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CMS's Oversight of Medicare Administrative Contractors' Cost Report Settlement Processes Was Not Adequate To Identify Settlements That Contained Obvious Errors and That Had Inadequate Supervisory Review

REPORT HIGHLIGHTS

November 2026 | OAS-25-06-154

CMS's Oversight of Medicare Administrative Contractors' Cost Report Settlement Processes Was Not Adequate To Identify Settlements That Contained Obvious Errors and That Had Inadequate Supervisory Review

Why OIG Did This Audit

- Previous OIG audits identified that Medicare administrative contractors (MACs) performed audits and desk reviews of annual cost reports submitted by Medicare-certified providers and then reopened some final settlements to correct them because of errors (caused by the MACs) or inconsistencies with the law, regulations, or Medicare manual instructions.
- This audit summarizes the results of six previous audits of MACs' reopened and corrected cost report final settlements because of errors in their audits and desk reviews in order to determine whether CMS's oversight of the MACs' cost report settlement processes was adequate.

What OIG Found

- In our 6 previous audits involving MAC cost report settlements, we identified a total of 234 cost report reopenings that were the result of errors made during audits or desk reviews and that resulted in corrected final settlements to providers totaling $31.6 million (which consisted of $23.3 million in overpayments and $8.3 million in underpayments).
- These cost report settlements contained obvious errors, and the MACs' supervisory review procedures that were in place during our previous audits did not detect the incorrect audit adjustments that we identified. MAC officials reported to us that their auditors and supervisors who were involved in desk reviews and audits of cost reports required additional training applicable to certain types of payments.
- CMS oversight of the MACs' cost report settlement processes was inadequate. Of the 234 cost report reopenings with settlement errors that our previous audits identified, CMS's quality assurance process had identified only 8 cost reports as having had settlement errors. CMS does not have visibility of the number or types of errors in cost report final settlements. Additionally, CMS does not require MACs to identify the cause of final settlement errors or any corrective actions taken and does not require MACs to conduct quality assurance reviews before issuing final settlements of cost reports.

What OIG Recommends

We made three recommendations to CMS, including that it enhance the oversight activities of its quality assurance process, that it require the MACs to submit annual reports on the numbers and types of errors they identify in final settlements of cost reports, and that it instruct the MACs to create a quality assurance review of cost reports that have had either an audit or a desk review only. The full recommendations are in the report.

CMS did not specifically concur or nonconcur with our first recommendation, concurred with our second recommendation, and did not concur with our third recommendation.

TABLE OF CONTENTS

INTRODUCTION 1

Why We Did This Audit 1

Objective 1

Background 2

Medicare Program 2

Medicare Cost Reports 2

Medicare Administrative Contractor Cost Report Desk Reviews and Audits 2

Cost Report Reopenings 3

Medicare Administrative Contractor Oversight Through Quality Assurance 4

CMS Oversight of Medicare Administrative Contractor Cost Report Settlement Activities 4

How We Conducted This Audit 5

FINDINGS 6

Medicare Administrative Contractors Reopened a Total of 234 Cost Reports Because of Obvious Errors They Made 6

CMS Oversight of Cost Report Settlements Was Inadequate 8

RECOMMENDATIONS 8

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE 9

APPENDICES

A: Audit Scope and Methodology 11

B: CMS Comments 13

INTRODUCTION

WHY WE DID THIS AUDIT

Medicare-certified institutional providers, including hospitals, skilled nursing facilities, and home health agencies, among others, are required to submit an annual cost report to their Medicare administrative contractor (MAC).[1] After performing a desk review and possibly an audit, the MAC makes a final settlement.[2] Previous Office of Inspector General (OIG) audits of some MACs found that they reopened some final settlements to correct them because of errors or inconsistencies with the law, regulations, or instructions in the Centers for Medicare & Medicaid Services (CMS) *Provider Reimbursement Manual* (the Manual) (collectively referred to as "errors in final settlements" for this report).[3] The errors in final settlements were caused by the MACs omitting, misclassifying, misreporting, miscalculating, or duplicating adjustments.

One of CMS's goals is for the MACs to arrive at correct final settlements of providers' cost reports. If there is an error made in the final settlement, the cost report final settlement may be reopened and adjusted to correct for the error (the Manual, CMS Pub. 15-1, Part I, § 2931.2).[4]

This report summarizes the findings from those previous audits, assesses the effectiveness of CMS and MAC oversight for the cost report settlement processes, and offers best practices and recommendations for both CMS and MACs to improve oversight and reduce cost report settlement errors.

OBJECTIVE

Our objective was to summarize the results of our previous audits of MACs' reopened and corrected cost report final settlements because of errors in their audits and desk reviews in order to determine whether CMS's oversight of the MACs' cost report settlement processes was adequate.

[1] MACs process Medicare Part A and Medicare Part B claims for a defined geographic area or "jurisdiction," servicing institutional providers, physicians, practitioners, and suppliers.

[2] All cost reports (with a few exceptions) have a desk review, but not all desk reviews result in a follow-up audit.

[3] See OIG Work plan for a list of related OIG reports.

[4] We refer to the reopening of cost report final settlements as "cost report reopenings" throughout the remainder of this audit report.

BACKGROUND

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 for extended care services for patients after discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of therapy services. CMS administers the Medicare program and contracts with MACs to, among other things, process and pay claims submitted by health care providers.

Medicare Cost Reports

Certain institutional providers, such as hospitals, skilled nursing facilities, home health agencies, renal dialysis centers, hospices, rural health clinics, community mental health centers, federally qualified health centers, and organ procurement organizations 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.

Providers attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the MAC performs a tentative settlement, then performs a desk review of the cost report and may conduct an audit, as appropriate, before final settlement.[5]

Medicare Administrative Contractor Cost Report Desk Reviews and Audits

MACs serve as the primary operational contact between the Medicare fee-for-service program and the health care providers enrolled in the program. MACs perform many administrative activities, including desk reviews and audits of cost reports.

MACs must conduct desk reviews of cost reports for all providers that file a Medicare cost report. Exceptions are made for cost reports for hospices and for providers that have low or no Medicare utilization. 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

[5] 42 CFR § 413.64(f)(2); the Manual, CMS Pub. No. 15-1, Part 1, § 2408.2; *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 20.

determine whether the cost report can be settled without an audit or whether an audit is necessary.[6]

All work performed by a MAC's staff during the desk review is subject to appropriate supervision, which includes instructing staff members, reviewing the work performed (supervisory review), and providing effective on-the-job training to ensure quality.[7] In contrast to the desk review, an audit is an examination of financial 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.[8] 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.[9] If the MAC finds that claimed amounts in a cost report are not in accordance with the law, regulations, or Medicare manual instructions, it can create an audit adjustment to ensure that the cost report complies with those requirements.[10]

Like desk reviews of cost reports, audits of cost reports are subject to supervisory review to ensure audit quality.[11] At the conclusion of the audit, or at the conclusion of the desk review and a subsequent decision not to perform an audit, the MAC issues a Notice of Provider Reimbursement (NPR) to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to the Medicare program.

Cost Report Reopenings

A cost report final settlement may be reopened at the request of the provider or on the MAC's own initiative within 3 years of the date of the NPR to re-examine and adjust the final determination of the amount of total reimbursement due the provider (42 CFR § 405.1885).[12] The decision by the MAC to reopen a settled cost report generally depends on whether new and material evidence has been submitted by the provider, an error was made during the final settlement process, or the settled cost report is found to be inconsistent with the law, regulations, and manual instructions (the Manual, Part I, § 2931.2).

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[6] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 20.1.

[7] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, §§ 20.3 and 60.13.

[8] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 40.

[9] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, §§ 30.1, 50.1, and 80.

[10] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, §§ 60.11 and 70.4.

[11] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 60.13.

[12] A MAC may reopen and revise a final settlement at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision.

The figure depicts the Medicare cost report submission, review, settlement (tentative and final), and reopening process.

Figure: Medicare Cost Report Process



Medicare Administrative Contractor Oversight Through Quality Assurance

CMS guidance states that MACs must establish internal quality control policies and procedures for their audit departments and communicate these policies and procedures to Medicare audit personnel. In establishing their internal quality control policies and procedures, MACs are instructed to consider, to the extent applicable to their operating environments, the nine elements of internal quality control taken from the Association of International Certified Professional Accountants (AICPA) *Statements of Quality Control Standards*,[13] such as independence and supervision.[14]

CMS Oversight of Medicare Administrative Contractor Cost Report Settlement Activities

Under the provisions of section 1874A(b)(3) of the Social Security Act, CMS has developed specific performance requirements for MACs to carry out functions such as cost report settlement activities. As part of its oversight of MACs, CMS developed the Quality Assurance Surveillance Plan (QASP), which provides a systematic approach to evaluate how well MACs are fulfilling the requirements of their Medicare contracts. A CMS contractor performs the Audit and Reimbursement (AR) QASP evaluations of each MAC each year, the results of which are publicly reported.[15]

[13] Now it is referred to as the AICPA *Statements on Quality Management Standards*.

[14] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 80.4.

[15] The AR QASP evaluations measure standards including payment suspension procedures, quality of cost report reopenings, System Tracking for Audit and Reimbursement database management, desk review and audit quality, cost report acceptability timeliness, tentative settlement timeliness, NPR timeliness, and cost report reopening timeliness, among others. The QASP program was in effect during our previous audits of individual MACs, but we did not review the QASP results for either those previous audits or this audit.

The QASP lists 13 AR performance standards, including Desk Review and Audit Quality (AR-4). The QASP program includes provisions for MACs that receive strongly favorable evaluations to receive award fees to recognize and motivate exceptional performance above what is outlined in the MAC's responsibilities.

A previous OIG audit examined QASP evaluation reports that CMS had issued during Federal fiscal years 2019 through 2021.[16] During that 3-year period, CMS selected 3 to 5 cost reports per year per MAC jurisdiction for QASP evaluations, totaling 123 cost reports across the 12 MAC jurisdictions, in which the NPR was issued during the contract year. CMS responded to that previous audit's findings by stating that under a "process improvement initiative" that CMS had undertaken beginning in 2022, it had doubled the sampling size for the AR-4 standard in the QASP program. CMS also explained that the submissions selected for QASP review were a combination of desk reviews and audits for provider cost reports with varying levels of complexity. Our previous audit also stated that CMS had 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. CMS stated that this process improvement effort has led to greater transparency in the overall QASP process.

HOW WE CONDUCTED THIS AUDIT

In our previous series of audits, we obtained information for multiple MAC jurisdictions regarding provider cost reports ending in Federal fiscal years 2016 and 2017 that MACs had reopened, some after performing an audit and some after performing a desk review only. For cost reports that had been reopened, we determined whether the reopenings were the result of one or more errors attributed to the MACs' reviews and performed further reviews as necessary. We did not perform any further reviews of cost reports that had been reopened based on directions by CMS or that were for new and material evidence, because those cost report reopenings did not involve errors made by the MACs.

Our previous audits were of Noridian Healthcare Solutions (Noridian); Novitas Solutions, Inc. (Novitas); National Government Services, Inc. (NGS); and Wisconsin Physicians Service Government Health Administrators (WPS).[17]

For both the previous series of audits and this audit, we reviewed CMS and MAC guidance on how to properly settle cost reports. We also interviewed CMS and MAC officials about the internal controls they use in efforts to ensure correct cost report settlements.

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

[16] *Medicare Administrative Contractors Did Not Consistently Meet Medicare Cost Report Oversight Requirements* (A-04-22-06264), Mar. 19, 2025.

[17] Novitas and NGS each underwent two audits; Noridian and WPS underwent one audit each.

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 A contains the details of our audit scope and methodology.

FINDINGS

Our previous audits of MACs' reopened and corrected cost report final settlements identified a number of MAC cost report settlements that contained obvious errors. Specifically, our 6 previous audits identified a total of 234 cost report final settlements that the responsible MACs reopened and corrected because of errors made during the MACs' audits or desk reviews.

Our previous audit work for this subject matter identified certain inadequacies in CMS's oversight of the MACs' cost report settlements. Our previous audits reported that of the 234 cost report reopenings with settlement errors, CMS's QASP process had identified only 8 cost reports as having had settlement errors. Our previous audits' findings also determined that CMS does not have visibility of the number or types of errors in cost report final settlements; nor does CMS require the MACs to identify the causes of such errors or the corrective action(s) taken. Our interviews with CMS and MAC officials confirmed our previous audits' judgments regarding the inadequacies in CMS's oversight of the MAC's cost report settlement process.

MEDICARE ADMINISTRATIVE CONTRACTORS REOPENED A TOTAL OF 234 COST REPORTS BECAUSE OF OBVIOUS ERRORS THEY MADE

In our 6 previous audits involving MAC cost report settlements, we identified a total of 234 cost report reopenings that were the result of errors made during audits or desk reviews and that resulted in corrected final settlements to providers. As shown in Table 1 on the following page, these errors totaled $31,645,756 (which consisted of $23,339,519 in overpayments and $8,306,237 in underpayments).

Table 1: Summary of Errors in Medicare Administrative Contractor Final Settlements

Audit Number	Issue Date	MAC	Number of Errors	Overpayment	Underpayment	Total Payment Error
AUDIT ERRORS						
A-06-22-05000	11/1/2023	Noridian	12	$12,091,105	$(814,744)	$12,905,849
A-06-23-05001	9/11/2024	Novitas	10	1,357,636	(285,076)	1,642,712
A-06-24-05000	10/28/2024	NGS	11	582,584	(237,790)	820,374
Audit Errors			***33***	***$14,031,325***	***$(1,337,610)***	***$15,368,935***
DESK REVIEW ERRORS						
A-06-24-04001	7/17/2025	WPS	15	$1,212,608	$(57,568)	$1,270,176
A-06-24-05003	8/28/2025	Novitas	122	4,963,475	(4,401,479)	9,364,954
A-06-24-05004	8/29/2025	NGS	64	3,132,111	(2,509,580)	5,641,691
Desk Review Errors			***201***	***$9,308,194***	***$(6,968,627)***	***$16,276,821***
Total Audit and Desk Review Errors			**234**	**$23,339,519**	**$(8,306,237)**	**$31,645,756**

Table 2 summarizes six examples of obvious errors in MAC final settlements that our previous audits of cost report reopenings had identified.

Table 2: Examples of Obvious Errors in Medicare Administrative Contractor Final Settlements[18]

EXAMPLES OF MAC AUDIT ERRORS	OAS Report	Over/(Under)payment to the Provider
1. Clerical Error in Charges	A-06-22-05000 (Noridian)	$6,257,113
2. Incorrect Hospital Status Change	A-06-22-05000 (Noridian)	$3,562,541
3. Incorrect Number of Payments Recorded	A-06-22-05000 (Noridian)	$901,012
EXAMPLES OF MAC DESK REVIEW ERRORS	**OAS Report**	**Over/(Under)payment to the Provider**
4. Incorrect Low-Volume Classification	A-06-24-04001 (WPS)	$215,427
5. Improper Reopening for Related Organization Costs	A-06-24-05003 (Novitas)	($560,557)
6. Incorrect Outpatient Outlier Payment Used	A-06-24-05004 (NGS)	$842,161

[18] Although Table 2 cites to only four of our previous six audit reports, the examples it summarizes appeared in our findings for all six previous audits.

The MACs' supervisory review procedures that were in place during our previous audits did not detect the incorrect audit adjustments that we identified. MAC officials reported to us during those audits that their auditors and supervisors who were involved in desk reviews and audits of cost reports required additional training applicable to certain types of payments.

In their comments on our previous reports' recommendations, the MACs described various best practices that they planned to implement to prevent errors in their desk reviews and audits of submitted cost reports. These best practices included the performance of additional reviews of cost reports prior to final settlement, improvements to the MACs' internal quality control processes, and enhanced education of staff on updated processes for cost report reviews and on MAC policies and procedures. Other best practices that the MACs described included the provision of adequate and timely feedback to staff involved in the cost report review process, as well as implementation of checklists and other quality control measures to verify adjustments to cost reports before they are brought to final settlement.

CMS OVERSIGHT OF COST REPORT SETTLEMENTS WAS INADEQUATE

Our previous audits and our work on this audit identified certain inadequacies in CMS's oversight of the MACs' cost report settlements. The previous audits reported that of the 234 cost report reopenings with settlement errors, CMS's QASP process had identified only 8 cost reports as having had settlement errors. Our previous audits also found that CMS can track whether a cost report is reopened but does not have visibility of the number of cost report settlement errors or the types of errors in the final settlements. CMS does not require MACs to identify the causes of errors in cost report final settlements or any corrective action(s) taken, nor does CMS require MACs to conduct pre-NPR quality assurance reviews. Additionally, CMS does not require that MACs' quality assurance departments conduct reviews before the MACs issue the final settlements of the cost reports when conducting audits or desk reviews.

CMS oversees the MACs' quality assurance process, although the selection of audits and desk reviews to undergo quality assurance reviews is left to the MACs' discretion. The findings in our previous audits suggest that CMS's QASP process, as structured at the time of those audits, did not accurately reflect the extent to which the MACs had to reopen submitted cost reports to correct errors. Additionally, because QASP scoring of MACs does not take into account the numbers and types of errors in cost report settlement, the MACs may be reluctant (notwithstanding the award fees mentioned earlier) to commit additional resources toward the goal of preventing errors in the settlement of cost reports.

RECOMMENDATIONS

- We recommend that CMS enhance the oversight activities of the QASP process by: (1) determining the extent to which MACs reopen cost reports because of final settlement errors or because the cost reports were not in accordance with Medicare requirements and (2) revising the QASP scoring for MACs to take into account relevant

data from cost reports that had to be reopened because the final settlements were in error.

- We recommend that CMS enhance its oversight of the MACs by requiring them to submit annual reports on the numbers and types of errors they identify in final settlements of cost reports and on the MACs' corrective action plans to address the causes of those errors.

- We recommend that CMS enhance its oversight of the MACs by instructing them to create a pre-NPR quality assurance review of cost reports that have had either an audit or a desk review only, in order to confirm the accuracy of the audits and desk reviews before the cost reports are brought to final settlement.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not specifically concur or nonconcur with our first recommendation, concurred with our second recommendation, and did not concur with our third recommendation.

For our first recommendation, CMS stated that it appreciates our findings regarding errors after final settlement. CMS added, though, that a reopening "does not, by itself, indicate that a MAC failed to comply with an applicable QASP requirement." CMS also stated that incorporating cost report reopenings into QASP scoring may not be an appropriate measure of MAC performance "because a reopening may reflect the MAC's appropriate use of an established process to correct an error." In addition, CMS said that it would continue to evaluate MAC performance through the QASP program and other existing oversight processes.

CMS concurred with our second recommendation and said that it agreed that gathering information regarding the number and types of errors identified in final cost report settlements could assist CMS in its oversight of MAC audit and reimbursement activities.

CMS did not concur with our third recommendation and stated that MAC desk reviews and audits are already subject to supervisory review requirements intended to ensure the quality and accuracy of the work performed prior to final settlement. CMS added that requiring an additional pre-Notice of Provider Reimbursement quality assurance review for all cost reports that have undergone a desk review or audit "would duplicate existing supervisory review requirements and require additional MAC resources."

CMS's comments appear in their entirety as Appendix B.

After reviewing CMS's comments on our first recommendation, we acknowledge that cost reports can and should be reopened when necessary. Having said that, we also believe that incorporating data from cost report reopenings into QASP scoring would create an incentive for

MACs to prevent repetitive errors by encouraging MACs to develop corrective actions to prevent such errors. Therefore, we maintain that our first recommendation remains valid.

With respect to CMS's comments on our third recommendation, we maintain that it remains valid and would promote effective oversight of Medicare programs. We acknowledge that CMS has established a process to reopen cost reports because of final settlement errors; however, the findings conveyed in this report indicate that the existing process is not entirely adequate to facilitate sufficient oversight or minimize the risk of recurrence of the types of errors we identified.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

In our previous series of audits, we obtained information for multiple MAC jurisdictions regarding provider cost reports ending in Federal fiscal years 2016 and 2017 that MACs had reopened, some after performing an audit and some after performing a desk review only. For cost reports that had been reopened, we determined whether the reopenings were the result of one or more errors attributed to the MACs' reviews and performed further reviews as necessary. Accordingly, we identified and reviewed a total of 234 cost report reopenings that resulted in corrected final settlements to providers totaling $31,645,756 (which consisted of $23,339,519 in overpayments and $8,306,237 in underpayments).

For each of these cost report reopenings, we obtained workpapers, adjustments, and final settlement summaries to identify whether the provider requested the reopening or the MAC initiated the reopening, the reasons for the reopening, and the financial effect of the corrected final settlement. We did not perform any further reviews of cost reports that had been reopened based on directions by CMS or that were for new and material evidence, because those cost report reopenings did not involve errors made by the MACs.

Our previous audits were of Noridian, Novitas, NGS, and WPS (footnote 17).

For both the previous series of audits and this audit, we reviewed CMS and MAC guidance on how to properly settle cost reports. We also interviewed CMS and MAC officials about the internal controls they use in efforts to ensure correct cost report settlements.

We assessed internal controls necessary to satisfy the audit objective. In particular, we gained an understanding of and reviewed the MACs' and CMS's policies and procedures regarding supervisory review before the final settlement of cost reports.

We issued our previous reports to various MACs between November 2023 and August 2025. We conducted audit work for this report from October 2025 to September 2026.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and Medicare manual instructions

- Obtained and reviewed information from our six previously issued OIG reports that involved cost reports for which MACs had performed an audit or a desk review only and had subsequently reopened the cost reports to correct obvious errors

- Obtained and reviewed, for the cost report reopenings, the reopening documentation, including the reasons for the reopening, the root causes of the errors that MACs identified, and the financial impacts of the reopened final settlements

- Obtained and reviewed the MACs' policies and procedures for their audits and desk reviews, their reopening processes, and their processes for supervisory review

- Assessed the adequacy of the MACs' supervisory review processes in terms of their ability to detect errors in cost reports for which the MACs had performed an audit or a desk review only

- Interviewed CMS and MAC officials to gain an understanding of the internal controls they used in efforts to ensure correct cost report settlements

- Analyzed the results of our previous reports, including the root causes of the errors that MACs identified, to assess CMS's oversight of the cost report reopening and settlement processes

- Discussed the results of our previous audits with MAC officials

- Discussed the results of this 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: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: September 29, 2026

TO: Tamara Lilly
Acting Deputy Inspector General for Audit Services

FROM: Dr. Mehmet Oz DR
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report, *CMS's Oversight of Medicare Administrative Contractors' Cost Report Settlement Processes Was Not Adequate To Identify Settlements That Contained Obvious Errors and That Had Inadequate Supervisory Review* (OAS-25-06-154)

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 ensuring that Medicare Administrative Contractors (MACs) appropriately perform cost report desk reviews, audits, and final settlements in accordance with applicable Medicare requirements.

Hospitals and health care providers are required to submit an annual Medicare cost report to continue receiving reimbursement from Medicare. The Medicare cost report details a variety of information such as costs, charges, days, discharges, and information related to specific payment methodology. MACs are required to perform some level of review on every cost report submitted before it can be considered "final settled." It is the responsibility of the provider to prepare an accurate cost report. It is the responsibility of the MAC to provide a reasonable level of assurance to CMS that any material errors in the data have been found and corrected. The level of review and assurance provided may range from a quick desk review to a more in depth "audit." Some cost reports that have been audited and settled are later reopened to correct the final settlement. The MACs maintain supporting documents for the cost reports that they reopen and the reasons for the reopenings. These supporting documents include information related to the monetary adjustments to correct the final settlements. MACs submit cost report-related information to CMS.

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 and CMS publicly reports on the performance of each MAC. As part of the QASP, CMS evaluates the quality of MAC desk review and audit activities, in addition to other performance standards. MAC desk reviews and audits are also subject to supervisory review requirements intended to ensure the quality and accuracy of the work performed.

To support MACs in their review of cost reports, CMS has provided a Uniform Desk Review program that provides guidance to MACs in conducting desk reviews. CMS also provides

various training methods to the MACs related to cost report and various reimbursement areas, including 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 are discussed. CMS has taken steps in recent years to improve its oversight of MAC audit and reimbursement activities. As OIG notes in the draft report, CMS doubled the sample size of cost reports reviewed for quality of MAC desk review and audit activities beginning in 2022 and revised the scoring methodology for this performance metric from an all-or-nothing disallowance to a tiered weight system. CMS continues to evaluate its oversight processes and identify opportunities to improve MAC performance and the accuracy of cost report settlements.

CMS thanks OIG for its efforts on this issue. OIG's recommendations and CMS's responses are below.

OIG Recommendation

The OIG recommends that CMS enhance the oversight activities of the QASP process by: (1) determining the extent to which MACs reopen cost reports because of final settlement errors or because the cost reports were not in accordance with Medicare requirements and (2) revising the QASP scoring for MACs to take into account relevant data from cost reports that had to be reopened because the final settlements were in error.

CMS Response

CMS appreciates OIG's findings regarding errors identified after final settlement. However, Medicare requirements permit MACs to reopen cost reports to correct errors or to address settlements that are not in accordance with Medicare requirements. Therefore, the occurrence of a reopening does not, by itself, indicate that a MAC failed to comply with an applicable QASP requirement.

Under QASP's Audit and Reimbursement Desk Review and Audit Quality performance standard (AR-4), CMS reviews MAC desk review and audit work to determine whether cost reports were settled in accordance with Medicare rules and regulations. Incorporating cost report reopenings into QASP scoring may therefore not be an appropriate measure of MAC performance because a reopening may reflect the MAC's appropriate use of an established process to correct an error. CMS will continue to evaluate MAC performance through the QASP and other existing oversight processes.

OIG Recommendation

The OIG recommends that CMS enhance its oversight of the MACs by requiring them to submit annual reports on the numbers and types of errors they identify in final settlements of cost reports and on the MACs' corrective action plans to address the causes of those errors.

CMS Response

CMS concurs with this recommendation. CMS agrees that information regarding the number and types of errors identified in final cost report settlements, including information regarding corrective actions taken by MACs, may assist CMS in its oversight of MAC audit and reimbursement activities.

OIG Recommendation

The OIG recommends that CMS enhance its oversight of the MACs by instructing them to create a pre-Notice of Provider Reimbursement quality assurance review of cost reports that have had either an audit or a desk review only, in order to confirm the accuracy of the audits and desk reviews before the cost reports are brought to final settlement.

CMS Response

CMS does not concur with this recommendation. MAC desk reviews and audits are already subject to supervisory review requirements intended to ensure the quality and accuracy of the work performed prior to final settlement.

Requiring an additional pre-Notice of Provider Reimbursement quality assurance review for all cost reports that have undergone a desk review or audit would duplicate existing supervisory review requirements and require additional MAC resources. CMS will continue to monitor MAC performance through its existing oversight processes and work with MACs, as appropriate, to address identified quality concerns.

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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