Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS Recovered Medicare Payments to Providers Under the COVID-19 Accelerated and Advance Payments Program in Compliance With Federal Requirements

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CMS Recovered Payments to Providers Under the COVID-19 Accelerated and Advance Payments Program in Compliance With Federal Requirements

Why OIG Did This Audit

- The Centers for Medicare & Medicaid Services (CMS) disbursed more than $103 billion in COVID-19 Accelerated and Advance Payments (CAAP) Program payments to more than 46,000 providers.
- COVID-19 created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for Health and Human Services (HHS), the Office of Inspector General (OIG) oversees HHS's COVID-19 response and recovery efforts. This audit is part of OIG's COVID-19 response strategic plan.
- This audit determined whether CAAP Program payments were recovered in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements.

What OIG Found

CMS recovered the CAAP Program payments made to providers in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements. As of the end of our fieldwork, of the 100 sampled providers totaling $4.4 billion in CAAP Program payments, the Medicare Administrative Contractors completed recovery from 97 sampled providers and continued the recovery from the remaining 3 providers.

What OIG Recommends

Based on our sample, we found that CMS recovered the CAAP Program payments made to providers in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements. Therefore, we do not have any recommendations.

CMS elected not to provide comments on our draft report.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) may provide temporary relief loans through the accelerated payment program for certain Part A providers and through the advance payment program for certain Part B providers and suppliers when these providers and suppliers face cashflow challenges due to circumstances beyond their control. These rarely used programs, which have existed for decades, are collectively referred to as the Accelerated and Advance Payments (AAP) Program. The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. No. 116-136), which Congress passed on March 27, 2020, expanded the AAP Program to more providers to relieve pandemic-caused financial strain. CMS has referred to this expansion as the COVID-19 Accelerated and Advance Payments (CAAP) Program.[1]

The CARES Act described the repayment terms for the CAAP Program payments. The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. No. 116-159), which Congress passed on October 1, 2020, amended the repayment terms of the CAAP Program.

As of September 17, 2020, CMS, through Medicare Administrative Contractors (MACs),[2] disbursed more than $103 billion in CAAP Program payments to more than 46,000 providers. A prior Department of Health and Human Services (HHS), Office of Inspector General (OIG) audit found that CMS and its MACs generally made CAAP Program payments to providers in compliance with the CARES Act and other Federal requirements.[3] The MACs began the recovery efforts 1 year after making the payments.

COVID-19 has created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for HHS, OIG oversees HHS's COVID-19 response and recovery efforts. This audit is part of OIG's COVID-19 response strategic plan.[4]

OBJECTIVE

Our objective was to determine whether CAAP Program payments were recovered in compliance with the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements.

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[1] As of October 8, 2020, CMS stopped accepting requests for CAAP program payments. To receive a CAAP Program payment, the CARES Act required providers to submit a request.

[2] CMS uses MACs to, among other things, process and pay Medicare claims submitted for medical services.

[3] *Payments Made to Providers Under the COVID-19 Accelerated and Advance Payments Program Were Generally in Compliance With the CARES Act and Other Federal Requirements* (A-05-20-00053).

[4] OIG's COVID-19 response strategic plan and oversight activities can be accessed at HHS-OIG's Oversight of COVID-19 Response and Recovery | HHS-OIG.

BACKGROUND

The Medicare Program

Under Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare has different parts that help cover specific medical services and supplies. Medicare Hospital Insurance, known as Part A, helps pay for inpatient hospitals, home health, skilled nursing facilities, and hospice care. Medicare Supplementary Medical Insurance, known as Part B, helps pay for physicians, outpatient hospitals, home health, durable medical equipment, and other services.[5]

In addition to using MACs to process and pay Medicare claims submitted for medical services, CMS uses Unified Program Integrity Contractors to investigate instances of suspected fraud, waste, and abuse in Medicare claims.

COVID-19 Accelerated and Advance Payments Program

On January 31, 2020, HHS declared that a COVID-19 public health emergency existed nationwide as of January 27, 2020. On March 27, 2020, the CARES Act (P. L. No. 116-136) was passed. The CARES Act expanded the AAP Program to relieve the pandemic-caused financial strain on providers. CMS has referred to this expansion as the CAAP Program. The CARES Act allowed CMS to promulgate CAAP Program eligibility criteria and repayment terms by providing program instructions rather than through notice-and-comment rulemaking. The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. No. 116-159) amended the CAAP Program payment repayment terms.

COVID-19 Accelerated and Advance Payments Program Repayment Terms and Recovery Process

Providers were allowed to repay their CAAP Program payments at any time by contacting their MACs. However, providers were not required to start repayment for 1 year from the date of the CAAP Program payments (repayment delay period). After the repayment delay period, MACs begin the recovery process. Specifically, beginning at 1 year from the CAAP Program payment date and continuing for 11 months, Medicare payments owed to providers were recouped at a rate of 25 percent. After the 11 months, continuing for 6 months, Medicare payments owed to providers were recouped at a rate of 50 precent. If the CAAP Program payment to a provider was not fully recovered within 29 months, the MAC issued a demand letter requiring the provider to repay the remaining balance.[6] Once the demand letter was

[5] Other Medicare parts (that are not relevant for this audit) are Medicare Part C and Medicare Part D.

[6] 29 months = 1-year repayment delay period + 11 months of 25 percent recoupment + 6 months of 50 percent recoupment.

issued, the remaining balance was considered an overpayment. If a provider disagreed with the overpayment, it had 15 days to submit a CAAP Debt Dispute to the MAC before the MAC began recouping 100 percent of the Medicare payments owed to the provider.[7] In addition, if the debt became delinquent, CMS referred the debt to the United States Department of the Treasury's (the Treasury's) Debt Management Services for Cross Servicing and Offset of Federal Payments.[8, 9, 10]

The demand letter provides guidance on how to request an extended repayment schedule (ERS) for providers experiencing financial hardship. An ERS is a debt payment schedule that allows a provider experiencing financial hardship to pay debts over 3 years, and an ERS may be extended to as many as 5 years if specific extreme hardship criteria are met.[11] A debt under ERS (ERS debt) is considered delinquent if the provider misses one installment payment. If the provider misses another payment following a delinquent status, the provider is considered in default.[12] Once a provider is in default, the MAC sends a notice of default to the provider within 5 calendar days,[13] suspends the ERS, and immediately resumes normal debt collection procedures.[14]

The MAC must consider a provider's request to reinstate the ERS, even after default. If reinstated, the provider must be required to submit new documentation to determine eligibility. The MAC must determine to reinstate the original ERS or revise the schedule, if

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[7] CMS details these repayment terms in a fact sheet, updated August 5, 2022, that is available online at: https://www.cms.gov/files/document/covid-accelerated-and-advanced-payments-fact-sheet-08-04-22.pdf. Accessed on May 5, 2024.

[8] Delinquent debt means "a debt which the debtor does not pay or otherwise resolve by the date specified in the initial demand for payment, or in an applicable written repayment agreement or other instrument, including a post-delinquency repayment agreement" (45 CFR § 30.2).

[9] Cross-servicing means "the program through which Fiscal Service provides delinquent nontax debt collection services pursuant to 31 U.S.C. 3711(g)" (87 Fed. Reg. 50249 (August 16, 2022)).

[10] Referral requirements are explained in *The Medicare Financial Management Manual*, Pub. 100-06, chapter 4. For example, CMS must give the provider 60 days prior notice before referring the debt to the Treasury.

[11] 42 CFR § 401.607(c)(2).

[12] *The Medicare Financial Management Manual*, Pub. 100-06, chapter 4, § 50.A.11. However, the regulatory requirement, at 42 CFR 401.607(c)(2)(v), states that missing one installment payment constitutes a default. Further, before the October 2023 update, *The Medicare Financial Management Manual*, Pub. 100-06, chapter 4, stated that missing one installment payment constitutes a default.

[13] Prior to an October 2023 revision, *The Medicare Financial Management Manual*, Pub. 100-06, chapter 4, required that the MAC send a notice of default to the provider within 5 *business* days. Under Rev. 12346, CMS changed this to 5 *calendar* days, effective Oct. 30, 2023.

[14] *The Medicare Financial Management Manual*, Pub. 100-06, chapter 4, § 50.A.11.

approved. If the schedule is revised, the MAC must ensure that the revised terms do not extend the original and revised schedule beyond 60 months.[15]

The Continuing Appropriations Act, 2021 and Other Extensions Act, section 2501, required providers to pay interest at 4 percent on overpayments.[16] CMS informed providers that if the repayment is not received within 30 days from the date of the demand letter, interest at the rate of 4 percent will accrue from the date the demand letter was issued and will be assessed each full 30-day period the balance remains unpaid.[17]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $103.1 billion in total CAAP Program payments made to 46,364 providers. We selected a stratified random sample of 100 providers that received CAAP Program payments totaling $4.4 billion.[18]

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

Appendix A contains the details of our audit scope and methodology, and Appendix B contains the details of our statistical sampling methodology.

RESULTS OF AUDIT

CMS recovered the CAAP Program payments made to providers in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements. As of the end of our fieldwork, for the 100 providers in our sample that received $4.4 billion in CAAP Program payments, the MACs completed recovery from 97 providers. Of the remaining three, the MACs continued the recovery based on the approved ERS for two providers and referred the remaining provider to the Treasury for debt collection. (See Table 1.)

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[15] *The Medicare Financial Management Manual*, Pub. 100-06, chapter 4, § 50.A.12.

[16] Federal regulations at 45 CFR § 30.18 authorize CMS to charge providers interest on overpayments not paid by the date specified in the demand letter. This section provides that the Secretary must charge an annual rate of interest that is determined and fixed by the Secretary of the Treasury, "unless a different rate is prescribed by statute."

[17] See footnote 7.

[18] The payment total was $4,402,151,971.

Table 1: Recovery Status of 100 Providers in Our Sample

Recovery Status	Number of Sample Providers	CAAP Program Payments	Total Recoveries	Balance Remaining to be Recovered
Completed	97	$4,382,635,639	$4,382,635,639	$0
Under ERS	2	19,069,957	18,503,001	566,956
Referred to the Treasury	1	446,375	445,837	538
Total	**100**	**$4,402,151,971**	**$4,401,584,477**	**$567,494**

The total recovery as of the end of our fieldwork was $4.40 billion, and the balance remaining to be recovered was $567,494.

COMPLETED RECOVERY FROM 97 SAMPLE PROVIDERS

MACs recovered the entire $4.38 billion in CAAP payments made to 97 of the 100 sampled providers.

RECOVERY FROM TWO PROVIDERS IS IN PROGRESS BASED ON EXTENDED REPAYMENT SCHEDULES

MACs continued the recovery of CAAP Program payments based on an approved ERS for two providers. Specifically, from one provider that received $97,499 in CAAP Program payments, the MAC recovered $20,842 through repayments and recoupments. For the remaining overpayment of $76,657 plus interest, the MAC approved an ERS for 52 monthly payments consisting of the first payment of $1,864 and the remaining 51 monthly payments of $1,608 each, effective April 1, 2023. As of the end of the fieldwork, this provider made every monthly payment, and the balance due from the provider was $58,718.

From another provider that received $18,972,458 in CAAP Program payments, the MAC recovered $17,205,607 through repayments and recoupments. For the remaining overpayment of $1,766,851 plus interest, the MAC approved an ERS for 24 monthly payments of $76,725 each, effective November 15, 2022. As of the end of the fieldwork, this provider completely made 17 monthly payments, partially made the 18th monthly payment due on April 15, 2024, and the balance due from the provider was $508,238.

RECOVERY FROM ONE PROVIDER IS IN PROGRESS THROUGH THE TREASURY

A MAC referred the remaining provider to the Treasury for debt collection. Specifically, from a provider that received $446,375 in CAAP Program payments, the MAC could not recoup because the provider did not submit Medicare claims during the 17-month recoupment period.

After sending demand letters and notices to the provider, the MAC referred the overpayment to the Treasury. As of the end of the fieldwork, the Treasury collected $445,837 plus interest, and the balance due from the provider was $538.

CONCLUSION

Based on our sample, we found that CMS recovered the CAAP Program payments made to providers in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act, and other Federal requirements. Therefore, we do not have any recommendations.

We shared our draft report with CMS, and it informed us that it did not have comments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $103,086,094,597 in total CAAP Program payments to 46,364 providers. We selected a stratified random sample of 100 providers that received a total of $4,402,151,971 in CAAP Program payments and reviewed the CAAP Program payment recovery from these providers.

We did not assess CMS's overall internal control structure during our audit. Instead, we limited our review to CMS's internal controls to ensure compliance with the CAAP Program payment recovery requirements.

We conducted our audit from January 2023 to August 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed the CARES Act, the Continuing Appropriations Act, 2021 and Other Extensions Act, other applicable Federal requirements, and CMS guidance;

- interviewed CMS officials to obtain an understanding of the CAAP Program payment recovery processes;

- obtained from CMS a list of 46,364 providers that received CAAP Program payments totaling $103,086,094,597;

- selected a stratified random sample of 100 providers (Appendix B) that received a total of $4,402,151,971 in CAAP Program payments;

- obtained from the MACs the Healthcare Integrated General Ledger Accounting System (HIGLAS) reports showing information on accounts receivables and HIGLAS downloads (HIGLAS databases) showing repayment details, and recoupment details for each of the 100 sampled providers;[19]

- determined that CMS created accounts receivable records for the CAAP Program payments by comparing the CAAP Program payment amounts seen in the sampling frame with the accounts receivable information in HIGLAS reports;

[19] HIGLAS is the centralized accounting system for the Federal financial accounting functions for all of CMS's programs.

- determined the repayments made by the providers during the repayment delay period by reviewing the repayment details in the HIGLAS databases;

- determined whether the MACs started recoupments immediately after the repayment delay period and continued 25-percent and 50-percent recoupments until the CAAP Program payments were fully recovered or the 17-month recoupment period ended, whichever occurred first, by reviewing recoupment details in the HIGLAS databases;

- identified providers for whom the recovery was not completed by the end of the 17-month recoupment period, by comparing the total recovery amounts at the end of the 17-month recoupment period and CAAP Program payment amounts;

- obtained from the MACs copies of demand letters that the MACs issued to providers, and HIGLAS databases showing recoupments made after the date of the demand letters;

- determined whether the MACs either made 100-percent recoupments from or approved ERS for providers whose CAAP payments remained as overpayments, by reviewing the database showing recoupments made after the date of the demand letters and ERSs;

- determined whether ERSs were appropriately approved by reviewing the communications between the MACs and the providers and supporting documentation that the providers submitted to the MACs;

- verified whether the MAC referred overpayments (for which the MAC did not receive an ERS request) to the Treasury for collections by reviewing the referral letter and HIGLAS database showing collections made through the Treasury; and

- discussed the results of our audit with CMS officials.

We shared our draft report with CMS, and it informed us that it did not have comments.

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 46,364 providers that CMS indicated received CAAP Program payments totaling $103,086,094,597.

SAMPLE UNIT

The sample unit was a provider.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing three strata as shown in Table 2:

Table 2: Sample Design and Sample Sizes

Stratum	Dollar Range of Sample Units		Number of Sample Units	Dollar Value of Sample Units	Sample Size
	Minimum	Maximum			
1	$4.90	$4,947,830.00	43,651	$19,021,723,342	33
2	4,959,240.00	51,862,424.52	2,261	39,822,013,317	33
3	51,877,170.00	522,801,000.00	452	44,242,357,938	34
		Totals	46,364	$103,086,094,597	100

Strata were created based solely on the dollar value of the sample unit.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services, statistical software.

METHOD OF SELECTING SAMPLE UNITS

We sorted the items in each stratum in ascending order by the unique combination of three fields: MAC jurisdiction, Provider Transaction Access Number, and Tax Identification Number (in that order). We then consecutively numbered the items in each stratum in the sampling frame. After generating the random numbers for our sample according to our sample design, we selected the corresponding frame items to be reviewed.

ESTIMATION METHODOLOGY

We found that, of the 100 providers that we randomly selected, CMS appropriately recovered the CAAP Program payments from 97 providers and continued the recovery from 3 providers either through the approved ERS or referral to the Treasury in compliance with the Continuing

Appropriations Act, 2021 and Other Extensions Act and other Federal requirements; as a result, we made no estimates.