciliation prior to issuing the NPR if the cost report requires an outlier reconciliation based on thresholds contained in the IOM Pub. 100-04, Chapters 3 and 4.
AR-24	Hospice CAPs	The Hospice aggregate cap is considered accurately computed when the calculation conforms to Regulation and Policy.
AR-25	Healthcare Cost Report Information System (HCRIS) Timeliness[36]	The MAC shall submit an extract of the following Medicare cost reports to CMS with HCRIS specifications within 210 days of the cost reporting period ending date or 60 days after receipt of the cost report, whichever is later. This submission must pass all level one edits and all HCRIS reject edits. The MAC shall within 30 days after issuance of the NPR to the provider, submit to CMS an extract of the following Medicare cost reports in accordance with HCRIS specifications. This submission must pass all level one electronic cost report edits and all HCRIS reject edits.

[36] HCRIS Timeliness (AR-25) was established in FFY 2021.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: February 5, 2025

TO: Amy Frontz
Deputy Inspector General for Audit Services

FROM: Steph Carlton
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Administrative Contractors Did Not Consistently Meet Medicare Cost Report Oversight Requirements

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to properly overseeing the Medicare Administrative Contractors (MACs), including oversight of cost report requirements.

A MAC is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or Durable Medical Equipment claims for Medicare Fee-For-Service (FFS) beneficiaries. CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program.

CMS evaluates MAC performance through the Quality Assurance Surveillance Plan (QASP) process, which is a systematic quality assurance approach to evaluate MAC fulfillment of contract requirements. The QASP process measures MAC compliance in several areas including Audit & Reimbursement. CMS publicly reports on the performance of each MAC.[1] The MACs may also receive an award fee as a result of their score. Award fees are provided to motivate exceptional performance above what is outlined in the MACs Statement of Work.

Institutional providers, such as hospitals and skilled nursing facilities, are required to submit a yearly cost report to their MAC. These cost reports are used to set future Medicare payment rates and reimburse providers for spending on medical education, uncompensated care, low-income patients, and high-cost Medicare cases. To support MACs in their review of cost reports, CMS has provided a Uniform Desk Review (UDR) program that provides guidance to MACs in conducting desk reviews. CMS also provides various training methods to the MACs related to the cost report and various reimbursement areas. Trainings include online training modules, routine webinars, and workgroups between CMS and MACs to discuss various issues that the

[1] CMS, MAC Performance Evaluations. Accessed at https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/mac-performance-evaluations.

MACs encounter in their work. In addition, CMS hosts an annual QASP overview webinar where identified issues from the prior year QASP process are discussed.

In May 2022, CMS began a process improvement initiative specific to Audit & Reimbursement performance on the MAC QASP. CMS conducted several sessions with MACs between September 2022 thru December 2022 and obtained feedback on the root causes of items that were causing the most nonconformances. After considering MAC feedback, CMS implemented six changes, two of which were directly related to the QASP sample selection process. The sampling size for the Desk Review and Audit Quality standard (referred to as AR-4) was doubled, and the selection of these samples is now a combination of desk reviews and audits from varying complexity of providers looking for a variety of areas as identified in the UDR and audit program. This process improvement effort has led to greater transparency in the overall QASP process. In addition, as OIG noted, in July 2023, CMS began additional MAC trainings and a process for MACs to request feedback and additional training sessions tailored to each MAC. These individualized MAC-specific training sessions allow both parties to discuss the issues and observations noted during the QASP process to prevent such scenarios in the future and improve the overall process.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future. OIG's recommendations and CMS' responses are below.

OIG Recommendation

Provide MACs with a thorough explanation of the QASP results.

CMS Response

CMS concurs generally with OIG's recommendation and based on the efforts since the time of this audit as detailed below, requests OIG consider this recommendation closed as implemented. During the QASP review, CMS meets weekly with each individual MAC to go through a detailed report outlining QASP findings and results. The MACs are afforded the opportunity to provide additional support prior to the formal rebuttal process that may assist CMS in their review of the finding or observation. Starting with the fiscal year 2024 QASP reviews, which began in October of 2023, the results are broken out into findings and observations, prior to the MACs receiving the evaluation reports. This allows the MACs to work to resolve the more pressing issues noted during the QASP review. OIG notes that CMS did not convey which issues were rated low, medium, and high. However, while stemming from the QASP, these ratings are specific to receipt of awards, outlined in the Award Fee Plan. CMS provides a definition for the "high" rating in the plan, while the medium and low rating may vary slightly from year to year. After the QASP review is completed, CMS offers individual meetings with each MAC to discuss the findings or any other concern with their QASP review.

OIG Recommendation

Update the audit program to incorporate revised change requests and TDLs so MACs can obtain a better understanding of CMS expectations and be evaluated on current requirements.

CMS Response

CMS concurs with OIG's recommendation. CMS issued a revised Uniform Desk Review (UDR) in 2021 that incorporated change requests and Technical Direction Letters (TDLs) and expanded on the instructions in the steps to provide detailed guidance on how to complete the UDR. CMS is currently working to incorporate change requests and TDLs into the audit programs to give MACs a

better understanding of CMS expectations of evaluation. CMS is also in the process of issuing a revised UDR that incorporates additional change requests or TDLs that have been issued since the latest version issued in 2021.

OIG Recommendation

Offer MACs additional training and guidance, based on the results of their QASP, and include best practices used by MACs.

CMS Response

CMS concurs generally with OIG's recommendation and based on the efforts since the time of this audit as detailed below, CMS requests OIG consider this recommendation closed as implemented. To support MACs in their review of cost reports, CMS has provided a Uniform Desk Review (UDR) program that provides guidance to MACs in conducting desk reviews. CMS also provides various training methods to the MACs related to the cost report and various reimbursement areas. Trainings include online training modules, routine webinars, and workgroups between CMS and MACs to discuss various issues that the MACs encounter in their work. In addition, CMS hosts an annual QASP overview webinar where identified issues from the prior year QASP process are discussed.

As OIG noted, in July 2023, CMS began additional MAC trainings and a process for MACs to request feedback and training sessions tailored to each MAC. These individualized MAC-specific training sessions allow both parties to discuss the issues and observations noted during the QASP process to prevent such scenarios in the future and improve the overall process. OIG noted that the MACs suggested CMS provide training that includes detailed case studies and best practices. CMS has provided training with case studies in the past; however, developing additional case studies is resource intensive and not necessarily transferrable to the review of other cost report reimbursement areas due to variations in providers. In 2021, CMS did update and issue a revised UDR to the MACs. The revised UDR expanded on the instructions in the steps to provide a more detailed guidance on how to complete the UDR.

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U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov