Which Authorizes CMS To Enter Into Contracts With Entities To Perform Cost Report Auditing, Medical Review,

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Introduction

The Centers for Medicare & Medicaid Services (CMS) plays a pivotal role in overseeing and managing the administration of federal healthcare programs, including Medicare and Medicaid. A critical component of CMS's oversight functions involves ensuring the integrity and accuracy of healthcare provider reimbursements. To fulfill these responsibilities effectively, CMS often contracts with external entities to perform tasks such as cost report auditing and medical reviews. But what legal and regulatory frameworks grant CMS the authority to establish these contractual relationships? Understanding the statutory, regulatory, and policy bases that authorize CMS to engage third-party organizations is essential for appreciating how healthcare program integrity is maintained.

Legal Foundations for Contracting Authority

Statutory Authority Under Federal Laws

The primary legal authorization for CMS to contract with external entities originates from several key federal statutes. These statutes outline the agency's broad authority to administer, supervise, and ensure the proper functioning of Medicare and Medicaid programs, including contracting powers.

- **Social Security Act (SSA)**: The foundation of Medicare law, the SSA, particularly sections related to the administration of the program, provides CMS with the authority to enter into agreements necessary for program operation. Notably, section 1874A of the SSA authorizes the Secretary of Health and Human Services (HHS) to establish programs for auditing and reviewing provider claims.
- **Medicare Act of 1965**: This act established Medicare and gave the Secretary broad authority to develop regulations, establish standards, and implement procedures necessary for program administration, including contracting for specialized functions.
- **Section 1862 of the SSA**: This section permits the Secretary to conduct audits and reviews of providers to prevent fraud, waste, and abuse,

which can be delegated through contractual arrangements.

Regulatory Framework and Authority

Beyond statutes, CMS's authority is further delineated through regulations that specify how the agency can implement statutory mandates.

- **42 CFR Part 405**: This regulation covers principles for audits and investigations, including contractor roles and responsibilities, establishing the legal basis for contractual relationships.
- **42 CFR Part 488 and 495**: These regulations detail the survey and certification process, including medical reviews and audits conducted by authorized entities.
- **Authority Delegations**: CMS often delegates specific responsibilities to contractors via formal agreements, such as Memoranda of Understanding (MOUs), which are grounded in the above statutes and regulations.

Delegation of Authority and Contracting Policies

CMS possesses the authority to delegate certain functions to qualified external organizations, including Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and other entities performing medical review and cost report audits.

1. **Federal Acquisition Regulations (FAR)**: CMS adheres to FAR guidelines governing procurement processes, ensuring that contracts are awarded in compliance with federal procurement laws.
2. **Program Integrity and Fraud Prevention**: Under authorities established by law, CMS contracts with entities to enhance oversight, reduce fraud, and recover improper payments.
3. **Performance of Specific Functions**: Contracting is authorized for functions such as cost report audits, medical reviews, and claims investigations, as these are essential to the integrity of the programs.

Key Programs and Statutory Provisions Enabling Contractual Functions

Recovery Audit Contractors (RACs)

The RAC program exemplifies CMS's authority to contract with external entities for claims review and audit functions. The statutory basis for RACs

is rooted in the Medicare Modernization Act of 2003, which explicitly authorized the Secretary to establish RAC programs to identify improper payments.

- **Medicare Modernization Act (MMA) of 2003:** This act provided the statutory foundation for RACs, empowering CMS to enter into competitive contracts with private firms to audit Medicare claims and cost reports.
- **Section 1893 of the SSA:** It authorizes the Secretary to develop and implement programs to identify and correct improper payments, including contracting with external auditors.

Medicare Cost Report Audits

Cost report audits are essential for verifying the accuracy of provider reimbursements. CMS contracts with independent certified public accounting firms and other qualified entities to perform these audits based on the authority granted by the SSA and associated regulations.

- **Section 1860D-12 of the SSA:** This provision discusses the authority to review and audit provider cost reports as part of ensuring proper Medicare payments.
- **Program Integrity Measures:** The authority to audit cost reports is also supported by provisions aimed at reducing fraud and ensuring compliance with statutory and regulatory standards.

Medical Review and Certification Processes

Beyond financial audits, CMS authorizes external entities to perform medical reviews necessary for determining the medical necessity of services, reviewing coding accuracy, and compliance with coverage policies.

- **42 CFR Part 405.1801-1804:** These regulations outline the procedures and authority for medical review activities, including the engagement of external reviewers.
- **Peer Review and Quality Oversight:** Statutes and regulations support contracting with medical review organizations to ensure healthcare quality and appropriateness.

Policy and Administrative Considerations

Procurement and Contracting Processes

CMS follows federal procurement regulations, including the FAR and agency-specific policies, to award contracts to external entities. The process involves:

1. Developing detailed statements of work (SOW) and contract requirements
2. Conducting competitive bidding processes or other authorized procurement methods
3. Ensuring compliance with federal procurement standards
4. Monitoring and oversight of contracted entities

Oversight and Compliance

Once contracts are awarded, CMS maintains oversight through:

- Regular audits and performance evaluations of contractors
- Enforcement of contractual obligations and compliance with applicable laws
- Adherence to privacy and data security requirements, especially for sensitive health information

Legal and Ethical Considerations

Contracted entities must operate within the bounds of federal laws, including:

- Federal Privacy Act and HIPAA regulations for data protection
- Anti-kickback statutes and fraud prevention laws
- Standards for impartial and fair review processes

Conclusion

The authority for CMS to enter into contracts with external entities for cost report auditing, medical reviews, and related functions is deeply rooted in the statutory framework of the Social Security Act, supported by regulations, and guided by federal procurement policies. These legal bases ensure that CMS can effectively delegate critical oversight functions to qualified organizations, thereby safeguarding the integrity of Medicare and Medicaid

programs. Through these contractual arrangements, CMS enhances its capacity to detect improper payments, ensure medical necessity, and maintain the financial sustainability of healthcare programs. As the healthcare landscape evolves, this statutory and regulatory foundation continues to underpin CMS's ability to collaborate with external partners in fulfilling its mission of program integrity and quality assurance.

Frequently Asked Questions

What federal agency authorizes CMS to contract with entities for cost report auditing and medical review?

The Centers for Medicare & Medicaid Services (CMS) is authorized by federal legislation, including the Social Security Act, to enter into contracts with qualified entities to perform cost report audits and medical reviews.

Under which statutory authority does CMS have the power to outsource cost report auditing to external entities?

CMS's authority to outsource such activities stems from the Social Security Act, specifically sections that govern Medicare program administration and provider oversight.

What are the key regulations that permit CMS to engage third-party contractors for medical review and cost report audits?

Key regulations include 42 CFR Part 424, which outlines provider audits and billing requirements, and the Federal Acquisition Regulation (FAR), which governs federal contracting processes.

How does CMS ensure the quality and integrity of audits performed by contracted entities?

CMS establishes strict contractual requirements, oversight mechanisms, and performance standards, including regular audits and reviews of contracted entities to ensure accuracy and compliance.

Are there specific types of entities authorized to perform CMS-contracted cost report audits and medical reviews?

Yes, CMS typically contracts with Certified Public Accountants (CPAs), professional auditing firms, and other qualified healthcare review organizations that meet federal standards and accreditation requirements.

Additional Resources

Which Authorizes CMS To Enter Into Contracts With Entities To Perform Cost Report Auditing, Medical Review

The Centers for Medicare & Medicaid Services (CMS) plays a pivotal role in overseeing the administration and regulation of the nation's healthcare programs. A key aspect of CMS's operational framework involves contracting with external entities to conduct cost report auditing and medical review activities. These contracts are essential for ensuring the financial integrity, compliance, and quality of care within Medicare and Medicaid programs. Understanding which authorizes CMS to enter into these contractual arrangements is crucial for stakeholders, including healthcare providers, auditors, policymakers, and beneficiaries, as it delineates the legal and administrative foundation for oversight functions.

Legal and Regulatory Foundations for CMS Contracting Authority

The authority for CMS to engage external entities in performing cost report audits and medical reviews is rooted in a combination of federal statutes, regulations, and administrative policies. These legal frameworks ensure that CMS's contracting processes are transparent, fair, and aligned with statutory objectives.

Primary Statutory Authorities

- Social Security Act (SSA):
The SSA is the foundational statute underpinning CMS's authority. Specifically, sections such as 1862(a)(1) and 1869 authorize CMS to oversee the correctness of provider payments, which includes auditing and review functions.
Key points:
- Grants CMS authority to establish programs for auditing provider claims.
- Provides the legal basis for entering into contracts with external entities to perform these audits.

- Medicare Modernization Act (MMA) & Affordable Care Act (ACA):
These legislative acts have expanded CMS's roles and clarified its authority to outsource certain functions, including medical reviews and cost report audits, to qualified contractors.

Administrative and Regulatory Frameworks

- Code of Federal Regulations (CFR):
- 42 CFR Part 421 and 422: Establish regulations governing Medicare administrative contractors (MACs) and other entities involved in claims processing and auditing.
- 42 CFR Part 488: Details conditions for certification and the scope of survey and certification activities, including medical review.

- CMS Program Integrity Policies:
CMS's policies and directives explicitly authorize the agency to contract with external organizations—such as Medicare Administrative Contractors (MACs) and Recovery Auditors—to perform specific functions related to cost report auditing and medical review.

Contracting Mechanisms and Oversight Structures

CMS's authority to contract is operationalized through formal procurement processes and specific contractual arrangements designed to ensure accountability and effectiveness.

Types of Contracts Used

- Medicare Administrative Contractor (MAC) Agreements:
- These are comprehensive contracts with private organizations authorized to process claims, perform audits, and conduct medical reviews.
- MACs are delegated authority under CMS’s statutory framework, with specific scopes outlined in their contracts.

- Recovery Audit Contractor (RAC) Contracts:
- Focused primarily on identifying improper payments through audits, including cost report reviews.
- RACs operate under contracts that specify their authority to review claims and cost reports.

- Program Safeguard Contractors (PSC):
- Contracted to detect and prevent fraud, waste, and abuse, including through medical review activities.

Legal and Administrative Oversight

- Procurement Regulations:
CMS follows the Federal Acquisition Regulation (FAR) and CMS-specific procurement policies to solicit, evaluate, and award contracts.
- These regulations ensure competitive and transparent contracting.

- Contract Management:
- Contracts specify scope, performance standards, reporting requirements, and compliance obligations.
- CMS maintains oversight through regular audits, performance reviews, and compliance checks.

Key Features and Processes of Contracted Cost Report Auditing and Medical Review

The contractual arrangements empower external entities to perform critical functions, which are vital for maintaining program integrity.

Scope of Work

- Conducting detailed audits of provider cost reports to ensure accurate reimbursements.
- Performing medical reviews of claims and supporting documentation to verify medical necessity and compliance.
- Identifying overpayments and underpayments.
- Supporting fraud detection efforts.

Features of Contracted Entities

- Must meet stringent qualification criteria, including experience, technical capability, and compliance history.
- Operate under strict confidentiality and data security protocols.
- Use standardized audit methodologies aligned with CMS policies.

Audit and Review Processes

- Pre-Audit Planning: Understanding provider profiles, historical data, and specific audit objectives.
- Fieldwork: Reviewing submitted cost reports, supporting documentation, and conducting interviews if necessary.
- Findings and Reporting: Documenting discrepancies, overpayments, or underpayments, and submitting formal reports to CMS.
- Follow-up: Coordinating recovery actions or appeals with providers.

Pros and Cons of CMS Contracting Authority in Cost Report Auditing and Medical Review

Understanding the advantages and potential drawbacks of outsourcing these functions provides insight into the effectiveness of current practices.

Pros

- Expertise and Specialization:
External auditors often possess specialized skills, advanced analytical tools, and industry experience, leading to more thorough and accurate reviews.

- Efficiency and Scalability:
Contracting allows CMS to manage large volumes of claims and reports without overextending internal resources.

- Enhanced Oversight and Fraud Prevention:
External entities can identify patterns of improper billing and fraud more proactively due to their focused expertise.

- Cost-Effectiveness:
Outsourcing can reduce internal administrative costs and leverage competitive

contracting to obtain high-quality services at lower prices.

Cons and Challenges

- Dependence on External Entities:
Heavy reliance on contractors may lead to issues if oversight is insufficient or if conflicts of interest arise.

- Variability in Performance:
Not all contractors perform at the same level; performance standards must be rigorously enforced.

- Complex Contract Management:
Managing multiple contracts requires substantial oversight, which can be administratively burdensome.

- Potential for Data Security Risks:
Sharing sensitive provider and patient data with external contractors necessitates stringent security measures.

Future Directions and Considerations

As healthcare fraud, waste, and abuse evolve, so too must the legal and operational frameworks governing CMS's contracting authority.

Legal and Policy Enhancements

- Updating statutes or regulations to clarify and expand contracting authority as needed.
- Incorporating more robust performance metrics and accountability measures.

Technological Integration

- Leveraging advanced analytics, artificial intelligence, and machine learning to enhance auditing precision.
- Ensuring external entities adhere to data security standards.

Stakeholder Engagement

- Increasing transparency regarding contracting processes and findings.
- Collaborating with providers to foster compliance and reduce administrative burdens.

Conclusion

The authority of CMS to enter into contracts with entities for cost report

auditing and medical review is well-established within the statutory and regulatory framework of the federal government. This authority enables CMS to leverage specialized external expertise, improve efficiency, and strengthen oversight of Medicare and Medicaid programs. While there are notable advantages, including expertise and cost-effectiveness, challenges such as dependency on contractors and data security considerations must be actively managed. Moving forward, continuous policy enhancements, technological advancements, and stakeholder engagement will be vital for optimizing these contractual arrangements, ensuring they serve the overarching goals of program integrity, financial sustainability, and quality care.

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