CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13891	**Date: July 30, 2026**
	Change Request 14541

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-06 Chapter 8, Contractor Procedures for Provider Audits

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 8, Contractor Procedures for Provider Audits to remove or replace obsolete language based on current policy and procedure. This update also includes revised contractor requirements in the following sections:

- 90 – Final Settlement of the Cost Report
- 100 – Cost Report Reopenings

EFFECTIVE DATE: August 28, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 28, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	8/10 through 160 (including subsections)
N	8/170/Exhibit I – Cost Report Acceptability Checklists
R	R 8/170/Exhibit II through VII, IX.A, X, and XI
N	N 8/170/Exhibit VIII – Exit Conference Format
N	8/17/0/Exhibit IX.B

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 13891	Date: July 30, 2026	Change Request: 14541

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- 100 – Cost Report Reopenings

II. GENERAL INFORMATION

A. Background: CMS periodically reviews the IOM to ensure that all policies remain current and are interpreted as intended.

B. Policy: This CR clarifies and updates Chapter 8 of IOM Publication 100-06.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14541.1	MACs shall be aware of all updates made to IOM Publication 100-06 Chapter 8 and ensure internal process alignment as of the effective date of the change request.	X								
14541.2	Section 90 – Final Settlement of the Cost Report Effective with outlier reconciliation approvals received from CMS on after January 1, 2027, MACs shall ensure all remaining steps in CMS Pub. 100-04 are completed and issue the NPR within 90 days from the date	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	the MAC received the outlier approval from CMS if the settlement timeframes stated above have passed. If the 90-day standard cannot be met due to extenuating circumstances, the MAC shall provide an explanation to their DPAO BFL, through their COR, including an estimated timeframe for settling the cost report.									
14541.3	Section 100 – Cost Report Reopenings Effective with provider requested reopenings received on or after January 1, 2027, MACs shall issue an NOR and/or a notice of denial to the provider in writing within 90 days of receipt of a reopening request. If an NOR and/or NOD cannot be issued within 90 days, the contractor shall document the reasonable justification for the delay.	X								
14541.4	Section 100 – Cost Report Reopenings Effective with outlier reconciliation approvals received from CMS on after January 1, 2027, MACs shall ensure all remaining steps in CMS Pub. 100-04 are completed and issue the RNPR within 90 days from the date the MAC received the outlier approval from CMS if the settlement timeframes stated above have passed. If the 90-day standard cannot be met due to extenuating circumstances, the MAC shall provide an explanation to their DPAO BFL, through their COR, including an estimated timeframe for settling the cost	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	report.									

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	*"Should" denotes a recommendation.*

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Financial Management Manual

Chapter 8 – Contractor Procedures for Provider Audits

Table of Contents

(Rev.13891; Issued: 07-30-26)

Introduction

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

A Medicare-certified institutional provider (provider) receives Medicare Part A (Medicare or Program) payments throughout its fiscal year based on submission of Medicare claims and the receipt of pass-through and lump-sum payments. These payments are estimates and provide Medicare reimbursement until the total Medicare liability to the provider is determined after the end of the provider's fiscal year end.

A provider is required to submit a Medicare Cost Report (MCR) on or before the last day of the fifth month following the close of their cost reporting fiscal year end to its Medicare Administrative Contractor (MAC), also referred to as the contractor. The Medicare Cost Report contains provider specific information including facility characteristics, utilization data, total expenses, overhead allocation, total charges, Medicare charges, in addition to various other financial data. The MCR determines the total Medicare liability to the provider for its fiscal year end. This total Medicare liability, less Medicare interim payments received throughout the cost reporting year, determines if the provider was underpaid or overpaid for the cost reporting period. In addition to determining the Medicare liability, the MCR is also used by other government agencies for payment and policy determination.

This Chapter explains the MCR life cycle from prior to submission through reopening and the contractor requirements for completing each phase of the *cost report life cycle. For purposes of Chapter 8, "Medicare Audit Activities" is defined as receipt and acceptance of MCRs, tentative retroactive adjustments (tentative settlements), desk reviews, wage index desk reviews, desk review exception resolutions, audits, including Worksheet S-10 audits, final settlements, reopenings, and special reimbursement issues.*

Additionally, this Chapter explains the procedures to be applied/implemented by contractors to ensure that acceptable *MCRs* are submitted by providers in a timely manner, that they are appropriately reviewed, and are properly settled.

This Chapter applies to all CMS contractors and their subcontractors.

NOTE: *In this Chapter, "days" means calendar days unless stated otherwise.*

10 – Receipt and Acceptance of Cost Reports

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

In accordance with 1815(a) of the Social Security Act and 42 CFR 413.20(b), all Medicare-certified institutional providers (i.e. hospitals, skilled nursing facilities, home health agencies, etc.) are required to submit an annual MCR to their MAC which serves to determine the facility's status, cost structure, and to achieve settlement of costs relating to health care services rendered to Medicare beneficiaries.

In accordance with 42 CFR 413.24(f)(2) and Provider Reimbursement Manual (PRM)15-2, Chapter 1, §104.A, providers that continue to participate in the Medicare Program are required to submit an MCR on or before the last day of the fifth month following the close of their cost reporting fiscal year end. If the cost report ends on a day other than the last day of the month, the provider is required to submit such MCR within 150 days after the last day of the cost reporting period. A full utilization MCR must be filed unless the provider qualifies for a low or no Medicare Utilization Cost Report as defined in the PRM 15-2 Chapter 1, §110.

A No Medicare Utilization Cost Statement and Certification for a provider that has not furnished any covered services to Medicare beneficiaries during the entire cost reporting period must be submitted within 150 days following the close of the reporting period (see CFR 413.24(g) and PRM 15-2, §110.A.).

In accordance with PRM 15-2, Chapter 1, §104.B, providers that terminate their agreement to participate in the Medicare program or change ownership, are required to submit an MCR within five months following the effective date of the termination of the provider agreement or the change of ownership (CHOW), respectively. From the time a provider files a CMS Form 855A for a CHOW until official notice of approval (pending CHOW), MCRs must continue to be submitted for the period(s) up to the effective date of the CHOW and for all subsequent fiscal year ends. Contractors shall continue to receive and review for acceptability all MCRs for periods that overlap the potential CHOW effective date, but all further work will be held until the CHOW approval is received (i.e. tentative settlement, desk review, and final settlement).

10.1 – Contractor's Responsibility Prior to Submission of Cost Reports

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

If the provider fails to file *its MCR* by the last *calendar* day of the *third* month following the close of *the provider's* cost reporting period, the contractor is required to send a reminder letter to the provider *using the Reminder Letter Template (see System for Tracking Audit and Reimbursement (STAR) User Manual)* to help ensure that the *MCR* will be filed timely. The reminder letter informs the provider of the due date for filing the *MCR* and the penalty for not filing the *MCR* timely. *If the contractor receives a late and retroactive tie-in notice where the five month cost report due date has passed, contractors shall send a reminder letter to the provider and calculate a due date 30 days from the date of the reminder letter. Contractors may allow an additional seven days for mail.*

Furthermore, the reminder letter *shall* include a statement that if the *MCR* cannot be submitted by the due date, the provider may request a reduced payment suspension rate during a grace period of 60 days. The reminder letter *shall* specify that this request should be submitted before the due date of the cost report. Also, the reminder letter shall notify each provider that all submitted *MCRs* are subject to a desk review and/or an audit.

If the contractor receives a request for a reduction in the rate of suspension either because the MCR will not be filed timely or because the submitted *MCR* was rejected and *the contractor* believes that the request should be approved, the contractor *shall* recommend to *CMS* that the provider's

suspension rate be reduced for a 60-day grace period. The contractor *shall* maintain a copy of the *provider's request and CMS'* approval/disapproval of this request in the provider's *Permanent* File *(PF)*.

The PS&R system shall be utilized for all cost reports with fiscal years ending January 31, 2009 and later. The PS&R *system* allows providers to obtain their own PS&R reports needed to file the cost report. The contractor is not required to send the provider their PS&R reports, unless the provider cannot access the system, and informs the contractor of the issue.

If the provider is unable to obtain access to the PS&R system, or cannot obtain their PS&R reports, and they contact their contractor for assistance, the contractor shall instruct the provider how to obtain their reports. The contractor may assist the provider by supplying them with the needed reports. Note that failure by the provider to contact the contractor in a timely manner does not warrant an automatic extension of the cost report due dates and could result in the provider's inability to file the cost report timely and thus be subjected to payment suspension.

The provider may also request detailed PS&R data (e.g. payment reconciliation report) to reconcile their records. The request is input by the provider using the PS&R *system*, but due to the sensitive data contained within these reports, the contractor must approve the request and send the reports to the provider via secure *or encrypted data transfer*. The contractor shall furnish a requested detailed PS&R report annually at no cost to the provider. If a provider requests interim (other than annual) detailed PS&R report data, provide the detailed data at intervals requested by the provider as long as they are reasonable. *The contractor* may charge the provider a fee for this extra service. The fee should be reasonably related to costs *the contractor* incurs for the added service and be commensurate with *the contractor's* charge to all other providers for similar data.

10.2 – Contractor's Responsibility If the Provider Fails to File a Cost Report Timely or the Cost Report is Rejected

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

If the provider fails to timely file their MCR to the MAC by the seventh day after the MCR due date (including extensions), the MAC shall issue a first demand letter per IOM 100-06, Chapter 3, §30.1 and Chapter 4, §20. The MAC shall also initiate 100% suspension of all Medicare payments on the seventh day if the cost report has not been received, an extension request has not been received and approved, or a provider's request for a reduction in the rate of suspension has not been approved.

NOTE: *If the seventh day falls on a weekend or holiday, then the first demand letter shall be issued, and payments will be suspended on the subsequent business day.*

If the MAC determines that the provider's as-submitted MCR is not acceptable, the contractor shall initiate 100% suspension of all Medicare payments immediately, if there is no grace period, until an MCR is filed and determined by the contractor to be acceptable in accordance with 42 CFR 405.371. (See PRM 15-2, Chapter 1, §130.4 for explanation of a grace period for suspension of payments applicable to cost reports that were filed early but were subsequently rejected.) The contractor shall

issue a formal cost report rejection letter notifying the provider of the reason for rejection and the payment suspension.

If the contractor determines that the initial submitted MCR is rejected, the contractor shall contact the provider via telephone or email/secure portal with read receipt within 24 hours of cost report rejection to notify the provider of the rejection and payment suspension, if applicable. The contractor shall initiate contact with the same provider contact in which the cost report rejection letter is mailed. A formal rejection letter is required to be issued to the provider explaining the reason(s) for the rejection and payment suspension, if applicable, upon determination that the cost report is not acceptable. A Letter of Rejection will not be issued, and payment suspension will not occur if the reason for rejection is due to a duplicate MCR submission or is rejected at the request of the provider.

Terminated providers *shall* immediately have 100 percent of their payments suspended for failure to file *an MCR* in a timely manner. If other than a terminated provider submitted a request for reduction in the rate of suspension and it was approved, the contractor *shall* suspend the provider's payment *at the percentage approved by CMS* for the first 60 days that the cost report is late. If an acceptable *MCR* has not been filed on the 61st day after the due date, the contractor *shall* change the rate of suspension to 100 percent. If the provider did not request a reduction in the rate of suspension or the contractor did not concur with the request for a reduced suspension rate, then 100 percent of the provider's payments *shall* be suspended if an acceptable *MCR* is not filed by the due date.

If system limitations preclude *the contractor* from suspending payments based on a reduced percentage rate, base the suspension on the dollar amount that results from applying the applicable percentage rate to the average payment for the six months prior to the suspension.

All interim and lump-sum payments made for the fiscal period ending [month/day/year] and all interim and lump-sum payments made in a subsequent period will be deemed an overpayment and will be immediately due in accordance with CMS Pub. 100-06, Chapter 4, §20. The contractor shall prepare *and issue* an *initial* demand letter(s) for all previous payments in accordance with *CMS Pub. 100-06, Chapter 4, §20*. Payment due dates and interest assessments are still based on the due date of the cost report.

10.3 – Acceptance of *the* Medicare Cost Report

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The contractor is required to make a determination of acceptability within 30 days of receipt of the provider's*: (1) initially submitted MCR; (2) refiled MCR due to rejection; or (3) amended MCR* (see 42 CFR 413.24(f)(5)(iii)). *Contractors shall use the latest version of CMS' Acceptability Checklist to determine if the provider's MCR is acceptable (see Exhibit I in §170 of this Chapter.) No changes shall be made to the CMS' Acceptability Checklist unless approved by CMS.*

The CMS' Acceptability Checklist (see Exhibit I in §170 of this Chapter), requires providers to submit supporting documentation, where applicable, as enumerated in the checklist. Failure to

supply all the items in the CMS Acceptability Checklist will cause the MCR to be rejected. Once the contractor completes the CMS Acceptability Checklist and decides the MCR is acceptable, the contractor is required to complete a tentative or final settlement within 90 days of the acceptance date. If the MCR is deemed unacceptable, the contractor shall follow §10.2 of this Chapter.

Generally, each provider must perform the following steps to properly submit an MCR to their designated MAC:

- *Generate an MCR consisting of an Electronic Cost Report (ECR) file and a Print Image (PI) file of the ECR (PDF or equivalent), using CMS-approved MCR vendor software.*

- *Submit the Worksheet S (Certification Page) signed by an officer or administrator of the provider. A "wet" signature is required for cost reports ending before December 31, 2017; an electronic signature is allowed for cost reports ending on or after December 31, 2017.*

- *Provide supporting cost report documentation including, but not limited to, the working trial balance, financial statements, Medicare Bad Debt Listing, Interns and Residents Information System data, etc.*

Providers may submit their Medicare Cost Report submission package to their MAC electronically using the CMS Medicare Cost Report e-Filing (MCReF) system, via mail, or hand delivery to their designated MAC. Effective July 2, 2018 and with cost report Fiscal Year Ends (FYEs) from 1/1/2010 to the present, MCReF is the only allowable electronic cost report filing portal. In addition to facilitating the file transfer of MCRs and their supporting files to the provider's MAC, MCReF also evaluates what files are required for a valid submission, and whether the attached files fulfill the requirements to be a valid submission in accordance with PRM 15-2. If any issues with the submitted materials are identified by MCReF, they are communicated back to the user immediately for correction. MCReF does not fully evaluate all aspects of submissions, which remain subject to the subsequent application of CMS' acceptability criteria by the contractor. Additional information regarding MCReF can be located on the CMS Website: https://www.cms.gov/medicare/audits-compliance/part-a-cost-report/medicare-cost-report-electronic-filing-mcref

Per 42 CFR 413.24(f) and PRM 15-1, Chapter 29, §2931.2.A., providers may be permitted under limited circumstances, or as required by CMS, to submit an amended cost report to revise a cost report that has been previously submitted and accepted by the contractor. Acceptance of amended cost reports are at the discretion of the contractors unless otherwise directed by CMS.

In accordance with the Federal Register, Vol. 80 dated November 13, 2015 at 70563-70564, for cost reporting periods beginning on or after January 1, 2016, contractors shall accept one amended MCR submitted within 12 months after the due date for the hospital's cost report solely for the specific purpose of revising the number of Medicaid-eligible patient days (after a hospital receives updated Medicaid-eligible patient days from the State) in order for the hospital to make an appropriate cost report claim for a disproportionate share hospital (DSH) payment adjustment. In submitting such an amended MCR, the hospital must include: (1) The number of additional

Medicaid-eligible patient days that the hospital is seeking to include in the DSH calculation; (2) A description of the process that the hospital used to identify and accumulate the Medicaid-eligible patient days that were reported and filed in the hospital's MCR at issue; and (3) An explanation of why the additional Medicaid-eligible patient days at issue could not be verified by the State by the time the hospital's initial MCR was submitted.

10.4 – Submission of Cost Report Data to CMS

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Contractors are required to submit an extract of the following *MCRs* to CMS in accordance with the Healthcare Cost Report Information System (HCRIS) specifications within 210 days of the cost reporting period ending date or 60 days after receipt of *as-submitted* cost reports, whichever is later *(60 days after receipt of amended cost reports). Contractors load HCRIS files into STAR to fulfill this requirement. If an electronic HCRIS file is not available, the contractor shall manually enter the cost report information into STAR. Contractors are responsible for ensuring all MCRs and cost statements are loaded or entered into STAR. Submissions shall pass all level one electronic cost report edits and all STAR HCRIS Load Control edits.*

The following cost report forms require a HCRIS submission in STAR for all cost report versions (as-submitted, amended, revised for S-10/wage index, final settled, and revised final settled). All other cost report forms require a manually entered cost report in STAR as this information is utilized by CMS. Home office cost statements are loaded or manually entered to STAR but are not transmitted to HCRIS.

***NOTE:** The electronic CMS Form 287-22 is effective for home office cost statement periods beginning on or after October 1, 2022.*

- CMS Form 2552-10, Hospital Cost Report, for cost report periods beginning on or after May 1, 2010
- CMS Form 2552-96, Hospital Cost Report, for cost reporting periods ending on or after September 30, 1996 *and beginning before May 1, 2010*
- *CMS Form 2540-24, Skilled Nursing Facility Cost Report, for cost reporting periods ending on or after September 30, 2025*
- *CMS Form 2540-10, Skilled Nursing Facility Cost Report, for cost reporting periods beginning on or after December 1, 2010 and ending before September 30, 2025*
- CMS Form 2540-96, Skilled Nursing Facility Cost Report, for cost reporting periods ending on or after *September* 30, 1996 *and beginning before December 1, 2010*
- *CMS Form 1728-20, Home Health Agency Cost Report, for cost reporting periods beginning on or after January 1, 2020 and ending on or after December 31, 2020*

- CMS Form 1728-94, Home Health Agency Cost Report, for cost reporting periods ending on or after December 31, 1994 *and ending before December 31, 2020*

- *CMS Form 265-11, Renal Dialysis Cost Report, for cost reporting periods ending on or after January 1, 2011*

- CMS Form 265-94, Renal Dialysis Cost Report, for cost reporting periods ending on or after December 31, 1994 *and beginning before January 1, 2011*

- *CMS Form CMS 1984-14, Hospice Cost Report, for cost reporting periods beginning on or after October 1, 2014*

- CMS Form 1984-99, Hospice Cost Report, for cost reporting periods beginning on or after April 1, 1999 *and beginning before October 1, 2014*

- *CMS Form 2088-17, Community Mental Health Center Cost Report, for cost reporting periods ending on or after September 30, 2018*

- *CMS Form CMS 2088-92, Outpatient Rehabilitation Cost Report, Community Mental Health Centers only, for cost reporting periods ending on or after March 31, 2010 and on or before September 29, 2018*

- *CMS Form CMS 222-17, Rural Health Clinic (RHC) Cost Report, for cost reporting periods ending on or after September 30, 2018*

- *CMS Form 222-92, Independent Rural Health Clinic Cost Report, for cost reporting periods ending on or after May 31, 2009 and ending before September 30, 2018*

- *CMS Form 224-14, Federally Qualified Health Center Cost Report, for cost reporting periods beginning on or after October 1, 2014*

- *CMS Form 222-92, Federally Qualified Health Center Cost Report, for cost reporting periods ending on or after May 31, 2009 and beginning before October 1, 2014*

- *CMS Form 216-94, Organ Procurement Organization and Tissue Typing Laboratory, for cost reporting periods beginning on or after October 1, 2018*

Consult the following HCRIS website link regarding the cost report submission requirements for any other CMS cost report form not listed above: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/?redirect=/CostReports/. If the cost report is deemed to be "Low Medicare utilization" or "No Medicare utilization," a HCRIS extract of the "*as-submitted*" cost report *is not required*.

10.5 – Initial/Tentative Retroactive Adjustments (Tentative Settlements)

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

42 CFR 413.64*(f)(2)* and the *PRM 15-1, Chapter 24*, §2408.2, stipulate that an initial/tentative retroactive adjustment *(tentative settlement)* must be made as quickly as possible after the receipt of a cost report from the provider. Therefore, *contractors shall complete a tentative settlement within 90 days of acceptance of the provider's: (1) Originally as-submitted accepted cost report and/or (2) An amended accepted cost report.* Prompt initial/tentative retroactive adjustments are essential to ensure proper cash flow to providers. Reducing or delaying tentative settlements until a final determination could jeopardize the financial viability of some providers.

Note: *If the contractor receives and accepts an amended cost report prior to the due date for and issuance of a tentative settlement for an earlier accepted submission, the contractor shall issue one tentative settlement based on the most current accepted cost report submission within the greater of the tentative settlement due date of the earlier accepted cost report or 30 days of the acceptance of the amended cost report.*

A tentative settlement is considered complete once the tentative settlement determination has been issued to the provider within 90 days of acceptance as noted above. The determination to the provider shall include the following:

- *Initial Demand Letter, if applicable (See CMS Pub. 100-06, Chapter 3 and 4);*
- *Tentative settlement determination letter; and*
- *Explanation of Tentative Settlement (calculation support for provider).*

MACs shall upload the above information, where applicable, into the STAR system within 30 days of issuing the tentative settlement determination to the provider.

Contractors are not required to make tentative *settlement* adjustments where one of the conditions listed in §2408.2 of PRM *15-1* applies. *Contractors are also not required to make tentative settlements for: (1) Hospice cost reports; (2) Cost reports final settled within 90 days from acceptance of the cost report; (3) Low or no Medicare Utilization cost reports which are ineligible for a tentative settlement; (4) Terminated providers, and (5) As directed by CMS (i.e. bankruptcy, fraud and abuse, etc.).*

Contractors shall use STAR automation, where applicable, to calculate and issue cost report tentative settlements for as-submitted and amended MCRs. The STAR automation of the tentative settlement standardizes the tentative settlement process for the contractors and improves timely reimbursement of the amount due to providers based on the as-submitted and amended MCRs.

For the purpose of a tentative *settlement* adjustment, accept costs as reported *unless previous experience with the cost report and provider documentation warrants a reduction in costs*. However, to avoid creating an overpayment, reduce the payment by any amounts attributable to obvious errors or inconsistencies in the cost report *and documentation requested during the acceptability process, but not submitted by the provider*. Also, give consideration to amounts owed the program by the provider (e.g., possible adjustments for prior periods and current period for unresolved issues,

unrecovered overpayment). *The following areas may be considered during the tentative settlement process:*

- *Correct SSI for acute care and rehabilitation providers (if applicable).*
- *Correct Per Resident Amounts (PRA) for teaching facilities that receive direct graduate medical education (DGME).*
- *The submitted bad debt listings contain the required information and reconcile to the cost report.*
- *Total interim payments reported on W/S E-1, Line 1 appear accurate when compared to PS&R payments or the PIP ledger.*
- *Lump-sum adjustments are accurately reported on W/S E-1.*
- *"Other Adjustments" on the W/S E schedules contain $0 or the provider has provided adequate documentation to support such amounts.*
- *Settlement data included on the W/S E series appears to accurately reflect PS&R data.*
- *The number of Interns and Residents are consistent with prior year.*

If the current year's tentative settlement results in an underpayment and the provider has existing Medicare overpayments, follow the instructions in *CMS Pub. 100-06,* Chapter 3. In instances where a provider is in bankruptcy or is part of bankruptcy proceedings, bankruptcy procedures will supersede these instructions.

Cost-to-charge ratios (CCRs) are used in determining outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the outpatient prospective payment system (OPPS). CCRs are also used to determine payments for extraordinarily high cost cases (cost outliers) under the *inpatient* acute care hospitals, inpatient *rehabilitation facilities, inpatient psychiatric facilities,* long term care hospitals*, and community mental health center* prospective payment systems (IPPS, *IRF PPS, IPF PPS,* LTCH *PPS, and CMHC* PPS, respectively).

The contractor is required to update the CCRs for providers reimbursed under the *IPPS,* OPPS, *IRF PPS, IPF PPS,* LTCH *PPS, and CMHC* PPS to reflect cost and charge information from a provider's most recent cost reporting period, whether tentative or final settled. Therefore, immediately after completion of the tentative settlement, calculate the updated CCRs in a manner described *in the applicable Chapter of CMS Pub. 100-04* and input *the CCR* into the Outpatient Provider Specific File (OPSF) and Provider Specific File (PSF) *no later than 30 days after the date of issuance of the tentative settlement*.

- If *the contractor* made adjustments during the tentative settlement for prior year audit adjustments or other changes and these adjustments have an impact of more than 20%

(plus/minus) on the CCRs from the "*as-submitted*" cost report, calculate the updated CCRs using the tentative settlement data.

- If the tentative settlement adjustments have an impact of 20% or less on the CCRs from the "*as-submitted*" cost report, or if no adjustments to the tentative settlement were made, calculate the updated CCRs using the hospital's "*as-submitted*" cost report.

MACs shall upload the above information, where applicable, into the STAR system within 30 days of issuing the final cost report settlement determination to the provider.

20 – Desk Reviews

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

20.1 – Definition

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The desk review is an analysis of the provider's *MCR* to determine its adequacy, completeness, accuracy, and reasonableness of the data contained therein. It is a process of reviewing information pertaining to the *MCR* and is designed to identify problems warranting additional review and, where appropriate, to resolve some of those problems/exceptions. The objective of the desk review is to determine whether the *MCR* can be settled without an audit or whether an in-house or field audit is necessary. For this purpose, every desk review *shall* contain a summary of the review results (see *Exhibit II* in §170 of this *Chapter*) and a decision as to the next step (e.g., settle without additional review, complete desk review exception resolution, perform in-house/field audit). If a decision is made to audit the *MCR*, a properly completed desk review is essential for planning the audit and establishing the audit objectives.

Desk reviews are required for all providers filing an *MCR* except *for* Hospice and low/no Medicare utilization providers. However, if *the contractor's* professional judgment dictates, *the contractor* may perform an appropriate desk review on a low Medicare utilization cost report.

A desk review is comprised of (1) the applicable Uniform Desk Review program, and (2) the desk review exception resolution (if applicable). The contractor shall use the specific CMS Uniform Desk Review program that is in effect at the time *the contractor begins* the desk review for each provider. The following information, as appropriate, *shall be used* in completing the specific desk review steps and later in planning the audit.

- Permanent File;
- Correspondence Files;
- PS&R;
- Current and Prior Year *MCRs*;

- Working Trial Balance;
- Financial Statements;
- *The responses and necessary supporting documents per the specific "Cost Report Reimbursement Questionnaire" cost report worksheet (e.g., Form CMS-2552-10, Worksheet S-2, Part II for hospitals);*
- *Applicable documentation (e.g., supporting documentation for reclassifications, adjustments, related organizations, and protested items) required to be submitted per the instructions in the specific provider-type cost reports;*
- *Prior Years Management Letter Comments (MLC);*
- *Points for Next Year (PFNY);*
- Prior Year Adjustment Report; and
- Prior Year *Desk Review and* Audit *(if applicable)* Workpapers.

20.2 – Components of the Uniform Desk Review (UDR)

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The UDR is comprised of a clerical review, selection of desk review type *(*either a *modified desk review,* limited desk review*,* or a full desk review*),* summary of UDR exceptions*, and the desk review exception resolution (if applicable).*

NOTE: The UDR is issued by CMS separately and is not included in this manual. *Additionally, the UDR program is a confidential document and released only to the Medicare Administrative Contractors.*

I. Clerical Review

A clerical desk review consists of *creating a comparative analysis of the MCR data between the prior and current year when needed for a modified, limited, or full desk review. Identify the steps in the related desk review program to determine which comparative analyses are needed for the specific cost report.*

II. Selection of Desk Review Type

Selection of the appropriate type of desk review is critical in making the desk review/audit process more efficient and economical. Accordingly, select the appropriate desk review (*modified,* limited, or full) based on provider type and *pertinent UDR materiality* thresholds in accordance with the instructions contained in the *desk review* programs.

The *materiality* thresholds *are* published in the *Modified Desk Review (MDR) and the Medicare Audit*

and Reimbursement Protocol (MARP) Section 3. If the *contractor* believes *that* the published thresholds *are inappropriate to a specific situation or to a provider group, the contractor may request an exception from their Division of Provider Audit Operations (DPAO) Business Function Lead (BFL) (through the MAC's Contracting Officer Representative (COR)).* The request *shall* contain a justification for the change. The *DPAO BFL (through the COR) will either approve or deny the request in writing. (For the purpose of this Chapter, the terms "DPAO BFL (through the COR) assigned to the contractor" and "CMS" are synonymous and will be used interchangeably.)*

NOTE: *The MARP Section 3 materiality thresholds and any revisions to materiality thresholds approved by CMS are confidential and are not to be included on any Medicare Audit Activity workpaper that is distributed to any source outside of the contractor organization unless prior approval is obtained by CMS.*

A. *Modified Desk Review*

The contractor shall complete the Modified Desk Review (MDR) specific to the provider type for MCRs that meet the modified desk review thresholds established by CMS. However, the contractor is not prohibited from completing a limited/full desk review on an MCR even if it falls below the limited/full desk review threshold if the contractor's professional judgment dictates. In this situation, the contractor shall document the reason for performing a limited/full desk review.

The Modified Desk Review program and/or STAR MDR program shall be included as a workpaper and easily identifiable in the modified desk review package. The contractor shall address all steps in this program either by inserting "Not Applicable (N/A)" or a workpaper reference in the "Desk Review W/P Ref" column. All "N/A" annotations shall be explained (e.g., provider did not claim reimbursement for that particular issue).

The modified desk review programs shall not be modified or reordered by the contractor unless the contractor receives advance approval for such revision/modification from CMS. The contractor shall clearly identify the approved changed/added steps in its programs and maintain copies of the CMS approvals as documentation.

B. *Limited Desk Review*

The contractor shall complete the limited desk review *specific to* the provider type for *MCRs that meet the limited* desk review thresholds established by CMS. *However, the contractor is not prohibited from completing a full desk review on an MCR even if it falls below the full desk review threshold if the contractor's professional judgment dictates. In this situation, the contractor shall document the reason for performing a full desk review.*

The limited desk review program shall be included as a workpaper and easily identifiable in the limited desk review package. The contractor shall address all steps in this program either by inserting "Not Applicable (N/A)" or a workpaper reference in the "Desk Review W/P Ref" column. All "N/A" annotations shall be explained (e.g., provider did not claim reimbursement for that particular issue).

The limited desk review programs shall not be modified or reordered by the contractor unless the contractor receives advance approval for such revision/modification from CMS. The contractor shall clearly identify the approved changed/added steps in its programs and maintain copies of the CMS approvals as documentation.

C. *Full Desk Review*

The *contractor shall complete a* full desk review *specific to the provider type* for *MCRs that meet* the *full* desk review thresholds *established by CMS*.

The full desk review program shall be included as a workpaper and easily identifiable in the full desk review package. The contractor shall address all steps in this program either by inserting "Not Applicable (N/A)" or a workpaper reference in the "Desk Review W/P Ref" column. All "N/A" annotations shall be explained (e.g., provider did not claim reimbursement for that particular issue).

*The full desk review programs shall not be modified or reordered by the contractor unless the contractor receives advance approval for such revision/modification from CMS. The contractor shal*l clearly identify the approved changed/added steps in its programs and maintain copies of the CMS approvals as documentation.

III. Summary of UDR Issues/Exceptions

Contractors shall use the "Uniform Desk Review - Summary of *UDR Issues/Exceptions*" worksheet (see *Exhibit II* in §170 of this *Chapter*) to list the exceptions identified through the UDR process *and describe their disposition. Contractors* may use an alternative format if it contains, at a minimum, the information in *Exhibit II. This worksheet also serves as the "audit scoping" and/or desk review exception resolution support.*

Column 1 (No.) – Number each exception *as the exception is identified on the desk review workpaper*. This facilitates future cross-referencing of issues flowing through *the desk review, desk review exception resolution,* audit, settlement, and if applicable, the *reopening and* appeals process. *If, in the contractor's judgment, there are other issues that did not surface as desk review exceptions but need to be considered as possible exception resolution, audit issues, or for possible further review, list them at the bottom of this column starting with the next number after the last desk review exception.*

Column 2 (UDR Reference) – Identify the UDR Module and the step *that generated the* specific exception *and desk review workpaper (if applicable) for each exception related to the desk review*. Identify *exceptions which were not generated during the desk review process* as "Other".

Column 3 (Description) – Write a brief, *specific* description of the issue/exception for each item listed in Column 1 (both desk review exceptions and other exceptions). *Some examples are: (1) instead of stating that "bad debts" is the exception noted, specify that the issue/exception pertains to the "bad debts collection effort," or "bad debt indigency determination," (2) instead of stating that "Nursing/Allied Health programs" is the exception noted, specify that the exception pertains to the*

"determination of provider operator status of Nursing/Allied Health programs, or "the allowability of direct costs for the program(s) reported on Worksheet A." For "Other" exceptions, also describe how the issue/exception was identified.

Column 4 (Units/$*s*) – Where applicable, insert the units and/or dollar amounts pertaining to each exception. Leave the column blank in situations where the amounts cannot be established at the time of the desk review.

Column 5 (No Further Action) – Check this column if the exception was satisfactorily resolved during the desk review, or, if not, there is a valid reason for not deferring or scoping it for desk review exception resolution or audit. If the exception was satisfactorily resolved during the desk review process, state this in Column 10; reference the UDR workpaper which supports this conclusion in Column 11; and, if applicable, enter the adjustment number in Column 9. Record this adjustment in the Adjustment Report (see Exhibit VII in §170 of this Chapter).

Column 6 (Exception Resolution) – Check this column if a desk review exception resolution will be completed to fully address the exception. The decision to scope the exception for desk review exception resolution shall be based on the related explanation stated in the "Remarks/Comments" column of the UDR. Enter this explanation in Column 10 and reference the workpapers supporting the decision in Column 11. For exceptions identified as "Other," explain the reason for the decision to further review the issue in Column 10 and reference the workpaper supporting this decision in Column 11.

Column 7 (Scoped for Audit) – Check this column if an audit will be completed to fully address the issue. The decision to scope the issue for audit shall be based on the related explanation stated in the "Remarks/Comments" column of the UDR. Enter this explanation in Column 10 and reference the workpapers supporting the decision in Column 11. For issues identified as "Other," explain the reason for the decision to further review the issue in Column 10 and reference the workpaper supporting this decision in Column 11.

Column 8 (Exception/Audit Deferred) – Check this column if the desk review exception resolution or audit of the exception is necessary but there are circumstances which prevent the contractor from scoping it for the current year's desk review exception resolution or audit. Specify in Column 10 the reason for this decision and reference the UDR workpapers which document the process used to arrive at that decision in Column 11.

- *Prepare a "Point for Next Year" which contains the date, FYE of the MCR, and a description of the deferred exception(s) and place it in the PF. In Column 11, reference the PF section where this Point for Next Year was placed. The contractor shall conduct the review or audit of this deferred issue(s) within two years from the date of the deferral.*

Column 9 (Adjusted for Settlement) – Identify in this column the adjustment number for exceptions resolved during the desk review *which resulted in an adjustment. (See instructions for Column 4.) Also, reference the UDR workpaper which contains the proposed adjustment in Column 11.*

Column 10 (Comments) – Include in this column the explanations/reasons as described in the instructions for each column.

- *Also, include in this column an explanation which supports the decision to review during desk review exception resolution or audit the exception and describe the specific audit requirements, objectives, and related audit step(s) for exceptions identified in Columns 6 & 7. If the contractor expands the scope of the audit for the "issue/area" beyond that of the specific exception related to that issue/area, the contractor shall also explain in this column the reason for doing so and describe the additional audit steps that will be performed. For example, if the desk review only generated an exception for "caps" applicable to direct Graduate Medical Education (DGME) but the contractor decides to expand the audit to encompass various other aspects of DGME, the contractor shall explain in this column the reason for the expansion and describe all the other audit steps that will be completed during the audit.*

Column 11 (UDR, Resolution, Audit, or PF W/P Ref.) – Enter in this column the desk review, desk review exception resolution, audit, or PF workpaper references related to each exception. These references shall specifically identify whether they represent a desk review, desk review exception resolution, audit, or PF workpaper. For exceptions that will be reviewed during desk review exception resolution or audit, there generally will be references to the desk review workpaper(s), desk review exception resolution, and audit workpaper(s).

Indicate in the designated boxes at the top of the "*Summary of UDR Issues/Exceptions*" the decision regarding the next step for the MCR (e.g., settlement without further review, d*esk review exception resolution,* field audit, and in-house audit).

The Summary of Issues/Exceptions shall be included in any desk review and audit package.

20.3 – *Guidelines for Completion of the* Desk Review (Including the Exception Resolution Process)

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

When completing the UDR (including resolving UDR exceptions during the desk review process) the contractors shall adhere to the standards outlined in this Chapter to: (1) use evidence that meets the standards required by CMS, (2) document the conclusion in accordance with the standards for documentation required by CMS, (3) prepare the desk review workpapers, and (4) follow the standards for supervisory review responsibilities pertaining to the desk review process.

The contractor shall complete all the applicable steps in the relevant CMS UDR program during the desk review process, as well as any steps added by the contractor which were approved by CMS. That is, the contractor shall not complete the UDR steps during the in-house or field audit because the results of the desk review are intended to assist in setting the scope of the audit. PS&R reconciliation and settlement verification steps can be referred to audit to ensure timeliness and accuracy. If issues/exceptions are identified during the completion of the desk review steps, and the

MCR is not scoped for audit, the contractor shall attempt to resolve these issues/exceptions or variances during the desk review exception resolution.

It is not appropriate for the contractor to deem the issue/exception or variance to be fully resolved during the desk review without the need for further review if the review leading to such conclusion was limited in nature (i.e., touched only the surface of the issue), whereas a "full" resolution of the exception or variance requires: (1) additional documentation; (2) amount of review effort required; and (3) adherence to specific review steps contained in the CMS' desk review program.

The following is an example of an exception inappropriately deemed by the contractor as fully resolved during the desk review: "The UDR comparative analysis identified a significant increase in the direct costs of the CAH's Clinic. The provider explained that the reason for the significant increase during the current year was due to reporting the costs for the Clinic cost center for a full year in the current MCR while this cost center was first established in the middle of the prior year and the cost reported in that MCR was not for a full year. During the desk review, the contractor accepted this explanation and concluded that no additional review was required. However, since the CAH is reimbursed on a reasonable cost basis and a full year's cost was first reported for this newly established cost center in the year under review, this cost will serve as the "base" for future UDR comparisons. Therefore, it was crucial for the contractor to determine whether the costs reported during the current year were reasonable, necessary, proper, and accurate. For this example, an appropriate review by the contractor could consist of reviewing the detailed trial balance for nonallowable or questionable accounts and requesting additional documentation from the provider to support these accounts. CMS expects the contractors to perform a thorough review of issues related to "cost-reimbursed items" (e.g., the costs of a CAH; pass-through payments for Nursing/Allied Health and Organ Acquisition of an acute care hospital) at the time the provider claims these costs/payments for the first time.

If it appears that *the exception identified when completing a desk review step requires an adjustment, but further review is necessary to make* an adjustment, *the contractor shall either* request the information from the provider before making the adjustment *or consider scoping the issue for further review*. For example, do not prepare an adjustment *during the desk review* if the provider claimed bad debts for Medicare deductible and coinsurance sooner than 120 days from the date of the first bill without first *determining if the provider deemed the patient indigent prior to 120 days from the first bill (for cost reporting periods beginning before October 1, 2020).*

When *requesting* additional documentation *to resolve a desk review exception during* the desk review *exception resolution* process, *the contractor shall be considerate of the amount of information being requested and shall* ensure that the request does not violate the provisions of the Paperwork Reduction Act (PRA) of 1980. Requests for additional documentation in connection with desk reviews are generally not subject to PRA requirements if *the contractor* adheres to the following procedures:

- A specific request for documentation shall be made to only one entity, (i.e., the provider whose *MCR* is under review), and

- Questions *shall* be specific to that provider's particular *MCR*.

The contractor shall request that the provider furnish this information/documentation within *two* weeks of the date of *the initial* request*; the due date for subsequent requests are determined by the MAC. Additionally, timeframes for the initial and subsequent requests may be extended at the MAC discretion.* If the provider does not furnish the documentation within that time period, either make an adjustment or consider scoping the issue for audit.

For MCRs that will not proceed to audit, the contractor shall send any adjustments made during the desk review process to the provider and request that, within two weeks *of receipt of the adjustments, the provider respond in writing with either their agreement with the adjustments or describe* any concerns with the adjustments. Also, *the contractor shall* inform the provider in writing that these adjustments will become final after any necessary modifications based on the written concerns and documentation supporting them *are reviewed. This adjustment report incorporates adjustments to the provider's as-submitted cost report so that the MCR reflects costs and data in conformity with the Medicare principles of payment. (See Exhibit VII in §170 of this Chapter.)*

If the exception or variance cannot be "fully" resolved during the desk review which includes desk review exception resolution, and the MCR is not scheduled for audit, the contractor shall consider scheduling the MCR for audit or create a point for next year to include in the permanent file. (See §130 of this Chapter for more information on the permanent file.)

20.4 – Wage Index Review

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Section 1886 (d)(*3*)(E) of the Social Security Act, "Adjusting for Different Area Wage Levels," requires the Secretary to adjust the proportion of hospital costs attributable to wages and wage-related costs for area differences in hospital wage levels. This adjustment factor, the wage index, reflects the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Wage Index reviews *shall* be completed *when directed by the CMS Division of Acute Care*. Use the latest wage index desk review program released by CMS *in STAR* prior to the due date of the wage index reviews.

Wage index periods follow the federal fiscal period of October 1 – September 30. If a hospital has more than one *MCR* beginning during the wage index period (for example, a hospital has two short period *MCRs* beginning on or after October 1, through September 30 of a given year), conduct a desk review on only one of the reporting periods. Select the longest period. If there is more than one period of that length, select the latest period.

All wage index adjustments will be included in the Adjustment Report for the provider's cost reporting period. This adjustment report incorporates adjustments to the provider's as-submitted cost report so that the MCR reflects costs and data in conformity with the Medicare principles of payment (see Exhibit VII in §170 of this Chapter).

Contractors are required to track wage index revisions in STAR and submit revised HCRIS files,

where applicable, to STAR and CMS by the due date(s) established by CMS.

30 – Audits

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Providers receiving payments under Part A and B of Title XVIII of the Act, as amended, are subject to audit of payments applicable to services rendered to Medicare beneficiaries. An audit may be done as a field audit or*, if appropriate,* as an in-house audit based on the discretion of the contractor *and as approved by CMS*.

30.1 – Definition of Audits

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

A field audit is an on-site examination of financial transactions, accounts, and reports as they relate to the *MCR* in order to test the provider's compliance with applicable Medicare laws, regulations, manual instructions, and directives. *The contractor shall use the latest CMS-approved audit program during a field audit applicable to the provider type in effect at the time when its audit program is tailored (see §50.2 of this Chapter). The CMS approved Audit Program shall not be altered or reordered by the contractor unless the contractor receives advance approval for such revision/modification from CMS. The contractor shall clearly identify the approved changed/added steps in its programs and maintain copies of the CMS approvals as documentation.*

An in-house audit is an examination of financial transactions, accounts, and reports as they relate to the *MCR* to test the provider's compliance with applicable Medicare laws, regulations, manual instructions, and directives that is performed at *a non-provider* location. An in-house audit is subject to the same standards/processes *as a field audit. The contractor shall use the latest CMS approved audit program during an in-house audit applicable to the provider type at the time when its audit program is tailored (see §50.2 of this Chapter).* In general, an in-house audit is the same as a field audit except all work is performed *at a non-provider location.*

In performing Medicare in-house and field audits, the contractor *shall* comply with the general, field work, and reporting standards of the Government Auditing Standards (GAS) issued by the Comptroller General of the United States as these standards are applicable to all audits performed by or for any Federal agency. If the contractor engages auditors *on its own initiative* under a subcontract (see §160 of this Chapter) to perform *or assist on any* Medicare *Audit Activity*, the subcontractor's auditors *shall* follow the same GAS and other standards that the contractor is required to follow. However, as specified in *§61.6.D.* of this Chapter, the contractor cannot delegate the performance of a supervisory review of *workpapers* to a subcontractor. CMS holds the contractor responsible for the subcontract work in the same manner as if its own employees performed the work.

NOTE: *For the purpose of this Chapter, unless otherwise noted, any reference to GAS is the 2018 Revision.*

Contractors may limit the scope of both in-house and field audits to a review of selected parts of a provider's *MCR* and related financial records. In addition, the audit procedures performed on

selected areas of the *MCR* may be limited. However, both the selected cost report areas and the related procedures to be applied *shall* be sufficient to meet the audit objectives established from the desk review. When in-house and field audits are being performed and additional audit procedures are required, or additional findings are discovered which may require additional audit procedures, the contractor shall make a prompt evaluation *of the Medicare impact of the related issues in light of its current audit plan. If the Medicare impact of the new issues outweighs the Medicare impact of other issues included in the current audit plan, the contractor shall seek CMS' approval to change its audit plan to address those additional issues.*

The required steps for addressing desk review and audit adjustments during an in-house and field audit are included in §60.0ff of this Chapter. All audit adjustments shall be included in the final Adjustment Report issued with the Notice of Program Reimbursement (NPR) package to the provider (see §70.5 of this Chapter). This report *includes all desk review (including desk review exception resolution), wage index, Worksheet S-10,* and audit adjustments *that will be incorporated into* the provider's *as-submitted* cost *report* so that the audited *MCR* reflects costs and data in conformity with the Medicare principles of payment *(see Exhibit VII in §170 of this Chapter).*

30.2 – Purpose of Audits

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Medicare in-house and field audits are conducted in order to: (1) provide reasonable assurance that program payments are based on Medicare reimbursement principles, and (2) develop other information that CMS needs to fulfill its responsibilities.

In carrying out *the* audit responsibilities, *the contractors'* primary goal is to arrive at a correct settlement of the *MCR*. In so doing, *the contractor shall* preserve the provider's interest and rights but at the same time apply program policies to specific situations to assure compliance with these policies. *The contractor's* authority does not extend to determining whether program policies and procedures are appropriate or *shall* be applied in a given circumstance. Rather, *the contractors'* responsibility is to enforce such policies and procedures and take corrective action where noncompliance exists.

40 – Planning and Management (Global Scoping) of Audits

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The contractor shall develop an audit plan to identify cost reports to be audited and resources to be expended, taking into consideration the guidance that CMS gives *the contractor* in *§§40.1 and 40.2* of this *Chapter* about the types of providers or potential issues to be audited. However, *contractors shall* not use these priorities as the sole *factor in* determining the planning process. The planning process is based on *the results of the desk review and the contractor's* empirical knowledge, past performance of the provider, last time audited, and the relative risk associated with the settlement amount calculated from the *MCR*. Generally, *the contractor* selects providers for audit based on their professional judgment *and those that* represent the greatest risk for incorrect payment.

Effective management of audit resources requires a continual decision-making process. As events occur throughout the *MAC's contract year* and circumstances come to light, the audit plan *shall* be continually evaluated, and priorities reassessed. If a greater audit requirement becomes evident, *the contractor shall* not *automatically* defer that audit work. Rather, *the contractor shall seek guidance from their BFL, through their COR, to determine if the audit work should be deferred or if an audit on the current audit plan can be replaced with this new audit.*

Contractors shall apply the appropriate level of resources for each audit to assure that payments made to a provider are not more or less than required under applicable law and regulations to achieve CMS's audit objectives.

40.1 – Cost Reports and Auditing of Multiple Provider Institutions

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Where an institution certified as a certain type (e.g., hospital, SNF, HHA) has a distinct unit certified as another provider type (e.g., a hospital has a SNF, HHA, or a unit excluded from inpatient prospective payment system), each such distinct unit or subprovider is, in effect, another department of the provider. Cost finding in such an institution involves allocation of the institution's costs between the main provider and subproviders (e.g., between the hospital and the SNF, HHA, or excluded unit). Thus, provider complexes with subproviders must file one *MCR* on the CMS cost reporting forms designated for the main provider (e.g., Form CMS-2552 for hospitals). Separate cost reports may not be filed for the provider-based components (subproviders). Therefore, in the *contractor's* audit plan, *the contractor shall* consider the audit of a multiple provider institution as one workload unit but, as appropriate, include audit procedures to review the provider-based component(s).

40.2 – Audit Priority Considerations

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

One or more of the following audit priority considerations may enter into the process of formulating *the contractor's* audit plan.

A. Significance of Total Medicare Program Payments

In a PPS *and cost reimbursed* environment, specific attention *should be directed* to the following reimbursement areas or issues *(as applicable based on the provider type), including but not limited to:*

- Bad debts
- Graduate medical education (GME)
- Indirect medical education (IME) *IPPS hospitals and "Teaching Hospital Adjustment" for IPF-PPS hospitals and units and IRF-PPS hospitals and units*

- Organ acquisition costs
- Disproportionate share hospital (DSH) payments *for IPPS hospitals and Low-Income Payment (LIP) for IRF-PPS hospitals and units*
- *RHC Special Payment Issues*
- *Uncompensated Care*
- Nursing/Allied Health pass-through payments
- Outlier payments

B. Types of Providers

Special attention may be required for certain types of providers because of known or anticipated problems or circumstances. *The contractor shall* consider the following in *formulating the* audit plan.

- New providers.
- Providers reimbursed on a cost basis (e.g., critical access hospitals*, federally qualified health centers, rural health centers, organ procurement organizations, etc.) or the Tax Equity and Fiscal Responsibility Act (TEFRA) basis (e.g.,* cancer hospitals*, children's hospitals, and hospitals located in the U.S. Virgin Islands, Guam, Northern Mariana Islands, and American Samoa*).
- End Stage Renal Disease *(ESRD)* Facilities need to be audited in accordance with the Balanced Budget Act *of 1997* requirements. The *review* of ESRD facilities *selected* for the three-year-cycle can be either *an in-house (desk audit) or* field audit. *Additionally, the ESRD three-year cyclical audits are not to be included on the contractor's CMS approved audit plan.*
- Providers receiving significant non-PPS payments.
- Providers that were not audited recently.

C. Conditions and Occurrences at the Provider

- Change of ownership, termination, or change of provider type (e.g., *acute to* critical access hospital).
- Cost report filed late without a satisfactory explanation.
- Fraud and abuse investigations as directed by the Office of Inspector General (OIG) or Department of Justice (DOJ).

50 – Scoping/Planning of Individual Audits

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

50.1 – Establishing the Objective/Scope of Audits

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Once a decision *is made* to perform an in-house or field audit on a given cost report by considering the Medicare priorities, *the contractor shall* use the results of the desk review, and its empirical knowledge of the provider to define the audit's objectives and the scope and methodology to achieve those objectives. The objectives are what the audit is to accomplish. They identify the audit subjects and performance aspects to be included, as well as the potential finding and reporting elements that the auditors expect. Scope is the boundary of the audit. It addresses such things as the depth of review of the issues/areas selected for audit. The methodology comprises the work in data gathering and in analytical methods auditors will use to achieve the objectives. Auditors *shall* design the methodology to provide sufficient, competent, and relevant evidence to achieve the objectives of the audit. Methodology includes not only the nature of the auditor's procedures, but also their extent (for example, sample size).

The desk review process and *the contractor's* knowledge of the provider help *the contractor* to determine the issues/areas to be addressed for each audit. If budget limitations or other factors prevent *the contractor* from including all the exceptions in the scope of the audit for that *MCR, the contractor shall consider expanding the hours assigned to the audit. If expanding the hours is not possible, the contractor shall rank* the exceptions based on their significance. Significance generally relates to the Medicare dollars *at risk* if the provider reports the issue/area incorrectly. This dollar impact *shall* be estimated using appropriate factors (e.g., expense amount, Medicare utilization, number of residents and associated per-FTE- resident amount, number of beds for indirect medical education) that pertain to the computation of the Medicare payment for that exception. If this cannot be accomplished, use the total Medicare dollar payment for the issue/area (e.g., amount of graduate medical education (GME) payment). Significance can also pertain to a present or future risk if the issue is not investigated.

If the contractor has determined to rank the issues/exceptions, the contractor shall use this ranking to determine which exceptions can be eliminated from the scope if it is not possible to audit them all. *This elimination consists of excluding* issues/areas starting from the issue ranked the lowest until reaching a level of audit resources that can be devoted to this specific audit. *The contractor shall* document and support the decision to not audit these issues/areas in separate desk review workpapers *supporting the ranking*. However, if in *the contractor's* professional judgment, all the issues/areas are significant, consider adjusting the audit plan by deferring or canceling other audit work (i.e., audits of other providers) of a lesser urgency. If there is no work of lesser urgency, seek guidance from *CMS. Any changes to the contactor's approved audit plan shall be approved in advance by the DPAO BFL as required by the contractor's Statement of Work.*

The contractor shall be specific in documenting the issues/areas that are scoped for audit. For example, instead of *including the generic audit scope of* "bad debts", specify that *traditional bad*

debts will be audited for timely billing and collection efforts. The contractor shall draft the audit program as outlined in §50.2 below to determine the extent of review to be performed on each issue scoped for further review.

50.2 – Tailoring of the Audit Program

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

An audit program provides the audit procedures that auditors *shall* follow to achieve the audit objectives. *The contractor shall* prepare a specific audit program for each in-house or field audit that *the contractor* performs. This audit program *shall* reflect the *steps to be completed in order to review the* issues/areas contained in the scoping document (e.g., the Summary of UDR *Issues/*Exceptions described in §20.2.III. of this Chapter). *The contractor shall use the steps from the latest approved CMS Audit Program applicable for the provider type in effect at the time when its audit program is being tailored. Additionally, unless directed by CMS, the contractor shall not alter or renumber the CMS approved Audit Program steps.*

NOTE: *The audit program is issued by CMS separately and is not included in this manual.*

Additionally, the audit program is a confidential document and released only to the contractors.

The contractor's audit program *shall*:

- Identify the audit objectives;
- Identify the issues, transactions or cost report entries to be audited, reviewed or verified;
- Identify the audit steps to be performed;
- Describe the tests to be applied.

60 – Audit Process

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

60.1 – Audit Confirmation Letter (Engagement Letter)

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The contractor *shall* send the provider an audit confirmation letter for all in-house or field audits. This letter will *identify* the major areas the contractor intends to review during its audit *and advise the provider of the* documentation that is *required prior to starting the audit*.

The field audit confirmation letter *shall* give a minimum of four weeks and a maximum of six weeks' notice of the contractor's intent to make an onsite visit for the purpose of conducting a field audit (see *Exhibit III.A* in §170 of this Chapter for a sample letter). *The in-house audit confirmation letter shall give a minimum of four weeks and a maximum of six weeks' notice of the contractor's intent to conduct an in-house audit (see Exhibit III.B in §170 of this Chapter for a sample letter).* The engagement letter *shall* be provider-specific and include the following:

- *Identification of the major areas the contractor plans to review.*

- *For a field audit,* a list of the required documents that are to be made available by the provider on the first day of the audit. *For an in-house audit, a list of the required documents and the due date that the provider must send copies of the documentation to the contractor by. The documentation due date shall be at least one week prior to the telephone entrance conference.*

- Date *and time* of the entrance conference. (See the entrance conference agenda – *Exhibit IV* in §170 of this Chapter.)

- A request that the provider assign a contact person to be the audit liaison.

- A tentative pre-exit conference date set for the last day of fieldwork *for a field audit or date set within one week of the anticipated completion date of all audit review work for an in-house audit*. (See the pre-exit conference format – *Exhibit VI* in §170 of this Chapter.)

- *For a field audit,* notice that an exit conference will be tentatively scheduled during the pre-exit conference to occur within eight weeks (or longer if extenuating circumstances arise) after all the outstanding documentation is furnished by the provider. *For an in-house audit, notice that a telephone exit conference will be conducted once all adjustments are finalized. (See the exit conference format – Exhibit VIII in §170 of this Chapter.)*

- Notice to the provider that all documentation and records requested prior to and during the *audit* must be given to *the contractor* in a timely manner and that failure to produce documentation will result in non-negotiable adjustments.

- Notice to the provider that, as a general rule, *the contractor* will not honor any reopening requests for the "lack of documentation" adjustments. This policy has no impact on the normal provider appeal rights with the Provider Reimbursement Review Board.

60.2 – Entrance Conference

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The entrance conference is an important step in the audit process as it sets the tone for the entire audit. The entrance conference serves to enhance communications between the contractor and the provider by covering a wide variety of issues. At a minimum, the participants at the entrance conference *shall* consist of the Medicare auditors who will perform the audit, all appropriate provider personnel (controller, provider liaison, accountants, cost report preparers), and provider consultants (if provider desires). See *Exhibit IV* in §170 of this *Chapter* for a sample of the Entrance Conference Agenda.

During the on-site entrance conference *for a field audit or telephone entrance conference for an in-house audit*, explain the purpose of the review and stress the need for cooperation especially concerning the release of documentation by the provider. Also, *the contractor shall* inform the

provider that if supporting documentation is not received, as a general rule, the associated Medicare *payment* will be disallowed, *and a reopening request will not be honored due to "lack of documentation." However, all reopenings are at the discretion of the contractor.* Additionally, address the following during the entrance conference.

- Discuss timeframes for conducting the on-site *or in-house* audit and schedule the pre-exit conference;
- Discuss the scope of the on-site *or in-house* audit areas to be reviewed, and the fact that the audit may turn up other issues not discussed at the entrance conference;
- Discuss all of the proposed desk review adjustments with the provider;
- Identify the provider's liaison and fully discuss the liaison's role to ensure full cooperation during the audit;
- *For on-site audits,* discuss administrative issues such as location of working space for the auditors, the hours during which the auditors will have access to this working space, use of copiers*/scanners, access to* files*, etc.*;
- Encourage the *third*-party cost report preparer to be available during the course of the audit and exit conference; and
- *Discuss timeframes for additional documentation that is requested during the audit. All requests shall be in writing and submitted to the designated provider's liaison. In general, the provider shall be given two to three working days to supply the requested additional documentation.*

At the start of the audit (generally after the entrance conference), inventory the provider prepared documentation noting any items missing from the initial engagement request. Notify the provider in writing of all missing items and request that the items be made available as soon as possible. Follow the same notification policy for any additional documentation that is requested during the audit.

NOTE: All contractor requests and provider responses *shall* follow PHI/HIPAA requirements when emailing or faxing information.

60.3 – Tests of Internal Control

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

A. Provider's Internal Control Structure

A provider's internal control structure consists of the policies and procedures established to provide reasonable assurance that the provider's objectives are achieved. The internal control structure consists of three elements:

- Control Environment – The collective effect of various factors on establishing, enhancing, or

mitigating the effectiveness of specific policies and procedures.

- Accounting System – The methods and records established to identify, assemble, analyze, classify, record, and report an entity's transactions and to maintain accountability for the related assets and liabilities.

- Control Procedures – The policies and procedures in addition to the control environment and accounting system that management has established to provide reasonable assurance that specific entity objectives will be achieved.

A provider generally has internal control structure policies and procedures that are not relevant to a particular audit and therefore need not be considered for that audit. For example, policies and procedures concerning the effectiveness, economy, and efficiency of certain management decision-making processes, while important to the provider, do not ordinarily relate to a Medicare audit.

B. Medicare's Policy Regarding Review of Internal Controls

In the Medicare audit environment, a review of and reporting on a provider's system of internal control is generally not warranted or cost effective. The auditor may conclude that it would be inefficient to evaluate the effectiveness of internal control policies and procedures and that the audit can be conducted more efficiently by expanding substantive tests.

The contractor may wish to gain an understanding of the provider's internal control structure when, in *the contractor's* professional judgment, this understanding and assessment of the internal controls would significantly affect the scoping of the Medicare audit. This does not mean or require that the internal controls need to be reviewed in every instance. *The contractor's* understanding can be obtained through sources such as the previous period's completed Internal Control Questionnaire (see *Exhibit V* in §170 of this Chapter), current year's management letter prepared by the provider's financial auditors (e.g., CPA firm), previous Medicare audit history, and empirical knowledge of the provider.

It is not necessary to test the provider's system of internal control for audits of specifically selected areas such as intern/resident counts or wage index reviews, or for reopenings. Furthermore, where CMS directs *the contractor* to perform a special audit, CMS may limit, or require no work, in the area of internal controls.

If internal controls are not reviewed, the decision *shall* be stated in the scope section of the audit report. In this situation, preparation of a report on internal controls is not required.

C. Obtaining an Understanding of the Internal Control Structure

If *the contractor* determines that it is necessary to review internal controls in a given situation (e.g., new providers, first audit by the contractor), complete the Internal Control Questionnaire (see *Exhibit V* in §170 of this *Chapter*). Since all the aspects of the provider's internal control structure are not relevant to a Medicare audit, this questionnaire is designed to allow *the contractor* to obtain an

understanding of the provider's internal control structure as it applies to Medicare audits. Medicare auditors are concerned with the allowability, reasonableness, classification, and accumulation of cost report data that *shall* be reported in accordance with Medicare principles of payment. Therefore, the Medicare auditor *shall* obtain an understanding of those aspects of the provider's internal control structure that affect the reliability of the cost report data that is being audited within the parameters of the Medicare audit in accordance with CMS' audit instructions. This understanding is ordinarily obtained by:

- Previous experience with the provider;
- Inquiries of appropriate personnel;
- Observation of the provider's activities and operations; and
- Inspection of the provider's documents and records.

Once the information required by the questionnaire has been obtained*, the contractor shall obtain the provider's written concurrence to the answers and documentation as a whole or on a question-by-question basis, as appropriate. If* in *the contractor's* professional judgment *there is a* need to test the internal control structure in subsequent years, *the contractor* may review and update the questionnaire answers and documentation during subsequent audits.

The contractor shall maintain the internal control questionnaire with all related documentation in a separate section of the permanent file and cross reference to supporting audit workpapers, if necessary.

60.4 – Coordination of Activities During Audits

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

In order to ensure that the in-house or field audit will accomplish its objectives, it is important to have the provider designate a staff person to serve in the role of the audit liaison. This person ensures that issues are addressed as they arise rather than at the completion of the audit. The provider liaison performs an active role during the audit. This person either provides requested information or ensures that the appropriate and responsible individual(s) on the provider's staff is made aware of the request for additional information.

The contractor's principal goal in carrying out the audit responsibilities is to arrive at a correct settlement of the *MCR*. In doing so, preserve both the provider's and government's interest. If during the audit *the contractor* uncovers circumstances in which a provider disadvantaged itself, advise the provider liaison of the issue(s). Also, maintain ongoing communications during the audit by discussing regularly with the provider liaison to handle the following:

- Requests for documentation that *was neither* mentioned in the audit confirmation letter *nor* requested during the entrance conference;

- *The contractor shall* follow up on *their* requests for additional information. The provider should respond in writing if *its staff* cannot comply with the agreed upon response date;

- Open audit issues, proposed adjustments and/or the general progress of the audit. Provide the audit liaison with the adjustments, including those being proposed due to lack of documentation, and the related workpapers (if requested by the provider) during the course of the audit.

60.5 – Pre-Exit Conference

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The contractor shall conduct a pre-exit conference on the last day that the audit team is conducting the fieldwork *(for field audits)* or the date established at the entrance conference *(for in-house audits). The contractor shall* give the provider a copy of all *proposed* adjustments and workpapers (where requested by the provider) including those proposed due to lack of documentation and discuss all the *proposed* adjustments that the provider wishes to *review*. Also, *the contractor shall* give the provider a written list of any outstanding documentation that *the contractor* requested but *has* not received to date. *The contractor shall* inform the provider to *supply the* additional documentation within *four* weeks. *The contractor shall* establish an exit conference date that will allow up to *eight* weeks from the end of the *four*-week period given to the provider to provide additional documentation. *The exit conference shall be scheduled and held within 12 weeks (84 days) from the pre-exit conference. If there are extenuating circumstances that prevent the exit conference from being held in 12 weeks (84 days), the contractor shall document the situation in their workpapers and inform their DPAO BFL, through their COR.*

See *Exhibit VI* in §170 of this *Chapter* for a sample Pre-Exit Conference Format.

60.6 – Finalization of Adjustments

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Use the time period between the pre-exit conference and exit conference to review any additional documentation submitted by the provider in response to *the contractor's* request at the pre-exit conference or in support of the proposed adjustments that the provider did not agree with. CMS encourages continuing dialogue during this period between *the contractor* and the provider for issues where agreement was not reached at the pre-exit conference. However, it is not necessary to consider any documentation that is received after the timetable provided at the pre-exit conference unless prior arrangements with the provider have been made.

While *the contractor shall* not refuse to accept documentation submitted after the established timeframes, *the contractor* does not need to consider it in the initial NPR issuance. If a reopening is later granted or a timely appeal is made, the late documentation may be considered at that time.

At the conclusion of *the contractor's* review of the provider's documentation, prepare an Adjustment Report (see *Exhibit VII* in §170 of this Chapter) and clearly identify all new or modified adjustments that the provider did not see previously by indicating the date of the change. Send this Adjustment

Report to the provider with a request to notify *the contractor* in writing within two weeks of any concerns with the new or modified adjustments. Also, inform the provider in writing that the adjustments will become final after *the contractor* makes any necessary modification based on those written concerns and documentation supporting them. Therefore, any documentation submitted later (e.g., at the exit conference) will not be considered for the purpose of issuing the NPR.

Unless *the contractor* can document extenuating circumstances *and has communicated these to their DPAO BFL through their COR, the contractor has* up to 12 weeks *(84 days)* from the pre-exit conference for the finalization of the adjustments. This period includes the *four* weeks given to the provider to submit additional documentation and the two weeks that *the contractor shall* give the provider to review and comment on any adjustments not presented at the time of the pre-exit conference.

60.7 – Exit Conference

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Each provider is entitled to an exit conference *regardless of whether the audit was completed at the provider site or remote location. The contractor shall* make the provider aware that if it wishes to waive a formal exit conference, it must notify *the contractor* of this decision in writing (e-mail note will suffice) at any time before the scheduled date of the exit conference. (See *Exhibit III.A or III.B* in §170 of this Chapter.)

The people participating in the exit conference should be those parties authorized to make final decisions with respect to the audit. In addition, CMS encourages third-party preparers of the *MCR* to participate.

The exit conference shall be held within 12 weeks (84 days) from the pre-exit conference. If there are extenuating circumstances that prevent the exit conference from being held in 12 weeks (84 days), the contractor shall document the situation in their workpapers and inform their DPAO BFL, through their COR.

At the start of the exit conference, *the contractor shall give* the provider all the adjustments (including those made due to lack of documentation) that were finalized in the manner described in *§60.6* of this Chapter. Also, *the contractor shall ensure the* provider *has received* copies of requested workpapers if they were not previously given to the provider. Since the provider had an opportunity to comment on all the adjustments during the pre-exit conference and during the finalization period, there *shall* be no need to change them during the exit conference.

If additional documentation is submitted during the exit conference, *the contractor shall* not refuse it. Rather, inform the provider that *the contractor* does not need to consider this documentation in the initial NPR since the documentation was not submitted within the established timeframes. If a reopening is later granted or a timely appeal is made, the late documentation may be considered at that time.

Also, *the contractor shall* explain during the exit conference that the provider may still appeal any

lack of documentation or other issues to the Provider Reimbursement Review Board (PRRB).

The exit conference *for audits* can be performed telephonically *or virtually unless waived by the provider. Additionally, the exit conference for field audits may be held at the provider site. The contractor shall* include a written record of the issues discussed, including the explanation pertaining to the lack of documentation adjustments in the workpapers.

See Exhibit VIII in §170 of this Chapter for a sample Exit Conference Format.

61 – *Documentation and Review Standards for All Medicare Audit Activities*

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

61.1 – Reliance on Work Done by Other Auditors

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

A. General Guidelines

Medicare *Audit Activities* are generally limited to tests of compliance with Medicare reimbursement policies and procedures. In performing these *activities, contractors* generally rely on the financial statements prepared by independent auditors. This includes the independent auditors' review of providers' accounting systems.

To the extent that an independent auditor issued an unqualified opinion on a provider's financial statement and has not identified any material weaknesses in the provider's internal control structure, rely on the provider's system of accounting, including related computer systems. This does not include reliance on records or systems that are maintained solely for purposes of completing a *MCR*. As mentioned in §60.3 of this Chapter, *the contractor* may wish to perform substantive tests of the records maintained solely for Medicare reimbursement purposes.

If an independent auditor issued a qualified opinion, an adverse opinion, or has identified material weaknesses in the internal control structure, evaluate the effect of the auditor's actions on *the contractor's* audit objective. If there has been no audit by an independent auditor, consider the audit resources available, the audit risk, and the audit objectives in deciding if there is a need to review the accounting systems.

Furthermore, *the contractor* may rely on work of other auditors (i.e., provider's internal or independent auditors and audit organizations established by the Federal and State Governments for programs other than Medicare) in situations where the scope of this work relates to issues that *the contractor* scoped for the Medicare audit. However, in this situation, *the contractor* must still satisfy itself with the quality of the other auditors' work by performing appropriate tests or by other acceptable methods.

B. Obtaining Management Letter and/or Documentation Prepared by Provider's Independent Auditors

If *the contractor* determines that it is necessary to gain an understanding of a provider's internal control structure or any other aspect of the accounting system, *the contractor* may request that the provider furnish the management letter or other documentation relevant to the Medicare audit that was prepared by an independent auditor or certified public accounting (CPA) firm.

Under §§1815(a) and 1833(e) of the Social Security Act, *the contractor* or CMS may review any documentation it deems necessary to determine whether payment for reasonable cost to a particular provider is appropriate. The implementing regulations at 42 CFR 413.20*, 413.24,* and *413.52* explain this further. 42 CFR 413.20(e) specifically allows suspension of payment if the *contractor* determines that the provider does not maintain adequate records for the determination of reasonable costs. Additionally, 42 CFR 405.372(a)(2) provides for suspension of payment for failure to provide specifically requested information. However, when the documentation is maintained by an independent auditor or certified public accounting (CPA) firm rather than by a provider, *the contractor* or CMS *shall* insist that the provider obtain the information from that audit entity. Since the law and regulations are directed to providers, not their auditors or CPA firms, CMS requires the provider to have the independent auditor release the documentation to CMS or the contractor. The independent auditor is at a minimum a de facto agent of the provider and should comply with the request. If the provider is not able to produce the documentation from the independent auditor/CPA firm, *the contractor* may disallow all the provider's cost/reimbursement associated with the cost report(s) under review or at least suspend payment until the documentation is provided if an appropriate determination of payment cannot be made without the documentation. CMS has limited recourse against the independent auditor or CPA firm if it refuses to comply.

Contractors shall keep independent auditors' management letters or other documentation obtained from a provider or the independent auditors in a secure place. Disclose the contents only to those directly involved with the audit.

61.2 – Designing Tests/Sampling

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The contractor shall design such tests as are necessary to accomplish their objectives and aid *the contractor* in reaching conclusions necessary to complete the *Medicare* Audit *Activity. The contractor shall* use sampling when this would be more efficient in testing the universe of transactions, entries, or statistical data within an area of consideration.

Sampling is the application of a procedure to less than 100 percent of the items within an account balance, class of transactions, or statistics *(e.g., an expense account with over 1,000 transactions)* to evaluate some characteristic of such balance, class, or statistics.

On the basis of facts known to *the contractor, the contractor shall* decide if all transactions, balances, or statistics that pertain to the issue/area being tested need to be reviewed in order to obtain sufficient evidence. In most cases, an auditor will test at a level less than 100 percent.

There are two general sampling approaches, nonstatistical and statistical. Either approach, when

properly applied, can provide sufficient evidential data related to the design and size of a sample, among other factors. A nonstatistical sample may support acceptance of findings, but findings must be scientifically established to support adjustments.

Some degree of uncertainty is inherent in applying *Medicare Audit Activity* procedures and is referred to as ultimate risk. Ultimate risk includes uncertainties due both to sampling and other factors. Sampling risk arises from the possibility that when a compliance or a substantive test is restricted to a sample, the auditor's conclusions may be different had the test been applied in the same way to all items in the account balance, class of transactions, or statistics.

If *the contractor* uses a sample(s) to test certain issues scoped for *analysis, the contractor shall* include a description of the sampling technique, all parameters used to select the sample, and confidence level in the audit workpapers. *By using statistical theory, the contractor shall quantify the sampling risk in limiting it to an acceptable level.*

A. Planning Samples

When developing a strategy and planning *the selection of an* appropriate sample*, consider:*

- The relationship of the sample to the *review* objective.

  For example, the following shall be considered, respectively, in the decision whether it is feasible to just use one sample for the review of Medicare bad debts:

  - *the contractor's review procedures for "regular Medicare-only Traditional bad debts," "dual eligible (Medicare and Medicaid) bad debts," and "Medicare-only indigent bad debts" is different.*

  Therefore, using only one sample creates a risk that the number of sample items selected may not be sufficient to test some of the different attributes;

- Preliminary estimates of materiality levels;

- The allowable risk of incorrect acceptance; and

- Characteristics of the population, i.e., the items comprising the universe *may not be homogenous.*

B. Selecting a Sampling Approach

Where the review objective would be best accomplished by stratifying the universe/population into categories ("regular Medicare-only Traditional bad debts," "dual eligible (Medicare and Medicaid) bad debts," and "Medicare-only indigent bad debts") and high and low strata (e.g., where Medicare bad debts are being tested), the contractor shall use its judgment in designating the threshold for this stratification and include the justification on the workpaper. Once determined, review 100% of the items in the high strata population and use statistical or non-statistical sampling

to test the low strata. Because either nonstatistical or statistical sampling can provide sufficient evidence, choose between them after considering their relative cost and effectiveness. Statistical sampling helps to:

- Design an efficient sample;
- Measure the sufficiency of the evidential matter obtained; and
- Evaluate the results.

However, statistical sampling involves additional costs of designing individual samples to meet the statistical requirements and selecting items to be examined.

On the other hand, using a non-statistical sampling method may prove to be more time-consuming and costly because any resulting findings shall be scientifically established to support adjustments of the universe. Thus, if findings are identified, the contractor shall redesign the sample using a statistical method.

In some situations, regardless of the sampling method used (i.e., statistical or non-statistical), the *review* objective would be best accomplished by stratifying the universe a*ccording to the attributes of the data to be reviewed. For example, when reviewing Medicare bad debts, it is beneficial to stratify the bad debts into "regular Medicare-only Traditional bade debts," "dual eligible (Medicare and Medicaid) bad debts," and "Medicare-only indigent bad debts," because the primary emphasis of review for each of those bad debt types (i.e., collection effort; receipt of documentation to support the State's adjudication of the claim; and provider's adherence to 42 CFR 413.89(e)(2)(ii) and the Provider Reimbursement Manual 15-1, Chapter 3, §312 when determining "indigence," respectively) is different. Therefore, such stratification ensures that a sufficient number of bad debts in each of those categories is included in the sample(s).*

C. Sampling Risk

In performing substantive tests of details, *the contractor shall* consider:

- The risk of incorrect acceptance that the sample supports the conclusion that the items are not materially misstated when they are; and
- The risk of incorrect rejection that the sample supports the conclusion that the items are materially misstated when they are not.

D. Using the Test Results

If the results of testing a sample that was selected using a non-statistical method indicate probable errors in the universe of transactions, entries, or statistics, *the contractor shall redesign the sample using a statistical method and* document the decision. If the results of testing a sample that was selected using a statistical method indicate probable errors in the universe, *the contractor shall use the output generated from the sampling methodology utilized and* document the decision.

The contractor shall not make an adjustment *that consists solely* of the error(s) identified *in the review of the sample without documenting* the reason for not considering the effect of the error(s) on the universe.

There are some transactions that could be sampled where a current year error also affects subsequent cost reporting periods. For example, the auditor has a review step to test asset additions by comparing the useful life of the asset included on the provider's Plant, Property, and Equipment (PPE) log to the American Hospital Association's (AHA) Estimated Useful Lives of Depreciable Assets (AHA Useful Life). The provider has over 100 asset additions, so the contractor selects a statistical sample of assets to review. A few of the assets in the statistical sample have a longer useful life based on the AHA Useful Life when compared to the useful life used in the provider's PPE. The auditor writes an adjustment based on the output generated from the statistical sampling methodology used in its testing. The auditor would create a lapsing schedule for each asset that was in error to show the depreciation expense based on the provider's PPE compared to the depreciation expense based on the AHA Useful Life; the difference would be adjusted each year until the asset is fully depreciated based on the asset's lapsing schedule. The auditor would also write a PFNY to inform the subsequent auditor of the assets requiring adjustment. The auditor would include the lapsing schedule and the PFNY in the Permanent File. In addition, the assets that were in error and adjusted each year would be removed from future asset testing since it was already determined that the assets were in error and thus, are adjusted each year until fully depreciated. (See §130 of this Chapter for more information on the permanent file.)

61.3 – Evidence

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The American Institute of Certified Public Accountants (AICPA) defines audit as: "The evaluation of information to be used as audit evidence informs the auditor's conclusion whether sufficient appropriate audit evidence has been obtained. As technology progresses, new techniques, including audit data analytics, remote auditing and the use of additional computer assisted auditing techniques are being employed. Along with this advancement also comes risk. This is your source of news, resources and learning relative to audit evidence and remote work."

The Generally Accepted Audit Standards (GAAS) standard on audit documentation states that: "Auditors support the conclusions in their reports with a work product called audit documentation, also referred to as working papers or work papers. Audit documentation supports the basis for the conclusions in the auditor's report. Audit documentation also facilitates the planning, performance, and supervision of the engagement and provides the basis for the review of the quality of the work by providing the reviewer with written documentation of the evidence supporting the auditor's significant conclusions. Examples of audit documentation include memoranda, confirmations, correspondence, schedules, audit programs, and letters of representation. Audit documentation may be in the form of paper, electronic files, or other media."

While the Medicare auditor does not express an opinion on financial statements, they are responsible for collecting sufficient and competent evidential data as a basis for drawing conclusions about the

Medicare Cost Report. *Contractors shall* ensure that evidence obtained during the course of *the cost report review* is sufficient to enable the auditor to support conclusions, adjustments, and recommendations. *Additionally, contractors shall ensure* that there is enough factual and convincing evidence so that a prudent person can arrive at the same conclusion as the auditor. Evidence *shall* be competent and relevant. That is, evidence *shall* be valid and reliable and have a logical relationship to the issue/subject under review.

Sources and Categories of Evidence

The contractor shall review all evidence, no matter from what source, with appropriate professional skepticism. The auditor *shall* keep an open mind but must question the validity of all evidence and determine its application to the situation under review. In addition, evidence uncovered by an auditor that the provider used *for purposes other than the preparation of the MCR*, such as a bank loan application, public stock filing, insurance claim, other government reports (e.g., tax returns, SEC filings), or reports from an outside agency have greater credibility than conflicting or self-serving evidence offered by the provider *related to a similar issue being reviewed for Medicare.*

The contactor shall obtain sufficient, *appropriate* evidence to ensure the propriety of costs claimed by the provider on its submitted *MCR* in order to determine that proper payment is made for services provided to Medicare beneficiaries. The evidence consists of physical inspection or observation and corroborating documents such as checks, invoices, contracts, vouchers, assignment/rotation schedules for interns and residents, *Medicaid remittance advices to support payment or non-payment of Medicare coinsurance and deductibles for dual eligible Medicare beneficiaries,* minutes of meetings, and written *and/*or oral testimony of provider employees.

The contractor shall base its tests on the best evidence available *and shall* consider the probative value of evidence offered in context of the hierarchy of order and types of evidence. *The auditors shall not* rely on evidence of a lower order or type if they can reasonably conclude that evidence of a higher order or type is available. *The contractor shall* insist that providers produce evidence of the highest order and type that *the contractor* believes is available.

Categories of evidence include *the following per GAS, Chapter 8 "Fieldwork Standards for Performance Audits," Paragraph 8.104 "Evidence":*

- Physical Evidence – This is obtained *by auditors* from direct *inspection or* observation of *people,* property, or events. *This evidence may be documented in summary memos, photographs, videos, drawings, charts, maps, or physical samples.* However, in certain circumstances, physical evidence may not be sufficient, especially if the auditor has to rely on personal knowledge to determine the propriety or value.

- Documentary Evidence – This type of evidence is the most commonly used and referred to by an auditor. *This is already existing information.* It is information such as letters, contracts, accounting records, invoices, checks, interns' and residents' rotation schedules, remittance advices, etc.

- Testimonial Evidence – This is probably the least reliable type of evidence as it is obtained *by inquiry or inspection* from others, both inside and outside the provider's organization. *For example,* through responses to inquiries and interviews. By itself, this category of evidence is unacceptable for Medicare purposes. Therefore, *the contractor shall* evaluate all such information and corroborate with additional evidence.

Auditors often use analytical processes, including computations, and comparisons to analyze any evidence gathered to determine whether it is sufficient and appropriate. In evaluating the effectiveness and usefulness of evidence, *the contractor shall* consider whether the objectives have been achieved. If the objectives were not achieved, the evidence was either not sufficient or was only sufficient to establish that there was a problem. *In this situation, the contractor shall* obtain additional evidence in order to reach a valid conclusion and achieve the objective.

If there is sufficient and reliable evidence that supports the conclusion that the provider's reported reimbursement amount for a specific area is incorrect, make an appropriate adjustment and document it in the workpapers. Likewise, if the provider does not furnish sufficient and reliable evidence to support the reported reimbursement amount for a specific area, make an adjustment to disallow the reimbursement in question. (See 42 CFR 413.20(a) and 42 CFR 413.24(a))

61.4 – Workpapers

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

AICPA *U.S. Audit* Standards *defines audit documentation as the following:*

- *"The record of audit procedures performed, audit evidence obtained, and conclusions the auditor reached (terms such as working papers or workpapers are also sometimes used)."*

- *"The record of the work performed, results obtained, and conclusions that the practitioner reached (also known as working papers or workpapers)."*

Per GAS, Chapter 8 "Fieldwork Standards for Performance Audits," Paragraphs 8.132 through 8.134 "Audit Documentation" include the following requirements:

- *"Auditors must prepare audit documentation related to planning, conducting, and reporting for each audit. Auditors should prepare audit documentation in sufficient detail to enable an experienced auditor, having no previous connection to the audit, to understand from the audit documentation the nature, timing, extent, and results of audit procedures performed; the evidence obtained; and its source and the conclusions reached, including evidence that supports the auditors' significant judgments and conclusions."*

- *"Auditors should prepare audit documentation that contains evidence that supports the findings, conclusions, and recommendations before they issue their report."*

- *"Auditors should design the form and content of audit documentation to meet the circumstances of the particular audit. The audit documentation constitutes the principal*

record of the work that the auditors have performed in accordance with standards and the conclusions that the auditors have reached. The quantity, type, and content of audit documentation are a matter of the auditors' professional judgment."

A. Definition

Workpapers contain evidence accumulated throughout the *Medicare* Audit *Activities* to support the work performed, the *overall* results, including adjustments made, and the judgment of the auditors. *Workpapers shall* stand on their own without the need for supplemental explanation or documentation.

Workpapers are the records kept by the auditor of the procedures applied, the tests performed, the information obtained, and the pertinent conclusions (findings, no findings, dollar adjustments) established during the audit. Examples of workpapers are *review* programs, analyses, memoranda, letters of confirmation and representation, abstracts of provider documents, and schedules or commentaries prepared or obtained by the auditor. Workpapers may be in the form of data stored on *various types of* media.

Prepare and maintain workpapers, the form and content of which should be designed to meet the circumstances of a particular *Medicare* Audit *Activity*. The information contained in workpapers constitutes the principal record of the work that the auditor has done and the conclusions that the auditor reached concerning significant matters.

B. General Content of Workpapers

Workpapers should ordinarily include documentation showing that:

- The work has been adequately planned and supervised. This includes consideration of *Medicare regulatory* requirements and any other payers, which are *standard practice for* Medicare *Audit Activities*.

- The evidence obtained, the procedures applied, and the testing performed have provided sufficient, competent evidential matter to support the auditor's conclusions.

C. Format of Workpapers

Ensure that the workpapers are prepared using the following standards.

Lead Workpaper:

The lead workpaper is the first workpaper in a group of supporting workpapers and is a summary and results of the work that was completed. It provides support for the conclusion that was reached on the issue being reviewed. Each group of supporting workpapers shall have a lead workpaper.

Start each lead workpaper, whether manually or electronically prepared, with the basic mechanical foundation containing:

- Provider name, number, and cost reporting period.
- Preparer's signature or initials *(once the workpaper is complete)*.
- Date the work was performed *(once the workpaper is complete)*.
- Proper heading *(title of workpaper)*, giving basic content of the workpaper.
- *Contain evidence of supervisory review of the work including initials and date the supervisory review was completed;*
- *Workpaper Number, Index, or Reference – Where the workpapers are prepared electronically and the summary (lead) workpaper file includes tabs which contain supporting workpapers, each supporting workpaper included in each tab shall also contain a workpaper number or reference. For example, if the summary/lead workpaper is M-1, and there are supporting workpapers M-1a and M-1b, those two supporting workpapers and tabs shall display the M-1a and M-1b references. Additionally, because paper copies of the workpapers are used for various purposes (e.g., appeals, court cases, external reviews), the workpaper numbers or references shall be visible on each hard copy of a workpaper (including all tabs) printed from the electronic files.*
- Purpose – A brief description of the work to be done on the workpaper and the objective to be achieved (e.g., a comparison of the contractor's PS&R with the *as-submitted* settlement data to validate the provider's claimed Medicare statistics).
- Source of Information – This informs the reviewer where the information used on the workpaper was obtained. The source *shall:*
  - *Include the exact name of the document used during the review such as "Revenue & Usage Report."*
  - *Include if the document was prepared by the provider (PBP-Prepared by Provider or PWP-Provider Workpaper) or contractor including a MAC's subcontractor (PBM-Prepared by MAC).*
  - *If the source is an interview, the workpaper shall include the name, department, title, phone number and email address of the person being interviewed along with the date, time, and location of the interview.*
  - *The source can be in the form of cross-referencing to the MCR, financial statements, Permanent File, or other workpapers. Cross-referencing is especially important because it enables the reviewer to see at a glance exactly where an amount, number etc. comes from. Cross-referencing requires both a "to" and "from" for the item, workpaper, or amount referenced and must be obvious and easily noticeable to anyone reviewing the workpaper. Copies, or if appropriate samples, of the information/ documents examined*

shall be retained in the workpapers.

- Scope of Work – The scope *is a listing/description of each step to be completed on the workpaper and allows* a reviewer to determine if an adequate test was performed to meet the *objectives of the purpose as stated on the workpaper*.

- *Findings – Findings are a detailed explanation of steps that were taken to arrive at the conclusion. Findings are based on the scope of the workpaper and are in logical sequence from start to finish. Findings are often in paragraph form.*

- Explanation of Tick Marks – Use tick marks to explain and cross-reference the work performed.

- Conclusion – When a workpaper is complete, the contractor shall state conclusions covering the results of the *findings*.

  - *Example 1 – No exceptions were noted in the test; therefore, the as-submitted number of full time equivalent (FTE) residents used for GME payment is accepted.*

  - *Example 2 – Exceptions were noted in the number of FTE residents used for the GME payment. Adjustment 3 is proposed to correct the as-submitted GME number of FTEs.*

Supporting Workpapers:

Supporting Workpapers supplement the lead workpaper and often include narrative or a document supporting a finding on the lead workpaper. The workpaper number, index, or reference of a supporting workpaper is an extension of the lead workpaper index.

Furthermore, all workpapers shall include:

- *Provider name, number, and cost reporting period.*

- *Preparer's signature or initials (once the workpaper is complete).*

- *Date the work was performed (once the workpaper is complete).*

- *Proper heading (title of workpaper), giving basic content of the workpaper.*

- Contain evidence of supervisory review of the work including initials and the date the supervisory review was completed.

- Contain sufficient information so that supplementary oral explanations are not required.

- Be legible, complete, and accurate in order to provide proper support for findings, judgments, conclusions, and to document the nature and scope of the work conducted. *When the workpapers are prepared electronically, the contractor shall use font size which will be*

readable when the workpapers are printed.

- Include summaries and lead schedules, as appropriate.

- Contain adequate indexing and cross-referencing to the *review* program, lead summaries, and Adjustment Report. Each *desk review and/or* audit step that is initialed on the *applicable* program *shall* contain a reference to the "specific" workpaper on which this step was addressed. It is not acceptable to just reference the general workpaper series for an area under each audit step for that area. For example, include a reference to *a specific workpaper* under the *review* step pertaining to an area/issue, do not draw a vertical line from that reference through all other audit steps for that area unless all the audit work for all those audit steps was actually detailed on that workpaper.

- Restrict information to matters that are materially important and relevant to the stated objectives of the review.

- Include an index to workpapers for ease of reference. *The contractor shall ensure that the references on the "listing" of electronic files (which also serves as the Index) match the references on the related workpapers contained in the file(s).*

- Include the *review* program. However, do not retain pages of a standard *review* program that are not applicable to the *specific review*. If, *for some reason, the review steps from the standard review* program *that were not applicable are included in the contractor's* specific *review program,* mark them "N/A" *with an explanation* instead of leaving them unmarked. *For example, if the bad debt review program is included in the workpapers but the provider did not claim bad debts, the auditor could include "N/A-Provider did not claim Medicare bad debts."*

D. Ownership and Custody of the Workpapers:

Workpapers are the property of *CMS and the contractor*. The rights of ownership, however, are subject to ethical limitations relating to the confidential relationship with providers.

The contractor shall adopt reasonable procedures for safe custody of workpapers in the field as well as in *the contractor's* office in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and retain them for a sufficient period of time to meet the needs of *the contractor's* operation and to satisfy legal requirements of record retention.

When requested, *the contractor shall* send original *hardcopy or electronic* workpapers to the appropriate CMS component or CMS' designated agent for review.

E. *Digitized (Electronic) Workpapers and Electronic Document Management Systems*

In today's environment, workpapers are typically prepared electronically and stored in an electronic document system. The contractors have a wide variety of digitized electronic workpaper vendors and

electronic document systems to choose from.

Workpapers sent to CMS shall be capable of being opened in one of the following: Adobe Portable Document Format (PDF), Microsoft Word, or Microsoft Excel. Hyperlinks included in electronic workpapers shall include a cross reference to the applicable workpaper.

61.5 – Documentation Standards

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Documentation that the evidence obtained, procedures applied, and tests performed provide sufficient, competent, and relevant evidence to support the auditor's opinions, judgments, conclusions, or recommendations is essential. After obtaining and testing the various types of evidence (e.g., invoices, bills, contracts, statistics such as the FTE number of interns and residents) considered necessary in the circumstances, retain at least a representative sample of such evidence. If only a sample of the evidence for each area is retained, refer to the evidence not retained and its relationship to the basis for the opinions, judgments, conclusions, or examinations.

Where adjustments are made, auditors should include copies of the provider documents that were reviewed *in the workpapers in determining the amount of adjustment*. For those documents *where copies are not available*, auditors may meet *GAAS* requirements *by documenting the means of identification*. Where adjustments were not made, auditors *shall* include in the workpapers copies of a representative sample of documents examined. Where materiality is a factor, define "materiality" within the scope and objective of *the contractor's* review.

61.6 – Supervision During the *Review* Process

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

GAS, Chapter 8 "Fieldwork Standards for Performance Audits," Paragraph 8.88 "Supervision" states: "Audit supervision involves *providing sufficient guidance and direction to* auditors *assigned to* the audit *to address* the audit objectives *and follow applicable requirements, while staying* informed about significant problems encountered, reviewing the work performed, and providing effective on-the-job training."

A. Staff Supervision

The contractor shall provide constant direct supervision of staff by a qualified supervisor to ensure that the *Medicare* Audit *Activity* is completed in accordance with the audit work plan. Supervision *is required so that* each *team* member understands the objective of each *activity*, how to perform and document the completion of the procedure in the workpapers, and how to evaluate the audit evidence. *The contractor shall* establish procedures *to ensure the staff* supervision *activities* are distinct from the responsibilities of individuals *who plan and manage the work*.

Also, the contractor shall establish policies and procedures to provide reasonable assurance that persons who are assigned to perform Medicare Audit Activities have the degree of technical training and competence required for the circumstances.

Assure that the policies and procedures for planning, performance, and supervision of *Medicare* Audit *Activities* meet *audit* standards of quality.

The contractor shall assure that the policies and procedures for planning, performance, and supervision meet the GAS standards of quality. The contractor shall provide procedures for planning individual *Medicare Audit Activities* in accordance with Medicare instructions, such as:

- The determination of staffing requirements and the need for specialized knowledge; and
- The development of estimates of time required to complete *each activity*.

The contractor shall also provide guidelines for maintaining standards of quality for work, such as:

- Guidelines for the form and content of workpapers;
- Procedures for resolving differences of professional judgment among team members; and
- Standard forms, checklists, and questionnaires appropriate to assist in the performance of *the activities*.

Furthermore, *the contractor shall* provide procedures for reviewing workpapers and reports.

B. Hiring

The contractor shall prepare staff job descriptions and policies and procedures for hiring to provide reasonable assurance that those employed are able to perform *Medicare Audit Activities* competently. *The contractor shall:*

- Plan for staffing needs at all levels;
- Establish quantified hiring objectives based on current workload, anticipated changes in workload, staff turnover, individual advancement and retirement, and current Medicare budget; and
- Establish qualifications and guidelines for evaluating potential hires at each professional level.

C. Advancement

The contractor shall establish policies and procedures for advancing staff to provide reasonable assurance that those selected for advancement have the qualifications necessary for fulfillment of the responsibilities assigned. *The contractor shall:*

- Specify qualifications deemed necessary for the various levels of responsibility within its Medicare *Audit and Reimbursement* department; and
- Evaluate the performance of personnel and periodically advise staff of their progress.

Maintain personnel files containing documentation relating to the evaluation process.

D. Supervisory Review Standards for Workpapers

The workpapers and associated files (e.g., permanent file) are the only evidence of the procedures *the contractor* performed to support the decision on the accuracy of the final settled *MCR*.

An element of supervision is a thorough supervisory review of the workpapers. This may require several levels of review, depending on the size and configuration of the organization. For example, in a larger organization, the in-charge auditor may be responsible for reviewing the work of other auditors on the team, and an independent supervisor reviews all work performed. While the ideal situation would have this second level review performed by an audit supervisor, the individual performing that function need not have that title. Rather, the individual may be a highly qualified senior auditor who is not part of the team performing the audit. In addition, a manager may also perform a subsequent higher- level review of the completed work.

The contractor's responsibility to review the workpapers includes work performed by all *the contractor's* employees and subcontractors*, if applicable,* regardless of the arrangements under which *the work is performed. The contractor* cannot delegate the responsibility to perform independent review of a subcontractor even if the subcontractor is another *MAC*.

The supervisory review also satisfies the audit standards requirement for due professional care in performing the *Medicare Audit Activity*. The first level of defense to ensure the quality of the workpapers is the supervision of the *Medicare Audit and Reimbursement* staff. The second level of defense to ensure the quality of the workpapers is the supervisory review. No improvement in the quality of the work will occur unless management recognizes the importance of the workpaper review, as the second most important line of defense in maintaining quality workpapers. Proper supervisory review:

- Ensures that the *Medicare Audit Activity* is completed in accordance with the *work* plan;
- Minimizes contradictions within the workpapers;
- Minimizes inappropriate or inaccurate interpretation of Medicare policies; and
- Assists in the evaluation and development of staff.

The contractor shall give the supervisory reviewer adequate time to complete a competent review. No matter how knowledgeable the reviewer is, the effectiveness of the review is directly proportionate to the time spent on the review. The reviewing supervisor must have sufficient knowledge and understanding of the following:

- Medicare laws, regulations, and payment policies;
- Medicare cost reporting requirements;

- GAS and the AICPA *Statements on Auditing Standards* (SAS); and
- Provider accounting procedures.

E. General Approach to Supervisory Review of Workpapers

The reviewing supervisor shall:

- Be critical and not perfunctory;
- Be methodical, careful, and thorough;
- Ensure that the workpapers support the objectives *previously defined*;
- Question the stated conclusions and be able to arrive at the same conclusions, based on the evidence presented on the workpapers; and
- Have a clear understanding of *the requirement that all information on the MCR be accurate even if there may not be a current reimbursement impact*.

F. Specific Points in the Supervisory Review of Workpapers

While the following points are not all-inclusive, the reviewing supervisor *shall*:

- Obtain an overall understanding of the provider by reviewing its correspondence file, permanent file, financial statements, and *as-submitted MCR*;
- Understand the work plan as determined by the review *program* and the resulting scope of *review*, as detailed in the *review* program;
- Discuss the *review* with the in-charge auditor to determine areas in which the auditors had problems;
- Ensure that the work plan is completed;
- Ensure that decisions to defer *review* steps identified in the initial audit scope are adequately documented;
- Ensure that the workpapers meet the mechanical and analytical requirements for quality workpapers;
- Ensure that Medicare payment policies are properly interpreted;
- Ensure that conclusions are supported by sufficient, competent, and relevant evidential matter;
- Ensure that conclusions drawn from the review procedures are supported by the work

performed;

- Ensure that the provider has been advised of proposed adjustments and given sufficient time to respond;
- Ensure that all the retained adjustments are incorporated in the Adjustment Report;
- *Ensure that all adjustments included in the Adjustment Report trace to the NPR or Revised Notice of Program Reimbursement (RNPR);*
- Ensure that the aggregate of all adjustments passed as immaterial do not have a significant impact on Medicare payment;
- Test calculations which have a direct impact on Medicare payment;
- *Ensure* areas which require more in-depth *review* in the subsequent *year are adequately documented*;
- Ensure that notes for future audits are prepared and included in the permanent reference file;
- Prepare review notes;
- Make a final check of the workpapers after the review notes are cleared;
- *Confirm* that unnecessary papers are deleted from the workpaper file;
- Retain supervisory review notes in the workpapers; and
- Every workpaper shall include evidence of supervisory review by inclusion of the reviewer's name or initials and date the workpaper was reviewed.

70 – Reporting Standards

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

70.1 – Content and Structure of the Medicare Cost Report Audit Report

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Complete the audit report on *the contractor's* letterhead specifying the name of the provider or provider complex whose *MCR* was audited. Include the provider and subprovider numbers for all components reported on the *MCR* for the provider complex. Also, include one NPR for the entire complex, identifying the provider/subprovider component name, number, and cost reporting period.

In preparing the Medicare *Cost Report* audit report, *the contractor shall*:

- Ensure that the audit report complies with GAS, Chapter *6, Paragraphs 6.50 through 6.52* entitled *"Presenting Findings in the Audit Report"*;

- Incorporate statements of positive and negative assurance for compliance with Medicare laws, regulations and instructions;

- Designate those individuals authorized to sign such reports;

- Incorporate statements referring to *the contractor's* consideration of the provider's internal control structure in planning substantive audit tests;

- Ensure that the audit report contains the following elements:

  - A statement that *the contractor* audited the provider's *Medicare Cost Report*;

  - A statement that the audit was conducted in accordance with GAS;

  - A statement that those standards require the contractor to plan and perform the audit to obtain reasonable assurance about whether the *MCR* reflects payment amounts and financial data in accordance with Medicare laws, regulations, and instructions;

  - A statement that the Medicare provider is responsible for compliance with Medicare laws, regulations, and instructions.

  - Reference the Medicare Cost Report Adjustment Report.

- Refer to areas selected for audit. Any area selected for in-house or field audit *shall* be listed.

- Include a listing of the applicable internal control policy and procedure categories, as they affect Medicare payment.

Use *Exhibits VIX.A and VIX.B* in §170 of this Chapter as an example of a Medicare audit report, including the report on the consideration of the internal control structure of the provider.

Edit the audit report to fit the particular circumstances of the audit. For example, if *the contractor* decided that a review of a provider's system of internal control was not applicable, use one of the alternative paragraphs to explain the basis for this decision. In this situation, the language pertaining to a review of internal control would not be applicable and *shall* not be included in *the contractor's* audit report to the provider. Conversely, if *the contractor* did perform a review of internal control, do not use the alternative paragraphs. Instead, use the language pertaining to the review of internal control system as appropriate.

70.2 – Form of Report if Medicare Cost Report was not Audited

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

If the *MCR* has been settled without audit, issue a report as part of the *Medicare Cost Report final* settlement. Use *Exhibit X* in §170 of this Chapter as a sample.

70.3 – Reporting of Indications of Illegal Acts

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Illegal acts would consist of fraud or abuse against the Medicare program. *Unless instructed by CMS,* do not issue a report for any Medicare *Audit Activity* where illegal acts or indications of illegal acts are discovered, and a fraud or abuse referral is made to CMS. Office of the Inspector General (OIG) will notify *the contractor* in writing of the content of the report to be used. However, issue a report in situations where for several years *the contractor has* made recurring adjustments, notified the provider, and has referred the situation to OIG.

70.4 – Adjustment Report

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The Adjustment Report is a complete listing, *presented* in a logical order *(e.g., Worksheet S, A, B, etc.)*, of adjustments arising from the contractor's examination of the *MCR*. It contains the description of each adjustment in sufficient detail to explain the provider's noncompliance, the adjustment amount, *the workpaper on which the adjustment was proposed, the Regulation and/or CMS Manual reference supporting the adjustment,* and the *MCR* reference where the adjustment is to be applied to the revised *MCR*.

Ensure that the Adjustment Report is prepared in the format of the sample report shown in *Exhibit VII* in §170 of this Chapter.

70.5 – *NPR/RNPR Package* – Medicare Cost Report and All Related Documentation

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The contractor shall issue a Notice of Program Reimbursement or Revised Notice of Program Reimbursement Letter to the provider that includes the following information per 42 CFR 405.1803 and PRM 15-1, §2905:

- *The contractor's determination of total program reimbursement due to or from the provider for the reporting period covered by the as-submitted or amended cost report.*
- *This determination is based on the provider's claimed total program reimbursement due the provider for this period, amounts arrived at in the settlement determination, and any underpayment or overpayment made to the provider.*
- *The contractor's final determination of the total amount of reimbursement due to or from the provider.*
- *The contractor's final determination for purposes of any future appeal rights.*

Maintain the following documents (as applicable) related to the *MCR* and Medicare audit*/no audit* report(s) in *the contractor's* files. Also, send *the NPR and RNPR packages that includes* all the

relevant documents detailed below to the provider at the time *the contractor* settles the *MCR*.

- Transmittal letter to the provider;
- *Initial Demand Letter, if applicable (See CMS Pub. 100-06, Chapter 3 and 4);*
- *NPR or RNPR Letter;*
- Auditor's report(s) for the audit and, if applicable, for internal control structure or a form of report where the *MCR* was settled without audit;
- Listing of areas selected for audit *for initial NPR, as applicable*;
- Listing of the *relevant* internal control policy and procedure categories, as they affect Medicare payment*, if applicable*;
- Listing of reportable conditions and material weaknesses (only if reportable conditions or material weaknesses were found);
- Management letter, if applicable;
- Cost report Adjustment Report;
- Audited or settled without audit *MCR for an NPR; and*
- *Revised MCR for an RNPR.*

The MACs shall upload the above information, if applicable, into the STAR system within 30 days of issuing a final or revised final cost report settlement.

80 – Standards for Performing Medicare Audit *Activities*

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

When performing Medicare Audit Activities, comply with the standards outlined in this Chapter. Although not exact, these standards reflect the GAS*, Chapters 1 through 9*.

These standards apply to all audit organizations, both government and nongovernmental (e.g., public accounting firms), that conduct government audits, unless specifically excluded. *Specifically, the standards for performing Medicare Audit Activities apply to both MACs and their subcontractors.* The general standards applicable to Medicare *Audit Activities* are:

- *Ethics;*
- Independence;
- *Professional Judgment;*

- *Competence;*
- *Continuing Education* and Training (CET);
- Due Professional Care; and
- Internal Quality Control.

80.1 – *Ethics*

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

GAS, Chapter 3 "Ethics, Independence, and Professional Judgment," Paragraph 3.04 "Ethical Principles" states: "Performing audit work in accordance with ethical principles is a matter of personal and organizational responsibility. Ethical principles apply in preserving auditor independence, taking on only work that the audit organization is competent to perform, performing high-quality work…"

In addition, Paragraph 3.06 "Ethical Principles" states: "The ethical principles that guide the work of auditors who conduct engagements in accordance with GAGAS are

- *the public interest;*
- *integrity;*
- *objectivity;*
- *proper use of government information, resources, and positions; and*
- *professional behavior."*

80.2 – Independence

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Auditors must maintain both independence of mind and independence in appearance. Independence ensures that auditors' conclusions are impartial and not influenced by personal or external interests. GAS, Chapter 3 "Ethics, Independence, and Professional Judgment," *Paragraphs* 3.18 and 3.19 "Independence" includes the following general requirements of independence:

- "In all matters relating to the GAGAS engagement, auditors and audit organizations must be independent from an audited entity."
- "Auditors and audit organizations should avoid situations that could lead reasonable and informed third parties to conclude that the auditors and audit organizations are not independent and thus are not capable of exercising objective and impartial judgment on all issues associated with conducting the engagement and reporting on the work."

Paragraph 3.22 "Independence" states: "Auditors and audit organizations maintain their independence so that their opinions, findings, conclusions, judgments, and recommendations will be impartial and will be viewed as impartial by reasonable and informed third parties."

The contractor shall establish policies and procedures to provide reasonable assurance that all Medicare Audit *Activities* and *reimbursement* professional staff maintains their independence so as not to impair, or appear to impair, *the contractor's* independence in carrying out its Medicare *Audit Activity* responsibilities.

See *Exhibit XI* in §170 of this Chapter for a sample of the Personal Impairments Statement to be completed by each individual involved in the *Medicare Audit* Activities to ensure that *they are* free of personal impairments. This statement can be completed by each individual on an annual basis and be updated during the year if circumstances that need to be disclosed arise.

80.3 – Professional Judgment

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

GAS, Chapter 3 "Ethics, Independence, and Professional Judgment," *Paragraph* 3.109 "Professional Judgment" states: "Auditors must use professional judgment in planning and conducting the engagement and in reporting the results." Furthermore, *Paragraph* 3.110 includes: "Professional judgment includes exercising reasonable care and professional skepticism."

Professional skepticism includes:

- A questioning mind;
- A critical assessment of evidence (documentation); and
- Being alert to evidence (documentation) that contradicts other evidence obtained or information that brings into question the reliability of documents or responses.

80.4 – Competence

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

GAS, Chapter 4 "Competence and Continuing Professional Education," *Paragraph* 4.03 "Competence," states: "The audit organization's management must assign auditors who before beginning work on the engagement possess the competence needed for their assigned roles." In addition, *Paragraph* 4.04 includes "The audit organization should have a process for recruitment, hiring, continuous development, assignment, and evaluation of personnel so that the workforce has the essential knowledge, skills, and abilities necessary to conduct the engagement."

Competence includes the knowledge, skills, and abilities obtained from education and experience and enables auditors to make sound professional judgments. It also includes possessing the technical knowledge and skills necessary for the type of work being done.

80.5 – Continuing Education and Training (CET)

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The contractor shall establish a program to ensure that its staff maintains professional proficiency through CET.

The following represent the continuing education responsibilities of an audit organization and also reflect additional guidance from CMS to help the contractor.

A. Education Required

CMS and GAS, Chapter 4 "Competence and Continuing Professional Education," Paragraph 4.16 "Continuing Professional Education" require that all persons responsible for planning, directing, performing Medicare cost report engagement procedures, or reporting on an engagement conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS) should develop and maintain their professional competence by completing at least 80 hours of continuing education and training (CET) every two years. For example, auditors who first start conducting *Medicare Audit Activities* on January 1, *2026*, *shall* complete the CET requirements as follows:

- The first 80 hours *shall* be completed by December 31, *2027*. Any excess over the 80-hour requirement does not carry forward to the next two-year cycle.

- After CET requirements for the first two-year period (i.e., January 1, *2026*, to December 31, *2027 in the example*) have been satisfied, a rolling count is permissible for measuring compliance with the requirements. Under a rolling count, compliance with the CET requirements is measured annually using the two most recent years.

- At least 20 hours *shall* be completed in each year of the two-year cycle.

- At least 24 of the 80 hours *shall* be in subjects directly related to government environment, to government auditing*, or the specific or unique environment in which the audited entity operates*. Since the contractor operates in a specific or unique environment, i.e., Medicare, it shall schedule the 24 hours of training in subjects related to the *Medicare* government environment and *associated activities*.

- Appropriate courses on Medicare and other health care related issues include, but are not limited to, GAS, Medicare policy development (how it affects *Medicare Cost Report reviews*), preparation and review of Medicare workpapers, current Medicare audit and payment issues, the AICPA Audit and Accounting Guide: Providers of Health Care Services, *and CMS Medicare Audit and Reimbursement training and webinars*.

- For purposes of the 80-hour and the 24-hour requirements, CMS interprets the term "conducting" and the phrase "conducting substantial portions of the field work" as referring to those individuals who perform substantial portions of the tests and procedures necessary to

accomplish the audit objectives. An individual is considered to be responsible for "conducting substantial portions of the field work," for purposes of the CET requirements, when the following conditions are met:

- On a given *Medicare Audit Activity,* the individual performs 20 percent or more of the total work; or

- In a given year, the individual's chargeable time to government *Medicare Audit Activities* is 20 percent or more of the individual's total chargeable time.

Staff who are involved in performing *Medicare Cost Report engagement procedures,* but not involved in *planning, directing, or reporting on an engagement conducted in accordance with GAGAS* and who charge less than 20 percent of their time to *these activities,* are required to take 24 hours of government related CET in each two year period. They are not required to comply with the 80-hour CET requirement.

Auditors who have been employed by the audit organization for less than one year of a given two-year period are not required to complete a minimum number of CET hours. However, entry-level auditors with less than one year with the audit organization *shall* receive appropriate training during their first year with the audit organization. Auditors employed by the audit organization for one year, but less than two years, in a given two- year period, *shall* complete a minimum of 20 hours of CET in the full calendar year. All auditors to whom the CET requirements for 80 hours and 24 hours apply have two years to meet the requirements.

Terminated employees *shall* have been trained in accordance with the contractor's plan of training, at least until a formal notice of termination is received or issued.

Auditors who have not completed the required number of CET hours for any two-year period for a legitimate reason will have the two months immediately following the two-year period to make up the deficiency. Auditors *shall* make up any deficiency in the 24-hour requirement first. The contractor shall not count any CET hours completed towards a deficiency toward either the 20-hour requirement in the year in which they are taken, or the 80-hour and the 24-hour requirements for the two-year period in which they are taken.

B. Employees Covered Under the CET Requirement

Any auditor who is responsible for planning, directing, *performing engagement procedures for, or reporting on an engagement conducted in accordance with GAGAS, including Medicare Audit Activities,* is subject to the CET requirements. Also, anyone whose decisions affect the outcome of government audits *(Medicare Audit Activities)* is covered by CET requirements.

Since the contractor may use various types of employees *to complete activities*, the following is CMS's interpretation of the applicability of CET requirements to certain types of employees:

- Auditors *(Including Audit Management)* – CET requirements extend to auditors *and*

management who *plan, direct, and/or* perform portions of the *Medicare Audit Activities*.

- Contract Auditors –When the contractor contracts with *external* firms for *Medicare Audit Activities* or to provide audit staff to work under its supervision, they are subject to the same requirements as the contractor. The contractor shall require compliance with the CET requirements as a specific condition of the subcontract. *The contractor* shall obtain written assurance that each *subcontractor employee* meets the CET requirements prior to the start of each *Medicare Audit Activity*.

- Temporary Auditing Staff – A temporary auditor who is hired for a very limited timeframe, not to exceed one quarter at a time or in one year, under the contractor's direct supervision, is not subject to CET requirements.

- Crossover Staff – Staff members used in multiple functions *shall* meet the CET requirements when their decisions could affect the outcome of *Medicare Audit Activities*. For CET purposes, employees who are transferred to the Medicare *Audit and Reimbursement* department are considered new hires, as are employees who are promoted to a professional staff level.

- External Consultants and Internal Consultants and Specialists – External consultants and internal consultants and specialists *shall* be qualified and *shall* maintain their professional proficiency in their area of expertise and specialization, but they are not required to meet CET requirements. For example, attorneys the contractor employs, who work in the provider appeals area, are not subject to the CET requirements, but they *shall* maintain their professional proficiency.

- Clerical and Paraprofessional Staff – Clerical and paraprofessional staff, including student interns, are not subject to the CET requirements.

The contractor shall review all position descriptions to ensure that they accurately reflect the employees' duties and responsibilities. If *the contractor has* concerns or questions on certain position descriptions, *the contractor shall* submit questions to *their BFL through their COR* for a determination. These position descriptions will be reviewed by CMS and the Office of the Inspector General (OIG) to determine the need for compliance with the CET requirements.

C. Contractor Responsibility

The contractor shall establish and implement a program to ensure that the auditors meet the CET requirements. *The contractor shall*:

- Prepare a general plan for training. Review and revise the plan, as appropriate, and allocate resources to ensure that all staff subject to CET requirements receive training.

- Implement the CET program to ensure that for every two-year period the 80-hour and 24-hour requirements are met, and that at least 20 CET hours are completed in each year of the

two-year period.

- Retain course information for *the contractor's* employees receiving CET credit for contractor sponsored courses. Maintain records for a five-year period from the completion of the two-year period. Maintain a record for each employee which reflects:
  - Record of participation;
  - Course agenda;
  - Course date(s);
  - Location at which the course was given;
  - Name(s) of instructor(s) and related training, education, and experience;
  - Number of CET credit hours *with field of study or subject matter*; and
  - Copy of course material presented.
- Retain course information for employees receiving CET credit for outside courses. Maintain records for a five-year period from the completion of the two-year period. Obtain a letter of completion or certificate, and retain a record for each employee which reflects:
  - Name of course;
  - Course date(s);
  - Location at which the course was given;
  - Course sponsor; and
  - Number of CET credit hours *with field of study or subject matter*.
- Submit to the *contractor's COR*, an annual certification by January 31 following the close of any calendar year, stating that it was compliant with the CET requirements.

D. General Guidelines for Training Courses

Continuing education and training may include such topics as current developments in audit methodology, accounting, assessment of internal controls, principles of management and supervision, financial management, statistical sampling, evaluation design, and data analysis. It also includes subjects related to the auditors' specific field of work. The contractor shall consider the following sources when developing a training program for auditors:

- Recognition for Courses Needed for CPA Licensing – In meeting the overall 80-hour requirement, courses approved or recognized by the AICPA or the respective state licensing

board that contribute to the auditors' professional proficiency are recognized for purposes of meeting the CET requirements.

- CMS-Sponsored Training – From time to time, CMS may contract with vendors to provide training courses and will notify *the contractor* of their availability. In addition, CMS may offer training in settings such as conferences *or webinar*.

- Contractor-Sponsored Training – The contractor *should* obtain sponsorship status for its training courses through its respective state CPA licensing board. This will help to ensure that the courses will meet the CET requirements. Also, the courses will be recognized for CPAs on *the contractor's* staff that is required to obtain continuing professional education credits for CPA licensure. In the development of in-house training, the contractor shall consider the AICPA's Statement on Standards for *Continuing Professional Education (CPE)* Programs. While in-house training is recognized as the most cost-efficient method of training, the contractor *shall* not rely solely on this method.

- Credit Hours – A CET credit hour may be given for each 50 minutes of participation in programs and activities that qualify. One-half CET hour increments (equal to 25 minutes) may also be given after the first CET hour has been earned in a given program or activity. For example, two 90-minute, two 50- minute, and three 40-minute presentations equal 400 minutes or eight CET hours. When the total minutes of a presentation are more than 50, but not equally divisible by 50, the CET hours *shall* be rounded down to the nearest one-half hour.

  A conference in which individual segments may be less than 50 minutes is counted as one program, rather than several short programs. The total minutes of all segments will be divided by 50 minutes in order to determine the CET hours for the program.

  For a college or university course, each unit of credit earned on a semester system will equal 15 CET hours. Each unit of credit earned on a quarterly system will equal 10 CET hours.

- Credit for Instructor Preparation Time – When an instructor or discussion leader serves at a program for which participants receive CET credit, and is at a level that increases professional competence, the contractor shall give CET credit for preparation and presentation time measured in terms of credit hours. For the first time a program is presented, CET hours will be received for actual preparation time, up to two times the class hours. For example, if a course is rated as eight CET hours, the instructor *shall* receive up to 24 hours of CET credit (16 hours for preparation and eight hours for class time). For repeated presentations, the instructor *shall* receive no credit unless the subject matter has changed sufficiently to require additional study or research. In addition, the maximum credit for preparation *shall* not exceed 50 percent of the total CET credit an instructor or discussion leader accumulates in a two-year CET reporting period.

- *Self*-Study Programs – *Self*-study programs that may receive CET credit *must include*

instructional strategies that clearly define learning objectives, guide the participant through a program of learning, and provide evidence of a participant's satisfactory completion of the program.

E. Staff Qualifications

Qualifications for staff members conducting Medicare *Audit Activities* include:

- A knowledge of the methods and techniques applicable to Medicare *Audit Activities*, and the education, skills, and experience to apply such knowledge to the *review* being conducted;
- A knowledge of the Medicare program;
- Skills to communicate clearly and effectively, both orally and in writing; and
- Skills appropriate for the *Medicare Audit Activity* work being conducted.

80.6 – Due Professional Care

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

In addition to the standards included in GAS, CMS also requires that the audit organization use due professional care when conducting Medicare Audit Activities and preparing related reports.

CMS places responsibility on the contractor and its auditors to follow all applicable standards in conducting Medicare *Audit Activities*.

Exercising due professional care means using sound professional judgment in establishing the scope, selecting the methodology, and choosing tests and procedures for the *Medicare Audit Activities*. Follow the same judgment in conducting the tests and procedures *for the Medicare Audit Activities* and in evaluating and reporting on the results *from these activities*.

A. Materiality and Significance

In planning *Medicare Audit Activities*, selecting the methodology, and designing audit tests and procedures, consider materiality and significance. Communicate to *the contractor's* audit staff *the contractor's* quantifiable parameters for materiality and significance.

B. Relying on the Work of Others

See *§61.1* of this Chapter for discussion on reliance on the work of other auditors.

C. Audit Follow-Up

Due professional care also includes follow-up on findings and recommendations from previous audits that could have an impact on the current objectives. Determine whether prompt and appropriate actions have been taken on findings and recommendations by provider officials or other appropriate organizations. Pay special attention to how the provider implemented recommendations

the contractor may have given in a prior year regarding nonallowable costs or items.

D. Audit Scope Impairments

For all *Medicare Audit Activities*, auditors *shall* consider whether audit scope impairments adversely affect their ability to conduct the *Medicare Audit Activity* in accordance with standards outlined within this *Chapter*. Audit scope impairments are factors external to the audit organization that can restrict the auditor's ability to render objective opinions and conclusions.

80.7 – Internal Quality Control

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

CMS also requires the audit organization to have an appropriate internal quality control system in place and to participate in an external quality control review program.

CMS requires that contractors shall establish an internal quality control program and provide reasonable assurance that *the contractor's* Medicare Audit *and Reimbursement* department:

- Has established, and is following, adequate audit *and reimbursement* policies and procedures; and
- Has adopted, and is following, applicable auditing standards.

A. External Quality Control Review (Review of the Internal Quality Control System)

In accordance with §30.8A in Chapter 7 of this manual, the Contractor shall contract with an independent certified public accounting (CPA) firm to perform a SSAE 18 SOC 1, Type II audit which includes a review of the internal control process. (Also, see Pub. 100-06, Chapter 7, §50.9, Control Objective I.10 (Provider Audit - Internal Control Process).) Any tests of *the contractor's* internal quality control system *shall* evaluate:

- The existence of such a system;
- Compliance with the system; and
- The effectiveness of the system.

B. Establishment of an Internal Quality Control System

Establish internal quality control policies and procedures for *the contractor's* Medicare *Audit and Reimbursement* department (i.e., all Medicare audit and *reimbursement* related activities). Communicate these policies and procedures to Medicare *Audit and Reimbursement* personnel. While the objective of internal quality control systems is always the same, the nature and extent of such systems can vary based on a number of factors. Normally, documentation of internal quality control policies and procedures would be expected to be more extensive in a larger contractor than a smaller contractor, and more extensive in a multi-office contractor than in a single- office contractor.

Therefore, in developing such a system, *the contractor shall* consider the following factors:

- The size of its Medicare *Audit and Reimbursement* department;
- The degree of operating autonomy allowed to its personnel and audit offices;
- The nature of its work;
- Its organizational structure; and
- The cost effectiveness of an internal quality control system.

C. Elements *and Application of Elements* of Internal Quality Control

In addition to the other elements of *GAS included in §80.0 of this Chapter,* consider each of the elements of internal quality control *policies and procedure that are included in the AICPA Statements of Quality Management Standards,* to the extent applicable to *the contractor's* operating environment, and in establishing *the contractor's* internal quality control policies and procedures.

The following elements of internal quality control relate and shall be applied to the Medicare environment:

1) Acceptance and Continuance (Fraud and Abuse)

The usual considerations for acceptance and continuance of clients of CPA firms are not applicable to the Medicare *Audit Activity* environment. Although the nature of the relationship with the *Medicare Audit Activity* subject is materially different from that experienced by a CPA firm, there is equivalent concern with a Medicare *Audit Activity* in which fraud and abuse is suspected.

Accordingly, make a full and immediate disclosure *in accordance with the MAC's Statement of Work (SOW) Section C.5.13* of suspected or detected fraud, abuse, illegal acts, or material misstatements or misrepresentations on the part of any provider, other organization or individual.

2) Inspection

Establish policies and procedures for inspection to provide reasonable assurance that the procedures relating to the other elements of internal quality control are being effectively applied. Monitor the effectiveness of inspection policies and procedures. Develop the procedures for inspection and ensure that inspections are performed by individuals acting on behalf of *the contractor's* management. The contractor *shall*:

- Prepare instructions and review programs for use in conducting inspection activities;
- Establish frequency and timing of inspection activities and criteria for selection of engagements; and

- Provide for reporting inspection findings to the appropriate management levels and for monitoring actions taken or planned.

90 – Final Settlement of the Cost Report

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Effective April 1, 2030, CMS requires contractors to settle (i.e., issue a NPR) all MCRs that are not scheduled for audit within 18 months of acceptance of the original as-submitted MCR unless there is a CMS approval and documented reason why the MCR cannot be settled (e.g., bankruptcy, OIG investigation, DOJ investigation). Amended cost reports that have been accepted by the contractor do not allow additional time for final settlement; if not scheduled for audit, final settlement of an amended cost report is considered timely if completed within 18 months after the acceptance date of the original as-submitted cost report. Additionally, any settlement that has been delayed because a prior year MCR is being audited, the settlement(s) will be considered timely if completed within the greater of 18 months from acceptance of the original as-submitted MCR or six months from the NPR date of the MCR that was audited.

Effective April 1, 2030, CMS requires contractors to settle (i.e., issue an NPR) all MCRs selected for audit and on a CMS approved audit plan within 12 months after the audit entrance conference date, and the entrance conference shall be held during the contract year in which the audit is included on that contract year's approved audit plan. Additionally, contractors shall issue the NPR to the provider within 60 days of the exit conference or within 60 days after the audit adjustments are finalized (using the timeframes described in *§60.6* of this Chapter) if an exit conference is waived.

As a general rule, if proper notification was given to the provider and adjustments were proposed due to "lack of documentation" as described in 42 CFR 413.20 and 42 CFR 413.24, issue the NPR without considering documentation received from the provider after the established timeframes unless there are circumstances that *the contractor or CMS* has previously approved.

If the provider used the PS&R settlement data to file the *MCR* or *the contractor* decides to use the PS&R data because the provider's reported settlement data is not documented properly, settle the *MCR* using a PS&R with a paid through date no earlier than 120 days prior to the issuance of the final *Adjustment Report.* If an adjustment report *is not issued* (e.g., there were no desk review exception resolution process adjustments or field audit adjustments), use a PS&R with a paid through date that is no earlier than 120 days prior to the NPR date. If *the contractor* settles the *MCR* later than 18 months after the end of the provider's fiscal year, use a PS&R with a paid through date that is no earlier than 15 months after the end of the provider's fiscal year.

Note: For instances where the MAC utilizes the One-Click PS&R Summary, the "PS&R Report Run Date" and the "Paid Claims Verified Current As Of" will be the same. For instances where the "Paid Claims Verified Current As Of" is more recent than the "PS&R Report Run Date", this serves to confirm that the system has verified that no further paid claims or adjustments have been received by PS&R for the included dates of service, from the date the report was run until the Verified Current As Of date. This indicates that these reports are still as current as a manual PS&R report requested

with Paid Dates through the date of the "Paid Claims Verified Current As Of".

The contractor is required to calculate and update the CCRs at final settlement into the OPSF and PSF no later than 30 days after the date of issuance of the final settlement following the steps in *§10.5 of this Chapter.*

Once the CCRs at final settlement are calculated, the contractor shall determine if an outlier reconciliation is required prior to issuing the NPR. To determine if an outlier reconciliation is required, contractors shall ensure all adjustments from Medicare Audit Activities are included in the cost report and follow the outlier reconciliation procedures identified in the applicable Chapter of CMS Pub. 100-04. If an outlier reconciliation is required, the contractor shall place the NPR on hold and follow the outlier reconciliation adjustment procedures identified in the applicable Chapter of CMS Pub. 100-04. Effective with outlier reconciliation approvals received from CMS on after January 1, 2027, the MAC shall complete the remaining steps in CMS Pub. 100-04 and issue the NPR within 90 days from the date the MAC received the outlier approval from CMS if the settlement timeframes stated above have passed. If the 90-day standard cannot be met due to extenuating circumstances, the MAC shall provide an explanation to their DPAO BFL, through their COR, including an estimated timeframe for settling the cost report.

The final settlement (NPR) package issued to the provider and uploaded to STAR shall include the items identified in §70.5 of this Chapter. Additionally, MACs shall include in the final settlement package, or under separate cover, a Notice of Reopening for Finalized Home Office Costs (if applicable).

***NOTE:** Once the NPR has been issued, the contractor is prohibited from revising/amending the date of the original revised NPR letter and revised MCR without going through the reopening process.*

90.1 – Submission of Settled Cost Report Data to CMS

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Within 30 days after issuance of the NPR to the provider, *the contractor shall* submit to CMS*, through STAR,* an extract of the *MCRs identified in §10.4 of this Chapter* in accordance with the HCRIS specifications.

Consult the following HCRIS website link regarding the MCR submission requirements for any other CMS cost report form not listed in §10.4 of this Chapter: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/?redirect=/CostReports/

Contractors are responsible for ensuring all MCRs and cost statements are loaded or entered in STAR. Submissions *shall* pass all level one electronic cost report edits and all *STAR* HCRIS *Load Control* reject edits. *Home office cost statements are loaded or manually entered in STAR but are not transmitted to HCRIS.*

***NOTE:** The electronic CMS Form 287-22 is effective for home office cost statement periods beginning on or after October 1, 2022.*

HCRIS requires a submission of the cost report data for "Low" or "No Medicare Utilization" providers. This submission is due within 30 days of the settlement of the cost report.

The *MCR* data is contained in the HCRIS database at CMS and is updated on a quarterly basis *to the public* on the CMS Website.

100 – Cost Report Reopenings

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Instructions that describe the circumstances under which the final determination on *an MCR* can be reopened are contained in 42 CFR 405.1885 and PRM *15-1, Chapter 29, §§*2931 and 2932. In accordance with these instructions, *the contractor* may reopen an *MCR* if it receives a written request to reopen from the provider within three years of the date that the NPR *or RNPR* was issued. *If the reopening relates to a revised NPR, only those issues adjusted in the revised NPR can be reopened. (See PRM 15-1, Chapter 29, §2931.1ff for additional information regarding time limits for reopening.)*

The contractor may also reopen an *MCR* within the three-year reopening period based on *the contractor's* own motion or at the request of CMS*; the notice of reopening (NOR) must be issued within three years from the date of the NPR or revised NPR. As stated above, if the reopening relates to a revised NPR, only those issues adjusted in the revised NPR can be reopened*. However, if fraud or similar fault is involved, *the contractor* can reopen the *MCR* at any time.

Effective with provider requested reopenings received on or after January 1, 2027, the contractor shall issue an NOR and/or a notice of denial (NOD) to the provider in writing within 90 days of receipt of a reopening request. If an NOR and/or NOD cannot be issued within 90 days, the contractor shall document the reasonable justification for the delay. An NOR does not guarantee that issues will be revised and included in a revised NPR, it only holds the MCR open for review of those issues included in the NOR.

The following three reasons as to why the MCR is being reopened shall be included in all NORs issued within the three-year reopening window except where noted:

1. *To incorporate settlement amounts from the previous cost report settlement(s) to ensure proper determination of payments, as necessary.*

2. *To ensure that all payments (including lump-sum, bi-weekly, and tentative payments) to and from the provider are incorporated into the cost report, as necessary.**

3. *To address any cost report software updates and edits, mathematical and flow items and carry forward amounts, as necessary.*

***Note:** NOR issue 2 above is not required for reopenings resulting from an Appeal being resolved through Administrative Resolution.*

A single *or combined* letter may be used as a notice of reopening of some issues and a denial of other issues. However, ensure that all issues that *will be reopened and all issues that will be denied* are listed in the written reopening notice. Where *the contractor* denies the reopening request for *any or all issues*, include in the written notification to the provider detailed reasons for the rejection. Such reasons could include:

- Untimely request, with an indication of the dates and documents being used in the determination.
- Incomplete request, with an explanation of why it was determined to be incomplete.
- Criteria for reopening not met, with an explanation of why the criteria were not met.

During its review of the reopening issues, the contractor, at a minimum, shall complete the relevant and applicable limited desk review steps and/or audit steps from the latest CMS-approved Desk Review Program and/or Audit Program (for the provider type) and document these steps in the scope of the workpaper. In addition, the contractor shall ensure the relevant and applicable settlement steps are completed and documented in the reopening workpapers to support any adjustments made for the three issues required to be included in the NOR as noted above. For example, support for prior settlement payments that were included as reopening adjustments to W/S E-1.

Where *the contractor* grants a provider's reopening request and discovers that additional information is still needed, whether before or after the three-year reopening period expires, send a written notice to the provider requesting that the needed information*/documentation* be submitted within *two weeks of the date of the initial request; the due date for subsequent requests are determined by the MAC. Additionally, timeframes for the initial and subsequent requests may be extended beyond two weeks, not to exceed 60 days, at the MAC discretion*. If the provider fails to submit the requested information, *the contractor* may *close the reopening and issue a letter stating the reopening is denied.*

The contractor shall also send the provider a written reopening notice detailing the issues when reopening the *MCR* on *the contractor's* own motion or at CMS' request. *When* reopening the *MCR at CMS' request, do not state in the NOR that the reopening issues generated from a CMS' Quality Assurance Surveillance Plan (QASP) review; instead, each issue in the NOR shall be specific to what is being reopened and reviewed. An NOR shall be issued when resolving issues that are under appeal. The appeal issues resolved shall be specifically identified in the NOR instead of stating the reopening is to effectuate an Administrative Resolution.* If necessary*, the contractor shall* send a written notice to the provider requesting that the needed information be submitted within a specified time (generally within 60 days of the request). If the provider fails to submit the requested information, adjust the *MCR* accordingly.

Whenever *the contractor* issues an NPR for a provider that is part of a chain before the *HOCS* is finalized, include an *NOR in the NPR package to adjust to the finalized HOCS.* However, *the*

contractor shall not issue such a reopening notice to a provider that is paid entirely under PPS. When the *HOCS* is finalized, close the reopening by issuing either a revised NPR or a notice that the reopening is being closed *without the issuance of an RNPR*.

If issues outside the scope of the *NOR* are discovered during the course of the reopening process, *the contractor* may address such issues only if the provider submits another reopening request before the expiration of the three-year reopening period or *if contractor initiated, the contractor* issues another notice of reopening within the three-year reopening period. *The contractor is prohibited from superseding or amending an NOR; instead, a separate NOR shall be issued for the new issues within the three-year reopening period described above. In addition, once an NOR has been closed either with the issuance of an RNPR or a closure letter for those reopenings that are closed without an RNPR, the NOR cannot be reinstated by deleting or suspending the closure letter. Rather, a new NOR letter shall be issued in the three-year reopening period.*

It is the expectation of CMS that all reopenings are reviewed and completed by the contractor in a timely manner and there shall be no large gap in time between requesting and receiving documentation along with receiving and reviewing documentation. The contractor shall issue a revised NPR for all reopened *MCRs* within 180 days of receipt of all information/documentation necessary to resolve the reopening issues. *Review of outlier reconciliation (if applicable) shall be completed prior to the issuance of a revised NPR.* Discuss with the *BFL (through the COR)* any situations where unforeseen circumstances prevent *the contractor* from meeting these expectations.

If applicable, the contractor is required to calculate and update the CCRs at revised final settlement into the OPSF and PSF no later than 30 days after the date of issuance of the revised final settlement following the steps in §10.5 of this Chapter.

Once the CCRs at revised final settlement are calculated, the contractor shall determine if an outlier reconciliation is required prior to issuing the RNPR. To determine if an outlier reconciliation is required, contractors shall ensure all adjustments from the reopening are included in the revised cost report and follow the outlier reconciliation procedures identified in the applicable Chapter of CMS Pub. 100-04. If an outlier reconciliation is required, the contractor shall place the RNPR on hold and follow the outlier reconciliation adjustment procedures identified in the applicable Chapter of CMS Pub. 100-04. Effective with outlier reconciliation approvals received from CMS on after January 1, 2027, the MAC shall complete the remaining steps in CMS Pub. 100-04 and issue the RNPR within 60 days from the date the MAC received the outlier approval from CMS if the settlement timeframes stated above have passed. If the 90-day standard cannot be met due to extenuating circumstances, the MAC shall provide an explanation to their DPAO BFL, through their COR, including an estimated timeframe for settling the cost report.

The revised final settlement package to the provider and uploaded to STAR shall include the items identified in §70.5 of this Chapter.

Furthermore, *the contractor is* required to submit HCRIS extracts to CMS each and every time that *the contractor* issues a *RNPR* following a reopening of an *MCR*. These submissions are due within

30 days after the issuance of the revised NPR. (See §§10.4 and 90.1 for details of the type of facility *MCRs* that are to be submitted.)

Reopening workpapers should include:

- *The reopening request (if applicable);*
- *The NOR or NOD (if applicable);*
- *Reopening workpapers (by issue);*
- *The original NPR package and previous RNPR(s) packages;*
- *The RNPR package applicable to the reopening; and*
- *Correspondence.*

Adjustment Report Guidelines:

- *Ensure that the Adjustment Report is prepared in the format of the sample report shown in Exhibit VII in §170 of this Chapter.*

110 – Responsibility When Provider Changes Contractors

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

If the provider changes contractors, the outgoing *and incoming* contractors *shall follow Chapter 3 of this Manual. The outgoing contractor* is responsible for *finalizing any open MCRs* that the provider filed while still being serviced by that contractor. This is based upon the contractual functions to be performed by contractors outlined in *§1874A of the Social Security Act and the MAC's SOW*. Contractors *are required* to make determinations of the amounts of payments to be made to providers, to account for funds in making such payments, and to audit their records. This clearly calls for the contractor servicing the provider to account for all transactions that have taken place while the relationship existed. This includes a *review* of the provider's records and determination of the final settlement as well as finishing any work related to appeals of *MCRs* that *the contractor was* responsible for settling.

Upon request, the outgoing contractor *shall* forward to the incoming contractor copies of the last as-submitted and settled *MCR* that they are responsible for and any other requested information/documentation. This provides *MCR* information so the incoming contractor can review and, if necessary, adjust the interim rate and perform the subsequent year's *Medicare Audit Activities*. If *the outgoing contractor* needs any of the workpapers to complete the work on pending appeals that they are responsible for and did not retain copies of those workpapers, request that the incoming contractor send copies at the time they are needed.

The incoming contractor *shall* generally audit the first *MCR* filed by a provider that is new to them as a result of changing contractors unless the provider (e.g., SNF or HHA) is paid entirely under the prospective payment methodology or the amount of Medicare reimbursement is insignificant. This

gives *the incoming contractor* a basis from which to review and evaluate subsequent years' *MCRs*. The audit of an *MCR* from a provider that changed contractors is:

- Limited to those issues, if any, pending from prior cost report examinations in the case of the contractor closing its final *MCR*, or

- Performed to the extent necessary to supplement information received from the prior contractor in the case of the contractor examining the provider's first *MCR*.

120 – Home Offices

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Where a provider is related within the meaning of 42 CFR 413.17 to a chain organization and services are furnished to the provider by the home office or other organizational entity of the chain, the reasonable costs of the services furnished are includable in the provider's costs for reimbursement. The reasonable costs of home office services are determined under guidelines in PRM *15-1, Chapter 21, §*2150ff. and other sections relating to specific costs.

120.1 – Responsibility for Home Office Costs of Chain Organizations

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

A home office can be serviced by one MAC (designated contractor) with its chain components serviced by numerous MACs (servicing contractors). CMS designates the contractor that will be responsible for the *review and finalization of the HOCS*. In making this determination, CMS Central Office (CO) considers geographical location of the home office.

When CMS CO determines which contractor will be responsible for the home office, it communicates its decision in writing to all the contractors servicing the providers in the chain.

120.2 – Designated Contractor's Responsibility if the Home Office Fails to File a Cost Statement

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Home office cost statements *(HOCSs)* that are prepared in accordance with PRM *15-1, Chapter 21,* §2150ff are to be submitted either: (1) before the last day of the fifth month following the close of the fiscal year if the home office's fiscal year ends on the last day of the month, or (2) on or before 150 days after the last day of the fiscal year if the home office's fiscal year ends on a day other than the last day of the month. If the chain home office fails to submit a cost statement within that time frame, the responsible/designated contractor for the home office *shall* notify the chain home office of its failure to submit a cost statement. *For cost reporting periods beginning on or after October 1, 2018, a HOCS is required to be submitted to each contractor that services a chain component of the chain home office if costs are allocated from a home office or chain organization. If the HOCS is not submitted to the servicing contractor, the MCR containing cost allocated from the home office shall be rejected by the servicing contractor(s). All* contractors servicing the providers in the chain *shall verify the receipt of the chain HOCS in STAR*.

120.3 – Planning/Scoping the Home Office Audit

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The responsibility for completing the desk review and scoping the audit of the *HOCS* rests with the designated contractor. If more than one contractor services the providers in the chain, the designated contractor may request any information its auditors need to scope the audit of the *HOCS* from other contractors. However, if *the designated contractor* does not audit a *HOCS* if all the providers in the chain are paid entirely under the prospective payment methodology or the aggregate amount of the related Medicare reimbursement for all the providers in the chain is immaterial*, the contractor may complete a modified, limited, or full* desk review *as applicable*.

If the *HOCS* is scoped for audit, the *designated* contractor *shall request any information from the servicing contractor(s)* that they have related to the providers they service which they consider relevant to the home office audit. This could include aspects of the chain's operations or *the contractor's* experience in their relationship with the chain that the designated contractor should be aware of or *shall* consider during the audit.

In determining the scope of the home office audit, the designated contractor considers: (1) the exceptions identified during the desk review of the *HOCS*, (2) the servicing contractors' requests for audit of provider records maintained at the home office*, and (3) the additional information furnished by the other contractors in response to its requests*.

120.4 – Timing and Completion of Home Office Audits

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Home offices of chain organizations are not providers; thus, their costs are not directly payable by Medicare. Home office costs are payable only when they are allocated to the providers in the chain and become part of the providers' allowable costs. Since the allocation of home office costs usually affects all providers in the chain, the audit of the *HOCS shall* be performed by the designated contractor as soon as possible after the receipt of the *HOCS* so that the servicing contractors can expeditiously finalize the settlement or reopening of provider *MCRs* pending the results of the home office audit. CMS expects that if a *HOCS* is not scheduled for an audit, the cost statements *shall* be finalized within 12 months from the date of acceptance effective for all *HOCSs* received on or after October 2005 *and 18 months from the date of acceptance effective April 1, 2030. A HOCS scheduled for an audit shall be finalized following the requirements in §90.1 of this Chapter.*

The designated contractor shall notify all the other contractors that service the providers within the chain *when the audit of the HOCS begins and keep those contractors* informed of the progress of the audit and any *adjustments*. The designated contractor *shall* forward the *adjustments* to the other contractors that service providers within the chain prior to the finalization of the adjustments. *Any issues relating to the determination and allocation of home office costs are to be resolved by the designated contractor.* If any of the other servicing contractors do not agree with *the designated contractor's* interpretation and application of a policy on a certain issue, that contractor(s) may

request that *the designated contractor* obtain an interpretation from CMS. Where *the designated contractor* requests an interpretation of policy from CMS, the resolution of the issue/adjustment *shall be delayed* until *the receipt of* a reply from CMS.

120.5 – Distribution of the *Finalized* Home Office Cost Statement

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The designated contractor *uploads* the *finalized HOCS and final settlement package to STAR (see §70.5 of this Chapter).* Contractors that service the providers within the chain *can obtain the status and the finalized HOCS from STAR. The designated contractor shall also provide adjustments to the servicing contractor(s) as requested or appropriate.*

The results of the *finalized HOCS* are binding *and relied* upon by the servicing contractors to identify the allowable portion of the home office costs that can be included in their providers' *MCRs*. The *finalized HOCSs are utilized* to make any necessary adjustments to the home office costs claimed by those provider(s) before they make a final *or revised final* settlement of the related *MCRs*. If at the request of the servicing contractor *the designated contractor reviewed* the provider's records that are maintained at the home office for specific issues outside the general *review* of the *HOCS*, forward the information related to those issues to the servicing contractor:

- The scope of the *Medicare Audit Activity* work performed,
- The schedule of audit adjustments with full explanation why they are necessary and their effect on the provider's cost report, and
- The results of discussions with home office personnel pertaining to the findings.

All *Medicare cost report* adjustments proposed by the designated contractor pertaining to the audit of provider records maintained at the home office are binding upon the servicing contractor. If the servicing contractor has any questions concerning the *adjustments* or *their* results, it should resolve the issues with the designated contractor before the settlement of the provider's cost report. However, when a disagreement cannot be resolved, the servicing contractor may request the *designated* contractor to obtain an interpretation from CMS.

120.6 – Standards for Issuance of an Audit Report for a Home Office

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The designated contractor will issue *a home office* audit report if it audits a *HOCS (see Exhibit IX.B in §170 of this Chapter).*

- If the report relates to a *HOCS*, a statement that GAS standards require the contractor to plan and perform the audit to obtain reasonable assurance about whether the Medicare *HOCS* is prepared in accordance with Medicare laws, regulations, and instructions, and
- A statement that the Medicare home office is responsible for compliance with Medicare laws,

regulations, and instructions.

120.7 – *Home Office Cost Statement* Responsibility When Designated Contractor Changes

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Where the *designated* contractor for the home office changes, the *incoming* contractor *becomes responsible for all open HOCSs. The outgoing* contractor *forwards all previous home office files including but not limited to the* prior years' *HOCSs,* desk reviews, audit reports, adjustments, and *finalized HOCSs to the incoming contractor*.

120.8 – Acceptance of Home Office Cost Statements

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Contractors *are required* to make a determination of acceptability within 30 days of receipt of an as-*submitted or amended HOCS*.

120.9 – Revisions to a Finalized Home Office Cost Statement

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

A HOCS is not a cost report, and as such, the reopening regulations do not apply. Revisions can be made to a finalized HOCS as long as one of its chain components is within the three-year reopening window or has a jurisdictionally valid appeal.

An NOR is not required when revising a HOCS. However, the designated contractor shall follow the timeline in §100 of this Chapter when revising a HOCS. The contractor shall follow §120.5 of this Chapter when distributing a revised HOCS.

130 – Provider Permanent File

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The permanent reference files are central files that contain provider information. *Contractors shall* maintain a current permanent reference file for each provider *and home office* with pertinent information for use during *Medicare Audit Activities. Contractors shall use the latest Permanent File Index from the latest CMS approved desk review program and ensure each component of the index is completed and maintained where applicable.*

The contractor shall review each management letter comment (MLC) that does not have a final disposition during the cost reporting year under review; these MLCs shall not be "passed" to a subsequent cost reporting year without being reviewed during the applicable year's Medicare Audit Activity. The contractor shall document in the Permanent File the steps completed to address the MLC during the applicable year's Medicare Audit Activity along with the auditor and reviewing official's signature or initials and date reviewed. Typically, when an MLC is first issued to the provider, adequate time is given to the provider in order to correct the deficiency and the cost reporting year in which the deficiency is to be corrected is included in the MLC. For example, if an

MLC is issued to the provider on 6/10/25 due to non-approved Worksheet B-1 basis relating to the 12/31/2023 desk review, the 12/31/2024 MCR would have already been submitted and would likely include the same non-approved basis. The MLC would be issued again for the 12/31/2024 MCR if the non-approved basis was used. The 12/31/2025 would be the first MCR in which the provider should have used the correct basis or requested approval to use an alternative basis.

The contractor shall review each point for next year (PFNY) that does not have a final disposition during the cost reporting year under review. The contractor shall conduct the review or audit of this deferred issue(s) within two years from the date of the deferral. For example, if a PFNY states that inpatient indigent bad debts should be reviewed due to insufficient documentation from the provider, this issue shall be reviewed within two years from the initial date of the deferral. The contractor shall document in the Permanent File the steps completed to address the PFNY during the applicable year's Medicare Audit Activity, along with the auditor and reviewing official's signature or initials, date reviewed, and the workpaper reference.

140 – Fraud & Abuse

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

140.1 – Definitions

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

A. Abuse

An abuse is the administrative violation of agency regulations, which impair the effective and efficient execution of the program. Violations may result in Federal monetary losses or in denial or reduction in lawfully authorized benefits to participants. They do not involve fraud.

B. Fraud

Fraud is obtaining something of value unlawfully, through willful misrepresentation. It embraces theft, embezzlement, false statements, illegal commissions, kickbacks, conspiracies, obtaining contracts through collusive arrangements and similar devices.

The following are examples (not all inclusive) of potential fraud or abuse:

- Recording of personal expense items as provider costs for patient care.
- Arrangements by providers with employees, independent contractors, suppliers, and others who appear to be designed primarily to overcharge the program with various devices, e.g., commissions, fee splitting, to siphon off or conceal illegal profits.
- A pattern of overutilization of services to inflate charges to increase reimbursement.
- Any evidence of payroll entries and disbursements to personnel who provide little or no services to the provider.

- Providers' concealment of business activities, which would affect eligibility for, or amount of, program reimbursement, e.g., undisclosed change of ownership or relationship with a supplying organization.
- Falsifying provider records in order to appear to meet the conditions of participation.
- Charging to the program costs not incurred, or which are attributable to nonchargeable services or nonprogram activities.
- Billing for supplies or equipment that are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency as to be virtually worthless.
- Duplicate billing which appears to be deliberate. This includes billing Medicare twice or billing both Medicare and the beneficiary for the same services.
- Deliberately providing or receiving Medicare payments on the account of other than the proper individual.
- Persistently and deliberately billing beneficiaries rather than Medicare for covered services.
- Soliciting, offering, or receiving a kickback, bribe, or rebate.
- An ineffective board of directors and/or audit committee.
- Abuse of internal accounting controls by administrative personnel.
- Indications of personal financial problems of administrators.
- Significant changes in business practices.
- Inadequate working capital or lack of flexibility in debt restrictions such as working capital ratios and limitations on additional borrowing.
- A complex corporate structure that does not appear to be warranted by the provider's size.
- Frequent changes of legal counsel or of key financial officers such as treasurer or controller.
- Premature announcement of profit or loss or of future expectations.
- Significant fluctuations in material account balances, financial interrelationships, inventory variances, or inventory turnover rates.
- Unusually large payments in relation to services rendered by lawyers, consultants, agents, and others.
- Difficulty in obtaining audit evidence with respect to unusual or unexplained entries,

incomplete or missing documentation, or alterations in documentation or accounts.

- Delays in responses or evasive responses by management to audit inquiries.

- Deliberately including cost, without disclosing the fact, in the provider *Medicare Cost Report* that specifically is nonreimbursable under the regulations. This excludes instances where the provider discloses that the *Medicare Cost Report* is filed under protest and where the protested issues and their reimbursement effect are disclosed.

140.2 – Contractor Responsibility In Suspected Fraud or Abuse Cases

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

It is *the contractor's* responsibility to provide necessary guidance to providers in preparing their *Medicare Cost Reports*. If during *the contractor's Medicare Audit Activities, the contractor* discovers certain items (e.g., expenses or allocation statistics for cost-reimbursed providers or cost-reimbursed areas of prospective payment system (PPS) providers, count of residents for graduate medical education or indirect medical education payments, bad debts, *etc.*) that are not allowable, make the necessary adjustments and inform the provider. Document all such adjustments made to the *MCR and issue a Management Letter Comment (MLC) allowing enough time for the issue to be properly stated in a subsequent submitted MCR.*

If these same nonallowable items appear on a subsequent *MCR*, *inform* the provider again why they are disallowed. Confirm this notification in a *subsequent MLC*. In this letter, advise the provider that further insistence on including the same nonallowable items in the next cost *reporting period in which an MCR has not yet been submitted* could result in referral to the U. S. Attorney General for consideration of criminal and/or civil prosecution. (If the provider's payment system changes in the current year (e.g., from cost-reimbursed to PPS and the item(s) disallowed in the prior year no longer has any reimbursement impact in the current year, do not issue this letter.)

Use the following model language.

> On our *review* for the period _____ to _____ certain items for which you receive reimbursement through the cost report were disallowed because they were determined by our auditors to be nonallowable. When we *reviewed* your cost report for the period _____ to _____ we found the following items which were disallowed in the prior period that were *again* included in the computation of your cost report reimbursement:
>
> In our last meeting *or conversation held on* _____, we advised you which specific items were not allowed and the reason for the disallowance. Your further insistence on including these nonallowable items in future cost reports without disclosure as protested items could result in the referral of this situation to the U. S. Attorney General for consideration of criminal and/or civil prosecution.
>
> Should you have any questions, please contact (contractor name).

If the provider continues to include these nonallowable items after receipt of the letter, follow *the contractor's* policies and procedures on fraud and abuse to refer the case.

However, if *the contractor has* some support that even the initial insertion of a nonallowable item on the *MCR* was intended by the provider to defraud the United States government, no warning to the provider is required before referring the matter to the Office of the Inspector General (OIG) for investigation and possible prosecution.

Where a contractor refers a questionable situation to the OIG, it is generally appropriate to continue the *Medicare Audit Activity* while the situation is investigated by the OIG. Occasionally, circumstances may require a *Medicare Audit Activity* to be discontinued pending the results of the investigation. These questions are resolved by CMS and the OIG.

***The contractor shall not,* under any circumstances, discuss a possible fraud or abuse situation with the provider or take any action to disallow or resolve such questionable situation prior to receiving instructions from the OIG.**

These instructions do not apply in situations where the provider disputes the allowability of an item and clearly indicates on the subsequent *Medicare Cost Report* that the particular item is still claimed as a protested item to establish the basis for an appeal.

150 – Access to Books, Documents, and Records of Provider's Subcontractors

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

150.1 – General

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Section 952 of the Omnibus Reconciliation Act of 1980, enacted December 5, 1980, amended §1861(v)(1)(I) of the Social Security Act to require that a contract (if its cost or value over a 12-month period is $10,000 or more) between a provider and a subcontractor *shall* contain a clause allowing the Department of Health and Human Services' (HHS) Secretary and the U.S. Comptroller General (or their representatives) access to the subcontractor's books, documents, and records that are necessary to verify the nature and extent of costs of services furnished under the contract. This clause *shall* be included in the contract in order for the costs of services furnished under the contract to be included as costs for Medicare reimbursement. In addition, the contract *shall* allow access to contracts of a similar nature between subcontractors and related organizations of the subcontractor, and to their books, documents, and records. The authorized representatives of the HHS Secretary are CMS, CMS' Medicare contractors, and the HHS Inspector General. In most instances, a contractor will be the entity requesting access.

This legislation (at 42 CFR 420.300 through 304) applies to contracts entered into or renewed after December 5, 1980; hence, contracts renewed after December 5, 1980 *shall* be amended to include the clause. The clause *shall* provide for access to the subcontractor's contract and books, documents, and records until four years have elapsed after the services are furnished under the contract or subcontract.

NOTE: A provider's cost of renegotiation with a subcontractor to include the access clause in their contract, if it is not excessive and can be adequately justified, is an allowable Medicare cost and therefore may be included in the Administrative and General cost center.

150.2 – Definitions

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

A. Books, Documents, and Records

All writings, recordings, transcriptions, and tapes of any description necessary to verify the nature and extent of the costs of services provided by a subcontractor. (**NOTE:** For the sake of brevity, the term "books, documents, and records" is hereinafter shortened to "books.")

B. Common Ownership

An individual(s) who possesses significant ownership or equity in the subcontractor and the entity providing the services under the contract.

C. Control

An individual, organization*, or institution thar has* the power, directly or indirectly, to significantly influence or direct the action or policies of an organization.

D. Provider

A hospital, skilled nursing facility, home health agency, hospice, comprehensive outpatient rehabilitation facility, or a *related organization (as defined in 42 CFR 413.17) of any of these providers. CMS subsequently defined "institutional providers" in 42 CFR 424.502 as any provider that submits a paper Medicare enrollment application using the CMS-855A or an associated internet-based PECOS enrollment application. See CMS Pub. 100-08, Chapter 10 for the current list of institutional providers.*

E. Subcontractor

Any entity, including an individual(s), that contracts with a provider to supply a service, either to the provider or directly to a beneficiary, for which Medicare reimburses the provider the cost of the service. This includes organizations related to the subcontractor that have a contract with the subcontractor for which the cost or value is $10,000 or more in a 12-month period.

F. Related to the Subcontractor

A subcontractor that is, to a significant extent, associated (or affiliated) with, owns (or is owned by), or has control of (or is controlled by), the organization furnishing the services, facilities, or supplies.

NOTE: If a provider contracts for services with a subcontractor, and the subcontractor thereafter contracts with a related organization (which will actually furnish the services), both contracts *shall* contain the access clause if one of the monetary criteria described in §150.4, is met.

G. Contract for Services

A contract through which a provider obtains the performance of an act(s), as distinguished from supplies or equipment. It includes any contract for both goods and services to the extent the value or cost of the service component is $10,000 or more within a 12-month period.

150.3 – Types of Contracts Covered by Access Provisions

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The access regulation applies to contracts concerning the purchase of services such as:

- Consultations, management, medical care provided by physician groups or hospital-based physicians (for which Medicare may reimburse providers on a cost basis);
- Linen services (rental of linens);
- Furnishing of meals (as opposed to the direct purchase of food);
- Legal and accounting services;
- Provider management and provider management information systems; and
- Insurance and leases for buildings and equipment.

Subcontracts for public utility services at rates established for uniform applicability to the general public are not subject to the regulation because the rates are already a matter of public record and are not negotiable. Similarly, contracts for workers compensation insurance are not subject to the regulation since the rates are non-negotiable and are also a matter of public record. Contracts concerning construction of buildings (including services of architects, painters, and interior decorators) need not contain the access clause; however, if a provider contracts with an interior decorator, painter, or other individual/company to perform service work on an existing building, the contract *shall* contain the access clause. When a provider contracts to purchase a product that includes a warranty of the product in the price, the contract is not subject to the regulation; however, a separately purchased warranty or service-maintenance contract *shall* contain the subject clause.

150.4 – Monetary Criteria

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

There are also monetary criteria to be considered in determining if a contract *shall* contain the access clause. If a contract is subject to the regulation as described in the preceding paragraph and one of the following criteria is met, the clause *shall* be included in the contract:

- Any contract for services for 12 months or less that is valued at $10,000 or more (e.g., a $12,000 contract for services that are completed in two months);
- Any series of contracts with a subcontractor for a service(s) that total $10,000 or more over a

consecutive 12-month period (e.g., two contracts for six months each that are valued at $8,000 each, or 12 contracts for one month each valued at $1,000 each, or a series of contracts costing $1,000 each for 10 months);

- Any contract that runs for more than 12 months, the apportioned value of which is $10,000 or more for a 12-month period (e.g., a contract for 18 months valued at $18,000 (the 12-month value is $12,000) or a contract for 24 months valued at $20,000, the 12-month value of which is $10,000); or,

- Any contract in which the cost or value of the services or service component is not specified, but the provider-projected services' value is $10,000 or more. (If a contract does not contain the cost or value of the services and does not include the access clause, and it is subsequently determined by a *contractor* (or other representative of the HHS Secretary) that the contract is subject to the statute, the provider risks not being reimbursed for the cost of the services under Medicare unless a good faith showing is made that would permit modification of the contract.)

These contracts between providers and subcontractors may be written or oral. With respect to a written contract, the access clause *shall* be made a part of the contract. Regarding an oral contract, a provider is required to have a written agreement (with a subcontractor) in the form of a letter of understanding that allows access to the pertinent books.

Providers are advised in PRM *15-1, Chapter 24,* §2440.4 that the following sample access clause language (which complies with the regulation) may be used:

> "Until the expiration of four years after the furnishing of the services provided under this contract, (**Name of Subcontractor**) will make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General, and their representatives, this contract and all books, documents, and records necessary to certify the nature and extent of the costs of those services. If (**Name of Subcontractor**) carries out the duties of the contract through a subcontract worth $10,000 or more over a 12-month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General, and their representatives to the related organization's books and records."

This language may not be suitable to all contracts. Therefore, contracting parties may use other clause language provided it contains the elements required in the regulation with respect to the nature of their contractual arrangement. Also, in those cases where the access provision is contained in a document other than the contract to which it applies, the sample clause will have to be modified accordingly.

150.5 – Access Clause Not in Contract

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

There may be situations where a provider, after applying the criteria of the regulation to a contract, erroneously decides that the contract does not require an access clause. In such unusual situations, if

the provider demonstrates satisfactorily that the decision not to include the clause was made in good faith with a reasonable basis(es), and the provider and subcontractor amends its contract to include an access clause within an acceptable (to the contractor) period of time after being advised that such amendment is required, the contractor shall treat the contract as meeting the requirements of the regulation. An example of a provider response demonstrating good faith with a reasonable basis is a situation where the provider honestly concluded that the cost or value of the service component of a goods and services contract was less than $10,000. With respect to contracts where services or services and goods are still being provided, any such amendment *shall* make clear that the access clause applies to books, documents, and records for the full term of the contract and not just for the period following the date of amendment. If a provider demonstrates satisfactorily that the decision not to include the clause was made in good faith with a reasonable basis but cannot amend the contract because the subcontractor is no longer in business, the contractor shall make a determination as to the reasonableness of the costs of the subcontractor's services using available information. The contractor shall take appropriate disallowance and/or recoupment action with respect to the cost of the services of the subcontractor if either the provider or subcontractor refuses to amend the contract, or the provider does not demonstrate satisfactorily that the decision not to include the clause was made in good faith with a reasonable basis.

There may also be situations in which an individual subcontractor refuses to enter into a contract containing the required access clause or will not agree to the addition of the access clause to an existing contract, which becomes necessary because of a contract modification. Providers are instructed in PRM *15-1, Chapter 24*, §2441 to contact the CMS Regional Administrator in their area if they have difficulty in finding another organization that will agree to the clause and offer the needed services at a cost at least as competitive as that of the original organization. (A provider that does not notify the Regional Administrator but instead, on its own initiative, contracts with a more expensive subcontractor or omits the access clause, risks not being reimbursed for the full cost of the services furnished under the contract.) If the Regional Administrator's efforts to persuade a subcontractor to include the required clause are unsuccessful, and no other subcontractor is available that will furnish the services at a competitive price and agree to the access provision, a provider may find it necessary to contract with another organization willing to accept the access clause, even though the cost of the services may be greater. In this situation, providers are requested to contact their contractor before entering into a contract to assure that the greater cost incurred will be considered during the *Medicare* Cost Report settlement process; this is not intended to be a pre-approval requirement.

150.6 – Reasons for Seeking Access

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

If a written accusation (from an HHS or non-HHS party) with suitable evidence against a provider or subcontractor of kickbacks, bribes, rebates, or other illegal activities is received, the *contractor* shall prepare a report of the situation and forward it to the regional Office of the Inspector General, HHS. However, if there is reason to believe that the costs claimed by a provider for services of a subcontractor are excessive or inappropriate, or evidence of possible nondisclosure of the existence

of a related organization is discovered, or it is determined that there is insufficient information to judge the appropriateness of the cost(s) claimed by a provider for services of a subcontractor, it may be necessary to examine the books of the subcontractor. Before requesting the subcontractor's books, the *contractor* shall determine if there is a more efficient, practical, or economical method of obtaining the necessary information. If there is such a method or other source (e.g., the provider is able to furnish substantiation for the cost of the services), the *contractor* shall obtain the needed information by that means before seeking to gain access to the subcontractor's books. If there is no alternate method or source, the *contractor* shall seek access but shall limit the access request to those books germane to the item(s) in question. It shall not make any unnecessarily burdensome or overly intrusive demands on a subcontractor or go on "fishing expeditions."

150.7 – Access Request Procedures

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Requests for access *shall* be in writing and contain all of the following elements:

- Reasonable identification of the books to which access is being requested;
- Identification of the subject contract or subcontract;
- Reason(s) why the appropriateness of the costs or value of the services of the subcontractor in question cannot be adequately or efficiently determined without access to the subcontractor's books;
- Authority in the statute and regulations for the access requested;
- If possible, identification of the individual(s) who will visit the subcontractor to obtain access to the books;
- Time and date of the scheduled visit; and
- Name of the duly authorized *contractor* staff member to contact if there are any questions.

150.8 – Subcontractor Response Requirements

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

- A subcontractor has 30 days from the date of a written request for access to books to make them available in accordance with the request.
- If a subcontractor believes a request is inadequate because it does not fully meet one or more of the required elements listed in §150.7 *of this Chapter*, it *shall* advise the *contractor* of the additional information needed within 20 days from the date of the request. Within 20 days from the date of the *contractor's* response (providing the additional information), the subcontractor *shall* make the books available.
- A subcontractor *shall* request (in writing) an extension of time within which to comply with

an access request if it believes, for good cause, that the requested material cannot be made available within the 30 day period (e.g., the requested material is located at a home office or in storage and there will be a delay due to retrieval time). If such a request is made, the contractor shall either grant an extension for good cause shown or, if no date can be mutually agreed upon for making the books available, initiate a delay or denial of reimbursement for the cost of the services.

- A subcontractor *shall* make requested material available for inspection and audit during its regular business hours.

NOTE: Since subcontractor books subject to access will contain both information germane to the cost item(s) in question as well as other business records (which could be sensitive in nature), CMS recommends that these books, or portions thereof, not be photocopied or otherwise reproduced. Instead, the contractor shall extract the germane information needed and record it in written workpapers. If absolutely necessary, the *contractor* shall photocopy/reproduce only the germane information.

- If a subcontractor is asked to reproduce books, the contractor shall reimburse the subcontractor for the reasonable costs of reproduction from Medicare funds. However, if a subcontractor reproduces books as a means of making them available, the contractor shall not reimburse the subcontractor for this reproduction.

- A subcontractor *shall*, at the request of a contractor, make the originals of any requested books available for inspection.

150.9 – Refusal of Subcontractor to Furnish Access

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

If it is determined that a subcontractor's books are necessary for a reimbursement determination and, despite all efforts, a subcontractor refuses to make them available, the *contractor* shall immediately notify the CMS Regional Administrator. If a subcontractor continues to refuse access, legal action may be initiated by CMS against that subcontractor. Also, the Regional Administrator will advise the subject provider that its subcontractor has refused access so that the provider may take whatever action it considers necessary for its financial protection (e.g., withholding of any balances due to the subcontractor under the contract).

150.10 – Freedom of Information Act (FOIA) Requests

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

If a *contractor receives a* request for release *of information* under the FOIA, the *contractor* shall immediately refer the FOIA request to:

Centers for Medicare & Medicaid Services
Freedom of Information Act Office
7500 Security Boulevard

Mail Stop C5-11-06
Baltimore, MD 21244

NOTE: The FOIA allows CMS to exempt from mandatory disclosure to requestors certain classes of records *(see 5 United States Code 552(b).)*, such as:

- trade secrets;
- commercial or financial information *obtained from a person;*
- personnel and medical files; and
- *privileged or confidential information.*

160 – Audit Subcontracts

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

In accordance with the Contract between the Secretary of Health and Human Services and the contractor, any subcontract involving a function or duty requires *disclosure to CMS*. Accordingly, the subcontract for *Medicare Audit Activities* requires *that the notification shall* be submitted to the *MAC's COR*.

160.1 – Routing of Audit Subcontract

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The MAC shall submit proposed audit subcontracts directly to the *MAC's COR*. If its contract responsibilities extend beyond regional boundaries, it *shall* submit the proposed subcontracts to the *MAC's COR* in which its home office is located.

160.2 – Competition

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

The provisions of the prime contract require the use of competitive proposals to the maximum practical extent in the award of subcontracts. The contractor shall obtain proposals from small and minority audit firms and consider their proposals in light of the factors listed below, to the extent that it finds it to be consistent with the efficient performance of the audit function.

The lowest price or lowest cost is the primary deciding factor in source selection, and the *contractor shall* justify a selection other than the low bidder. However, award of an audit subcontract may properly be influenced by the proposal that promises the greatest value in terms of:

- Anticipated performance – compliance with Medicare regulations and procedures.
- Ultimate productivity – compliance with terms of the contract.
- Consideration of the existing and potential workload of the prospective audit firm.

- Qualified staff capable of performing Medicare audit.
- Prior performance in Medicare audits.
- Reputation of the audit firm.
- Location of offices.

170 – EXHIBITS

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Exhibit I – Cost Report Acceptability Checklists

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

HOSPITAL ACCEPTABILITY CHECKLIST
Cost Report Form CMS-2552-10

Page 1

Provider Name: _____ *CCN:* _____
Subunits: _____ *CCN:* _____

Period Covered: From: _____ *To:* _____
Postmark Date: _____ *Receipt Date:* _____

Review to ensure the following is correctly completed and/or submitted with the cost report.

Part I - In order to ACCEPT the cost report, Questions 1 through 5, 8 and, if applicable, Questions 6 & 7 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
1. Has the provider submitted the Electronic Cost Report (ECR) utilizing a CMS approved vendor with current specification date via a CD, a flash drive, or MCReF electronic submission transmission?				
2. Does the ECR pass ALL Level 1 edits?				
3. Has the provider submitted a Print Image (PI) file of the cost report?				
4. Does the Certification Page (Worksheet S) of the ECR file include a valid electronic/digital signature with the checkbox marked or an original signature signed in ink by the provider's administrator or chief financial officer?				
5. Does the ECR encryption code printed on the signed certification page match exactly the encryption code in the ECR file Type 4?				

Part I - In order to ACCEPT the cost report, Questions 1 through 5, 8 and, if applicable, Questions 6 & 7 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
6. *Has the provider submitted the following required supporting documentation that must be submitted for applicable areas of the cost report for cost reporting periods beginning on or after October 1, 2018?* a. *Bad Debt: Detailed bad debt listing that corresponds to the amount of bad debt claimed in the provider's cost report.* b. *Disproportionate Share Hospital (DSH): Detailed listing of the hospital's Medicaid eligible days claimed in the provider's cost report. For an amended cost report that changes its Medicaid eligible days: an amended listing or an addendum to the original listing of the hospital's Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the provider's amended cost report.* c. *Charity Care and Uninsured Discounts for DSH eligible hospitals: Detailed listing of charity care and/or uninsured discounts that corresponds to the amounts claimed in the DSH eligible provider's cost report.* d. *Home Office Cost Allocations: For costs allocated from a home office or chain organization – a Home Office Cost Statement (HOCS) submitted to the chain provider's servicing contractor.*				

Part I - In order to ACCEPT the cost report, Questions 1 through 5, 8 and, if applicable, Questions 6 & 7 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
7. *If this is a teaching hospital, (i.e., hospital engaged in approved GME program in medicine, osteopathy, dentistry, or podiatry – 42 CFR 415.152), did the hospital submit an electronic file of the IRIS which passes all IRIS data edits and contains all the interns and residents information for this cost reporting period? An electronic file of the IRIS must be submitted for all teaching hospitals including those providers that file a no-Medicare utilization or low-Medicare utilization cost report.* a. *For cost reports with fiscal years beginning on or after October 1, 2021, did the provider file their IRIS data using the XML format?* b. *For cost reports with fiscal years beginning on or after October 1, 2022, do the XML IRIS GME and IME FTEs correspond to the total GME and IME FTEs reported on the as-filed cost report?* ***NOTE:*** *CAHs are excluded from this requirement because they are reimbursed on cost. LTCHs are excluded from the IME FTE requirement because it is not reported on the LTCH Medicare cost report settlement worksheet.*				
8. *Does the settlement summary on the signed certification page agree with the settlement summary on the Medicare Cost Report (MCR) produced from the ECR file by the contractor? (**NOTE:** If the settlement summary on the signed certification page does not agree with the settlement summary on the MCR produced from the ECR file by the contractor, ascertain the nature of the error prior to rejection to ensure that the error was not caused by the contractor's vendor software. If the MCR is rejected, include an explanation to the provider of the reason for the rejection.)*				
9. *If the cost report is deemed unacceptable, contact the provider within 24 hours of cost report rejection to notify of rejection and payment suspension, if applicable.*				

Problem Areas Noted During Acceptance Process:

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*Provider Contact:*_____
*Telephone Number:*_____ *Date of Contact:*_____
*Deadline for Resolution:*_____ *Mail:*_____

*Prepared By:*_____ *Date:* _____*Accepted [] Rejected []*
(check one)
*Reviewed By:*_____ *Date:* _____*Accepted [] Rejected []*
(check one)

SKILLED NURSING FACILITY ACCEPTABILITY CHECKLIST
Cost Report Form CMS-2540-24

Page 1

Provider Name: _____ *CCN:* _____
Subunits: _____ *CCN:* _____

Period Covered: From: _____ *To:* _____
Postmark Date: _____ *Receipt Date:* _____

Review to ensure the following is correctly completed and/or submitted with the cost report.

Part I - In order to ACCEPT the cost report, Questions 1 through 5, 7 and, if applicable, Question 6 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
1. Has the provider submitted the Electronic Cost Report (ECR) utilizing a CMS approved vendor with current specification date via a CD, a flash drive, or MCReF electronic submission transmission?				
2. Does the ECR pass ALL Level 1 edits?				
3. Has the provider submitted a Print Image(PI) file of the cost report?				
4. Does the Certification Page (Worksheet S) of the ECR file include a valid electronic/digital signature with the checkbox marked or an original signature signed in ink by the provider's administrator or chief financial officer?				
5. Does the ECR encryption code printed on the signed certification page match exactly the encryption code in the ECR file Type 4?				

Part I - In order to ACCEPT the cost report, Questions 1 through 5, 7 and, if applicable, Question 6 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
6. *Has the provider submitted the following required supporting documentation that must be submitted for applicable areas of the cost report for cost reporting periods beginning on or after October 1, 2018?* a. *Bad Debt: Detailed bad debt listing that corresponds to the amount of bad debt claimed in the provider's cost report.* b. *Home Office Cost Allocations: For costs allocated from a home office or chain organization – a Home Office Cost Statement (HOCS) submitted to the chain provider's servicing contractor.*				
7. *Does the settlement summary on the signed certification page agree with the settlement summary on the Medicare Cost Report (MCR) produced from the ECR file by the contractor? (**NOTE:** If the settlement summary on the signed certification page does not agree with the settlement summary on the MCR produced from the ECR file by the contractor, ascertain the nature of the error prior to rejection to ensure that the error was not caused by the contractor's vendor software. If the MCR is rejected, include an explanation to the provider of the reason for the rejection.)*				
8. *If the cost report is deemed unacceptable, contact the provider within 24 hours of cost report rejection to notify of rejection and payment suspension, if applicable.*				

Problem Areas Noted During Acceptance Process:

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*Provider Contact:*_____
*Telephone Number:*_____ *Date of Contact:*_____
*Deadline for Resolution:*_____ *Mail:*_____

*Prepared By:*_____ *Date:* _____*Accepted [] Rejected []*
(check one)
*Reviewed By:*_____ *Date:* _____*Accepted [] Rejected []*
(check one)

HOME HEALTH AGENCY/HOSPICE ACCEPTABILITY CHECKLIST
Cost Report Forms: CMS-1728-94 (HHA); CMS-1984-14 (Hospice)

Provider Name: _____ *CCN:* _____
Subunits: _____ *CCN:* _____

Period Covered: From: _____ *To:* _____
Postmark Date: _____ *Receipt Date:* _____

Review to ensure the following is correctly completed and/or submitted with the cost report.

Part I - In order to ACCEPT the cost report, Questions 1 through 6 and, if applicable, Question 7 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
1. Has the provider submitted the Electronic Cost Report (ECR) utilizing a CMS approved vendor with current specification date via a CD, a flash drive, or MCReF electronic submission transmission?				
2. Does the ECR pass ALL Level 1 edits?				
3. Has the provider submitted a Print Image (PI) file of the cost report?				
4. Does the Certification Page (Worksheet S) of the ECR file include a valid electronic/digital signature with the checkbox marked or an original signature signed in ink by the provider's administrator or chief financial officer?				
5. Does the ECR encryption code printed on the signed certification page match exactly the encryption code in the ECR file Type 4?				

Part I - In order to ACCEPT the cost report, Questions 1 through 6 and, if applicable, Question 7 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
*6. Does the settlement summary on the signed certification page agree with the settlement summary on the Medicare Cost Report (MCR) produced from the ECR file by the contractor? (**NOTE:** If the settlement summary on the signed certification page does not agree with the settlement summary on the MCR produced from the ECR file by the contractor, ascertain the nature of the error prior to rejection to ensure that the error was not caused by the contractor's vendor software. If the MCR is rejected, include an explanation to the provider of the reason for the rejection.)*				
7. Has the provider submitted the following required supporting documentation that must be submitted for applicable areas of the cost report for cost reporting periods beginning on or after October 1, 2018? a. *Bad Debt: Detailed bad debt listing that corresponds to the amount of bad debt claimed in the provider's cost report.* b. *Home Office Cost Allocations: For costs allocated from a home office or chain organization – a Home Office Cost Statement (HOCS) submitted to the chain provider's servicing contractor.*				
8. If the cost report is deemed unacceptable, contact the provider within 24 hours of cost report rejection to notify of rejection and payment suspension, if applicable.				

Problem Areas Noted During Acceptance Process:

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*Provider Contact:*_____
*Telephone Number:*_____ *Date of Contact:*_____
*Deadline for Resolution:*_____ *Mail:*_____

*Prepared By:*_____ *Date:* _____*Accepted [] Rejected []*
(check one)
*Reviewed By:*_____ *Date:* _____*Accepted [] Rejected []*
(check one)

OUTPATIENT FACILITIES ACCEPTABILITY CHECKLIST
Cost Report Forms: CMS 2088-17 (CMHC); CMS 216-94 (OPO and Histo Lab); CMS 222-17 (RHC/FQHC); CMS 265-11 (ESRD); CMS 224-14 (FQHC PPS)

Provider Name: _____ *CCN:* _____

Period Covered: From: _____ *To:* _____
Postmark Date: _____ *Receipt Date:* _____

Review to ensure the following is correctly completed and/or submitted with the cost report.

Part I - In order to ACCEPT the cost report, Questions 1 through 6 and, if applicable, Question 7 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
1. Has the provider submitted the Electronic Cost Report (ECR) utilizing a CMS approved vendor with current specification date via a CD, a flash drive, or MCReF electronic submission transmission?				
2. Does the ECR pass ALL Level 1 edits?				
3. Has the provider submitted a Print Image (PI) file of the cost report?				
4. Does the Certification Page (Worksheet S) of the ECR file include a valid electronic/digital signature with the checkbox marked or an original signature signed in ink by the provider's administrator or chief financial officer?				
5. Does the ECR encryption code printed on the signed certification page match exactly the encryption code in the ECR file Type 4?				

Part I - In order to ACCEPT the cost report, Questions 1 through 6 and, if applicable, Question 7 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
*6. Does the settlement summary on the signed certification page agree with the settlement summary on the Medicare Cost Report (MCR) produced from the ECR file by the contractor? (**NOTE:** If the settlement summary on the signed certification page does not agree with the settlement summary on the MCR produced from the ECR file by the contractor, ascertain the nature of the error prior to rejection to ensure that the error was not caused by the contractor's vendor software. If the MCR is rejected, include an explanation to the provider of the reason for the rejection.)*				
7. Has the provider submitted the following required supporting documentation that must be submitted for applicable areas of the cost report for cost reporting periods beginning on or after October 1, 2018? *a. Bad Debt: Detailed bad debt listing that corresponds to the amount of bad debt claimed in the provider's cost report.*				
8. If the cost report is deemed unacceptable, contact the provider within 24 hours of cost report rejection to notify of rejection and payment suspension, if applicable.				

Problem Areas Noted During Acceptance Process:

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*Provider Contact:*_____
*Telephone Number:*_____ *Date of Contact:*_____
*Deadline for Resolution:*_____ *Mail:*_____

*Prepared By:*_____ *Date:* _____*Accepted [] Rejected []*
(check one)
*Reviewed By:*_____ *Date:* _____*Accepted [] Rejected []*
(check one)

HOME OFFICE ACCEPTABILITY CHECKLIST
Cost Statement Form CMS-287-05

Page 1

Home Office Name: _____Home Office No _____

Period Covered: From: _____ To: _____
Postmark Date: _____ Receipt Date: _____

Review to ensure the following is correctly completed and/or submitted with the cost report.

Part I - In order to ACCEPT the cost report, Questions 1 through 3 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
1. Is the filed cost statement completed on Form CMS-287-05 or an appropriate substitute form that has been approved by CMS?				
2. Are the cost statements legible enough to be reproduced?				
3. Does the certification page of the ECR file include a valid electronic/digital signature with the checkbox marked or an original signature signed in ink by an officer of the home office?				

Problem Areas Noted During Acceptance Process:

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Provider Contact:_____
Telephone Number:_____ Date of Contact:_____
Deadline for Resolution:_____ Mail:_____

Prepared By:_____ Date: _____Accepted [] Rejected []
(check one)
Reviewed By:_____ Date: _____Accepted [] Rejected []
(check one)

HOME OFFICE ACCEPTABILITY CHECKLIST
Cost Statement Form CMS-287-22

Page 1

Home Office Name: _____ *Home Office No* _____

Period Covered: From: _____ *To:* _____
Postmark Date: _____ *Receipt Date:* _____

Review to ensure the following is correctly completed and/or submitted with the cost report.

Part I - In order to ACCEPT the cost report, Questions 1 through 4 and, if applicable, Question 5 must have a "YES" response:	*YES*	*NO*	*N/A*	*COMMENTS*
1. Has the provider submitted the Electronic Cost Report (ECR) utilizing a CMS approved vendor with current specification date via a CD, a flash drive, or MCReF electronic submission transmission?				
2. Does the ECR pass ALL Level 1 edits?				
3. Has the provider submitted a Print Image (PI) file of the cost report?				
4. Does the Certification Page (Worksheet S) of the ECR file include a valid electronic/digital signature with the checkbox marked or an original signature signed in ink by an officer of the home office?				
5. Does the ECR encryption code printed on the signed certification page match exactly the encryption code in the ECR file Type 4?				
6. If the cost Statement is deemed unacceptable, contact the home office within 24 hours of the cost statement rejection to notify of rejection and payment suspension, if applicable.				

Home Office Acceptability Checklist
Cost Report Form CMS-287-22

Page 2

Problem Areas Noted During Acceptance Process:

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Provider Contact:_____ Telephone Number:__ Date of Contact:_____ Deadline for Resolution:_____ Mail:_____

Prepared By:_____ Date: _____Accepted [] Rejected [] (check one) Reviewed
By:_____ Date: _____Accepted [] Rejected [] (check one)

Exhibit II – Summary of Uniform Desk Review Issues/Exceptions

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Summary of *Uniform Desk Review* Issues*/Exceptions*

(Instructions are contained in *§20.2.III. of this Chapter.*)

Provider Name:		Settlement without Further Review:	
Provider Number:		Desk Review Exception Resolution:	
Period From:		Field Audit:	
To:		In-House Audit:	

No.	UDR Reference	Description	Units/$s	No Further Action	Exception Resolution	Scoped for Audit	Exception/ Audit Deferred	Adjusted for Settlement	Comments	UDR, Resolution, Audit, or PF W/P Ref.
1	2	3	4	5	6	7	8	9	10	11

Exhibit III.A – Audit Confirmation Letter – Field Audit

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Date

Addressee
Address
City, State Zip Code

Provider *Name:*
Provider *Number:*
FYE:

Dear :

This is to inform you that your facility has been selected by (contractor name) for a field audit of your *MM/DD/*YYYY cost report. The audit will commence on MM/DD/YYYY, (four to six weeks from the date of the letter) with an entrance conference to be held the day we arrive on site. Please arrange for a conference room or adequate space for this meeting. We ask that at the least the chief financial officer, the person who prepared the cost report, and anyone designated as your liaison for the audit is present at the entrance conference. In addition, we ask that the information listed on the attached schedule be available on the date we arrive. This list will enable you to accumulate the necessary documentation we will need to begin the audit prior to the entrance conference.

If you need to postpone the audit entrance date, please notify us two weeks prior to the scheduled audit and we will attempt to accommodate your request. This is necessary as our audit work plan has been set, and we will need time to reschedule the audit staff. Again, all documentation found on the attached list must be available at the entrance conference. This will enable us to review the information and expedite our audit process while minimizing the impact on your personnel. Be aware that this list is not all- inclusive and that we may request additional documentation necessary to conduct and complete our audit. If the information is not provided, we will make audit adjustments to disallow the costs associated with the requests.

Any proposed audit adjustments will be given to you during the course of the audit. You may request the workpapers that support the adjustments at any time. A pre-exit conference will be held on the last day of the audit fieldwork which is tentatively planned to be on MM/DD/YYYY. In this meeting we will go over outstanding information requests and all of the audit adjustments available at that time. You will have four weeks to provide any outstanding information or information to refute any previously proposed audit adjustment. (We do not need to consider any additional documentation that you furnish after the expiration of the four week period in the Notice of Program Reimbursement (NPR)). We will schedule an exit conference within 12 weeks following the pre-exit conference. Prior to the exit conference, we will provide you with new or modified audit adjustments that we propose after the pre-exit conference and allow you two weeks to comment on

them. If you wish to waive a formal exit conference, please notify (name of contractor) of this decision in writing (e-mail note will suffice).

The Notice of Program Reimbursement will be issued to you within 60 days from the exit conference or within 60 days from the date that we finalize the audit adjustments if an exit conference is waived.

We believe these time frames and requirements will help expedite the completion of the field audit and settlement of your cost report. These provisions will be uniformly applied to all providers. We believe that with your cooperation we will have better field audits and more accurate settlements of cost reports.

If you wish to discuss this matter, please contact at .

Sincerely,

Signature, Title

Enclosures

cc:

Exhibit III.B – Audit Confirmation Letter – In-House Audit

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Date

Addressee
Address
City, State Zip Code

Provider Name:
Provider Number:
FYE:

Dear :

This is to inform you that your facility has been selected by (contractor name) for an in-house audit of your *MM/DD/*YYYY cost report. The audit will commence on MM/DD/YYYY, (four to six weeks from the date of the letter) with a telephone entrance conference to be held (the date and time of the telephone conference). We ask that at the least the chief financial officer, the person who prepared the cost report and anyone designated as your liaison for the audit participates during the entrance conference. In addition, we ask that the information listed on the attached schedule be sent to the contractor's location one week prior to (the date of the telephone entrance conference).

If you need to reschedule the entrance conference, please notify us two weeks prior to scheduled audit, and we will attempt to accommodate your request. Again, all documentation found on the attached list must be sent one week prior to the telephone conference. This will enable us to review the information and expedite our audit process while minimizing the impact on your personnel. Be aware that this list is not all- inclusive and that we may request additional documentation necessary to conduct and complete our audit. If the information is not provided, we will make audit adjustments to disallow the costs associated with the requests.

Any proposed audit adjustments will be sent to you during the course of the audit. You may request the workpapers that support the adjustments at any time. A pre-exit telephone conference will be tentatively planned to be on MM/DD/YYYY. During this telephone conference, we will go over outstanding information requests and all of the audit adjustments available at that time. You will have four weeks to provide any outstanding information or information to refute any previously proposed audit adjustment. (We do not need to consider any additional documentation that you furnish after the expiration of the four-week period in the Notice of Program Reimbursement (NPR)).

We will schedule a telephone exit conference within 12 weeks following the pre-exit conference. Prior to the exit conference, we will provide you with new or modified audit adjustments that we propose after the pre-exit conference and allow you two weeks to comment on them. If you wish

to waive a formal exit conference, please notify (name of contractor) of this decision in writing (e-mail note will suffice).

The Notice of Program Reimbursement will be issued to you within 60 days from the exit conference or within 60 days from the date that we finalize the audit adjustments if an exit conference is waived.

We believe these time frames and requirements will help expedite the completion of the in-house audit and settlement of your cost report. These provisions will be uniformly applied to all providers. We believe that with your cooperation we will have better in- house audits and more accurate settlements of cost reports.

If you wish to discuss this matter, please contact at .

Sincerely,

Signature, Title

Enclosures

cc:

Exhibit IV – Entrance Conference Agenda

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Entrance Conference Agenda:	
MAC Name:	
Provider Name:	
Provider Number:	
FYE:	
Auditor Name:	
Entrance Conference Date:	
Entrance Conference Time:	
Entrance Conference Location:	
Provider Representative(s)*:	
MAC Representative(s)*:	
Others in Attendance*:	

**Include title/position, email address, phone number, and any other applicable contact information.*

Entrance Conference Agenda Items:	
1. Staff Introductions:	

2. Provider Liaison(s):	• *Obtain the provider designation of "contact" or "liaison" for auditors to work with on a daily basis.*
	  ○ *Obtain the liaison's contact information*.*
	  ○ *Fully discuss the liaison's role to ensure full cooperation during the audit.*

3. Third-Party Cost Report Preparer:	• *Encourage the third-party cost report preparer to be available by telephone/email during the course of the audit and exit conference. Include third-party cost report preparer's name and contact information below.*
4. Audit Areas:	• *Discuss areas to be audited and that the audit may discover other issues that were not discussed at the entrance conference.*
5. Audit Schedule:	• *Discuss timeframes for conducting the audit and schedule a tentative date for the pre-exit conference.*
	• *Discuss timeframes for additional documentation that is requested during the audit. All requests should be in writing, which will be emailed to the provider's liaison. In general, the provider should be given three to five working days to supply the requested documentation.*
	• *Inform the provider that if requested documentation is not received, as a general rule, the MAC will disallow the costs and not reopen the cost report, due to lack of documentation, after the Notice of Program Reimbursement (NPR) is issued.*
	• *Establish a schedule of ongoing communication during the audit to update the provider on audit progress, possible audit adjustments, and documentation still required.*
6. Proposed Adjustments:	• *Discussion of proposed adjustments, if any, to the current year's cost report identified during the review.*

7. On-Site Audit Procedures:	***On-Site Audit Only:***
	• *Establish administrative procedures for such things as:*
	  ○ *Use of copy machine*
	  ○ *Work hours*
	  ○ *Access to Working Space (i.e. identification, access badge, entry code(s), etc.)*
	  ○ *Parking*
	  ○ *Overnight Document Storage*
	  ○ *Provider documentation received during field audit*

8. Other Items:	• *Discuss any other questions from the MAC or provider arising during the Entrance Conference.*

**Include title/position, email address, phone number, and any other applicable contact information.*

Exhibit V – Internal Control Questionnaire

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

This questionnaire is effective for *Medicare Audit Activities* and reflects those elements of an internal control structure that are more relevant to the outcome of a Medicare *cost report* audit. *(See §20.2.III. of this Chapter for additional information.)*

Answer all questions on the questionnaire "Yes," "No," or "Not Applicable," as appropriate and indicate whether the answer was obtained by inquiry, investigation, or both. Provide both name and title of the person supplying the information. Answers requiring support must include proper documentation or explanation or be cross- referenced to the appropriate workpaper in the current audit file. If a brief explanation is sufficient to adequately support the answer, it is not necessary to write an overly detailed description of the procedures.

The questionnaire is not all-inclusive and may be supplemented according to the needs of the provider being audited. If some internal control procedures other than those stated or implied by the questionnaire exist and affect the Medicare audit, include a description or explanation on a supporting workpaper.

Internal Control Questionnaire

Provider Name:

Provider Number:

Cost Report Reporting Period To:

Cost Report Reporting Period From:

Related Parties:

Home Office Number:

Management Group:

Applicable Period(s) of Report(s)

Person Responding: *(Name and Title)*

a. Question

b. Source (a = Inquiry, b =Observation, c = Tests)

c. Initials of person supplying information. (Initials *shall* be explained and the appropriate title supplied in a supporting workpaper)

d. Response (Yes, No, N/A)

e. W/P Reference

Question	Source	Initials	Response	WP Ref
I. Control Environment				
1. Was an independent audit of the provider's financial statements for this cost reporting period performed?				
A. If yes, was a copy of the reviewed financial statements filed with the as-submitted cost report?				
B. If yes, were the independent auditor's adjustments incorporated into the as-submitted cost report?				
2. If so, what was the audit opinion of the independent auditors?				
A. Unqualified opinion.				
B. If opinion is qualified, describe the reason why.				
3. Has the provider made a written representation on whether it received an *SSAE 18 SOC 1, Type II Audit* report on reportable conditions of internal control (whether given on a written or oral basis to the provider by the financial auditors)?				
4. Describe any reportable conditions in the *SSAE 18 SOC 1, Type II Audit* report that are applicable to the Medicare audit.				
5. Does the provider have a current organization chart defining lines of responsibility? If yes, obtain a copy.				
6. *What general ledger accounting system is used by the hospital?*				
A. Does the provider have an established chart of accounts?				
B. If yes, is it the same as the prior year?				
C. If not the same as the prior year or not received in the prior year, obtain a copy.				
7. Are the Board of Directors' meeting minutes available for review?				

Question	Source	Initials	Response	WP Ref

If yes, obtain a copy.

8. Does the provider have a policy on bonding its employees in positions of financial trust?
9. Does the provider have a policy regarding treatment of employees who violate control policies?
10. List the names of employees exercising the following functions:

    President
    Administrator
    CFO
    Controller
    Medicare Reimbursement Manager
    Internal Auditor
    Director of Nursing

    A. Are any of the above related to each other or others working in the organization?

    B. If the answer to A. is "yes," list the positions, incumbents, etc., who are related and state the relationships:

11. Does the provider have an internal audit function?

    A. If so, does the internal audit function report to an executive other than the chief accounting officer?

    B. If other than the CEO, specify to whom the internal auditor reports:

II. Accounting System

1. Does the provider have adequate written statements and explanations of its accounting policies and procedures? Do the policies require that:

    A. Accounting transactions are recorded in accordance with generally accepted accounting principles (GAAP)?

    B. Journal entries are approved by a designated individual at an appropriate level. Specify the individual and title:

    C. Journal entries require an adequate explanation and supporting documentation?

Question	Source	Initials	Response	WP Ref

D. Monthly reconciliations and timely closings are made to the accounting records.

2. *Does the provider have a policy to ensure the person who prepares checks is restricted from signature authority?*
   A. *Are funds transferred between bank accounts questioned/reviewed?*
   B. *Are checks completely filled out (vendor, amount) before they are signed?*
   C. *Is original supporting documentation required before checks are signed?*
3. Does the provider maintain a policy manual covering:
   D. Approval for financial transactions?
   E. Guidelines for controlling expenditure functions, such as purchasing and travel authorization?
   F. *Safekeeping,* maintenance, *and storage* of accounting records?
4. Are the provider's accounting and policies and procedures adequately communicated to employees?
5. Does the provider use a computer system in its accounting operations?
6. Does the provider have policies and procedures that govern the use and operation of the computer system?
7. Have accounting principles been consistent with those maintained in the preceding year?
8. Are periodic interim financial statements prepared and submitted to management?
9. Does the provider's accounting system have suitable account classifications?
10. Does the general ledger include accounts of related organizations?
    If so, identify the accounts and the related organizations.

III. Control Procedures

1. Statistics – Worksheet S-3 (or equivalent worksheet):
   A. Does the provider have policies and procedures for accumulating the following census statistics?
      If yes, obtain a copy.
      1. Patient days (including observation bed days).

Question	Source	Initials	Response	WP Ref

2. Patient visits
3. Number of beds by unit.

B. Does the provider have written policies and procedures for counting its interns and residents for both indirect medical education and graduate medical education? If so, obtain a copy.

2. Expenses – Worksheet A:

A. What is the source document for the expenses filed on Worksheet A of the cost report?

B. Are credits and refunds from vendors properly controlled and recorded to ensure that expenses are not overstated?

C. Payroll expenses:

1. Are employees required to punch a time clock or equivalent time logging system?
2. Is the payroll periodically checked against personnel records for:
   a. Continuing employment?
   b. Rate of pay?
3. Is the payroll checked for departmental allocation and time worked?
4. What documentation does the provider have to support its physicians' salary allocations to the provider component, the professional component, and the teaching component?
5. If an employee works in two departments, how is the time split supported?

3. Cost allocation statistics – Worksheet B-1:

A. List each cost allocation statistic.

1. Obtain a written description from the provider describing how each type of statistic is accumulated and maintained.
2. If the method for accumulating any statistic is different from that of prior cost reporting periods, obtain a description and explanation of the change. This includes changing from time records to time studies.

B. What are the provider's procedures for requisitioning drugs and medical

Question	Source	Initials	Response	WP Ref

supplies from inventory and allocating them to departments?

4. Patient Care Charges – Worksheet C:
   A. What is the source document for reporting charges on Worksheet C of the cost report?
   B. Obtain a copy of the written procedures describing how routine, intensive care, ancillary, outpatient, and other patient care charges are recorded and accumulated by the provider.
      1. Does the provider have procedures to ensure that the same charge is recorded for all classes of payers for the same service?
      2. Does the provider have procedures in place to ensure that all charges are properly recorded:
         a. In accordance with the provider's charge schedule?
         b. In the correct department? As inpatient or outpatient?
      3. Does the provider have procedures in place to ensure that adjustments to billed charges are properly credited to the correct department?
5. Billing and Collection:
   A. Medicare as Secondary Payer – Does the provider have procedures in place to:
      1. Obtain information on primary and secondary payers from patients on admission or at time of outpatient service?
      2. Revise the billing where the primary payer is identified subsequent to the original billing?
   B. What is the provider's collection policy for unpaid patient bills?
      1. Does the provider have the same collection policy and procedures for both Medicare and non-Medicare patients?
      2. Does the provider use a collection agency?
   C. What is the provider's policy in writing off Medicare bad debts as uncollectible?

      Obtain a copy.
      1. Does the provider have policies in place to determine indigence?

Question	Source	Initials	Response	WP Ref
2. Are the amounts written off as Medicare bad debts related only to covered deductible and coinsurance amounts?				
D. Does the provider have procedures in place to identify recoveries of bad debts previously written off and charged to the Medicare program?				
6. Capital-related costs:				
A. What are the provider's formal capitalization and depreciation policies? Obtain a copy.				
B. Does the hospital directly assign capital-related costs to departments? If so, what are the provider's policies and procedures on directly assigned capital costs?				
C. How does the provider record additions, transfers, and retirements?				
D. What follow-up procedures exist which ensure the proper handling of the gain or loss from the sales of assets?				
E. How are records maintained for equipment and facilities used by the hospital, but owned by others?				
F. At what level does the provider require normal authorization for new or renewed loans?				
G. How does the provider ensure that all investment income, profits (and losses to the extent applicable) arising from funds diverted from patient care are properly offset against interest expense?				

EXHIBIT VI – Pre-Exit Conference Format

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Contractor Name:

Provider Name:

Provider Number: **FYE:**

Auditor: **Date:**

Location: **Time:**

Provider Representative(s):

Contractor Representative(s):

Other:

Pre-Exit Conference Agenda Items

1. Discussion of proposed agenda items.
2. Discussion of documentation that is still needed by the auditor to complete their review.
3. Define responsibilities for all open items.
4. Establish timeframes for:
    a. Providing documentation to auditors.
    b. Provider responding to proposed audit adjustments.
    c. Response by contractor to provider once documentation is received.
    d. Receipt of final adjustments.
    e. Contractor to provide adjustment workpapers as requested by provider.
5. Ensure all provider records are returned.

Exhibit VII – Adjustment Report
(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Instructions for Completion of the Adjustment Report

A. Heading

Complete as indicated.

B. Adjustment Numbers

Include a complete list of adjustments*, presented in a logical order (e.g., Worksheet S, A, B, etc.), of adjustments arising from the contractor's examination of the MCR. Adjustments should be* numbered consecutively as they are recorded in the Adjustment Report.

C. Cost Report *Form* References

Identify the CMS form, worksheet, line number, and column number to which the adjustment applies. For example, reference to Form CMS-2552-*10*, Worksheet C, Part I, line *50*, column 6, Operating Room (the cost center affected by the application of the adjustment), would indicate an adjustment to revise/remove total inpatient charges reported for the Operating Room.

D. Explanation of Adjustments

Provide a narrative description of the adjustment. The description *shall* be adequate enough to identify the item being adjusted and the reason (e.g., decreasing the GME FTE count of interns and residents *due to nonallowable rotations*, removing nonallowable cost, reclassifying cost or other data *due to incorrect grouping on Worksheet A*). The narrative description of the audit adjustment *shall* also include appropriate reference to law, regulations, or program policy and procedures, and the contractor's workpaper where the adjustment was first proposed.

E. Worksheet A Line Number

For adjustments pertaining to Worksheet A-6 and Worksheet A-8, indicate in this column the Worksheet A lines that are affected by the adjustment. For example, if vending machines expenses were included on Line *10* of Worksheet A, any Worksheet A-8 adjustments increasing or reducing those expenses will affect Worksheet A, Line *10*. Thus, in the Worksheet A Line column insert "*10*."

F. *Worksheet A-6 Letters*

Indicate in this column the letters that are used to identify the Worksheet A-6 reclassification adjustments. For example, the first Worksheet A-6 reclassification adjustment *shall* be annotated with the letter that follows the last letter used for reclassifications on the "submitted" Worksheet A-6. All the subsequent reclassification adjustments *shall* follow the letters in the alphabet. If all the

letters of the alphabet are used up and there are other reclassification adjustments to be made, double the letters starting with "A." For example, use "AA" as the adjustment that follows "Z."

G. Basis

Insert in this column the type of Worksheet A-8 adjustment. For "cost' adjustments use "A" and for "income offsets" use "B."

H. As Reported or As Adjusted

- As Reported – Show the amount included in the unaudited cost report for the cost center that will be affected by the adjustment. For example, where the proposed adjustment will change the employee benefits statistical allocation of the Administrative & General (A&G) cost center as reported by the provider, the amount shown will be the statistic as reported for this cost center on Form CMS- 2552-*10*, Worksheet B-1, line *5*, column *4*.

- As Adjusted – Where the A&G cost center has previously been adjusted by the audit capability, the contractor shall insert in this column the amount shown "As Adjusted" for the previous adjustment. Reference *shall* be made to this previous adjustment, e.g., (see adjustment no. 1).

I. Increase or Decrease

Insert the amount of the adjustment. The adjustment amount should be indicated by brackets if it represents a (decrease) of the amount in the "As Reported or As Adjusted" column.

J. As Adjusted

This column is the result of adding or subtracting the adjustment amount from the previously reported amount.

Adjustment Report - Sample Format

These adjustments will be incorporated in our revised Statement of Reimbursable Cost for the period ending .

Adjustment Report

Provider Name:

Provider Number:

(A) = Heading

Cost Report Reporting Period To:

Cost Report Reporting Period From:

(B) Adj #	*(C)* Form	*(C)* Page or Schedule	*(C)* Line	*(C)* Col.	*(D)* Explanation of Adjustments	*(E)* W/S A Line #	*(F)* A-6 Letter	*(G)* Basis	*(H)* As Reported or As Adjusted	*(I)* Increase or Decrease	*(J)* As Adjusted
1	*2552-10*	*A-8*	*20*	*2*	*Vending Machines*	*10*		*B*	*$0*	*$(11,690)*	*$(11,690)*
					W/P 4-4B. To offset income earned from vending machines. 42 CFR 413.9 & CMS 15-1, §2102.3						
2	*2552-10*	*B-1*	*5*	*4*	*Administrative & General*				*$5,659,255*	*$(252,000)*	*$5,407,255*
			194.01	*4*	*Nonallowable Marketing*				*0*	*252,000*	*252,000*
					W/P 11-6. To reflect adjustments made to salaries for the Employee Benefits statistics, the stat is based on Gross salaries. 42 CFR 413.24 & CMS 15-1, §2306						
3	*2552-10*	*C, Part I*	*50*	*6*	*Operating Room*				*$2,875,965*	*$342,105*	*$3,218,070*
					W/P 2-1. To revise Inpatient Operating Room charges to agree to the provider's trial balance. 42 CFR 413.24 & CMS 15-1, §2304						

EXHIBIT VIII – Exit Conference Format

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

Contractor Name:			
Provider Name:			
Provider Number:		***FYE:***	
Auditor:		***Date:***	
Location:		***Time:***	
Exit Conference Waived:			
Provider Representative(s):			
Contractor Representative(s):			
Other:			

*(**NOTE:** If the exit conference is waived, include support for the waiver.)*

Exit Conference Agenda Items

1. *Discussion of proposed agenda items:*
2. *Distribution and review of all finalized adjustments to be covered during the exit conference:*
3. *Summary of Provider's response to the adjustments from pre-exit conference:*
4. *Requested workpapers sent to provider (include date):*
5. *Notice of Program Reimbursement will be issued on or before:*
   *(**NOTE:** A copy of the appeal rights and procedures will be included with the Notice of Program Reimbursement)*

Exhibit IX.A – Form of Report on Audit of Medicare Cost Report *(Provider)*
(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

CONTRACTOR LETTERHEAD

Provider Name:

Provider Number(s):

Cost Reporting Period:

We have audited the provider(s) Medicare cost report for the cost reporting period stated above.

We conducted our audit in accordance with the directives in CMS Pub. 100-06, Chapter 8. They require that we plan and perform the audit to obtain reasonable assurance that the cost report settlement reflects payment amounts and financial data in accordance with Medicare laws, regulations, and instructions.

A less than full scope audit was made of this cost report in accordance with CMS's audit instructions. The examination was confined to the specific areas selected for audit as indicated on the attached listing.

Preparation of the cost report and compliance with Medicare laws, regulations, and instructions is the responsibility of the provider(s) management. As part of obtaining reasonable assurance about whether the cost report settlement reflects payment amounts and financial data in accordance with Medicare laws, regulations, and instructions, we performed tests of compliance with certain provisions of the Medicare laws, regulations, and instructions.

In planning and performing our audit of the provider's cost report for the period, we considered its internal control structure, as it pertained to those items in the scope of our audit of the Medicare cost report, to determine auditing procedures for the purpose of expressing our opinion on the cost report and not to provide assurance on the internal control structure.

(Select one of the following alternative paragraphs on the consideration of the internal control structure, if applicable.)

We have concluded that it would be inefficient to evaluate the effectiveness of internal control structure policies and procedures and, in accordance with the *Government Auditing Standards* (GAS), we conducted the audit more efficiently by expanding substantive audit tests, thus placing little reliance on the internal control structure.

or

The objectives of this financial related audit did not require an understanding of the internal control structure.

or

The existing internal control structure contained so many weaknesses we had no choice but to rely on substantive testing, thus virtually ignoring the internal control structure.

NOTE: *The following* will not be included if the contractor uses one of the alternative paragraph above.

The provider(s) management is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control policies and procedures. The objectives of an internal control structure provide management with reasonable, but not absolute assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with generally accepted accounting principles. Because of inherent limitations in any internal control structure, errors or irregularities may occur and not be detected. Also, projections of any evaluation of the internal control structure to future periods is subject to risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

For purposes of this report, we have classified the significant internal control structure policies and procedures, as they affect the Medicare audit in the categories listed in the attached report.

For the internal control structure categories listed, we obtained an understanding of the design of relevant policies and procedures and whether they have been placed in operation, and we have assessed control risk.

(If reportable conditions were noted, the contractor incorporates the following statement, along with paragraphs describing the reportable conditions.)

We noted certain matters involving the internal control structure and its operation that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure that, in our judgment, could adversely affect the entity's ability to record, process, summarize, and report financial-related data consistent with the assertions of management in the Medicare cost report.

Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be material weaknesses under standards established by the American Institute of Certified Public Accountants. A material weakness is a reportable condition in which the design or operation of the specific internal control structure elements does not reduce to a

relatively low risk that errors or irregularities in amounts that would be material in relation to the cost report being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

(If no material conditions or reportable conditions were noted, the contractor incorporates the following statement.)

We noted no matters involving the internal control structure and its operation that we consider to be material weaknesses as defined above.

(The following paragraph is an optional paragraph under either consideration for items that are less than reportable conditions and for general comments.)

However, we noted certain matters involving the internal control structure and its operation that we have reported to the provider's management in a separate letter dated (the contractor inserts the date of the letter).

The results of our tests indicate that, with respect to the items tested, the provider(s) complied in all material respects with Medicare laws, regulations, and instructions, except for the items listed in the attached Adjustment Report. With respect to items not tested, nothing came to our attention that caused us to believe that the provider(s) has not complied in all material respects with these provisions.

The attached Medicare cost report has been adjusted for these items of noncompliance in accordance with the attached Adjustment Report.

This report is intended for the information of the provider(s) and CMS. This restriction is not intended to limit the distribution of the report, which is a matter of public record, unless otherwise restricted by applicable laws.

(Signature)
Name and Title

NPR Date

Exhibit IX.B – Form of Report on Audit of Medicare Home Office Cost Statement
(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

CONTRACTOR LETTERHEAD

Home Office Name:

Home office Number:

Cost Statement Reporting Period:

We have audited the Home Office Medicare cost statement for the period stated above.

We conducted our audit in accordance with the directives in CMS Pub. 100-06, Chapter 8. They require that we plan and perform the audit to obtain reasonable assurance that the cost statement reflects financial data in accordance with Medicare laws, regulations, and instructions.

A less than full scope audit was made of this cost statement in accordance with CMS's audit instructions. The examination was confined to the specific areas selected for audit as indicated on the attached listing.

Preparation of the cost statement and compliance with Medicare laws, regulations, and instructions is the responsibility of the home office(s) management. As part of obtaining reasonable assurance about whether the cost statement reflects financial data in accordance with Medicare laws, regulations, and instructions, we performed tests of compliance with certain provisions of the Medicare laws, regulations, and instructions.

In planning and performing our audit of the home office's cost statement for the period, we considered its internal control structure, as it pertained to those items in the scope of our audit of the Medicare cost statement, to determine auditing procedures for the purpose of expressing our opinion on the cost statement and not to provide assurance on the internal control structure.

(Select one of the following alternative paragraphs on the consideration of the internal control structure, if applicable.)

We have concluded that it would be inefficient to evaluate the effectiveness of internal control structure policies and procedures and, in accordance with the Government Auditing Standards (GAS), we conducted the audit more efficiently by expanding substantive audit tests, thus placing little reliance on the internal control structure.

or

The objectives of this financial related audit did not require an understanding of the internal

control structure.

or

The existing internal control structure contained so many weaknesses we had no choice but to rely on substantive testing, thus virtually ignoring the internal control structure.

***NOTE:** The following will not be included if the contractor uses one of the alternative paragraph above.*

The home office(s) management is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control policies and procedures. The objectives of an internal control structure provide management with reasonable, but not absolute assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with generally accepted accounting principles. Because of inherent limitations in any internal control structure, errors or irregularities may occur and not be detected. Also, projections of any evaluation of the internal control structure to future periods is subject to risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

For purposes of this report, we have classified the significant internal control structure policies and procedures, as they affect the Medicare audit in the categories listed in the attached report.

For the internal control structure categories listed, we obtained an understanding of the design of relevant policies and procedures and whether they have been placed in operation, and we have assessed control risk.

(If reportable conditions were noted, the contractor incorporates the following statement, along with paragraphs describing the reportable conditions.)

We noted certain matters involving the internal control structure and its operation that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure that, in our judgment, could adversely affect the entity's ability to record, process, summarize, and report financial-related data consistent with the assertions of management in the Medicare cost statement.

Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be material weaknesses under standards established by the American Institute of Certified Public Accountants. A material weakness is a reportable condition in which the design or operation of the specific internal control structure elements does not reduce to a relatively low risk that errors or irregularities in amounts that would be material in relation to the

cost statement being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

(If no material conditions or reportable conditions were noted, the contractor incorporates the following statement.)

We noted no matters involving the internal control structure and its operation that we consider to be material weaknesses as defined above.

(The following paragraph is an optional paragraph under either consideration for items that are less than reportable conditions and for general comments.)

However, we noted certain matters involving the internal control structure and its operation that we have reported to the home office's management in a separate letter dated (the contractor inserts the date of the letter).

The results of our tests indicate that, with respect to the items tested, the home office(s) complied in all material respects with Medicare laws, regulations, and instructions, except for the items listed in the attached Adjustment Report. With respect to items not tested, nothing came to our attention that caused us to believe that the home office(s) has not complied in all material respects with these provisions.

The attached Medicare cost statement has been adjusted for these items of noncompliance in accordance with the attached Adjustment Report.

This report is intended for the information of the home office(s), provider(s) it services, and CMS. This restriction is not intended to limit the distribution of the report, which is a matter of public record, unless otherwise restricted by applicable laws.

(Signature)
Name and Title

Home Office Cost Statement Finalization Date

Exhibit X – Form of Report for Medicare Cost Report That Has not Been Audited

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

CONTRACTOR LETTERHEAD

Provider Name:

Provider Number(s):

Cost Reporting Period:

We have reviewed the provider(s) Medicare cost report for the cost reporting period stated above.

Preparation of the cost report and compliance with Medicare laws, regulations, and instructions are the responsibility of the provider(s) management.

We have performed a review of the cost report. The attached Medicare cost report has been adjusted, where required, for items of noncompliance discovered during our review, which are listed in the attached Adjustment Report.

This report is intended for the information of the provider(s) and CMS. This restriction is not intended to limit distribution of this report, which is a matter of public record, unless otherwise restricted by applicable law.

(Signature)
Name and Title

NPR Date

Exhibit XI – Personal Impairments Statement

(Rev. 13891; Issued: 07-30-26; Effective: 08-28-26; Implementation: 08-28-26)

I certify that I am free of personal or financial impairments on this assignment/the assignments that I will be involved in during the fiscal year*. These personal impairments may include, but are not limited to the following:

- Official, professional, personal, or financial relationships that might cause me to limit the extent of the inquiry, to limit disclosure, or to weaken or slant *Medicare Audit Activity* findings in any way.
- Preconceived ideas toward individuals, groups, organizations, or objectives of a particular program that could bias the *Medicare Audit Activity*.
- Previous responsibility for decision-making or managing the entity that would affect current operations of the entity or program being *reviewed*.
- Biases that result from employment in, or loyalty to, a particular group, organization, or level of government.
- Subsequent performance of a *Medicare* Audit *Activity* by myself if, for example, I have previously approved invoices, payrolls, claims and other proposed payments of the entity or program being *reviewed*.
- Concurrent or subsequent performance of a *Medicare* Audit *Activity* by myself, if I had previously maintained the official accounting records.
- Financial interest, direct or substantial indirect, in the *reviewed* entity or program.
- Job offer received during the engagement.

Signature: _____

Date: _____

Approval: _____

Date: _____

* (Underline the applicable phrase depending on whether the impairment statement applies to a single