

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**HRSA MADE SOME POTENTIAL  
OVERPAYMENTS TO PROVIDERS  
UNDER THE PHASE 2  
GENERAL DISTRIBUTION OF THE  
PROVIDER RELIEF FUND PROGRAM**

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March 2024  
A-09-22-06001

# *Office of Inspector General*

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## Report in Brief

Date: March 2024

Report No. A-09-22-06001

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

The Provider Relief Fund (PRF) provided funds to eligible hospitals and other health care providers (providers) for health care-related expenses or lost revenue attributable to COVID-19. The Phase 2 General Distribution went to Medicaid, CHIP, and dental providers and assisted living facilities. From July 3, 2020, through June 21, 2021, HRSA distributed about \$4.9 billion to more than 100,000 providers. HRSA calculated each payment based on 2 percent of the provider's patient care revenue. To receive a PRF payment, a provider had to submit an application and supporting documentation, such as a Federal income tax return, to support reported revenue. A provider also had to meet certain requirements, such as not being excluded from participating in Medicaid. This audit is part of OIG's oversight of HHS's COVID-19 response and recovery efforts. Our objective was to determine whether PRF payments under the Phase 2 General Distribution were correctly calculated, supported by appropriate documentation, and made to eligible providers.

### How OIG Did This Audit

Our audit covered 73,449 tax-filing taxpayer identification numbers (TINs) for Medicaid and CHIP providers, dental providers, and assisted living facilities for which each provider had received a total of \$10,000 or more from July 3, 2020, through June 21, 2021, under the Phase 2 General Distribution. HRSA disbursed \$4.8 billion to these providers. We selected a statistical sample of 150 providers (each represented by a TIN).

## HRSA Made Some Potential Overpayments to Providers Under the Phase 2 General Distribution of the Provider Relief Fund Program

### What OIG Found

For all 150 sampled providers, HRSA made PRF payments to eligible providers. However, for 17 of the 150 sampled providers, HRSA made PRF payments that were not correctly calculated (15 sampled providers) or were not supported by appropriate documentation (2 sampled providers). As a result, HRSA made \$18.4 million in potential overpayments to the 17 sampled providers. On the basis of our sample results, we estimated that HRSA made \$159.4 million in potential overpayments to providers (3.3 percent of the total PRF payment amount that we audited).

### What OIG Recommends and HRSA Comments

With respect to PRF payments made to providers under the Phase 2 General Distribution, we made three recommendations to HRSA, including that HRSA conduct a review of the 17 sampled providers we identified that had potential overpayments of \$18.4 million and determine the amount of and seek repayment of any overpayments. Furthermore, should HRSA need to rapidly disburse similar payments to providers in response to a future national emergency, we recommend that HRSA consider taking specified steps to safeguard taxpayer money, such as requiring providers to submit supporting documentation for all revenue information provided on applications for payments. (The full text of our recommendations is shown in the report.)

HRSA partially concurred with our first recommendation and concurred with our second and third recommendations. HRSA did not state whether it concurred with our remaining recommendations but said that it will review these recommendations should it need to rapidly disburse similar payments to providers in the future. HRSA provided information on actions that it had taken or planned to take to address our recommendations.

Regarding our first recommendation, HRSA stated that it had identified 16 sampled providers with potential overpayments totaling \$7,241,390 instead of 17 sampled providers with potential overpayments totaling \$18,381,187 (as shown in our draft report). After considering HRSA's comments and reviewing additional documentation that HRSA provided, we maintain that for the 17 sampled providers, HRSA made PRF payments that were not correctly calculated or were not supported by appropriate documentation. However, we recategorized the finding for 1 sampled provider and adjusted the total potential overpayment amount for the 17 sampled providers from \$18,381,187 to \$18,371,939 for the final report.

[View the full report.](#)

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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 bills, which the President signed into law, to establish the Provider Relief Fund (PRF).<sup>1</sup> The PRF provided funds to eligible hospitals and other health care providers (which we collectively refer to as “providers” in this report) 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. These Federal laws appropriated to the PRF a combined \$178 billion in funds, which were generally distributed as direct payments to providers in a series of General and Targeted Distributions.<sup>2</sup>

Under the General Distributions, PRF payments were distributed in four phases to eligible providers, such as providers that participate in the Medicaid program. On July 3, 2020, the Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), began distributing PRF payments under the Phase 2 General Distribution to Medicaid, the Children’s Health Insurance Program (CHIP), and dental providers. Later HRSA also included assisted living facilities in those distributions. As of June 21, 2021 (the end of our audit period), HRSA had distributed about \$4.9 billion to 103,830 providers in Phase 2.<sup>3</sup>

HRSA calculated each PRF payment to a provider under the Phase 2 General Distribution based on 2 percent of the provider’s patient care revenue.<sup>4</sup> To receive a PRF payment, a provider was required to submit a PRF application and documentation, such as a Federal income tax return (Federal tax return), to support the revenue reported on the application. Furthermore, a provider had to meet certain eligibility requirements, such as not being excluded from participating in Medicaid.

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<sup>1</sup> The Coronavirus Aid, Relief, and Economic Security Act, P.L. No. 116-136, was signed into law on Mar. 27, 2020; the Paycheck Protection Program and Health Care Enhancement Act, P.L. No. 116-139, was signed into law on Apr. 24, 2020; and the Consolidated Appropriations Act, 2021, P.L. No. 116-260, was signed into law on Dec. 27, 2020.

<sup>2</sup> Under the Targeted Distributions (which were not covered by this audit), PRF payments were distributed to eligible providers or specific provider types in areas particularly affected by the COVID-19 outbreak.

<sup>3</sup> The payment and attestation data HRSA provided included 111,390 payments made to 103,830 unique taxpayer identification numbers (TINs) from July 3, 2020, through June 21, 2021 (audit period). Throughout this report, we use the term “tax-filing TIN” to refer to a TIN that a provider entered on its Federal income tax return 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 tax-filing TIN as a “provider.”

<sup>4</sup> Patient care revenue does not include revenue such as grants, insurance, investment, or real estate revenue.

The COVID-19 national emergency (which ended May 11, 2023) posed unprecedented challenges to HHS to distribute PRF payments in a fast, fair, and transparent manner and to provide immediate financial relief to providers on the front lines of the COVID-19 response. For that reason, this audit assessed whether PRF payments that HRSA made to providers under the Phase 2 General Distribution were correctly calculated, supported by appropriate documentation, and made to eligible providers. These PRF payments were disbursed from July 3, 2020, through June 21, 2021 (audit period).<sup>5</sup> Furthermore, this audit is one of several Office of Inspector General (OIG) audits that will examine various aspects of PRF payments, including HHS's and HRSA's oversight of payment calculations and provider eligibility, as well as providers' compliance with Federal requirements for reporting and using PRF payments.<sup>6</sup>

COVID-19 has created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for HHS, OIG oversees HHS's COVID-19 response and recovery efforts. This audit is part of OIG's COVID-19 response strategic plan.<sup>7</sup>

## **OBJECTIVE**

Our objective was to determine whether PRF payments under the Phase 2 General Distribution were correctly calculated, supported by appropriate documentation, and made to eligible providers.

## **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, WHO characterized

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<sup>5</sup> Within 7 months of the signing of the first Federal law appropriating funds for the PRF (March 2020), HRSA rapidly distributed \$3.5 billion of the \$4.9 billion (71 percent) total payments distributed under the Phase 2 General Distribution.

<sup>6</sup> The first report, *HHS's and HRSA's Controls Related to Selected Provider Relief Fund Program Requirements Could Be Improved* ([A-09-21-06001](#)), was issued Sept. 26, 2022. The second report, *HHS's Oversight of Automatic Provider Relief Fund Payments Was Generally Effective but Improvements Could Be Made* ([A-02-20-01025](#)), was issued Oct. 30, 2023.

<sup>7</sup> OIG's COVID-19 response strategic plan and oversight activities can be accessed at <https://oig.hhs.gov/coronavirus/index.asp>.

COVID-19 as a pandemic.<sup>8</sup> Later, on March 13, 2020, then-President Trump declared the COVID-19 outbreak a national emergency.<sup>9</sup>

In response to the national emergency, the PRF was established to 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.<sup>10</sup> The PRF program received a combined \$178 billion in funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act; the Paycheck Protection Program and Health Care Enhancement Act; and the Consolidated Appropriations Act, 2021.<sup>11</sup> 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 made to eligible providers. HHS refined and updated these methodologies, requirements, and oversight procedures as PRF payments were being made to providers.

### **General Distributions Under the Provider Relief Fund**

According to HRSA, 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:

- \$50 billion under Phase 1 for eligible providers that billed Medicare fee-for-service;

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<sup>8</sup> 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.

<sup>9</sup> The national emergency ended on May 11, 2023.

<sup>10</sup> 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.”)

<sup>11</sup> 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).

- \$18 billion under Phase 2 for Medicaid and CHIP providers, dental providers, and assisted living facilities;<sup>12</sup>
- \$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;<sup>13</sup> and
- \$17 billion under Phase 4 for eligible providers with losses or incurred expenses from July 1, 2020, through March 31, 2021.

The HHS Office of the Secretary was responsible for PRF program oversight and policy decisions so that the program met its mission to distribute funds as quickly as possible for providers' health care-related expenses or lost revenue (e.g., due to canceled elective services) attributable to COVID-19. Within HHS, HRSA was responsible for providing day-to-day oversight and management of all aspects of the PRF program.<sup>14</sup>

### **Provider Relief Fund Payments Under the Phase 2 General Distribution**

Beginning on July 3, 2020, HRSA distributed PRF payments under the Phase 2 General Distribution to Medicaid and CHIP providers as well as dental providers, and later to assisted living facilities. The payments were based on completed applications submitted through the PRF Application and Attestation portal (application and attestation portal), which was used to help collect information from providers during the application and attestation process. As of June 21, 2021, HRSA had distributed about \$4.9 billion to 103,830 providers in Phase 2.<sup>15, 16</sup>

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<sup>12</sup> HHS received less than \$18 billion in applications from providers for Phase 2 General Distribution funding. As a result, the PRF allocation was revised to \$5.98 billion.

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

<sup>14</sup> HHS and HRSA, *PRF General & Targeted Distribution Cycle Memo*, dated Sept. 30, 2020, and Sept. 30, 2021. The 2021 memo stated that the HHS Office of the Secretary was replaced by the HHS Immediate Office of the Secretary.

<sup>15</sup> Under the Phase 2 General Distribution, HRSA assigned a "wave" number and a "subwave" number to a group of payments based on the payment recipient type (i.e., Medicaid or CHIP provider, dental provider, or assisted living facility) and the payment issuance date. Specifically, HRSA assigned two wave numbers (i.e., waves 8 and 15) and their related subwave numbers (e.g., 8A, 8Fa, 8Fb, and 15A) to a group of payments made under the Phase 2 General Distribution.

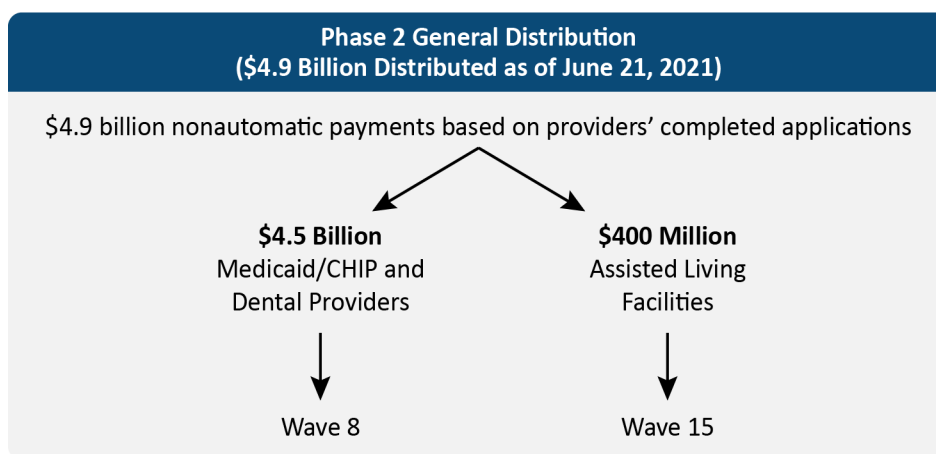
<sup>16</sup> A provider that received a previous payment under the Phase 1 General Distribution may have been eligible to apply for additional PRF payments under the Phase 2 General Distribution if the provider had not yet received a payment that was approximately 2 percent of its patient care revenue.

For PRF payments under the Phase 2 General Distribution, the following sections describe: (1) HRSA’s calculations of the payments, (2) provider submission of supporting documentation for the payments, and (3) provider eligibility requirements for the payments.

### *HRSA’s Calculation of Provider Relief Fund Payments*

HRSA calculated the PRF payments for waves 8 and 15 and related subwaves under the Phase 2 General Distribution. Figure 1 illustrates how payments under the Phase 2 General Distribution were disbursed in designated waves.

**Figure 1: Disbursement of Payments Under Phase 2 General Distribution in the Designated Waves**



Specifically, HRSA worked with a HRSA contractor (Contractor A) to calculate each PRF payment to a provider under the Phase 2 General Distribution. According to HHS’s *Provider Relief Programs: Provider Relief Fund and American Rescue Plan Rural Payments Frequently Asked Questions* (PRF FAQs), the payment was generally based on 2 percent of the provider’s patient care revenue.

When applying for payments under the Phase 2 General Distribution, a provider was required to enter the following on the PRF application: (1) its revenue, (2) the fiscal year for that revenue, and (3) the percentage of revenue from patient care.<sup>17</sup> (We refer to these three items as “revenue information.”) Contractor A used the revenue information reported on the application to calculate the PRF payment. Contractor A submitted methodology memos to HRSA to document the contractor’s process for preparing payment files, which included calculating payments.<sup>18</sup>

<sup>17</sup> The PRF FAQs instructed providers to report the revenue amount from the provider’s most recent Federal tax return for 2017, 2018, or 2019.

<sup>18</sup> According to HRSA, it developed the payment calculation methodology, which Contractor A documented in the methodology memos.

If a provider had received previous payments under the General Distribution or Targeted Distribution and had not yet received a payment that was approximately 2 percent of patient care revenue, the provider could receive additional payments under the Phase 2 General Distribution. To ensure that the total payment made to a provider did not generally exceed 2 percent of the provider’s patient care revenue, Contractor A accounted for the payments that a provider had previously received when it determined the payment amount under the Phase 2 General Distribution. Contractor A then prepared the payment files and provided them to HRSA for approval, which sent the payment files to another HRSA contractor (Contractor B) to disburse payments to each provider.

Figure 2 shows HRSA’s overall payment calculation methodology for payments under the Phase 2 General Distribution.

**Figure 2: HRSA’s Overall Payment Calculation Methodology for Payments Under the Phase 2 General Distribution**

$$\left[ \left( 2\% \right) \times \left( \text{Provider's 2019 or Most Recent Tax Year's Revenue} \times \% \text{ of Revenue From Patient Care}^* \right) \right] - \left[ \text{Previous PRF Payments} \right]$$

\*According to HHS’s *Instructions for Phase 2 - General Distribution Via Provider Relief Fund Application and Attestation Portal*, “patient care” does not include revenue such as grants, insurance, investment income, or real estate revenue.

### *Provider Submission of Supporting Documentation for Provider Relief Fund Payments*

When a provider applied for PRF payments under the Phase 2 General Distribution, the provider was required to submit a PRF application and documentation supporting the revenue and the fiscal year for that revenue reported on the application. Documentation included the provider’s most recent Federal tax return for 2017, 2018, or 2019, or a written statement explaining why it was exempt from filing a Federal tax return (e.g., it was a State-owned hospital or health care clinic). However, for the percentage of revenue from patient care, HRSA did not require a provider to submit supporting documentation. For example, a provider could self-report on the application that 100 percent of its revenue came from patient care. Furthermore, the provider was required to report on the application its organization taxpayer identification number (TIN) and any subsidiary TINs to show the parent-subsidary relationship.

Contractor A analyzed the provider’s revenue and TIN information for potential flags that HRSA defined, such as: (1) potential duplicate payments, (2) inconsistent subsidiary TIN information, and (3) potential payments more than \$1 million. If Contractor A identified any providers with one of these flags, another HRSA contractor (Contractor C) prepared a list of those providers and submitted the list to Contractor D for manual review.

Contractor D reviewed the revenue reported on the providers' applications and the revenue shown in any supporting documentation and then prepared a list of providers that: (1) did not submit supporting documentation, (2) had conflicting revenue information (e.g., the revenue reported on the application was more than the established percentage of the revenue shown in the supporting documentation), or (3) had special situations (e.g., did not include a breakdown of the revenue by subsidiary TINs, if any, on the supporting documentation).<sup>19</sup> Contractor D referred these providers to HRSA for further review by submitting a list (i.e., Contractor D's worksheet summarizing the results of its manual review or the summary review worksheet) so that HRSA could determine whether payments should be made to the providers.

### *Provider Eligibility Requirements for Provider Relief Fund Payments*

To be eligible for PRF payments under the Phase 2 General Distribution, a provider must not have been terminated from participation in Medicare or be precluded from receiving payment through Medicare Advantage or Medicare Part D; must not be excluded from participation in Medicare, Medicaid, and other Federal health care programs; and must not have had Medicare billing privileges revoked. To determine a provider's eligibility, HRSA checked whether a provider's TIN was included in several sanctions lists (e.g., the Centers for Medicare & Medicaid Services' [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). Furthermore, a provider's TIN or its subsidiary TIN must be included in the State-provided curated lists of eligible Medicaid and CHIP providers and in the HHS-created curated lists of Medicare providers, dental providers, and assisted living facilities (curated lists).<sup>20, 21</sup>

## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered 73,449 tax-filing TINs for Medicaid and CHIP providers, dental providers, and assisted living facilities for which each provider had received a total payment of \$10,000 or more from July 3, 2020, through June 21, 2021, under the Phase 2 General Distribution of the PRF. HRSA disbursed total payments of \$4.8 billion to these providers.

We selected for review a stratified random sample of 150 providers (each represented by a tax-filing TIN) and did the following:

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<sup>19</sup> An example of conflicting revenue information between the revenue on the PRF application and the revenue in the supporting documentation is when a provider's revenue reported on the application was more than the established percentage of the revenue reported on the Federal tax return.

<sup>20</sup> According to HRSA, a provider could also establish eligibility for payment under the Phase 2 General Distribution by having previously received a PRF payment under the Targeted Distribution.

<sup>21</sup> Providers' compliance with Federal requirements for reporting and using PRF payments is outside the scope of this audit.

- To determine whether HRSA correctly calculated the PRF payment amount for each provider, we recalculated the PRF payment amount by following the steps outlined in Contractor A’s methodology memos for calculating payments.
- To determine whether the PRF payments were supported by appropriate documentation as identified in HHS’s instructions for the PRF application, we reviewed the supporting documentation (e.g., a Federal tax return) that HRSA provided for each sampled provider. In addition, after reviewing the supporting documentation, we obtained additional documentation (e.g., general ledgers and audited financial statements) from 35 of the 150 sampled providers to verify the revenue information reported on each application when that information appeared to conflict with the revenue information included in the supporting documentation.<sup>22</sup>
- To determine whether payments were made to eligible providers, we reviewed the sanctions lists and curated lists.

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, Appendix B describes our statistical sampling methodology, and Appendix C contains our sample results and estimates.

## FINDINGS

For all 150 sampled providers, HRSA made PRF payments to eligible providers. However, for 17 of the 150 sampled providers, HRSA made PRF payments that were not correctly calculated (15 sampled providers) or were not supported by appropriate documentation (2 sampled providers).

Specifically, for the 15 sampled providers for which PRF payments were not correctly calculated, HRSA made payments:<sup>23</sup>

- without subtracting payments that had previously been made to providers’ subsidiary organizations (6 sampled providers),

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<sup>22</sup> For example, we performed this additional review for a provider if the provider had entered 100 percent as its percentage of revenue from patient care on the PRF application and appeared to have non-patient care revenue based on our review of the provider’s Federal tax return.

<sup>23</sup> The total number of sampled providers is greater than 15 because 2 providers had more than 1 deficiency.

- based on incorrectly calculated patient care revenue (5 sampled providers),
- based on revenue information that providers incorrectly entered on PRF applications (5 sampled providers), and
- based on revenue information for which bad debt was not subtracted (1 sampled provider).

For the remaining two sampled providers, HRSA made payments based on revenue that was not supported by Federal tax returns.

As a result, HRSA made \$18.4 million in potential overpayments to the 17 sampled providers.<sup>24</sup> On the basis of our sample results, we estimated that HRSA made \$159.4 million in potential overpayments to providers (3.3 percent of the total PRF payment amount that we audited).<sup>25</sup>

For an additional four sampled providers, HRSA made payments without subtracting PRF payments that had previously been made to providers' subsidiary organizations (three sampled providers) and based on revenue information that was incorrectly entered on the PRF application (one sampled provider). However, these providers voluntarily returned to HRSA the payments totaling \$282.5 million.<sup>26</sup>

These potential overpayments occurred because certain HRSA procedures for processing and reviewing providers' PRF applications and supporting documentation did not ensure that PRF payments were correctly calculated and were supported by appropriate documentation. For example, HRSA's procedures did not include requiring providers to submit documentation supporting the percentage of revenue from patient care.

To prepare for a possible public health emergency in the future, HRSA should use the information included in this report when determining lessons learned from administering PRF

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<sup>24</sup> HRSA made \$18,371,939 in potential overpayments to the 17 sampled providers. We consider these payments potential overpayments because HRSA allows providers to use the overpaid amounts on expenses attributable to COVID-19 or lost revenue before HRSA's deadline for using the payments. Furthermore, according to HRSA, the overpayments would be accounted for when HRSA calculates subsequent phase distributions to a provider. Specifically, HRSA may calculate a smaller payment or no payment to a provider by accounting for the overpayment (which HRSA refers to as a "passive offset"). Without further reviews, we cannot confirm whether providers used overpaid amounts on expenses attributable to COVID-19 or lost revenue before the HRSA deadline for using the payments and whether later phase distributions to a provider accounted for the overpayments and resulted in a smaller payment or no payment to the provider.

<sup>25</sup> Specifically, we estimated that HRSA made potential overpayments of \$159,379,359. In addition, the 90-percent confidence interval for potential overpayments to providers in the sampling frame was \$82,323,127 to \$236,435,591.

<sup>26</sup> The amount that the four sampled providers returned to HRSA was \$282,508,037. When estimating the total potential overpayments, we did not include this amount because the providers had voluntarily returned their payments before we selected them as part of our sample.

distributions during the COVID-19 national emergency. HRSA should also look for additional ways to safeguard taxpayer money when rapidly disbursing payments to health care providers in response to future national emergencies.

### **HRSA MADE PROVIDER RELIEF FUND PAYMENTS THAT WERE NOT CORRECTLY CALCULATED**

HRSA made incorrectly calculated PRF payments to 15 sampled providers. Specifically, HRSA made payments: (1) without subtracting payments that had previously been made to providers' subsidiary organizations, (2) based on incorrectly calculated patient care revenue, (3) based on revenue information that was incorrectly entered on the PRF applications, and (4) based on revenue information for which bad debt was not subtracted.

#### **HRSA Made Payments to Providers Without Subtracting Payments That Had Previously Been Made to Providers' Subsidiary Organizations**

According to HHS's instructions for the application and attestation portal, a provider enters its organization TIN in the portal and enters any subsidiary TINs in the portal's section "List all Subsidiary TIN(s) Associated with this Entity." HRSA collects the TIN information to identify organizational structure (i.e., the parent-subsidiary relationship) so that HRSA does not make incorrect payments to a parent organization that includes the revenue of a subsidiary organization on its Federal tax return and files a Federal tax return on behalf of a subsidiary organization. Furthermore, according to Contractor A's methodology memos, PRF payments that providers and their subsidiaries previously received are subtracted from providers' potential payments under the Phase 2 General Distribution. In addition, the PRF FAQs included guidance that PRF payments under the Phase 2 General Distribution were generally based on 2 percent of the provider's patient care revenue.

HRSA made payments to six sampled providers without subtracting PRF payments that had previously been made to the providers' subsidiary organizations.<sup>27</sup> As a result, HRSA made potential overpayments of \$7,274,503 to these providers.<sup>28</sup>

The following are two examples of HRSA's incorrectly calculated payments to providers:

- One sampled provider submitted a PRF application with a 2019 Federal tax return and supporting documentation that listed its 18 subsidiary organizations and their revenues, which were part of the revenue entered on the provider's Federal tax return. The

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<sup>27</sup> HRSA also made payments to three other sampled providers without subtracting PRF payments that had previously been made to the providers' subsidiary organizations. However, these providers voluntarily returned to HRSA their payments totaling \$254,714,960.

<sup>28</sup> HRSA also made a potential overpayment to one of the six sampled providers based on incorrect revenue information, i.e., for which bad debt was not subtracted from the provider's reported revenue on its PRF application. (See the finding in the section "HRSA Made a Payment to a Provider Based on Revenue Information for Which Bad Debt Was Not Subtracted.")

18 subsidiary organizations had received previous PRF payments of \$1,146,080 under the Phase 1 General Distribution. However, HRSA did not subtract that amount when it calculated the provider's PRF payment under the Phase 2 General Distribution. As a result, HRSA paid this provider \$31,627,424 instead of \$30,481,344, which was \$1,146,080 more than it should have paid.

- For another sampled provider, on February 24, 2021, HRSA calculated a PRF payment of \$11,901,774 under the Phase 2 General Distribution. However, HRSA could not disburse the payment on that date because the provider was not enrolled in a health care payment delivery solution that HRSA required a provider to enroll in if it was to receive more than \$100,000 in PRF payments. Therefore, the payment was withheld until June 8, 2021. During the period when the payment was withheld (from February 24, 2021, through June 8, 2021), HRSA made \$3,690,600 in PRF payments to the provider's subsidiary organizations. However, on June 8, 2021, HRSA made a payment of \$11,901,774 to the provider without accounting for the \$3,690,600 that it had already paid to the provider's subsidiary organizations. Furthermore, HRSA did not subtract \$832,911 of previous PRF payments that had been disbursed to the provider's subsidiary organizations when it calculated the provider's PRF payment under the Phase 2 General Distribution. As a result, HRSA paid the provider \$4,523,511 (\$3,690,600 + \$832,911) more than it should have paid.<sup>29</sup>

According to HRSA's process document for Contractor D's manual review of information submitted by providers, the manual review was required to identify only providers that met one of three conditions (e.g., providers that did not include a breakdown of the revenue by subsidiary TINs, if any, on the supporting documentation) and to refer those providers to HRSA for further review. Because the manual review identifies only providers that meet certain conditions, Contractor D did not identify all providers with subsidiary organizations that may have received previous payments and whose revenue was included in each provider's Federal tax return, and it did not refer those providers to HRSA for further review.<sup>30</sup>

Furthermore, HRSA did not have a process to recalculate PRF payments to a provider for which HRSA had withheld the disbursement of approved payments, i.e., by considering additional payments that HRSA had made to a provider's subsidiary organizations during the period when the payment was withheld.

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<sup>29</sup> This provider received the potential overpayment of \$11,901,774, which consisted of \$3,690,600 from previous PRF payments that had been disbursed to the provider's subsidiary organizations (during the period when the \$11,901,774 payment was withheld) and were not subtracted; \$832,911 from previous PRF payments that had been disbursed to the provider's four subsidiary organizations and were not subtracted; and \$7,378,263 from the adjustment made to the percentage of revenue from patient care—from 99 percent to 70 percent. (See the finding in the following section, "HRSA Made Payments to Providers Based on Incorrectly Calculated Patient Care Revenue.")

<sup>30</sup> Contractor D reviewed four of the six sampled providers and referred one provider for HRSA's further review because the provider's reported quarterly data were unclear (not because the providers' subsidiary organizations received previous payments).

Finally, according to HRSA, it did not have data to confirm that the subsidiary organization TINs that the providers reported on their applications were correct and complete.<sup>31</sup>

### HRSA Made Payments to Providers Based on Incorrectly Calculated Patient Care Revenue

According to HHS’s instructions for the PRF application, a provider enters on the application the revenue from its most recent Federal tax return for 2017, 2018, or 2019.<sup>32</sup> For example, if a provider is a tax-exempt organization, it reports the amount entered on line 9 from Form 990, U.S. Return of Organization Exempt from Income Tax, after subtracting any joint venture income. HRSA refers to this amount as “revenue.” In addition, the application instructions state that a provider enters the percentage of its revenue that represents the amount received for patient care furnished for the same fiscal year as the revenue entered. The application instructions also state that a provider should exclude non-patient care revenue from its percentage of revenue from patient care, such as grants, insurance, investment income, or real estate revenue.

Figure 3 shows the formula used to calculate patient care revenue according to the PRF FAQs.

**Figure 3: Formula Used To Calculate Patient Care Revenue**

$$\text{Patient Care Revenue} = \left( \begin{array}{c} \text{Provider's 2019 or} \\ \text{Most Recent Tax} \\ \text{Year's Revenue} \end{array} \right) \times \left( \begin{array}{c} \% \text{ of Revenue} \\ \text{From Patient} \\ \text{Care} \end{array} \right)$$

HRSA made payments to five sampled providers based on incorrectly calculated patient care revenue.<sup>33</sup> Specifically, Contractor A used: (1) the provider’s total revenue reported on the PRF application, which included non-patient care revenue, or (2) the incorrect percentage of revenue from patient care reported on the application. As a result, HRSA made potential overpayments of \$7,545,737 to the five sampled providers.

Of the five sampled providers, three were tax-exempt providers that entered on their applications the revenue from line 12 (total revenue) instead of line 9 (program service

<sup>31</sup> CMS’s Provider Enrollment, Chain, and Ownership System provides information on organizational structure that shows the parent-subsidary relationship when available, which HRSA could use, in part, to develop for future use a dataset for parent-subsidary relationships.

<sup>32</sup> HHS’s *Instructions for the Distribution for Medicaid, CHIP, and Dental Providers Via Enhanced Provider Relief Fund Payment Portal* for applications submitted before Aug. 10, 2020, and *Instructions for Phase 2 – General Distribution Via Provider Relief Fund Application and Attestation Portal* for applications submitted on or after Aug. 10, 2020.

<sup>33</sup> HRSA made two payments to another sampled provider based on incorrectly calculated patient care revenue, which resulted in a total potential overpayment of \$126,271. We obtained from HRSA the provider’s application and a worksheet showing that HRSA made a later payment to the provider by accounting for the potential overpayment of \$126,271. When estimating the total potential overpayment, we did not include this amount.

revenue) from Form 990 of the Federal tax return. The revenue from line 12 included non-patient care revenue. For example, one provider entered revenue of \$9,063,381 from line 12, which included \$499,176 of non-patient care revenue, instead of \$8,564,205 from line 9 of Form 990. As a result, HRSA paid this provider \$179,455 based on revenue of \$9,063,381 instead of \$169,571 based on revenue of \$8,564,205, which was \$9,884 more than it should have paid.<sup>34</sup>

The remaining two sampled providers reported the incorrect percentage of revenue from patient care on their applications. For example, a provider reported on the application that the percentage of revenue from patient care was 99 percent, which included real estate revenue. However, the additional documentation that we obtained from the provider showed that the percentage of revenue from patient care was 70 percent. As a result, HRSA paid this provider \$11,901,774 based on the 99 percent instead of \$4,165,480 based on the 70 percent, which was \$7,378,263 more than it should have paid.<sup>35</sup>

Contractor D manually reviewed the supporting documentation for one of the five sampled providers and referred the provider to HRSA for further review because the provider's reported quarterly data were unclear. However, Contractor D did not indicate to HRSA whether it had reviewed the percentage of revenue from patient care. HRSA then made a payment based on the provider's percentage of revenue from patient care entered on the application (99 percent) and did not request from the provider additional documentation supporting that percentage.

According to HRSA, it required providers to submit Federal tax returns and considered these returns to be sufficient to calculate the revenue from patient care. However, the Federal tax return for this sampled provider did not include detailed information on what made up the reported revenue, which may have consisted of revenue from both patient and non-patient care. Without detailed information on what made up the reported revenue, the provider's percentage of revenue from patient care could not have been calculated.

For the remaining four sampled providers, because the potential payments were less than \$1 million, according to HRSA, the providers' applications were not manually reviewed.

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<sup>34</sup> The provider entered 99 percent for its percentage of revenue from patient care.

<sup>35</sup> We determined that the entire amount of \$11,901,774 that the provider received was the potential overpayment. This potential overpayment included: (1) \$3,690,600 from previous PRF payments that had been disbursed to the provider's subsidiary organizations (during the period when the \$11,901,774 payment was withheld) and were not subtracted and (2) \$832,911 from previous PRF payments that had been disbursed to the provider's four subsidiary organizations and were not subtracted. (See footnote 29.) Because the potential overpayment cannot exceed the amount that the provider received, for this finding, we determined that only \$7,378,263 of the \$7,736,294 (\$11,901,774 – \$4,523,511) was a potential overpayment.

## **HRSA Made Payments to Providers Based on Revenue Information That Was Incorrectly Entered on Provider Relief Fund Applications**

According to HHS's instructions for the PRF application, a provider enters on the application the revenue from its most recent Federal tax return for 2017, 2018, or 2019.

HRSA made payments to providers based on revenue information that was incorrectly entered on the providers' PRF applications. Specifically, HRSA made payments to five sampled providers that generally had entered extra digits for revenue on their applications.<sup>36</sup> As a result, HRSA made potential overpayments of \$3,521,328 to these providers.

For example, one sampled provider entered revenue of \$44,630,500 on its application instead of the \$446,305 shown on its Federal tax return. The provider entered two extra zeroes that overstated its revenue by \$44,184,195.<sup>37</sup> As a result, HRSA paid this provider \$892,610 instead of \$8,926, which was \$883,684 more than it should have paid.

According to HRSA, the payments were made based on self-reported revenue on the providers' applications, and the applications were not flagged for manual review. In addition, HRSA's application and attestation portal did not have a function that requested a provider to check that the revenue amount reported in the revenue field of the application was entered correctly.

## **HRSA Made a Payment to a Provider Based on Revenue Information for Which Bad Debt Was Not Subtracted**

According to HHS's instructions for the PRF application, a provider enters on the application the revenue from its most recent Federal tax return for 2017, 2018, or 2019. A provider that is a partnership, C corporation, or S corporation is required to subtract bad debt when calculating the revenue to be reported on the application.<sup>38</sup>

Figure 4 on the next page shows a portion of a fictitious partnership organization's Form 1065, U.S. Return of Partnership Income, that we created for illustration purposes. The provider in this example should enter on the application the net amount for revenue (\$49,700,000) by subtracting the amount on line 12 (bad debt of \$300,000) from the amount on line 1c (gross receipts or sales balance of \$50,000,000).

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<sup>36</sup> HRSA paid another sampled provider \$27,793,077 based on revenue information that the provider incorrectly entered on its PRF application; however, this provider voluntarily returned the payment to HRSA.

<sup>37</sup> According to HRSA, it has resolved this issue in later phases of the General Distributions by limiting all of the revenue fields on the PRF application to whole numbers and adding formatting with commas to make any error more apparent to a provider. We did not verify HRSA's resolution of this issue.

<sup>38</sup> According to the Internal Revenue Service, bad debt is the "total debts that became worthless in whole or in part during the tax year."

**Figure 4: A Portion of a Sample Form 1065 for a Federal Tax Return With Bad Debt**

<b>Income</b>	<b>1a</b> Gross receipts or sales . . . . .	<b>1a</b>	53,000,000	
	<b>b</b> Returns and allowances . . . . .	<b>1b</b>	3,000,000	
	<b>c</b> Balance. Subtract line 1b from line 1a . . . . .			<b>1c</b> 50,000,000
	<b>2</b> Cost of goods sold (attach Form 1125-A) . . . . .			<b>2</b>
	<b>3</b> Gross profit. Subtract line 2 from line 1c . . . . .			<b>3</b> 50,000,000
	<b>4</b> Ordinary income (loss) from other partnerships, estates, and trusts (attach statement) . . . . .			<b>4</b>
	<b>5</b> Net farm profit (loss) (attach Schedule F (Form 1040 or 1040-SF)) . . . . .			<b>5</b>
	<b>6</b> Net gain (loss) from Form 4797, Part II, line 17 (attach Form 4797) . . . . .			<b>6</b>
<b>7</b> Other income (loss) (attach statement) . . . . .			<b>7</b>	
<b>8</b> <b>Total income (loss).</b> Combine lines 3 through 7 . . . . .			<b>8</b> 50,000,000	
<b>or limitations)</b>	<b>9</b> Salaries and wages (other than to partners) (less employment credits) . . . . .			<b>9</b> 11,000,000
	<b>10</b> Guaranteed payments to partners . . . . .			<b>10</b>
	<b>11</b> Repairs and maintenance . . . . .			<b>11</b> 200,000
	<b>12</b> Bad debts . . . . .			<b>12</b> 300,000

HRSA made a payment to one sampled provider that reported on its application incorrect revenue—i.e., for which bad debt was not subtracted. As a result, HRSA made a potential overpayment of \$12,768 to this provider.<sup>39</sup>

Specifically, the sampled provider submitted two applications: the first one on June 19, 2020, and the second one on October 7, 2020. On the first application, the provider reported revenue of \$50,052,851 for 2019 and submitted a 2019 Federal tax return as supporting documentation. In accordance with HHS’s application instructions, the provider correctly subtracted bad debt of \$638,407 when it reported revenue on the first application. Based on that application, HRSA made a payment of \$1,001,057 to the provider.<sup>40</sup> On the second application, the provider reported revenue of \$50,691,258 for 2019 without subtracting bad debt of \$638,407 as required. The provider resubmitted the same 2019 Federal tax return that it had submitted with the first application. Based on the higher revenue that included bad debt, HRSA made an additional payment of \$12,768 to the provider. As a result, HRSA paid this provider a total of \$1,013,825 instead of \$1,001,057, which was \$12,768 more than it should have paid.

Contractor D manually reviewed both of the provider applications and indicated in its summary review worksheet for the second application that the “applicant did not adjust for bad debt

<sup>39</sup> HRSA made a payment to another sampled provider: (1) based on revenue information for which bad debt was not subtracted, which resulted in a potential overpayment of \$13,337, and (2) without considering the provider’s revised revenue information, which resulted in a potential overpayment of \$534,925. We obtained from HRSA the provider’s application and a worksheet showing that HRSA made a later payment to the provider by accounting for the potential overpayment of \$548,262 (\$13,337 + \$534,925). When estimating the total potential overpayments, we did not include this amount.

<sup>40</sup> When calculating this first payment, HRSA did not subtract a payment of \$146 that had previously been made to this provider under the Phase 1 General Distribution. If HRSA had subtracted this amount from \$1,001,057, the provider would have received a first payment of \$1,000,911 under the Phase 2 General Distribution. We included the potential overpayment of \$146 as part of the finding “HRSA Made Payments to Providers Without Subtracting Payments That Had Previously Been Made to Providers’ Subsidiary Organizations.”

expense” and provided the worksheet to HRSA for further review. However, HRSA made the additional payment of \$12,768 based on the second application.

According to HRSA, it made the additional payment of \$12,768 because the revenue reported on the application was not more than the established percentage of revenue shown in the supporting documentation. In addition, HRSA’s application process allowed providers to submit multiple applications but did not allow them to indicate that the applications included revised revenue information.

### **HRSA MADE PROVIDER RELIEF FUND PAYMENTS THAT WERE NOT SUPPORTED BY APPROPRIATE DOCUMENTATION**

According to HHS’s instructions for the PRF application, a provider enters on the application the revenue from its most recent Federal tax return for 2017, 2018, or 2019. The PRF FAQs and HHS’s application instructions specified that providers upload the most recent Federal tax return for 2017, 2018, or 2019.

HRSA made payments to two sampled providers based on revenue reported on the PRF applications that was not supported by the providers’ Federal tax returns. As a result, HRSA made potential overpayments of \$17,603 to these providers.

For example, for 2019, one sampled provider reported revenue of \$2,739,760 on its application. However, the provider did not submit a 2019 Federal tax return as supporting documentation. Instead, it submitted a 2018 Federal tax return with revenue of \$2,333,929.<sup>41</sup> HRSA did not request that the provider submit its 2019 Federal tax return to support the revenue of \$2,739,760 for 2019 and calculated the payment of \$8,116 based on the revenue amount reported on the application. As a result, HRSA paid this provider \$8,116 more than it should have paid.

According to HRSA, Contractor D did not manually review sampled providers’ supporting documentation because the potential payments were less than \$1 million.

### **HRSA MADE AN ESTIMATED \$159 MILLION IN POTENTIAL OVERPAYMENTS TO PROVIDERS**

HRSA made \$18,371,939 in potential overpayments to 17 of the 150 sampled providers. On the basis of our sample results, we estimated that HRSA made \$159,379,359 in potential overpayments (3.3 percent of the total PRF payment amount that we audited).<sup>42</sup> HRSA could have saved approximately \$159,379,359 in PRF payments during our audit period.

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<sup>41</sup> The sampled provider submitted two PRF applications: one for 2018 and another for 2019. It had received a previous payment of \$46,679 based on the 2018 application. On the 2018 application, the provider reported revenue of \$2,333,939, which was \$10 more than the revenue reported on the 2018 Federal tax return.

<sup>42</sup> See footnote 25.

For an additional four sampled providers, HRSA made payments without subtracting all of the payments that had previously been made to providers' subsidiary organizations (three sampled providers) and based on revenue information that was incorrectly entered on the PRF application (one sampled provider). However, these providers voluntarily returned to HRSA their payments of \$282,508,037.<sup>43</sup>

### **CERTAIN HRSA PROCEDURES FOR PROCESSING AND REVIEWING PROVIDER RELIEF FUND APPLICATIONS AND SUPPORTING DOCUMENTATION DID NOT ENSURE THAT PAYMENTS WERE CORRECTLY CALCULATED AND WERE SUPPORTED BY APPROPRIATE DOCUMENTATION**

The potential overpayments occurred because certain HRSA procedures for processing and reviewing PRF applications and supporting documentation did not ensure that PRF payments were correctly calculated and were supported by appropriate documentation. Specifically:

- HRSA's procedures did not include an in-depth review of all providers' supporting documentation when manual reviews were conducted to identify all providers with subsidiary organizations that may have received previous payments and whose revenue was included in the providers' Federal tax returns.
- HRSA's procedures did not include recalculating PRF payments to a provider for which HRSA had withheld the disbursement of approved payments, i.e., by considering additional payments that HRSA had made to a provider's subsidiary organizations during the period when the payment was withheld.
- HRSA did not have data to confirm that the subsidiary organization TINs that providers reported on their applications were correct and complete.
- HRSA's procedures did not include requiring providers to submit documentation supporting the percentage of revenue from patient care.
- HRSA's application and attestation portal did not have a function that requested a provider to check that the revenue amount reported in the revenue field of its application for payment was entered correctly. The portal allowed a provider to submit multiple applications but did not allow the provider to indicate that the applications included revised revenue information (e.g., higher revenue that included bad debt), which could have impacted the payments the provider was eligible to receive.

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<sup>43</sup> Because these providers voluntarily returned their payments, we did not include these payments when estimating the total potential overpayments.

## CONCLUSION

The COVID-19 national emergency posed unprecedented challenges to HRSA to distribute PRF payments in a fast, fair, and transparent manner and to provide immediate financial relief to providers on the front lines of the COVID-19 response. For that reason, this audit assessed whether PRF payments that HRSA made to providers under the Phase 2 General Distribution were correctly calculated, supported by appropriate documentation, and made to eligible providers.

Our audit found that for all 150 sampled providers, HRSA made PRF payments to eligible providers. However, for 17 of the 150 sampled providers, HRSA made PRF payments that were not correctly calculated (15 sampled providers) or were not supported by appropriate documentation (2 sampled providers). For example, HRSA made payments based on incorrectly calculated patient care revenue. On the basis of our sample results, we estimated that HRSA made \$159.4 million in potential overpayments to providers.<sup>44</sup>

These potential overpayments occurred because certain HRSA procedures for processing and reviewing providers' PRF applications and supporting documentation did not ensure that PRF payments were correctly calculated and were supported by appropriate documentation. For example, HRSA's procedures did not include requiring providers to submit documentation supporting the percentage of revenue from patient care.

To prepare for a possible public health emergency in the future, HRSA should use the information included in this report when determining lessons learned from administering PRF distributions during the COVID-19 national emergency. HRSA should also look for additional ways to safeguard taxpayer money when rapidly disbursing payments to health care providers in response to future national emergencies.

## RECOMMENDATIONS

With respect to PRF payments that were already made to providers under the Phase 2 General Distribution, we recommend that the Health Resources and Services Administration do the following:

- Conduct a review of the 17 sampled providers we identified that had potential overpayments of \$18,371,939 and determine the amount of and seek from these providers repayment of any overpayments.
- Identify other providers with subsidiary organizations that had revenues included in the providers' Federal tax returns. Determine whether the payments made to the subsidiary organizations were correctly accounted for when calculating payments for the providers under the Phase 2 General Distribution. In addition, determine the

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<sup>44</sup> See footnote 25.

amount of and seek from these providers repayment of any overpayments. If it is not feasible to review all providers, HRSA could conduct a cost-benefit analysis for conducting manual reviews to identify providers and, if the benefit outweighs the cost, it could select some providers to review.

- Identify other providers for which payments under the Phase 2 General Distribution were approved and withheld, determine whether their subsidiary organizations received additional payments during the period when the payments were withheld, and if so, recalculate the payments made to these providers and determine the amount of and seek from these providers repayment of any overpayments.

Furthermore, should HRSA need to rapidly disburse similar payments to providers in response to a future national emergency, we recommend that HRSA consider taking the following steps (to the extent they are applicable) to safeguard taxpayer money, which could have saved approximately \$159,379,359 during our audit period:

- Work with CMS to use the information from CMS's Provider Enrollment, Chain, and Ownership System and use Federal tax returns (e.g., Schedule R of Form 990 for information on a tax-exempt provider's subsidiary organizations), in part, to develop a more complete dataset to show parent-subsidiary relationships.
- Require providers to submit supporting documentation for all revenue information provided on applications for payments (e.g., the percentage of revenue from patient care).
- Establish an application and attestation portal function that requests a provider to check that the revenue amount entered in the revenue field of its application for payment is entered correctly. For example, HRSA could modify its application and attestation portal by adding a step in which, after a provider enters its revenue amount, the portal generates a new screen that displays the entered amount and requests that the provider confirm the amount.
- Add a field in the application for payment that allows a provider to indicate that an application includes revised revenue information that may impact the payment that a provider is eligible to receive.

#### **HRSA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, HRSA partially concurred with our first recommendation and concurred with our second and third recommendations. HRSA did not state whether it concurred with our fourth recommendation but said that it will review this recommendation should it need to rapidly disburse similar payments to providers in the future. (HRSA referred to our fourth through seventh recommendations as "recommendation #4" and

addressed our four recommendations in one section of its comments.) HRSA provided information on actions that it had taken or planned to take to address our recommendations.

After considering HRSA's comments and reviewing additional documentation that HRSA provided, we maintain that our first recommendation is valid, but we adjusted the potential overpayment amount for the 17 sampled providers.

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 D.

## **HRSA COMMENTS**

HRSA had the following comments on our four recommendations:

- Regarding our first recommendation, HRSA partially concurred and stated that where it concurs with our finding, it will seek repayment. HRSA stated that in one case it did not find any overpayment, and in five cases it agreed that there was an overpayment but disagreed with the amount. HRSA stated that it had reviewed our findings and identified 16 sampled providers with potential overpayments totaling \$7,241,390 instead of 17 sampled providers with potential overpayments totaling \$18,381,187. HRSA stated that some of the payments we identified as overpayments were: (1) incorrectly calculated or did not follow HRSA's payment calculation methodology and (2) were based on information not available to HRSA at the time the payments were calculated. HRSA also stated that in accordance with the program's standard postpayment oversight processes, HRSA will analyze the information associated with these payments and will take appropriate action, including seeking repayment.
- Regarding our second recommendation, HRSA concurred and stated that it had weighed the costs and benefits of reviewing all Phase 2 applications to identify providers whose applications included subsidiary organizations' revenue and had determined that reviewing all Phase 2 applications in this manner is not feasible. However, HRSA said that as part of its program integrity work, it maintains a list of postpayment discrepancies that it tracks and works to resolve, and depending on the availability of resources, HRSA will consider adding this recommendation to its postpayment followup.
- Regarding our third recommendation, HRSA concurred and stated that it required providers to enroll in a health care payment delivery solution for payments greater than \$100,000 (a fraud risk mitigation step). HRSA stated that pending a provider's enrollment, payments were placed on hold, sometimes for several weeks. HRSA also stated that in some instances it did not recalculate a payment to account for any payments issued to the provider's subsidiary organizations while the parent organization's payment was on hold. HRSA said that as part of its program integrity work, it maintains a list of postpayment discrepancies that it tracks and works to

resolve, and depending on the availability of resources, HRSA will consider adding this recommendation to its postpayment followup.

- Regarding our fourth recommendation (shown as the fourth through seventh recommendations in the “Recommendations” section of this report), HRSA stated that it will review this recommendation should it need to rapidly disburse similar payments to providers in the future. HRSA said that it took actions in subsequent application cycles that align with this recommendation, such as updating the portal to limit revenue fields to whole numbers and adding formatting to assist applicants. HRSA also said that it had updated the instructions and provided robust technical assistance to support providers applying in Phases 3 and 4. HRSA stated that the recommendation to add a field in the payment application that allows a provider to indicate that an application includes revised revenue information that may impact the payments that a provider is eligible to receive was not feasible for Phase 2 payments. HRSA stated that in Phase 3, it permitted only a single application per provider and considered only the last, on-time application.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Regarding HRSA’s comments on our first recommendation, we maintain that for the 17 sampled providers, HRSA made PRF payments that were not correctly calculated or were not supported by appropriate documentation. However, after reviewing additional documentation that HRSA provided for 1 of these sampled providers, we recategorized the finding for this provider and adjusted the potential total overpayment amount for the 17 sampled providers.

Specifically, we removed this sampled provider from our finding on PRF payments that were not supported by appropriate documentation and added it to our finding on PRF payments that were not correctly calculated. Because this sampled provider entered incorrect and extra digits for revenue on its payment application, we included the provider in the finding section “HRSA Made Payments to Providers Based on Revenue Information That Was Incorrectly Entered on Provider Relief Fund Applications.”<sup>45</sup> As a result of recategorizing the finding for the 1 sampled provider, we adjusted the total potential overpayment amount for the 17 sampled providers from \$18,381,187 (as shown in the draft report) to \$18,371,939.

In its comments, HRSA identified 16 sampled providers with potential overpayments totaling \$7,241,390 instead of 17 sampled providers with potential overpayments totaling \$18,371,939. The difference of \$11,130,549 includes \$7,378,263 that HRSA paid to one sampled provider based on using 99 percent as the percentage of revenue from patient care (which the provider reported on its application) to calculate the patient care revenue amount instead of 70 percent

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<sup>45</sup> The sampled provider entered revenue of \$46,239,198 on its application instead of the \$462,392 shown on its Federal tax return. The provider entered one incorrect digit and two extra digits that overstated its revenue by \$45,776,806. As a result, HRSA paid this provider \$924,784 instead of \$9,248, which was \$915,536 more than it should have paid.

(which was shown in additional documentation we obtained from the provider). According to HRSA, for this sampled provider, we calculated the overpayment based on information that was not available to HRSA at the time the payment was calculated. However, as part of its program oversight, HRSA could have instructed providers to submit documentation to support the percentage of revenue from patient care reported on applications for payments.

For the remaining recommendations, we believe the actions that HRSA stated it has taken or plans to take should improve the safeguarding of taxpayer funds distributed as part of the Phase 2 General Distribution and taxpayer funds that could be distributed in a future public health emergency.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered 73,449 tax-filing TINs for Medicaid and CHIP providers, dental providers, and assisted living facilities for which each provider had received a total payment of \$10,000 or more from July 3, 2020, through June 21, 2021, under the Phase 2 General Distribution of the PRF. HRSA disbursed total payments of \$4,800,368,201 to these providers.

We selected for review a stratified random sample of 150 providers (each represented by a tax-filing TIN), for which HRSA paid \$736,982,240.

We did not perform an overall assessment of the internal structure of HRSA because our objective did not require us to do so. Rather, we limited our review of internal controls to those that were significant to our objective. Specifically, we: (1) reviewed the PRF FAQs, terms and conditions of the Phase 2 General Distribution, and instructions for the PRF application to obtain an understanding of HRSA's policies and procedures for the Phase 2 General Distribution payment calculation and the requirements for supporting documentation and provider eligibility; and (2) interviewed HRSA officials and its contractors to obtain an understanding of controls related to the Phase 2 General Distribution payment calculation and the requirements for supporting documentation and provider eligibility.

Our review enabled us to establish reasonable assurance of the accuracy and completeness of the data obtained from HRSA.

We conducted our audit from May 2021 through September 2023.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the PRF FAQs, terms and conditions of the Phase 2 General Distribution, and instructions for the PRF application to obtain an understanding of HRSA's policies and procedures for the Phase 2 General Distribution payment calculation and the requirements for supporting documentation and provider eligibility;
- interviewed officials from HRSA and its contractors to obtain an understanding of controls related to the Phase 2 General Distribution payment calculation and the requirements for supporting documentation and provider eligibility;
- reviewed Contractor A's methodology memos to obtain an understanding of the Phase 2 General Distribution payment calculation;

- obtained from HRSA and analyzed the payment and attestation data for the Phase 2 General Distribution, including the crosswalk for subsidiaries;
- created a sampling frame that consisted of 73,449 provider tax-filing TINs, each of which received a total of \$10,000 or more during our audit period, for which HRSA disbursed a total payment of \$4,800,368,201 (Appendix B);
- selected a stratified random sample of 150 providers from our sampling frame and, for each sampled provider, obtained from HRSA the supporting documentation (e.g., the PRF application and Federal tax return submitted by the provider) and determined whether the PRF payments were calculated correctly, supported by appropriate documentation, and made to an eligible provider;<sup>46</sup>
- analyzed the Phase 1 General Distribution and Targeted Distribution PRF payment data from HRSA to determine whether any of the 150 sampled providers had received previous PRF payments and whether those payments should have been subtracted when HRSA calculated the PRF payment under the Phase 2 General Distribution;
- estimated the total potential overpayments that HRSA made to providers for PRF payments that were not calculated correctly or supported by appropriate documentation (Appendix C); 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.

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<sup>46</sup> After reviewing HRSA's supporting documentation for each of the 150 sampled providers, we obtained additional documentation (e.g., general ledgers and audited financial statements) from 35 of those sampled providers to verify their revenue information reported on the PRF application when that information appeared to conflict with the revenue information shown in the supporting documentation.

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### SAMPLING FRAME

The sampling frame consisted of 73,449 provider tax-filing TINs for Medicaid and CHIP providers, dental providers, and assisted living facilities for which each provider received a total payment of \$10,000 or more from July 3, 2020, through June 21, 2021, under the Phase 2 General Distribution of the PRF and for which HRSA disbursed total payments of \$4,800,368,201.

### SAMPLE UNIT

The sample unit was a provider tax-filing TIN–total payment.<sup>47</sup>

### SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample (Table 1). The four strata were based on total payments received by a provider tax-filing TIN.

**Table 1: Strata for Our Sample**

Stratum	Dollar Range of Total Payments Received	Frame Size	Value of Frame	Sample Size
1	Total payments equal to or greater than \$10,000 but less than or equal to \$70,000	62,959	\$1,660,646,484	45
2	Total payments greater than \$70,000 but less than or equal to \$500,000	9,587	1,412,277,996	40
3	Total payments greater than \$500,000 but less than or equal to \$8,000,000	878	1,035,589,300	40
4	Total payments greater than \$8,000,000	25	691,854,421	25
	<b>Total</b>	<b>73,449</b>	<b>\$4,800,368,201</b>	<b>150</b>

### SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS) statistical software.

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<sup>47</sup> For the purposes of this report, we refer to a provider’s tax-filing TIN as a “provider.”

## **METHOD OF SELECTING SAMPLE ITEMS**

We sorted the providers that received a total payment of \$10,000 or more in ascending order based on the provider's tax-filing TIN. We then consecutively numbered the providers in each stratum of the sampling frame. After generating the random numbers for our sample according to our sample design, we selected the corresponding frame items for review.

## **ESTIMATION METHODOLOGY**

We used the OIG-OAS statistical software to estimate the dollar amount of potential overpayments that HRSA made to providers. Specifically, we used the software to compute the point estimate and corresponding two-sided 90-percent confidence interval (Appendix C).

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 2: Sample Details and Results**

<b>Stratum</b>	<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>No. of Sample Items With Potential Overpayments</b>	<b>Value of Potential Overpayments</b>
1	62,959	\$1,660,646,484	45	\$1,164,824	1	\$8,116
2	9,587	1,412,277,996	40	5,425,340	4	91,751
3	878	1,035,589,300	40	38,537,655	9	5,143,732
4	25	691,854,421	25	691,854,421	3	13,128,340
<b>Total</b>	<b>73,449</b>	<b>\$4,800,368,201</b>	<b>150</b>	<b>\$736,982,240</b>	<b>17</b>	<b>\$18,371,939</b>

**Table 3: Estimated Value of Potential Overpayments in the Sampling Frame  
(Limits Calculated at the 90-Percent Confidence Level)**

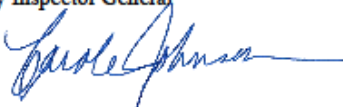
Point estimate	\$159,379,359
Lower limit	82,323,127
Upper limit	236,435,591

## APPENDIX D: HRSA COMMENTS



5600 Fishers Lane  
Rockville, MD 20857



**DATE:** October 27, 2023  
**TO:** Juliet T. Hodgkins  
Principal Deputy Inspector General  
**FROM:** Carole Johnson  
Administrator   
**SUBJECT:** OIG Draft Report: A-09-22-06001

Attached is the Health Resources and Services Administration's response to the above referenced report. If you have any questions, please contact Sandy Seaton in the Health Resources and Services Administration's Office of Federal Assistance Management at (301) 443-2432.

Attachment

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Health Resources and Services Administration  
[www.hrsa.gov](http://www.hrsa.gov)

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN  
SERVICES ON THE OFFICE OF THE INSPECTOR GENERAL'S PRELIMINARY DRAFT  
REPORT A-09-22-06001

The Health Resources and Services Administration (HRSA) appreciates the opportunity to comment on the Office of Inspector General's (OIG) audit of Provider Relief Fund (PRF) Phase 2 General Distribution payments.

The audit reviewed whether the Department of Health and Human Services and HRSA Phase 2 General Distribution PRF payments were correctly calculated, supported by appropriate documentation and made to eligible providers. Phase 2, which began in 2020, represented the second distribution of the PRF for which providers submitted applications for payment. The audit covered \$4.9 billion in PRF payments that were disbursed to more than 100,000 providers, covering 73,449 tax filing taxpayer identification numbers. Payment recipients included providers who participated in Medicaid and Children's Health Insurance Program, dental providers and assisted living facilities who did not also participate in Medicare and therefore had not been eligible for an earlier payment.

The goal of the PRF program was to help enable the health care system to remain operational at a time when many health care providers were experiencing unprecedented and abrupt losses in revenue and increased expenses. As you know, there were incredible demands on providers in responding to the pandemic and a Congressional directive to distribute the funds "in consideration of the most efficient payment systems practicable." Therefore, HRSA established a risk mitigation strategy to manually review Phase 2 applications that met certain criteria, including potential payments over \$1 million, to ensure greater pre-payment scrutiny of higher risk, larger payments and to leverage post-payment oversight through reporting and audits for the broader set of providers who received funds. This strategy also took into account that many of the providers who were eligible under Phase 2 were smaller providers with smaller profit margins and less administrative capacity to complete complex applications.

Additionally, HRSA used an approach that sought to manage risk while ensuring timely processing of applications in response to Congress' directive and providers' needs. As a result, it established a policy to manually review applications where reported revenues and expenses did not fall within expected ranges. In addition, since the methodologies used to calculate subsequent PRF payments took into account prior payments, a potential overpayment would have been corrected by reducing the subsequent payment by the value of the prior payments. In these instances, HRSA reviewed all payments made to the providers reviewed by OIG and found that often the Phase 2 potential overpayment was offset by a subsequent payment in Phase 3 and recoupment was operationalized in this way. In these cases, the findings were removed from the OIG's recommendations.

HRSA's response to the OIG draft recommendations are as follows:

**Recommendation #1**

Conduct a review of the 17 sampled providers we identified that had potential overpayments of \$18,381,187 and determine the amount of and seek these providers repayment of any

1

overpayments.

**HRSA Response #1**

HRSA partially concurs with OIG's recommendations. Where HRSA concurs with the OIG finding, HRSA will seek repayment. However, in one case, HRSA does not find any overpayment and, in five cases, HRSA agrees that there was an overpayment, but disagrees with the amount. In total, of the 17 providers that OIG identified as having overpayments, HRSA reviewed OIG's findings and identified 16 providers with overpayments totaling \$7,241,390. The delta between the OIG's findings and HRSA's review is equal to \$11,139,798. Some of the payments that OIG identified as overpayments were incorrectly calculated or did not follow HRSA's payment calculation methodology. Further, some of the payments that OIG identified as overpayments were based on information not available to HRSA at the time the payments were calculated. In accordance with the program's standard post-payment oversight processes, HRSA will analyze the information associated with these payments and based on the results of that analysis, will take appropriate action including seeking repayment.

**Recommendation #2**

Identify other providers with subsidiary organizations that had revenues included in the providers' Federal tax returns. Determine whether the payments made to the subsidiary organizations were correctly accounted for when calculating payments for the providers under the Phase 2 General Distribution. In addition, determine the amount of and seek from these providers repayment of any overpayments. If it is not feasible to review all providers, HRSA could conduct a cost-benefits analysis for conducting manual reviews to identify providers and, if the benefit outweighs the cost, it could select some providers to review.

**HRSA Response #2**

HRSA concurs with OIG's recommendation. HRSA weighed the costs and benefits of reviewing all Phase 2 applications to identify providers whose applications included subsidiary organizations' revenue, in-line with the OIG recommendation. HRSA determined that reviewing all Phase 2 applications in this manner is not feasible. However, as part of HRSA's program integrity work, HRSA maintains a list of post-payment discrepancies that it tracks and works to resolve. Depending on the availability of resources, which are significantly limited by the recission of funds through the Fiscal Responsibility Act, HRSA will consider adding this recommendation to its post-payment follow-up.

**Recommendation #3**

Identify other providers for which payments under Phase 2 General Distribution were approved and delayed, determine whether their subsidiary organizations received additional payments during the period of delay, and if so, recalculate the payments made to these providers and determine the amount of and seek from these providers repayments of any overpayments.

**HRSA Response #3**

HRSA concurs with OIG's recommendation. HRSA required providers to enroll in OptumPay, a fraud risk mitigation step for payments greater than \$100,000. Pending the provider's enrollment in OptumPay, payments were placed on hold, sometimes for several weeks. In some instances, HRSA did not recalculate the payment to account for any payments issued to the provider's subsidiary organizations while the parent's payment was on hold. As part of HRSA's program integrity work, HRSA maintains a list of post-payment discrepancies that it tracks and

works to resolve. Depending on the availability of resources, which are significantly limited by the rescission of funds through the Fiscal Responsibility Act, HRSA will consider adding this recommendation to its post-payment follow-up.

#### **Recommendation #4**

Furthermore, should HRSA need to rapidly disburse similar assistance payments to providers in response to a future national emergency, we recommend that HRSA consider taking the following steps (to the extent they are applicable) to safeguard taxpayer money, which could have saved approximately \$159,582,349 during our audit period:

- a. Work with CMS to use the information from CMS's Provider Enrollment, Chain, and Ownership System and use Federal tax returns (e.g., Schedule R of Form 990 for information on a tax-exempt provider's subsidiary organizations), in part, to develop a more complete dataset to show parent-subsidiary relationships.
- b. Require providers to submit supporting documentation for all revenue information provided on applications for assistance payments (e.g., the percentage of revenue from patient care).
- c. Establish an application and attestation portal function that requests providers to confirm that the revenue entered on their applications for assistance payments is correct. For example, HTSA could modify its application and attestation portal by adding a step in which, after a provider enters its revenue amount, the portal generates a new screen that displays the entered amount and requests that the provider confirm the amount.
- d. Add a field in applications for assistance payments that allows a provider to indicate that an application includes revised revenue information that may impact the payment that a provider is eligible to receive.

#### **HRSA Response #4**

HRSA will review this recommendation should it need to rapidly disburse similar assistance payments to providers in the future. HRSA took actions in subsequent application cycles that align with this recommendation. For example, HRSA updated the portal to limit the revenue fields to whole numbers and added formatting to assist applicants. In addition, HRSA updated the instructions and provided robust technical assistance to support providers applying in Phases 3 and 4.

Finally, the recommendation to add a field in the application that allows a provider to indicate that an application includes revised revenue information that may impact the payment that a provider is eligible to receive was not feasible for Phase 2 payments, which were made on a rolling basis. However, in Phase 3, HRSA only permitted a single application per provider and only the last, on-time application was considered.