

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HHS'S AND HRSA'S CONTROLS
RELATED TO SELECTED PROVIDER
RELIEF FUND PROGRAM REQUIREMENTS
COULD BE IMPROVED**

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**September 2022
A-09-21-06001**

Office of Inspector General

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Report in Brief

Date: September 2022
Report No. A-09-21-06001



Why OIG Did This Audit

The Provider Relief Fund (PRF) provides funds to eligible hospitals and other health care providers (providers) for health-care-related expenses or lost revenue attributable to COVID-19. HHS is responsible for PRF program oversight and policy decisions, and the Health Resources and Services Administration (HRSA) within HHS provides day-to-day oversight and management of the program. Providers that received PRF payments under the Phase 1 General Distribution are subject to requirements for submission of revenue information and attestation of acceptance or rejection of payments. This audit is part of OIG's oversight of HHS's COVID-19 response and recovery efforts.

Our objective was to determine whether HHS's and HRSA's controls related to selected PRF program requirements (i.e., those related to the requirements for submission of revenue information and attestation of rejection of payments) ensured that providers received the correct payments from the Phase 1 General Distribution.

How OIG Did This Audit

Our audit covered about \$48 billion in PRF payments that were disbursed to 323,498 Medicare providers from April 10 through December 17, 2020. We performed audit procedures, including interviewing HRSA officials and contractors and analyzing payment and attestation data. To test controls, we selected a random sample of 45 providers.

HHS's and HRSA's Controls Related to Selected Provider Relief Fund Program Requirements Could Be Improved

What OIG Found

In the context of unprecedented challenges from the COVID-19 national emergency, HHS and HRSA developed controls related to selected PRF program requirements designed to ensure that providers received the correct PRF payments from the Phase 1 General Distribution in a fast, fair, and transparent manner. However, we determined that some of these controls could be improved.

We found that HHS and HRSA did not have certain procedures. Specifically, HHS's and HRSA's procedures did not include: (1) requesting and reviewing providers' supporting documentation to verify the estimated revenue losses in March and April 2020, (2) subtracting the automatic payments made to providers' subsidiaries when certain nonautomatic payments were calculated, and (3) specifying a deadline for providers to return rejected payments. We also found that HHS's and HRSA's procedures had weaknesses. Specifically: (1) HHS's and HRSA's payment thresholds for manual review of information submitted by providers were set at a level that resulted in only 2 percent of providers undergoing manual review, and (2) HRSA's process to open and view the data file containing subsidiaries' taxpayer identification numbers (subsidiary TINs) extracted from providers' applications led to an error that caused the use of incorrect subsidiary TINs when payments were calculated.

We understand that HHS and HRSA's operational objective at the beginning of the national emergency was to rapidly disburse PRF payments to support providers facing severe economic hardship during the national emergency because the Coronavirus Aid, Relief, and Economic Security Act required HHS and HRSA to make payments considering "the most efficient payment systems practicable to provide emergency payment." We also understand that because of this statutory requirement, HHS and HRSA prioritized rapid disbursement of payments over the risk of making improper payments, because HHS and HRSA determined that activities to lower the risk would have delayed the payments. However, as HRSA fully implements postpayment quality control review processes, it should consider the information and recommendations included in this report.

In addition, to prepare for a possible public health emergency in the future, HHS should use the information and recommendations included in this report when determining lessons learned from administering PRF distributions during

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



the COVID-19 national emergency, and look for additional ways to safeguard taxpayers' money when rapidly disbursing assistance payments to health care providers in response to future national emergencies.

What OIG Recommends and HRSA Comments

We made five recommendations to HRSA, including that HRSA continue to perform postpayment quality control reviews of selected providers, consider reviewing 189 providers that were identified for manual review, and seek repayment of any overpayments from providers. We also recommended that HRSA ensure that the HHS Program Support Center collects payments made to selected providers that did not return their rejected payments as of March 9, 2022. Furthermore, we recommended that HRSA could conduct a cost-benefit analysis for manual review of additional providers that had the potential to receive payments below existing payment thresholds and, if the benefit outweighs the cost, it could select additional providers for review. The full text of our recommendations is shown in the report.

HRSA concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. These actions included reviewing the 189 providers identified for manual review and seeking repayments for any overpayments, sending rejected but not returned payments to the Program Support Center for collection of any outstanding amounts owed, and conducting a cost-benefit analysis for manual review of providers.

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INTRODUCTION

WHY WE DID THIS AUDIT

On March 13, 2020, then President Trump declared the COVID-19 outbreak a national emergency. In response, Congress passed three separate laws to establish the Provider Relief Fund (PRF) and provide funds to eligible hospitals and other health care providers (providers) for: (1) health-care-related expenses or lost revenue (e.g., due to canceled elective services) attributable to COVID-19 and (2) COVID-19 testing and treatment for uninsured individuals.¹ These Federal laws appropriated to the PRF a combined \$178 billion in funds, which are generally distributed as direct payments to providers in a series of General and Targeted Distributions.²

The national emergency posed unprecedented challenges to the Department of Health and Human Services (HHS) to distribute PRF payments in a fast, fair, and transparent manner and provide immediate financial relief to providers on the front lines of the COVID-19 response. Within a month of the signing of the first Federal law appropriating funds for the PRF, HHS developed initial PRF distribution and payment calculation methodologies, PRF requirements for providers, and oversight procedures designed to help ensure that correct payments were rapidly disbursed to eligible providers.³ Then, on April 10, 2020, HHS began distributing PRF payments to Medicare providers under the Phase 1 General Distribution. As of December 17, 2020, HHS had distributed about \$48 billion to more than 320,000 Medicare providers.⁴

¹ The Coronavirus Aid, Relief, and Economic Security Act, P.L. No. 116-136, signed into law on March 27, 2020; the Paycheck Protection Program and Health Care Enhancement Act, P.L. No. 116-139, signed into law on April 24, 2020; and the Consolidated Appropriations Act, 2021, P.L. No. 116-260, signed into law on December 27, 2020.

² Under the General Distributions, PRF payments are distributed in four phases (Phases 1, 2, 3, and 4). For example, under the Phase 1 General Distribution, PRF payments are distributed to eligible Medicare providers that billed Medicare fee-for-service (Medicare Parts A or B) in calendar year 2019. Under the Targeted Distributions, PRF payments are distributed to specific eligible provider types or to providers in areas particularly affected by the COVID-19 outbreak.

³ HHS refined and updated these methodologies, requirements, and oversight procedures as PRF payments were being disbursed to providers.

⁴ The payment data provided by the Health Resources and Services Administration (HRSA) within HHS included 423,644 payments made to 323,498 unique taxpayer identification numbers (TINs) from April 10, 2020, through December 17, 2020 (our audit period). Throughout this report, we use the term “Medicare billing TINs” to refer to the TINs that providers entered on Medicare claims. This category of TINs consisted of providers that were standalone, parent, and subsidiary organizations, each of which could bill Medicare on its own behalf. We use the term “tax filing TINs” to refer to TINs that providers entered on their Federal income tax or annual information returns, which included parent organizations that filed returns on behalf of themselves and their subsidiary organizations. For the purposes of this report, we refer to a provider’s Medicare billing TIN or tax filing TIN as a “provider.”

HHS is responsible for PRF program oversight and policy decisions, and the Health Resources and Services Administration (HRSA) within HHS provides day-to-day oversight and management of the program. Providers that received PRF payments under the Phase 1 General Distribution are subject to program requirements, such as the requirements to submit revenue information and attest to the acceptance or rejection of payments.⁵ To ensure that providers received the correct PRF payments from the Phase 1 General Distribution, HHS and HRSA established controls related to these requirements. For example, HHS and HRSA developed guidance to help providers apply for PRF payments and attest to acceptance or rejection of payments they received.

This audit assessed HHS's and HRSA's controls related to the requirements for submission of revenue information and attestation of rejection of PRF payments disbursed under the Phase 1 General Distribution. These PRF payments were disbursed from April 10 through December 17, 2020 (audit period). (We refer to these requirements as "selected PRF program requirements" in this report.) Furthermore, this audit is the first of several Office of Inspector General (OIG) audits that will examine various aspects of PRF payments, including HHS's and HRSA's controls over payment calculation and provider eligibility, COVID-19 diagnostic testing and treatment services under HRSA's COVID-19 uninsured program, and providers' compliance with Federal requirements for reporting and using PRF payments.⁶

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 the OIG's COVID-19 response strategic plan.⁷

OBJECTIVE

Our objective was to determine whether HHS's and HRSA's controls related to selected PRF program requirements ensured that providers received the correct payments from the Phase 1 General Distribution.

⁵ There are other PRF program requirements, such as the requirement that a provider must not have been terminated from participation in Medicare.

⁶ Under the COVID-19 uninsured program, HHS reimbursed health care providers' claims generally at Medicare rates for testing uninsured individuals for COVID-19, treating uninsured individuals with a COVID-19 diagnosis, and administering COVID-19 vaccines to uninsured individuals.

⁷ 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

COVID-19 National Emergency and the Provider Relief Fund

COVID-19 is a disease caused by a highly contagious coronavirus, called SARS-CoV-2. On January 30, 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a Public Health Emergency of International Concern and on March 11, 2020, the WHO characterized COVID-19 as a pandemic.⁸ Later, on March 13, 2020, then-President Trump declared the COVID-19 outbreak a national emergency.

In response to the national emergency, Congress passed three separate laws to establish the PRF and provide funds to eligible hospitals and other health care providers for: (1) health-care-related expenses or lost revenue attributable to COVID-19 and (2) COVID-19 testing and treatment for uninsured individuals.⁹ The PRF program received a combined \$178 billion in funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which was signed into law on March 27, 2020; the Paycheck Protection Program and Health Care Enhancement Act, which was signed into law on April 24, 2020; and the Consolidated Appropriations Act, 2021, which was signed into law on December 27, 2020.¹⁰ Under the CARES Act, Congress directed that PRF payments be distributed to “eligible healthcare providers” using the “most efficient payment systems practicable to provide emergency payment.”

Because of the unprecedented national emergency, HHS faced substantial challenges in distributing PRF payments in a fast, fair, and transparent manner to provide immediate financial relief to providers on the front lines of the COVID-19 response. Within a month of the signing of the first Federal law appropriating funds for the PRF, HHS developed initial PRF distribution and payment calculation methodologies, PRF requirements for providers, and oversight procedures designed to help ensure that correct payments were rapidly disbursed to eligible providers. HHS refined and updated these methodologies, requirements, and oversight procedures as PRF payments were being disbursed to providers.

⁸ A pandemic is an epidemic that has spread over several countries or continents, usually affecting many people. An epidemic is an increase, often sudden, in the number of cases of a disease above what is normally expected in a population in a specific area.

⁹ According to HHS’s *Instructions for the Distribution for Medicaid, CHIP, and Dental Providers Via Enhanced Provider Relief Fund Payment Portal*, “lost revenue attributable to COVID-19” means “the amount of any patient care revenue that you as a healthcare provider lost due to coronavirus, net of any increased revenues due to coronavirus (e.g., insurance reimbursed treatment).” This revenue may include revenue losses associated with fewer outpatient visits or canceled elective procedures or services. (In August 2020, HRSA removed from the instructions the field for lost revenue and the definition of “lost revenue attributable to COVID-19.”)

¹⁰ Congress appropriated \$8.5 billion of COVID-19-related relief for rural providers that are enrolled in the Medicare or Medicaid programs (American Rescue Plan Act of 2021, P.L. No. 117-2). This funding is administered by HRSA and has similar limitations and requirements as the PRF but is not part of the PRF.

General Distributions Under the Provider Relief Fund

To support providers facing severe economic hardship that affected their ability to respond to emerging health crises and to prevent the loss of life during the national emergency, HHS allocated most of the PRF funds in a series of General and Targeted Distributions.

For the General Distributions, HHS initially allocated \$109.5 billion to providers in four phases:¹¹

- \$50 billion under Phase 1 for eligible providers that billed Medicare fee-for-service (FFS);
- \$18 billion under Phase 2 for Medicaid and Children’s Health Insurance Program (CHIP) providers, dental providers, and assisted living facilities;¹²
- \$24.5 billion under Phase 3 for:
 - behavioral health providers that were not previously eligible for the General Distribution and
 - previously eligible providers with losses or incurred expenses during the first half of calendar year 2020;¹³ and
- \$17 billion under Phase 4 for eligible providers with losses or incurred expenses from July 1, 2020, through March 31, 2021.¹⁴

Phase 1 General Distribution Under the Provider Relief Fund

There were two rounds of the Phase 1 General Distribution under the PRF:¹⁵

- *Round 1 (Automatic Payments)*. Beginning on April 10, 2020, round 1 payments were distributed to providers. About \$30.2 billion in payments were distributed automatically

¹¹ These providers consisted of for-profit and not-for-profit organizations.

¹² Providers that received previous PRF payments under the Phase 1 General Distribution may have been eligible to apply for Phase 2 payments.

¹³ Providers that received previous PRF payments under the Phase 1 or Phase 2 General Distributions may have been eligible to apply for Phase 3 payments.

¹⁴ According to HRSA, allocations changed over time when funding was not fully obligated under the initial allocation. For example, the allocated funds in Phase 2 changed from \$18 billion to \$5.1 billion because HHS received less than \$18 billion in requests for funding from eligible applicants. As a result, as of January 6, 2022, about \$86.3 billion of the initial \$109.5 billion was allocated for the General Distributions.

¹⁵ For each round of the Phase 1 General Distribution, HHS and HRSA assigned a “wave” and “subwave” number to a group of payments based on the payment issuance date.

to 322,854 providers under waves 1 through 3, for which the providers did not need to apply or submit documentation (e.g., Federal income tax returns) in advance of receiving these payments.¹⁶ We refer to these payments as “automatic payments.”

- *Round 2 (Automatic and Nonautomatic Payments).* Beginning on April 24, 2020, round 2 payments were distributed to providers. First, about \$9.2 billion in automatic payments were distributed to 14,834 providers under wave 4 based on revenue data from providers’ Medicare cost reports on file with the Centers for Medicare & Medicaid Services (CMS).¹⁷ Second, about \$8.6 billion in payments were distributed to 85,956 providers under waves 5 and 13 based on completed applications submitted through HHS’s online application portal (i.e., nonautomatic payments).¹⁸ In total, as of December 17, 2020, about \$17.8 billion in round 2 payments had been distributed to 100,790 providers.¹⁹

As of December 17, 2020, a total of about \$48 billion had been distributed to 323,498 Medicare providers.²⁰ Appendix B shows the distribution date, total number of taxpayer identification numbers (TINs), and total PRF payments distributed for each wave and subwave under round 1 and round 2 payments from the Phase 1 General Distribution.

Figure 1 on the next page illustrates how payments under the Phase 1 General Distribution were disbursed in two rounds and the designated waves and subwaves.

¹⁶ HHS and HRSA assigned waves 1 through 3 and their related subwaves 1a, 1b, 2a, and 3a to round 1 payments under the Phase 1 General Distribution.

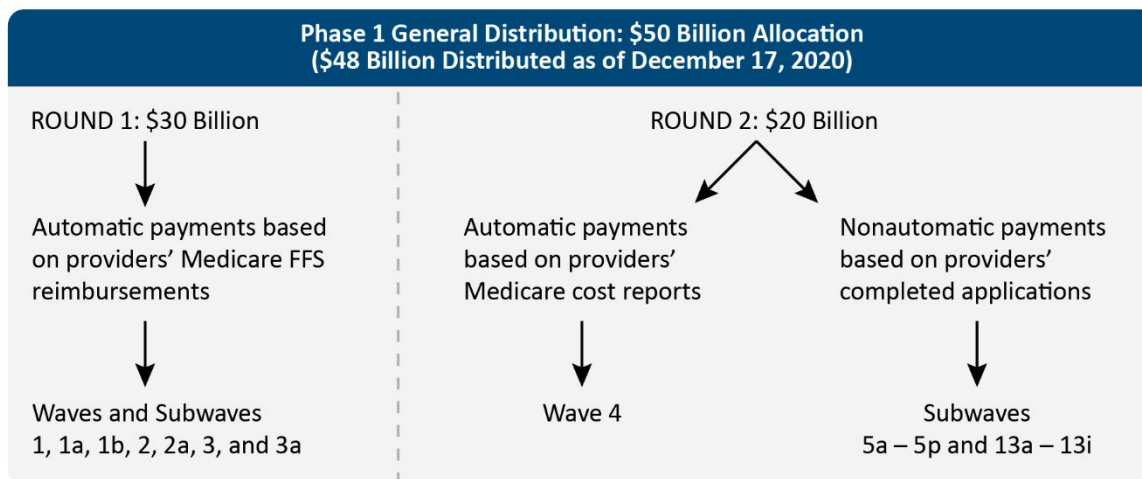
¹⁷ Wave 4 did not have any related subwaves.

¹⁸ HHS and HRSA assigned waves 5 and 13 and their related subwaves 5a through 5p and 13a through 13i to round 2 payments under the Phase 1 General Distribution. Waves 6 through 12 were assigned to payments for other distributions. For example, wave 8 was assigned to payments for the Phase 2 General Distribution.

¹⁹ As of January 6, 2022, the payment distribution for round 2 was still ongoing.

²⁰ The payment data for the Phase 1 General Distribution, provided by HRSA, included 423,644 payments made to 323,498 provider TINs (either Medicare billing TINs or tax filing TINs). Each provider, represented by a TIN, may receive more than one payment.

Figure 1: Disbursement of Payments Under Phase 1 General Distribution in Two Rounds and the Designated Waves and Subwaves



Calculation of Payments Under the Phase 1 General Distribution

The HHS Immediate Office of the Secretary (IOS) calculated the payments for waves 1 through 4 (automatic payments) and subwaves 5a through 5c (nonautomatic payments).²¹ HRSA, through one of its contractors, calculated the payments for subwaves 5d through 5p (nonautomatic payments) and subwaves 13a through 13i (nonautomatic payments).

Round 1 payments (i.e., waves 1 through 3) were determined using the providers' proportionate share of Medicare FFS reimbursements in 2019. Round 2 payments (i.e., waves 4, 5, and 13) were generally determined based on the lesser of: (1) 2 percent of a provider's 2018 or most recent complete tax year's gross receipts or (2) the sum of estimated revenue losses in March and April 2020.²² If a provider received a round 1 payment equal to or more than 2 percent of its 2018 or most recent complete tax year's gross receipts, the provider could not receive a round 2 payment.²³

Figure 2 on the next page shows the overall payment calculation methodology for round 1 and round 2 payments.

²¹ IOS is responsible for operations and coordination of the work of the Secretary of HHS.

²² According to HRSA, only patient care revenues from providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 may be included in the gross receipts.

²³ It is possible that a provider may have received a payment of more than 2 percent of its 2018 gross receipts because round 1 payments were based on the share of Medicare FFS reimbursements in 2019.

Figure 2: Overall Payment Calculation Methodology for Round 1 and Round 2 Payments

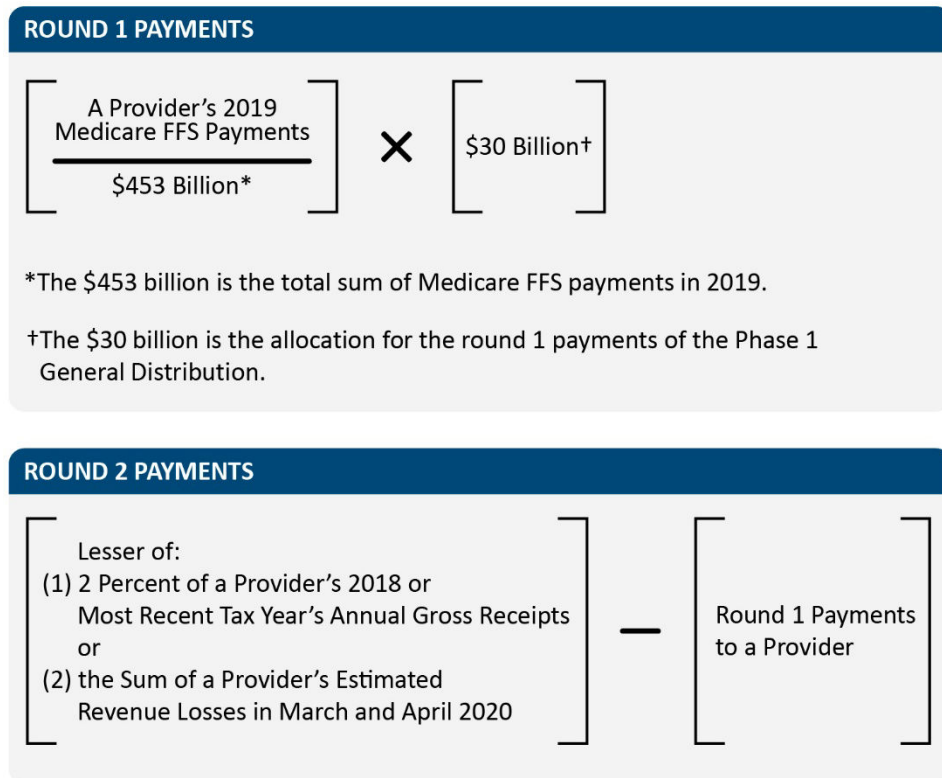
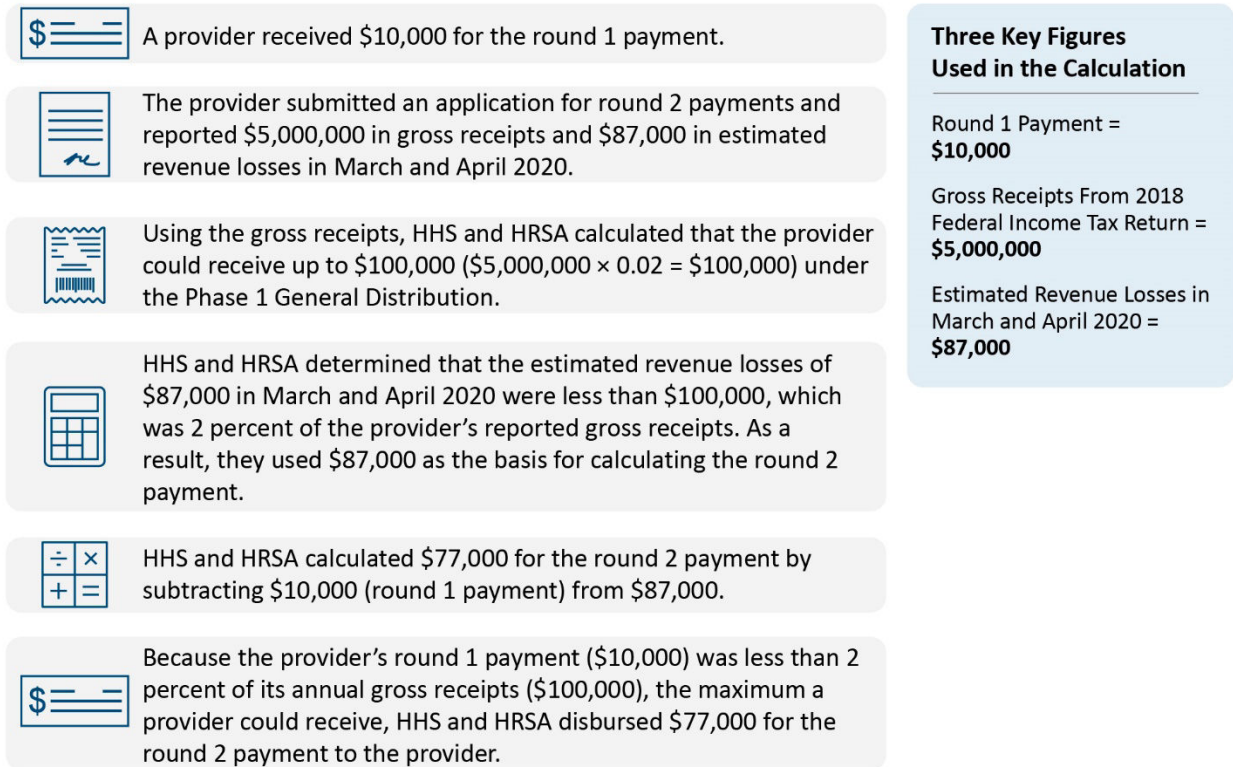


Figure 3 on the next page shows an example of how HHS and HRSA calculated a provider's round 2 payment.

Figure 3: Example of a Provider’s Payment Calculation for a Round 2 Payment



Provider Relief Fund Program Requirements for Providers

Providers receiving PRF payments must meet PRF program requirements, such as submitting revenue information and attesting to the acceptance or rejection of PRF payments.²⁴

Requirement for Submission of Revenue Information

Providers are required to submit general revenue data for calendar year 2018 when applying to receive a round 2 payment (i.e., nonautomatic payment).

Requirement for Attestation of Acceptance or Rejection of Payments

Providers formally acknowledge (i.e., attest to) acceptance or rejection of a payment through the online attestation portal.²⁵ If a provider chooses to keep the payment, the provider can:

²⁴ There are other PRF requirements, such as the requirement that a provider must not have been terminated from participation in Medicare. Furthermore, each phase of the General Distribution has its own provider-eligibility requirement. For example, to be eligible for a Phase 1 General Distribution payment, providers must have billed Medicare FFS (Parts A or B) in calendar year 2019.

²⁵ The attestation portal is an online portal that guides providers through the attestation process to accept or reject their PRF payments. UnitedHealth Group, a HRSA contractor, designs and maintains the attestation portal.

(1) attest to being eligible for the payment by acknowledging acceptance of the payment and (2) accept the terms and conditions of the payment. (This is referred to as “active attestation.”) If a provider chooses to reject the payment, it can do so through the attestation portal by attesting, “I am not accepting payment and I will either destroy the check or refund the full amount . . .” and clicking the “I Reject Payment” button. Furthermore, the provider is given instructions on how to return the rejected payment. A provider that received a PRF payment and kept it for at least 90 days without performing active attestation of the payment or rejecting the payment is deemed to have attested to accepting both the payment and its associated terms and conditions. This is referred to as “deemed attestation.”

HHS’s and HRSA’s Oversight of the Provider Relief Fund Program

The HHS Office of the Secretary is responsible for PRF program oversight and policy decisions so that the program can meet its mission to distribute funds as quickly as possible for providers’ health-care-related expenses or lost revenue attributable to COVID-19. Within HHS, HRSA is responsible for providing day-to-day oversight and management of all aspects of the PRF program.²⁶

At the start of the Phase 1 General Distribution (i.e., in early April 2020), HHS and HRSA developed prepayment validation processes to help ensure that correct payments were disbursed to eligible providers.²⁷ For example, HRSA would determine whether providers were included in several sanctions lists (e.g., CMS’s list of individuals or entities that are currently barred from participation in Medicare and OIG’s list of individuals and entities excluded from participation in Federal health care programs). If the providers were included on any of these lists, HRSA would remove them from the payment files used to disburse payments to providers.

Furthermore, on December 14, 2020, HRSA developed a postpayment manual to outline postpayment quality control review processes to help verify that providers had received correct payments and to recover any overpayments.²⁸ The manual stated that because “payment inaccuracies and full provider eligibility data may not have been available at the time of payment and is now available during the post-payment period,” HRSA would: (1) review application information, payment calculations, and source data (e.g., data that included prior payments made to providers) to identify errors in payments that were disbursed to providers; (2) reassess provider eligibility and improper payments; and (3) recover an overpayment that

²⁶ HHS and HRSA, *PRF General & Targeted Distribution Cycle Memo*, dated September 30, 2020.

²⁷ HHS had prepayment validation processes for payments made under waves 1 through 4 (automatic payments) and subwaves 5a through 5c (nonautomatic payments). HRSA had prepayment validation processes for payments made under subwaves 5d through 5p and wave 13 (nonautomatic payments).

²⁸ *Post-Payment Manual—Post-Payment Matrix, Quality Control Review (QCR), and Post-Payment QCR Recovery Standard Operating Procedures (SOP)*. From December 14, 2020, through September 22, 2021, HRSA revised this manual 14 times.

exceeded a threshold of \$10,000.^{29, 30} The manual also stated that HRSA’s assessment would include reviews of data submitted by providers to confirm that PRF payments were used in accordance with the terms and conditions.³¹

HRSA received support from contractors for overseeing the PRF program. For example, Acumen, LLC, calculated payments and prepared payment files for HRSA’s use, and UnitedHealth Group processed and disbursed payments.

Standards for Internal Control in the Federal Government

Federal agencies, including HHS and HRSA, are required to comply with the Government Accountability Office’s (GAO’s) *Standards for Internal Control in the Federal Government* (Green Book). Internal control is a process that management uses to help an entity achieve its objectives. GAO’s standards provide criteria for designing, implementing, and operating an effective internal control system. Among other requirements, an agency must design control activities to achieve objectives and respond to risks.³²

The Office of Management and Budget (OMB) Circular No. A-123, *Management’s Responsibility for Enterprise Risk Management and Internal Control* (July 15, 2016), page 28, states:

When determining risk tolerance in disaster situations, managers weigh the program’s operational objective of expeditiously providing assistance against the objective of lowering the likelihood of fraud, because activities to lower fraud risks—such as the risk that ineligible individuals submit fraudulent applications for benefits—[cause] delays in service. As a result, managers are willing to accept a somewhat higher risk of fraud than under normal circumstances in order to provide emergency assistance in a timely manner.

In addition, *Government Auditing Standards*, known as the Yellow Book (2018 revision, paragraph 8.75), states that in some circumstances, certain conditions could indicate a heightened risk of fraud. Examples of these conditions include when management is willing to

²⁹ According to the manual, an improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments).

³⁰ If HRSA identified an overpayment that exceeded a threshold of \$10,000, it notified the provider to initiate repayment of the overpayment. If a payment was made to an ineligible provider, HRSA would seek repayment for a payment greater than \$100, or if a provider rejected a payment, HRSA would seek repayment for the entire payment even if it was less than \$10,000.

³¹ Providers that received one or more payments that exceeded \$10,000 in aggregate during the established reporting period were required to report on their use of PRF payments using their normal basis of accounting (e.g., cash basis). For example, providers that received payments from April 10 through June 30, 2020, were required to report during period 1 (July 1 through September 30, 2021), with a grace period through November 30, 2021.

³² Green Book, “Control Activities,” paragraph 10.01.

accept unusually high levels of risk in making significant decisions or the nature of the entity's operations provide opportunities to engage in fraud.

HHS's and HRSA's Control Activities Related to Selected Provider Relief Fund Program Requirements

Within a month from the national emergency declaration, HHS and HRSA established several control activities related to submission of revenue information and attestation of acceptance or rejection of payments.^{33, 34} Specifically, they developed: (1) guidance; (2) application and attestation portals; and (3) procedures for calculating payments, verifying information submitted by providers, and collecting overpayments, rejected payments, or other repayments from providers.^{35, 36}

Guidance

HHS and HRSA developed the following guidance:

- *Provider Relief Programs: Provider Relief Fund and American Rescue Plan Rural Payments Frequently Asked Questions* (PRF FAQs): The PRF FAQs were developed to help providers apply for PRF payments and attest to acceptance or rejection of payments they received.³⁷ For example, the PRF FAQs stated that a provider should submit an application to request nonautomatic payments under the Phase 1 General Distribution.³⁸ The PRF FAQs included instructions for providers to provide the following four pieces of information:
 - the provider's "Gross Receipts or Sales" or "Program Service Revenue" as submitted on its Federal income tax return,

³³ According to HRSA, during 2020 many providers had to close their businesses and, as a result, the ability of providers to get information needed to apply for the PRF was hampered. In addition, HRSA's efforts to obtain and assess this information in real time was significantly hampered, especially as the number of PRF payments increased over time.

³⁴ HHS and HRSA continued to refine and update these control activities as the PRF payments were being disbursed to providers.

³⁵ HHS allocates returned payments to future distributions of the PRF.

³⁶ Other repayments included unspent funds as a result of HRSA's assessment of whether providers used PRF payments for COVID-19-related expenses.

³⁷ According to HRSA, the first version of the PRF FAQs was publicly available on HRSA's website on April 25, 2020. The title and the content of these FAQs changed over time. The title of the first version was "General Distribution Portal FAQs," and the content has been continuously updated as PRF payments have been disbursed to providers.

³⁸ For those providers who received the automatic payments, HHS sent an email informing them to submit an application for additional payments (i.e., nonautomatic payments).

- the provider’s estimated revenue losses in March and April 2020 due to COVID-19,
 - a copy of the provider’s most recently filed Federal income tax return,³⁹ and
 - a list of the TINs for any of the provider’s subsidiary organizations that received relief funds but did not file separate Federal income tax returns.⁴⁰
- *PRF General & Targeted Distribution Cycle Memo*: This memo identified key processes and controls related to disbursement of the General and Targeted Distributions. For example, one key process was the payment rejection and return process. According to the memo, each rejected and returned transaction through the Automated Clearing House (ACH) includes a specific “reject and return reason code” (i.e., an R code) and a description of the code (e.g., “R23: Credit Entry Refused by Receiver”).⁴¹ If a return with an R23 code was made, HRSA’s contractor Optum Bank contacted the provider and confirmed whether the provider intentionally rejected the payment. If the provider confirmed that it wanted to reject the payment, Optum Bank validated the integrity of the returned transaction by matching the provider’s TIN with the TIN identified on a transaction returned through the ACH to make sure that the return was correct and identified the transaction with the R23 code in the payment file.

Application and Attestation Portals

Under the direction of HHS and HRSA, UnitedHealth Group developed the application and attestation portals to facilitate the collection of information from providers during the application and attestation processes. Table 1 on the next page lists the application and attestation portals used for the Phase 1 General Distribution.

³⁹ Although HRSA requested that providers submit copies of their Federal income tax returns, it requested that not-for-profit organizations submit their annual information returns (Internal Revenue Service Form 990, Return of Organization Exempt From Income Tax).

⁴⁰ These organizations are accounted for in the parent organization’s tax filing.

⁴¹ ACH is the primary system used for transfers of electronic funds between financial institutions and allows payments to be made online.

Table 1: Application and Attestation Portals for the Phase 1 General Distribution *

Portal Name	Deployment Date	Other Names	Purpose
CARES Act PRF Attestation Portal	4/13/2020	Attestation Portal 1.0	To allow providers to attest to acceptance or rejection of a payment.
General Distribution Portal	4/27/2020	Portal 1.0 CARES Act PRF Application Portal	To allow providers to apply for payments under wave 5.
PRF Application and Attestation Portal	6/9/2020	Portal 2.0	To allow providers to: (1) apply for payments under wave 13 and (2) attest to acceptance or rejection of a payment. [†]
PRF Application and Attestation Portal	10/5/2020	Portal 3.0	To allow providers to: (1) apply for payments under wave 13 and (2) attest to acceptance or rejection of a payment. [‡]

* According to HRSA, these portals and phases had different payment methodologies and expanded eligibility criteria to support distribution of funds to a broader group of providers and took into account “changing dynamics on the ground.”

[†] This portal replaced Attestation Portal 1.0 and Portal 1.0 and also allowed providers to apply for payments under Phase 2 of the General Distributions.

[‡] This portal replaced Portal 2.0 and also allowed providers to apply for payments under Phases 2 and 3 of the General Distributions.

The application and attestation portals guided providers when they applied for additional payments or attested to accepting or rejecting payments. For example, for the providers’ Medicare billing TINs in Attestation Portal 1.0 or tax filing TINs in Portal 2.0, providers were asked to enter the last six digits of their bank account numbers and the payment amounts that were disbursed to providers using these TINs. Providers were then asked to review the information for each TIN and click either “Review and Accept” or “Reject” for each payment. If “Review and Accept” was clicked, the provider was asked to check the box acknowledging receipt of the payment and agreeing to the PRF terms and conditions. If “Reject” was clicked, the provider was given instructions on how to return the payment.

Procedures for Calculating Payments, Verifying Information Submitted by Providers, and Collecting Overpayments or Rejected Payments From Providers

HRSA developed procedures for calculating PRF payments; verifying information submitted by providers on applications (i.e., manual review); and collecting overpayments, rejected

payments, or other repayments from providers. HRSA hired contractors to support HRSA in carrying out these procedures:⁴²

- *Acumen*: Acumen implemented the PRF payment calculation methodologies developed by HHS and developed payment files for HRSA's use. It calculated payments for subwaves 5d through 5p and wave 13.⁴³ Acumen developed and provided the payment files to and for approval by HRSA, which then sent the payment files to UnitedHealth Group and Optum Bank to direct disbursement of payments to providers.⁴⁴

Acumen also implemented the validation methodology, which HHS and HRSA developed, to identify: (1) characteristics that would preclude a provider from receiving payments or (2) an application as requiring manual review. For example, if a provider had the potential to receive more than \$2 million under wave 5 or more than \$1 million under wave 13, the provider was identified for manual review by other contractors (i.e., McKinsey & Company or CliftonLarsonAllen).⁴⁵

- *McKinsey & Company*: For providers that Acumen identified as having the potential to receive more than \$2 million under subwaves 5b and 5c, McKinsey & Company verified the revenue information included in a provider's application by manually reviewing documentation submitted by the provider to support the information.⁴⁶ For example, McKinsey & Company confirmed that the provider's submitted documentation was an approved document (e.g., the Federal income tax return). Furthermore, for providers that Acumen identified as having the potential to receive more than \$2 million under subwaves 5d through 5p and more than \$1 million under subwaves 13a through 13i, McKinsey & Company prepared a list of those providers and submitted the list to CliftonLarsonAllen for manual review.
- *CliftonLarsonAllen*: For the providers on the list from McKinsey & Company, CliftonLarsonAllen verified the revenue information on each application by manually

⁴² HHS, IOS, requested that the Office of the Assistant Secretary for Planning and Evaluation (ASPE) use ASPE's existing contract with Acumen to initially support HHS's work for the PRF distribution. Acumen's work was subsequently moved to a contract directly with HRSA in June 2020.

⁴³ HRSA stated that an official from the Council of Economic Advisers (an agency within the Executive Office of the President), who was on detail to HHS, IOS, was involved in calculating and disbursing PRF payments for waves 1 through 4 and subwaves 5a through 5c.

⁴⁴ Acumen issued methodology memos to document its process for developing the payment files, which included the calculation of payments.

⁴⁵ HHS and HRSA set these payment thresholds for manual review of submitted information.

⁴⁶ Payments to providers that Acumen identified as having the potential to receive more than \$2 million under subwave 5a were not included as part of HHS IOS's calculation of payments. The list of providers was submitted to CliftonLarsonAllen for manual review.

reviewing documentation submitted by the provider to support the information. For example, if the amount reported on the application was above the established threshold (e.g., a provider's reported gross receipts on the application was more than the established percentage of the reported gross receipts on the Federal income tax return), the application was not processed for payment. HHS and HRSA required that the provider resubmit its revenue information and include supporting documentation to be considered for an additional payment.

- *HHS's Program Support Center*: The Program Support Center (PSC) performed activities related to collecting overpayments, rejected payments, or other repayments from providers.⁴⁷ For example, HRSA set up a procedure to send to PSC a list of the providers that had not returned their rejected payments for recovery.

HOW WE CONDUCTED THIS AUDIT

Our audit covered about \$48 billion in PRF payments that were disbursed to 323,498 providers from April 10 through December 17, 2020.⁴⁸ We obtained from HRSA the payment and attestation data for our audit period.

HHS and HRSA's control objective was to ensure that providers received the correct PRF payments from the Phase 1 General Distribution in a fast, fair, and transparent manner. We assessed the design and implementation of HHS's and HRSA's controls that were related to selected PRF program requirements (i.e., for the submission of revenue information and attestation of rejection of payments) and determined whether these controls achieved the control objective by:

- performing audit procedures, which included conducting interviews with HRSA officials and HRSA contractors, reviewing the guidance developed by HHS and HRSA (i.e., the PRF FAQs and the *PRF General & Targeted Distribution Cycle Memo*), reviewing screenshots of the steps from the application and attestation portals, reviewing Acumen's methodology memos on calculating payments, and analyzing payment and attestation data (e.g., identifying rejected and returned payments); and
- testing the controls by selecting a random sample of 45 providers that kept all their payments, totaling \$194.1 million, to determine whether the reported revenue

⁴⁷ According to HRSA, a Memorandum of Understanding with PSC was signed and effective November 18, 2020.

⁴⁸ The last date that providers attested to acceptance or rejection of these payments was December 19, 2020.

information on each provider's application was supported by documentation (e.g., Federal income tax returns). We reviewed 40 of the 45 sampled providers.⁴⁹

We did not assess HHS's and HRSA's controls for providers' attestation of acceptance of payments, because a provider was allowed to make a deemed attestation (i.e., the provider was not required to make an active attestation) that it was eligible for a payment and that it was accepting the terms and conditions of the payment.

Because this audit assessed HHS's and HRSA's controls related to selected PRF program requirements, we did not determine whether the payments made to providers were correct or incorrect. Although we determined for each finding the amount of the payments made to providers (i.e., the potential effect), we could not conclusively determine that these payments were correct or incorrect, because payment calculations for future distributions of the PRF may take previous payments into account.⁵⁰

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 describes our audit scope and methodology.

FINDINGS

In the context of unprecedented challenges from the COVID-19 national emergency, HHS and HRSA developed controls related to selected PRF program requirements designed to ensure that providers received the correct PRF payments from the Phase 1 General Distribution in a fast, fair, and transparent manner. However, we determined that some of these controls could be improved.

To ensure that providers received the correct PRF payments from the Phase 1 General Distribution, HHS and HRSA developed the PRF guidance; application and attestation portals; and procedures for calculating PRF payments, verifying revenue information submitted by providers, and collecting overpayments, rejected payments, or other repayments from providers. However, HHS's and HRSA's procedures may not have ensured that all providers

⁴⁹ In general, we reviewed providers that submitted an application for nonautomatic payments and made an active attestation or a deemed attestation of acceptance of all payments (automatic and nonautomatic payments). Of the 45 sampled providers, we did not review 5 providers because these providers received only automatic payments and did not apply for additional payments (nonautomatic payments) during our audit period. There were no applications or supporting documentation to review.

⁵⁰ OIG has planned audits that include an objective to identify improper payments.

received the correct PRF payments from the Phase 1 General Distribution because these procedures did not include:

- requesting and reviewing providers' supporting documentation to verify the estimated revenue losses in March and April 2020,
- subtracting the automatic payments made to providers' subsidiary organizations when certain nonautomatic payments were calculated, and
- specifying a deadline for providers to return rejected payments.

According to HRSA officials, they, along with HHS, did not want to overburden providers by requesting supporting documentation for March and April 2020 estimated revenue losses that may not have been accessible (because of a provider's office closure or quarantine due to COVID-19). In addition, during the early implementation of the PRF program, it was not apparent to HRSA that it needed to provide additional guidance to encourage the timely return of funds by providers that rejected the payments.

We also determined that some providers may not have received the correct PRF payments from the Phase 1 General Distribution because certain HHS and HRSA procedures had weaknesses. Specifically, HHS's and HRSA's payment thresholds for manual review of information submitted by providers were set at a level that resulted in only 2 percent of providers undergoing manual review. In addition, HRSA's process to open and view the data file containing subsidiary organizations' taxpayer identification numbers (subsidiary TINs) extracted from providers' applications led to an error that caused the use of incorrect subsidiary TINs when payments were calculated. According to HRSA, it established payment thresholds for manual review based on its risk tolerance given the unprecedented public health emergency (i.e., HRSA's willingness to accept a somewhat higher risk of improper payments than under normal circumstances). HRSA also stated that establishing a comprehensive review of submitted information from all providers would have delayed the PRF payments, which were intended to prevent severe disruption to the Nation's health care system.

Because HHS and HRSA did not have certain procedures and had weaknesses in other procedures, some providers may not have received the correct PRF payments. Furthermore, the allocation of returned payments to future PRF distributions may have been delayed.

We understand that HHS and HRSA's operational objective at the beginning of the national emergency was to rapidly disburse PRF payments to support providers facing severe economic hardship during the national emergency because the CARES Act required HHS and HRSA to make payments considering "the most efficient payment systems practicable to provide emergency payment." We also understand that because of this statutory requirement, HHS and HRSA prioritized the rapid disbursement of payments over the risk of making improper payments because HHS and HRSA determined that activities to lower the risk would have delayed the payments. However, as HRSA fully implements postpayment quality control review

processes, it should consider the information and recommendations included in this report. For example, the established payment thresholds for manual review may have been reasonable at the beginning of the national emergency; however, they were set at a level that resulted in only 2 percent of providers undergoing manual review. HRSA could conduct a cost-benefit analysis for manual review of additional providers and, if the benefit outweighs the cost, HRSA could select additional providers for review.

In addition, to prepare for a possible public health emergency in the future, HHS should use the information and recommendations included in this report when determining lessons learned from administering PRF distributions during the COVID-19 national emergency, and look for additional ways to safeguard taxpayers' money when rapidly disbursing assistance payments to health care providers in response to future national emergencies.

HHS'S AND HRSA'S CONTROLS DID NOT INCLUDE CERTAIN PROCEDURES TO ENSURE THAT PROVIDERS RECEIVED THE CORRECT PROVIDER RELIEF FUND PAYMENTS

HHS's and HRSA's controls related to submitted revenue information and attestation of rejection of payments may not have ensured that certain providers received the correct payments because HHS's and HRSA's procedures did not include: (1) reviewing providers' supporting documentation to verify the estimated revenue losses in March and April 2020, (2) subtracting the automatic payments made to providers' subsidiary organizations when certain nonautomatic payments were calculated, and (3) specifying a deadline for providers to return rejected payments.

Without these procedures, there was a risk that providers may have received incorrect payments.

HHS and HRSA Did Not Have Procedures To Request and Review Providers' Supporting Documentation To Verify Estimated Revenue Losses in March and April 2020

HHS and HRSA developed the following control activities for submission of revenue information to ensure that providers received the correct PRF payments:

- Providers were requested to provide the following information through the application portal: (1) a provider's "Gross Receipts or Sales" or "Program Service Revenue" (i.e., revenue) as reported on the provider's Federal income tax return, (2) the provider's estimated revenue losses in March and April 2020 due to COVID-19, and (3) a copy of the provider's most recently filed Federal income tax return.⁵¹ The reported revenue or estimated revenue losses were used to calculate payments disbursed to providers under wave 5, and the copy of the Federal income tax return was used to verify the reported revenue information on a provider's application.

⁵¹ HHS and HRSA required providers to submit audited financial statements or management-prepared financial statements to support the reported revenue if providers' Federal income tax returns were not available.

- Providers that had the potential to receive more than \$2 million in payments under wave 5 were identified for manual review. The manual review included comparing the revenue reported on the provider's application with the gross receipts reported on the Federal income tax return and determining the reasonableness of the provider's reported revenue.

However, HHS and HRSA did not have procedures to request and review providers' supporting documentation to verify the estimated revenue losses in March and April 2020 when calculating providers' payments based on the estimated revenue losses under wave 5. Although the application and attestation portals collected the providers' estimated revenue losses for these months, and providers were notified by email to resubmit their applications if those losses met certain characteristics, HHS and HRSA did not require providers to submit supporting documentation for the estimated revenue losses. As a result, HHS and HRSA were unable to verify those losses.

Of the 3,834 providers whose payments were calculated based on their estimated revenue losses in March and April 2020 under wave 5, 3,767 providers attested to acceptance of payments and kept payments of about \$756 million.⁵² HHS and HRSA disbursed payments to these providers without requesting that they submit supporting documentation. Furthermore, of the 3,767 providers, 189 were identified for manual review because they had the potential to receive more than \$2 million in payments under wave 5. These 189 providers attested to acceptance of payments and kept a total of \$538 million.⁵³ However, the providers' reported estimated revenue losses were not verified with supporting documentation because HHS and HRSA did not have supporting documentation to use for verification.⁵⁴

According to HRSA, HRSA was required by statute to rapidly distribute funds to providers. Therefore, HRSA did not want to overburden providers by requesting supporting documentation that may not have been accessible because of a provider's office closure or quarantine due to COVID-19 and by creating obstacles or delays in receiving PRF payments. Additionally, HRSA took into account that providers may not have known what their estimated revenue losses would amount to at the start of the pandemic and that they needed time to calculate their estimated revenue losses.

⁵² The unrounded amount is \$755,624,100.

⁵³ The unrounded amount is \$537,985,907.

⁵⁴ If it is not feasible to review all 3,767 providers that attested to acceptance of payments and kept the payments based on the estimated revenue losses in March and April 2020 under wave 5, HRSA could consider reviewing 189 providers that were identified for manual review and attested to acceptance of payments and kept a total of \$538 million, which was about 71 percent of the \$756 million. HRSA could also conduct a cost-benefit analysis for the manual review of additional providers and, if the benefit outweighs the cost, it could select additional providers for review.

Because HHS and HRSA did not have procedures to request and review providers' supporting documentation to verify the estimated revenue losses in March and April 2020, there was a risk that some providers may have received incorrect payments that were calculated using incorrect estimated revenue losses.

HHS Did Not Have Procedures To Subtract Automatic Payments Made to Providers' Subsidiary Organizations When Certain Nonautomatic Payments Were Calculated

HHS developed the following control activities to prevent providers that file Federal income tax returns covering multiple legal entities (e.g., parent organizations that include their subsidiary organizations' revenue information in their consolidated tax returns) from being overpaid:

- HHS requested that providers with subsidiary organizations report during the application process the TINs of subsidiary organizations that received payments but did not file separate Federal income tax returns.
- When calculating round 2 payments (i.e., waves 4, 5, and 13), HHS developed a payment calculation methodology that would generally prevent a provider from receiving a payment if round 1 payments (including payments to the provider's subsidiary organizations) were equal to or more than 2 percent of the provider's gross receipts.
- HRSA's payment calculation methodology for subwaves 5d through 5p and subsequent wave 13 included subtracting automatic payments that providers' subsidiary organizations received under waves 1 through 4.

However, HHS did not have procedures to subtract the automatic payments made under waves 1 through 4 to providers' subsidiary organizations when nonautomatic payments under subwaves 5a through 5c were calculated.^{55, 56}

Of the 22,645 providers that attested to acceptance of payments and kept all of their payments under subwaves 5a through 5c, 315 providers had 476 subsidiary organizations that received payments totaling \$46.5 million under waves 1 through 4 and did not file their own Federal

⁵⁵ According to Acumen, this issue was identified after disbursing the wave 5 payments and HRSA began to establish a postpayment quality control process to resolve the issue. Furthermore, Acumen officials stated that the overpayments would most likely be taken into account when calculating payments under the Phase 3 General Distribution (i.e., the Phase 3 "true-up" process). We verified that this issue is being resolved through the established postpayment quality control review process.

⁵⁶ Based on Acumen's document describing its payment calculation methodology, we confirmed that the payments made under waves 1 through 4 to a provider's subsidiary organization were subtracted when calculating a provider's payments under subwaves 5d through 5p and subwaves 13a through 13i.

income tax returns.⁵⁷ However, HHS did not subtract \$46.5 million in payments when it calculated the payments disbursed under subwaves 5a through 5c to these 315 providers. Because HHS did not have procedures to subtract these payments, the 315 providers received \$46.5 million more than they should have.

Figure 4 shows an example of the effect of not subtracting a payment made under wave 1 to a provider’s subsidiary organization when calculating the provider’s subsequent payment under subwave 5c.

Figure 4: Example of the Effect of Not Subtracting a Payment Made Under Wave 1 to a Provider’s Subsidiary Organization When Calculating the Provider’s Subsequent Payment Under Subwave 5c

Breakdown of Payments Made to the Provider and the Provider’s Subsidiary Organization

\$3,891,882* = 2 percent of the provider’s reported gross receipts (total payment that a provider is eligible to receive under waves 1 – 5).

	Total Payment Made	Total Payment That Should Have Been Made
Payment received by the provider under wave 1	\$2,186,255	\$2,186,255
Payment received by the provider’s subsidiary organization under wave 1	\$69,950	\$69,950
	\$3,891,882 – 2,186,255 <u>\$1,705,627</u>	\$3,891,882 – 2,186,255 <u>\$1,635,677</u>
Payment under subwave 5c	\$1,705,627	\$1,635,677
	\$2,186,255 + 69,950 <u>\$2,256,205</u>	\$2,186,255 + 69,950 <u>\$2,256,205</u>
Total Payments	<u>\$3,961,832</u>	<u>\$3,891,882</u>

* For this example, we confirmed that the payment amount was determined based on 2 percent of the provider’s gross receipts totaling \$3,891,882, which was less than the sum of the provider’s estimated revenue losses in March and April 2020 of \$12,358,971.

The provider’s subsidiary organization received a payment of \$69,950 under wave 1. HHS did not subtract this payment when calculating the payment of \$1,705,627 under subwave 5c. As a result, the provider and the provider’s subsidiary together received \$3,961,832. If the payment of \$69,950 had been subtracted, the provider would have received a payment of \$1,635,677 under subwave 5c, and the provider and the provider’s subsidiary organization together would have received \$3,891,882. This provider received \$69,950 more than it should have.

⁵⁷ The unrounded amount is \$46,485,609. As of December 17, 2020, these 22,645 providers had not received any subsequent payments under subwaves 5d through 5p and subwaves 13a through 13i. Because our audit covered the Phase 1 General Distribution, we do not have the payment data for the Phase 3 General Distribution. Therefore, we do not know whether the 315 providers applied for and received payments under the Phase 3 General Distribution, which would have triggered the true-up process.

HHS and HRSA Did Not Have Procedures That Specified a Deadline for Providers To Return Rejected Payments

HHS and HRSA developed the following control activities to ensure that providers returned payments they rejected because if a provider does not return a rejected payment, the total payment that the provider receives will be incorrect:

- HHS gave providers the option to attest to acceptance or rejection of their payments by accessing the attestation portal within a specified number of days (e.g., 90 days) of receiving payments. If a provider chose to reject the payment, it could do so through the attestation portal by attesting, “I am not accepting payment and I will either destroy the check or refund the full amount . . .” and clicking the “I Reject Payment” button. If a provider received two payments, the provider could reject one payment and accept the other one.
- HHS and HRSA instructed providers to contact their financial institution and ask the institution to refuse the received ACH credit by initiating an ACH return using the ACH return code “R23 - Credit Entry Refused by Receiver.”⁵⁸
- HHS and HRSA requested that providers that were paid by paper check and rejected a payment destroy the check if it was not deposited or mail the check to UnitedHealth Group with a written request to return the payment.
- HRSA contracted with PSC to collect rejected payments from providers.⁵⁹

Figure 5 on the next page shows the instructions in the PRF FAQs for rejecting payments in the attestation portal and highlights a key change related to returning the rejected payments.

⁵⁸ If a provider received PRF payments via ACH, the provider was required to return the payments via ACH.

⁵⁹ According to HRSA, a Memorandum of Understanding with PSC was signed and effective November 18, 2020.

Figure 5: Instructions in the Provider Relief Fund FAQs for Rejecting Payments in the Attestation Portal and Returning Rejected Payments*

May 6, 2020	May 20, 2020	June 12, 2020	August 10, 2020
<p>Within 30 days of receiving payment, providers may return their General Distribution payment by going into the attestation portal to indicate they are rejecting the funds. The CARES Act Provider Relief Fund Payment Attestation Portal will guide providers through the attestation process to reject the funds.</p>	<p>Within 45 days of receiving payment via the ACH or within 60 days of check payment issuance, providers may return a payment by going into the attestation portal to indicate that they are rejecting the funds. The CARES Act Provider Relief Fund Payment Attestation Portal will guide providers through the attestation process to reject the funds.</p>	<p>Within 90 days of receiving payment, providers may return a payment by going into the attestation portal to indicate that they are rejecting the funds. The CARES Act Provider Relief Fund Payment Attestation Portal will guide providers through the attestation process to reject the funds.</p>	<p>Within 90 days of receiving payment, providers may return a payment by going into the attestation portal to indicate that they are rejecting the funds. The CARES Act Provider Relief Fund Payment Attestation Portal or the Provider Relief Fund Application and Attestation Portal will guide providers through the attestation process to reject the funds.</p> <p>Providers must return the payment within 15 calendar days of rejecting the payment.</p>

* The dates shown in the figure are the dates when the PRF FAQs’ section on rejecting payments was updated. The yellow highlight indicates a change in the instructions that established a specific deadline for *returning* rejected payments.

Although HHS and HRSA had procedures that specified a deadline (e.g., within 90 days of receiving payment) for providers to reject payments in the attestation portal by indicating that they were *rejecting* the payments (i.e., by clicking the “I Reject Payment” button), the procedures laid out in the PRF FAQs did not include until August 10, 2020, a specific deadline for *returning* rejected payments.⁶⁰ On that date, HHS updated the PRF FAQs, instructing providers to return payments within 15 calendar days of rejecting them (i.e., the 15-day limit).

⁶⁰ Until August 10, 2020, neither the PRF FAQs nor any of HRSA’s written correspondence to providers included a specific deadline for returning rejected payments. Before May 6, 2020, UnitedHealth Group sent an email or a letter to providers informing them that they must sign an attestation confirming receipt of the funds and agreeing to the terms and conditions of payment within 30 days of receipt. UnitedHealth Group also informed providers that a failure to return payments within 30 days of receipt would be considered acceptance of the terms and conditions. However, the email or letter did not include a specific deadline for providers to return rejected payments.

Of the 323,498 providers that received PRF payments, 144 providers rejected payments that they received in the amount of \$10,000 or more by clicking the “I Reject Payment” button in the attestation portal but had not returned the rejected payments of \$52.8 million as of December 17, 2020.^{61, 62} Of the 144 providers, 140 rejected their payments in the attestation portal before August 10, 2020. According to HRSA, as of March 9, 2022, of the 144 providers, 26 had returned their payments, totaling \$2.9 million, but there were still 118 providers that had not returned their payments, totaling \$49.9 million.⁶³

According to HRSA, as the PRF program matured and through discussions of the process for collecting overpayments, rejected payments, or other repayments from providers, it became apparent that HRSA needed to provide additional guidance to encourage the timely return of payments by providers that rejected payments. To provide additional guidance, in August 2021 HRSA added information in the PRF FAQs clarifying that if a provider does not return the payment within 15 calendar days of rejecting the payment in the attestation portal, the provider is considered to have accepted the payment and must abide by the terms and conditions associated with the payment.

If HRSA does not ensure that providers return their rejected payments in a timely manner, the allocation of returned payments to future PRF distributions may be delayed.⁶⁴

HHS’S AND HRSA’S PROCEDURES TO ENSURE THAT PROVIDERS RECEIVED THE CORRECT PROVIDER RELIEF FUND PAYMENTS HAD WEAKNESSES

HHS’s and HRSA’s payment thresholds for manual review of revenue information that providers submitted on their applications were set at a level that resulted in only 2 percent of providers undergoing manual review. In addition, HRSA’s process to open and view the data file containing subsidiary TINs extracted from providers’ applications led to an error that caused the use of incorrect subsidiary TINs when payments were calculated.

HHS’s and HRSA’s Payment Thresholds Were Set at a Level That Resulted in Only 2 Percent of Providers Undergoing Manual Review for Submitted Information

HHS and HRSA developed the following control activities to ensure that providers received the correct PRF payments:

⁶¹ The unrounded amount is \$52,794,028.

⁶² According to HRSA, after establishing the deadline in the August 10, 2020, guidance, UnitedHealth Group sent instructions on returning the rejected payments, including instructions regarding the 15-day limit, to providers that rejected them.

⁶³ The unrounded amounts were \$2,909,700 and \$49,884,328, respectively.

⁶⁴ According to the PRF FAQs, HHS will allocate returned payments to future distributions of the PRF (e.g., distributions in subsequent phases of the General Distributions).

- Providers were requested to upload copies of their Federal income tax returns to the application and attestation portals. If a provider was not required to file a Federal income tax return, the provider was requested to upload a statement explaining the reason and to submit the most recent audited or management-prepared financial statement.
- Providers that had the potential to receive more than \$2 million in payments under wave 5 and more than \$1 million in payments under wave 13 were identified for manual review of their submitted information. The manual review included reviewing providers' supporting documentation (e.g., a Federal income tax return) to verify the reported revenue and determining the reasonableness of the revenue reported on the application.

Although HHS's and HRSA's procedures included manually reviewing providers that had the potential to receive payments above \$2 million for wave 5 and \$1 million for wave 13, these thresholds resulted in HHS and HRSA reviewing only 2 percent of providers, which received about 57 percent of the total payments. Specifically, HHS and HRSA did not review providers' supporting documentation to verify the reported revenue for providers that had a potential to receive \$2 million or less in payments under wave 5 or \$1 million or less in payments under wave 13.

Of the 78,718 providers that received payments under either waves 5 or 13, 72,646 providers attested to acceptance of at least 1 payment and kept at least 1 payment, collectively totaling \$6.6 billion.⁶⁵ Table 2 shows the number of unique providers that attested to acceptance of payments and kept their payments under waves 5 or 13 and whether their reported revenues were verified with supporting documentation.

Table 2: Number of Unique Providers That Attested to Acceptance of Payments and Kept Their Payments Under Waves 5 or 13 and Whether Their Reported Revenues Were Verified

Reported Revenue Verified?	No. of Unique Providers	Percentage of Providers	Total Payments *	Percentage of Payments
Yes	1,625	2%	\$3.8 billion	57%
No	71,021	98%	2.8 billion	43%
Total	72,646	100%	\$6.6 billion	100%

* The unrounded amounts are \$3,766,224,919, \$2,837,029,108, and \$6,603,254,027.

For our audit period, HHS and HRSA reviewed providers' supporting documentation to verify the reported revenue for only 1,625 providers (or 2 percent of the total number of providers) that attested to acceptance of payments and kept their payments under waves 5 and 13. These 1,625 providers received and kept \$3.8 billion (or 57 percent) of the total payments. However,

⁶⁵ The unrounded amount is \$6,603,254,027.

71,021 providers (or 98 percent of the total number of providers) attested to acceptance of payments and kept \$2.8 billion (or 43 percent) of the total payments without HHS and HRSA verification of their reported revenue.

According to HRSA, reviewing submitted information for all providers would have delayed the distribution of PRF payments intended to prevent severe disruption to the Nation's health care system. HRSA stated that it established payment thresholds for manual review of information submitted by providers on their applications based on HHS and HRSA's risk tolerance given the unprecedented public health emergency.⁶⁶ HRSA cited the OMB Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control.⁶⁷

We understand that the statute required HHS and HRSA to distribute PRF payments rapidly to providers at the beginning of the public health emergency. However, HRSA could perform reviews of additional providers as the postpayment quality control review processes are being fully implemented. Although the existing payment thresholds for manual review may have been reasonable at the beginning of the public health emergency, they were set at a level that resulted in only 2 percent of the total number of providers undergoing manual review. Because the PRF program was quickly implemented based on statutory language requiring HRSA to distribute payments quickly, HRSA said it was willing to accept a somewhat higher risk of improper payments than under normal circumstances. However, the higher risk of improper payments may exist not only among providers that were reviewed but also among providers that were not reviewed.⁶⁸ Therefore, HRSA could conduct a cost-benefit analysis for manual review of additional providers and, if the benefit outweighs the cost, HRSA could select additional providers for review.

Because HHS and HRSA did not perform manual reviews of providers' supporting documentation to verify the reported revenue for 98 percent of the total number of providers, there was a risk that some of these providers may have received incorrect PRF payments, which may have been calculated using incorrect revenue on their applications.

⁶⁶ HRSA refers to the payment thresholds for manual review as "data checks."

⁶⁷ OMB Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control (July 15, 2016), p. 28, states: "When determining risk tolerance in disaster situations, managers weigh the program's operational objective of expeditiously providing assistance against the objective of lowering the likelihood of fraud, because activities to lower fraud risks—such as the risk that ineligible individuals submit fraudulent applications for benefits—[cause] delays in service. As a result, managers are willing to accept a somewhat higher risk of fraud than under normal circumstances in order to provide emergency assistance in a timely manner."

⁶⁸ According to *Government Auditing Standards*, paragraph 8.75, in some circumstances, certain conditions could indicate a heightened risk of fraud. Examples include when management is willing to accept unusually high levels of risk in making significant decisions or the nature of the entity's operations provide opportunities to engage in fraud.

HRSA’s Process To Open and View the Data File Containing Subsidiary Organizations’ Taxpayer Identification Numbers Extracted From Providers’ Applications Led to an Error That Caused the Use of Incorrect Numbers When Payments Were Calculated

HRSA developed a procedure to prevent providers that file Federal income tax returns covering multiple legal entities (e.g., parent organizations that include their subsidiary organizations’ revenue information in their consolidated tax returns) from being overpaid. Specifically, HRSA developed an automated process to extract subsidiary TINs from providers’ applications and used the extracted subsidiary TINs when it calculated the payments for subwaves 5d through 5p and subsequent wave 13.

However, HRSA’s process to open and view the data file containing extracted subsidiary TINs led to a transcription error in which a “leading zero” was added in front of the digits in a subsidiary TIN and the last digit of the TIN was dropped. HRSA used Microsoft Excel to open and view subsidiary TINs after extracting those TINs from providers’ applications. To prevent the transcription error, HRSA should have imported the extracted data into Microsoft Excel before opening and viewing subsidiary TINs.⁶⁹ This error caused the use of incorrect subsidiary TINs when HRSA calculated payments under subwaves 5d through 5e.

Figure 6 shows an example of the differences between two subsidiary TINs reported on applications and the TINs that were opened and viewed.

Figure 6: Example of the Differences Between Subsidiary Organizations’ TINs Reported on the Applications and TINs That Were Opened and Viewed

Subsidiary TIN	
Reported on Application	Opened and Viewed
8xxxxxxx8	08xxxxxxx 8
4xxxxxxx0	04xxxxxxx 0

Of the 9 sampled providers that had subsidiary organizations that received payments but did not file their own Federal income tax returns (out of 40 sampled providers we reviewed), 2 sampled providers had subsidiary organizations whose extracted TINs were incorrect as a result of a transcription error. HRSA did not verify that the subsidiary TINs were correct after opening and viewing the extracted subsidiary TINs. If HRSA had imported the extracted data into Microsoft Excel, HRSA would not have had to verify that the subsidiary TINs were correct because Microsoft Excel would have not caused the transcription error. HRSA used the incorrect subsidiary organization TINs for two providers when it calculated the payments under

⁶⁹ According to HRSA, in July 2020 it implemented a quality control process to verify that the correct subsidiary TINs were used when calculating payments (i.e., subsidiary TINs without transcription errors).

subwaves 5d through 5e. As a result, these two sampled providers received more payments than they should have.

Example of a Provider That Received a Larger Payment Than It Should Have Because an Extracted Subsidiary TIN Did Not Match the Reported Subsidiary TIN

For one sampled provider that reported three subsidiary TINs on its application, one of the TINs extracted from the application did not match one of the three TINs reported on the application because of a transcription error. The payment received by the subsidiary organization was \$1,139,932. Acumen did not subtract this amount when calculating the provider's payment under subwave 5e. As a result, this provider received \$1,139,932 more than it should have.

CONCLUSION

In the context of unprecedented challenges from the COVID-19 national emergency, HHS and HRSA developed controls related to selected PRF program requirements (i.e., for providers' submission of revenue information and attestation of rejection of payments) designed to ensure that providers received the correct PRF payments from the Phase 1 General Distribution in a fast, fair, and transparent manner. However, we determined that some of these controls could be improved.

HHS and HRSA did not have certain procedures. For example, HHS did not have procedures to subtract the automatic payments made to providers' subsidiary organizations when certain nonautomatic payments were calculated. In addition, HHS and HRSA's procedures had weaknesses. For example, HRSA's process to open and view the data file containing subsidiary TINs extracted from providers' applications led to an error that caused the use of incorrect subsidiary TINs when payments were calculated.

Because HHS and HRSA did not have certain procedures and had weaknesses in other procedures, some providers may not have received correct PRF payments. Furthermore, the allocation of returned payments to future PRF distributions may have been delayed.

We understand that HHS and HRSA's operational objective at the beginning of the national emergency was to rapidly disburse PRF payments to support providers facing severe economic hardship during the national emergency, because the CARES Act required HHS and HRSA to make payments considering "the most efficient payment systems practicable to provide emergency payment." We also understand that because of this statutory requirement, HHS and HRSA prioritized the rapid disbursement of payments over the risk of making improper payments, because HHS and HRSA determined that activities to lower the risk would have delayed the payments. However, as HRSA fully implements postpayment quality control review processes, it should consider the information and recommendations included in this report. For

example, the established payment thresholds for manual review may have been reasonable at the beginning of the national emergency; however, they were set at a level that resulted in only 2 percent of providers undergoing manual review. HRSA could conduct a cost-benefit analysis for manual review of additional providers and, if the benefit outweighs the cost, HRSA could select additional providers for review.

In addition, to prepare for a possible public health emergency in the future, HHS should use the information and recommendations included in this report when determining lessons learned from administering PRF distributions during the COVID-19 national emergency, and look for additional ways to safeguard taxpayers' money when rapidly disbursing assistance payments to health care providers in response to future national emergencies.

RECOMMENDATIONS

As the postpayment quality control review processes are being fully implemented, we recommend that the Health Resources and Services Administration do the following to verify that providers received the correct PRF payments from the Phase 1 General Distribution of the PRF:

- Continue to perform postpayment quality control reviews, including the review of 3,767 providers that attested to acceptance of payments and kept payments of about \$756 million under wave 5 based on the estimated revenue losses in March and April 2020, and seek repayment of any overpayments from providers. If it is not feasible to review all providers, HRSA could consider reviewing 189 providers that were identified for manual review and attested to acceptance of payments and kept a total of \$538 million, which was about 71 percent of the \$756 million. Furthermore, HRSA could conduct a cost-benefit analysis for manual review of additional providers and, if the benefit outweighs the cost, it could select additional providers for review.
- Determine the impact on subsequent payments of the \$46.5 million in payments that HRSA made to 315 providers for which HHS did not subtract the automatic payments made to the providers' subsidiary organizations, and seek repayment of any overpayments from providers. Furthermore, for subsequent payments, identify whether there were any other providers for which HHS did not subtract the automatic payments made to the providers' subsidiary organizations, determine the impact of not subtracting these payments, and seek repayment of any overpayments.
- Ensure that PSC collects payments made to the 118 providers that did not return their rejected payments as of March 9, 2022.
- Establish a process to review providers' supporting documentation to verify the reported revenue for the 71,021 providers that had the potential to receive \$2 million or less in payments under wave 5 or \$1 million or less in payments under wave 13 and had attested to acceptance of payments and kept their total payments of \$2.8 billion. HRSA

could conduct a cost-benefit analysis for manual review of additional providers that had the potential to receive payments below the existing payment thresholds and, if the benefit outweighs the cost, it could select additional providers for review.

- Determine whether there were other providers that were impacted by the use of incorrect TINs for subsidiary organizations, recalculate the payments for these providers, and seek repayment of any overpayments.

HRSA COMMENTS

In written comments on our draft report, HRSA concurred with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.⁷⁰ However, HRSA noted concerns with some of our findings. HRSA also provided technical comments on our draft report, which we addressed as appropriate. HRSA's comments, excluding the technical comments, are included as Appendix C.

HRSA had the following comments on our five recommendations:

- Regarding our first recommendation, HRSA stated that it will review the 189 providers identified for manual review and will also conduct a cost-benefit analysis to determine whether manual reviews of additional providers are feasible.
- Regarding our second recommendation, HRSA stated that it has already begun to resolve the issue (i.e., determining the impact on subsequent payments of the \$46.5 million in payments that HRSA made to 315 providers) through the established postpayment quality review process, including seeking repayments for any overpayments identified.
- Regarding our third recommendation, HRSA stated that it will send rejected but not returned payments to the Program Support Center for collection of any outstanding amounts owed.
- Regarding our fourth recommendation, HRSA stated that it will conduct a cost-benefit analysis for manual review of providers and will assess adding "a new discrepancy to [its] post payment quality control review process to include manual review of Phase 1 providers meeting this criteria."⁷¹

⁷⁰ We provided a copy of the draft report to HHS and requested that HHS provide any written comments on the report's findings and conclusions. However, HHS did not provide us with written comments.

⁷¹ HRSA's postpayment manual refers to "discrepancies" as issues that require analyzing provider data and documenting evidence to support repayment decisions.

- Regarding our fifth recommendation, HRSA stated that it has already begun to resolve the issue (i.e., determining whether there were other providers that were impacted by the use of incorrect TINs for subsidiary organizations) through the established postpayment quality review process. HRSA also stated that it conducted an initial impact analysis in March 2021 on wave 5 and found providers impacted by this issue. HRSA stated, however, that the potential overpayment could have reduced future payments for those providers that applied for funding through the various portals (e.g., Portal 3).

Furthermore, HRSA noted concerns with some of our findings. First, HRSA noted that the reference to fraud throughout the report is incongruent with the audit objective because the audit specifically focused on payment calculation methodology and related internal controls rather than provider fraud, which would have involved the review of submitted documentation for fraudulent information. HRSA requested that the term “fraud” be replaced with the term “improper payments.” We considered this request and replaced the term as appropriate. Second, HRSA noted that the finding regarding the deadline to return rejected payments does not relate to the audit’s focus on correct payment calculation. We want to clarify that the audit’s focus was not on correct payment calculation. Rather, the audit’s focus was on HHS’s and HRSA’s controls related to selected PRF program requirements for ensuring that providers received the correct payments from the Phase 1 General Distribution. Finally, HRSA noted concerns with the remaining findings regarding (1) supporting documentation and estimated revenue losses and (2) the payment threshold for manual review of documentation. For those findings, we made appropriate changes based on the technical comments that HRSA provided.

OTHER MATTERS: METHODOLOGY USED IN CALCULATING PROVIDER RELIEF FUND PAYMENTS CHANGED OVER TIME FOR THE PHASE 1 GENERAL DISTRIBUTION

To receive additional PRF payments from round 2, providers completed an application and submitted supporting documentation through HHS’s application portal. HRSA used the information provided through the application portal to calculate the payments for waves 5 and 13.

HRSA used different methodologies when calculating the payments for waves 5 and 13.⁷² Table 3 on the next page shows the differences between the payment calculation methodologies used for waves 5 and 13.

⁷² According to HRSA officials, the methodologies used to calculate the payments related to waves 5 and 13 differed because of changes in the application and attestation portals over time. Providers that used Portal 1 or the CARES Act PRF Application Portal to submit their applications received the payments under wave 5. Providers that used Portals 2.0 and 3.0 (PRF Application and Attestation Portal) to submit their applications received the payments under wave 13 and Phases 2 and 3 of the General Distributions.

Table 3: Differences in Methodologies That HRSA Used To Calculate the Payments for Waves 5 and 13

Methodology That HRSA Used To Calculate Payments for Wave 5	Methodology That HRSA Used To Calculate Payments for Wave 13
<p>HRSA requested that providers enter on their applications “Gross Receipts or Sales” or “Program Service Revenue” (i.e., gross revenue) from their Federal income tax returns.</p>	<p>HRSA requested that providers subtract returns and allowances and exclude: (1) any income reported on the Internal Revenue Service’s Wage and Tax Statement Form (W-2), (2) joint venture income, and (3) bad debts from the gross receipts or sales reported on their applications. HRSA also requested that providers enter on their applications the gross receipts and the percentage of patient care from their gross receipts. HRSA then determined net patient revenue, which was used in part to calculate the payments related to wave 13. The following is a simplified version of the new patient revenue calculation:</p> $(Gross Receipts - Returns and Allowances, Any Income Reported on the W-2, Joint Venture Income, and Bad Debts) \times (Percentage Related to Patient Care) = Net Patient Revenue$
<p>HRSA requested that providers enter on their applications the estimated revenue losses in March and April 2020.</p>	<p>HRSA did not request that providers enter on their applications the estimated revenue losses in March and April 2020 for applications collected in Portal 2. However, for applications collected in Portal 3, HRSA requested that providers enter operating revenues and operating expenses from patient care for quarters 1 and 2 of 2019 and 2020. HRSA used this information to calculate the losses.*</p>
<p>HRSA calculated and disbursed payments to providers using the providers’ Medicare billing TINs.</p>	<p>HRSA calculated and disbursed payments to providers using the providers’ tax filing TINs because using these TINs would provide more complete financial information to the provider.†</p>

Methodology That HRSA Used To Calculate Payments for Wave 5	Methodology That HRSA Used To Calculate Payments for Wave 13
<p>HRSA calculated the payments based on the lesser of 2 percent of a provider’s 2018 (or most recent complete tax year) gross receipts or the sum of estimated revenue losses in March and April 2020.</p>	<p>HRSA calculated the payments for the applications collected in Portal 2 based on 2 percent of net patient revenue from the providers’ most recent financial documentation (e.g., the Federal income tax returns for 2017, 2018, or 2019 or audited financial statements).</p> <p>HRSA calculated the payments for the applications collected in Portal 3 based on the greater of up to 88 percent of a providers’ reported losses or 2 percent of net patient revenue from the providers’ most recent financial documentation (e.g., the Federal income tax returns for 2017, 2018, or 2019 or internal audited financial statements).</p>

* HRSA required providers to submit supporting documentation (e.g., internally prepared financial statements) for operating revenues and expenses.

† HRSA said it observed the following when disbursing payments under wave 5: (1) several applications had different Medicare billing TINs but had the same parent organization, (2) only parent organizations filed the Federal income tax return, and (3) it made more sense to have providers apply under the parent organization that files the tax return and use the providers’ tax filing TINs to calculate and disburse payments.

Differences in the payment calculation methodology may result in providers receiving different payments, depending on the waves (waves 5 or 13) for which providers submit their applications. For example, if a provider’s 2018 gross receipts used under the wave-5 payment calculation were not the same as the net patient revenue used under the wave-13 payment calculation, the payment that the provider would receive under wave 5 would be different than the payment the same provider would receive under wave 13.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$47,951,935,987 in PRF payments that were disbursed to 323,498 providers from April 10 through December 17, 2020.⁷³ We obtained from HRSA the payment data and the attestation data for our audit period.

HHS and HRSA's control objective was to ensure that providers received the correct PRF payments from the Phase 1 General Distribution in a fast, fair, and transparent manner. We assessed the design and implementation of HHS's and HRSA's controls that were related to selected PRF program requirements (i.e., for the submission of revenue information and attestation of rejection of payments) and determined whether these controls achieved the control objective by:

- performing audit procedures detailed in the "Methodology" section on the next page and
- testing the controls by selecting a random sample of 45 providers that kept all of their payments, totaling \$194,068,160, to determine whether the reported revenue information on each provider's application was supported by documentation (e.g., Federal income tax returns). We reviewed 40 of the 45 sampled providers.⁷⁴

We did not assess HHS's and HRSA's controls for providers' attestation of acceptance of payments, because a provider was allowed to make a deemed attestation (i.e., the provider was not required to make an active attestation) that it was eligible for a payment and that it was accepting the terms and conditions of the payment.

Because this audit assessed HHS's and HRSA's controls related to selected PRF program requirements, we did not determine whether the payments made to providers were correct or incorrect. Although we determined for each finding the amount of the payments made to providers (i.e., the potential effect), we could not conclusively determine that these payments were correct or incorrect, because payment calculations for future distributions of the PRF may take previous payments into account.

⁷³ The last date that providers attested to acceptance of these payments and kept these payments was December 19, 2020.

⁷⁴ In general, we reviewed providers that submitted an application for nonautomatic payments and made an active attestation or a deemed attestation of acceptance of all payments (automatic and nonautomatic payments). Of the 45 sampled providers, we did not review 5 providers because these providers received only automatic payments and did not apply for additional payments (nonautomatic payments) during our audit period. There were no applications or supporting documentation to review.

We reviewed all five components of internal controls: control environment, risk assessment, control activities, information and communication, and monitoring.⁷⁵ Because our audit was designed to provide only reasonable assurance that the internal controls we reviewed were effective, it would not necessarily have detected all internal control deficiencies.

We conducted our audit from October 2020 to June 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the Green Book's components and principles to determine their significance to our audit objective;
- reviewed the PRF FAQs, the *PRF General & Targeted Distribution Cycle Memo*, and the screenshots of the steps from the application and attestation portals to obtain an understanding of HHS's and HRSA's policies and procedures related to selected PRF program requirements;
- interviewed officials from HRSA and its contractors to obtain an understanding of controls related to selected PRF program requirements;
- obtained from HRSA and analyzed the payment and attestation data to determine:
 - the total payments disbursed as of December 17, 2020, and
 - the attestation status of the payment (e.g., whether the provider attested to acceptance of the payment and kept the payment);
- reviewed Acumen's methodology memos to obtain an understanding of the calculation of payments under the Phase 1 General Distribution;
- randomly selected 45 providers that kept all of their payments, totaling \$194,068,160, and for 40 of these sampled providers, reviewed:
 - the gross revenue on the providers' application forms and supporting documentation (e.g., the Federal income tax returns) and

⁷⁵ GAO's *Standards for Internal Control in the Federal Government: September 2014* (GAO-14-704G), known as the Green Book, sets the internal control standards for Federal entities. The Green Book defines internal control as the plans, methods, policies, and procedures used by management to fulfill the mission, strategic plan, goals, and objectives of the entity. The Green Book approaches internal control through a hierarchal structure made up of the five components.

- the subsidiary TINs reported on the providers' application forms (for providers with any related subsidiary TINs) and the subsidiary TINs used when the providers' payments were calculated; and
- discussed the results of our audit with HRSA officials.

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

**APPENDIX B: ROUND 1 AND ROUND 2 PAYMENTS FROM THE
PHASE 1 GENERAL DISTRIBUTION**

Table 4 shows the distribution date, total number of TINs, and total PRF payments for each wave or subwave under round 1 payments from the Phase 1 General Distribution as of December 17, 2020.

**Table 4: Round 1 Payments From the \$30 Billion Allocation of the Phase 1
General Distribution (Automatic Payments)***

Wave or Subwave	Distribution Date	Total Number of Taxpayer Identification Numbers	Total Payment Amount
1	4/10/2020	144,173	\$26,143,124,405
1a	4/21/2020	497	104,622,495
2	4/17/2020	151,504	3,655,751,295
2a	4/17/2020	532	14,223,628
3	4/17/2020	22,492	216,679,469
3a	4/17/2020	270	8,272,031
1b	7/2/2020	3,386	23,384,147
Total		322,854	\$30,166,057,470

* The total number of TINs includes TINs that received more than one payment across the different waves.

Table 5 shows the distribution date, total number of TINs, and total PRF payments for each wave or subwave under round 2 payments from the Phase 1 General Distribution as of December 17, 2020.

**Table 5: Round 2 Payments From the \$20 Billion Allocation of the Phase 1
General Distribution (Automatic and Nonautomatic Payments)* †**

Wave or Subwave	Distribution Date	Total Number of Taxpayer Identification Numbers	Total Payment Amount
4	4/24/2020	14,834	\$9,177,151,026
5a	5/15/2020	11,025	451,405,406
5b	5/26/2020	11,987	261,906,075
5c	5/28/2020	2,399	625,100,850
5d	6/15/2020	18,071	1,079,058,004
5e	6/19/2020	12,412	1,483,390,451
5f	7/7/2020	2,690	778,953,776
5g	7/16/2020	899	92,491,846
5h	7/21/2020	284	1,549,729,160
5i	7/27/2020	496	53,806,552
5j	8/3/2020	168	113,723,266
5k	8/10/2020	469	237,208,491

Wave or Subwave	Distribution Date	Total Number of Taxpayer Identification Numbers	Total Payment Amount
5l	8/17/2020	191	128,814,027
5m	8/24/2020	96	140,907,170
5n	8/31/2020	51	41,136,723
5o	9/8/2020	402	45,162,111
5p	9/28/2020	34	86,904,293
13a	9/11/2020	2,611	112,034,682
13b	9/14/2020	5,169	238,915,350
13c	9/24/2020	1,799	84,880,634
13d	10/1/2020	2,097	219,245,498
13e	10/16/2020	1,581	165,594,484
13f	10/29/2020	417	97,247,069
13g	11/9/2020	149	37,352,697
13h	11/23/2020	216	163,842,983
13i	12/17/2020	10,243	319,915,893
Total		100,790	\$17,785,878,517

* All payments disbursed from round 2 were nonautomatic payments except for wave 4 payments, which were disbursed as automatic payments.

† The total number of TINs includes TINs that received more than one payment across the different waves.

APPENDIX C: HRSA COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services
Administration

Rockville, MD 20857

TO: Gregory E. Demske
Acting Principal Deputy Inspector General

FROM: Carole Johnson
HRSA Administrator

DATE: July 29, 2022

SUBJECT: Office of Inspector General Draft Report titled, "HHS' and HRSA's Controls Related to Selected Provider Relief Fund Program Requirements Could Be Improved, A-09-21-06001"

Attached is the Health Resources and Services Administration's (HRSA) response to the Office of Inspector General draft report titled, "HHS' and HRSA's Controls Related to Selected Provider Relief Fund Program Requirements Could Be Improved, A-02-19-02001." If you have any questions, please contact Sandy Seaton in HRSA's Office of Federal Assistance Management at (301) 443-2432.

A handwritten signature in cursive script that reads "Carole Johnson".

Carole Johnson
Administrator

**Health Resources and Services Administration’s Comments on the OIG Draft Report –
“HHS’ and HRSA’s Controls Related to Selected Provider Relief Fund Program
Requirements Could Be Improved” (A-09-21 06001)**

GENERAL COMMENTS

Thank you for the opportunity to review and provide comment on the Office of Inspector General’s (OIG) audit on the initial set of payments to providers made through the Provider Relief Fund (PRF). The audit covers Phase 1 of the General Distribution (\$50 billion of the \$178 billion appropriated for the PRF) and covers a time period that ended in 2020.

The OIG study began in 2020, early in the pandemic and shortly after the Health Resources and Services Administration (HRSA) began making Phase 1 provider payments. In the last 3 years, during the course of the study, HRSA completed Phase 1 payments, as well as payments for Phase 2, 3, and 4. Consequently, HRSA has benefited from its engagement with OIG during the course of this study, its own internal controls, and other internal reviews, to improve and enhance the accuracy of PRF payments. As such, HRSA addressed many of the study’s findings and recommendations and incorporated them into the PRF payment procedures. Furthermore, HRSA will incorporate this feedback into its post payment activities.

HRSA notes that the PRF’s authorizing statute clearly articulates the Congressional directive to make PRF payments expeditiously in response to the pandemic. Given this directive, HRSA’s primary goal was to address the immediate needs of providers in order to ensure patients were and continue to be well served. While the study notes that PRF reviewed two percent of the provider applications, PRF reviewed over half (57 percent) of the total amount of payments to providers. PRF deliberately focused on payment dollar amounts rather than number of providers to maximize the impact of reviews given the extenuating circumstances, not the least of which was the extreme volume of providers and payments handled. Furthermore, given these circumstances, PRF intentionally designed controls that would address financial stewardship while limiting the administrative burden on the thousands of providers seeking timely financial assistance.

HRSA concurs with the study’s findings related to subsidiary Taxpayer Identification Numbers (TIN) and corrected this issue in subsequent general distributions. HRSA also concurs with the finding regarding the inclusion of Wave 1-4 payments in the first few Wave 5 payment batches. HRSA addressed this issue in later Wave 5 processing and may have resolved the issue by deducting prior payments across Portals 2 through 4, as the study noted. In addition, PRF addressed the finding related to the deadline for returning rejected payments.

HRSA notes the following concerns regarding the study’s findings. First, the reference throughout the report to fraud is incongruent with its study objective, as the audit specifically focused on payment calculation methodology and related internal controls rather than provider fraud, which would have involved the review of submitted documentation for fraudulent information. Further, the Phase 1 design incorporated elements to mitigate fraud, such as paying known and verified providers, specifically those who participate in Medicare whose authenticity and active participation could be confirmed. Thus, the frequent use of “fraud” throughout the report is misleading and the agency respectfully requests its replacement with the more appropriate “improper payments.”

**Health Resources and Services Administration’s Comments on the OIG Draft Report –
“HHS’ and HRSA’s Controls Related to Selected Provider Relief Fund Program
Requirements Could Be Improved” (A-09-21 06001)**

With regards to the study’s finding related to supporting documentation and estimated revenue losses, and the related payment threshold for manual review of documentation, the statute required the Department of Health and Human Services (HHS) to use “the most efficient payment systems practicable to provide emergency payment.” This requirement, along with the imperative to quickly provide funding to providers to support continued operations, framed the process. Requiring additional provider documentation and employing a lower threshold for manual review would have significantly delayed payments without mitigating the risk of improper payments.

For Wave 5 calculations, HRSA paid providers the lesser of two percent of gross receipts or their reported losses for March 2020 and April 2020. HRSA did not require documentation of estimated revenue losses in these months, given the lack of standard estimation techniques that would be applicable to the wide range of providers and circumstances. It should be noted that in Phase 1 Wave 5, only one percent of providers received payments based on estimated revenue losses, while 99 percent of providers were paid based on two percent of gross receipts, for which HRSA did require and have supporting documentation.

Finally, HRSA notes the study’s finding regarding the deadline to return rejected payments does not relate to the study’s focus on correct payment calculation. HRSA did clarify in its August 2021 updates to the Frequently Asked Questions that the deadline was 15 days after having rejected the payment in the attestation portal. More importantly, HRSA has also made clear that any provider who retains a payment accepted the Terms and Conditions and is subject to the program requirements.

HRSA is committed to timely and effective oversight and will continue to take appropriate action to ensure good stewardship of federal resources. HRSA’s responses to the study’s draft recommendations are as follows:

OIG RECOMMENDATIONS

1. Perform post-payment quality control reviews of 3,767 providers that attested to acceptance of payments and kept payments of about \$756 million under wave 5 based on the estimated revenue losses in March and April 2020, and seek repayment for any overpayments from providers, if applicable. If it is not feasible to review all providers, HRSA could consider reviewing the 189 providers identified for manual review and attested to acceptance of payments and kept a total of \$538 million, which was about 71 percent of the \$756 million. Furthermore, HRSA could conduct a cost-benefit analysis for manual review of additional providers, and if the benefit outweighs the cost, it could select additional providers for review.

HRSA RESPONSE

HRSA concurs with the recommendation to review the 189 providers identified for manual review and who attested to acceptance of payment and kept the total \$538 million. HRSA will also conduct a cost-benefit analysis to determine if additional manual reviews are

**Health Resources and Services Administration’s Comments on the OIG Draft Report –
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feasible.

2. Determine the impact on subsequent payments of the \$46.5 million in payments that HRSA made to 315 providers for which HHS did not subtract the automatic payments made to the providers’ subsidiary organizations, and recoup any overpayments from providers. Furthermore, for subsequent payments, identify whether there were any other providers for which HHS did not subtract the automatic payments made to the providers’ subsidiary organizations, determine the impact of not subtracting these payments, and recoup any overpayments.

HRSA RESPONSE

HRSA concurs with this recommendation and has already begun to resolve this issue through the established post-payment quality control review process. HRSA will assess the impact on subsequent payments for the 315 identified providers and their subsidiaries, identifying overpayments that remain uncorrected across all waves of PRF funding. HRSA notes that any potential overpayments could have reduced future payments for those providers that applied for funding in Portals 2, 3, or 4 (meaning the provider may not have received more funds than intended if looking across waves). Through both process improvements and reduction of future payments, HRSA addressed many of these potential overpayments in Phases 3 and 4. Once Phase 4 disbursements are complete, HRSA will conduct a secondary analysis to assess the full impact. HRSA will seek repayments for any overpayments identified in accordance with HRSA’s Post-Payment Manual.

3. Ensure that the Program Support Center collects payments made to the 118 providers that did not return their rejected payments as of March 9, 2022.

HRSA RESPONSE

HRSA concurs with this recommendation. HRSA will send these rejected but not returned payments to the Program Support Center for the collection of any outstanding amounts owed.

4. Establish a process to review providers’ supporting documentation to verify the reported revenue for the 71,021 providers that had the potential to receive \$2 million or less in payments under wave 5 or \$1 million or less in payments under wave 13 and had attested to acceptance of payments and kept their total payments of \$2.8 billion. HRSA could conduct a cost-benefit analysis for manual review of additional providers that had the potential to receive payments below the existing payment thresholds, and if the benefit outweighs the cost, it could select additional providers for review.

HRSA RESPONSE

HRSA concurs with this recommendation to conduct a cost-benefit-analysis for manual review of providers and will assess adding a new discrepancy to our post payment quality control review process to include manual review of Phase 1 providers meeting this criteria.

5. Determine whether there were other providers impacted by the use of incorrect TINs for subsidiary organizations, recalculate the payments for these providers, and recoup any

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overpayments.

HRSA RESPONSE

HRSA concurs with this recommendation and has already begun to resolve this issue through the established post-payment quality control review process. HRSA conducted an initial impact analysis in March 2021 on Wave 5 and found 192 providers impacted by this issue; however, the potential overpayment could have reduced future payments for those providers who applied for funding in Portals 2, 3, or 4 (meaning the provider may not have received more funds than intended if looking across waves). Through both process improvements and reduction of future payments, HRSA addressed many of these potential overpayments in Phases 3 and 4. Once Phase 4 disbursements are complete, HRSA will conduct a secondary analysis to assess the full impact.