Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HHS'S OVERSIGHT OF AUTOMATIC PROVIDER RELIEF FUND PAYMENTS WAS GENERALLY EFFECTIVE BUT IMPROVEMENTS COULD BE MADE

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Report in Brief
Date: October 2023
Report No. A-02-20-01025

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

HHS's Oversight of Automatic Provider Relief Fund Payments Was Generally Effective but Improvements Could Be Made

Why OIG Did This Audit

The Provider Relief Fund (PRF) provides funds to eligible providers for health care-related expenses or lost revenue attributable to COVID-19. HHS was responsible for PRF program oversight and policy decisions, and the Health Resources and Services Administration (HRSA) provided day-to-day oversight of the program from April 10 through April 24, 2020 (audit period).

Providers that received automatic PRF payments under the Phase 1 General Distribution were subject to several program requirements, such as not having had their Medicare billing privileges revoked. To ensure that providers received the correct PRF payments from the Phase 1 General Distribution, HHS and HRSA established oversight procedures related to these requirements. This audit is part of OIG's oversight of HHS's COVID-19 response and recovery efforts.

Our objective was to determine whether HHS ensured that Phase 1 General Distribution automatic PRF payments were:
(1) properly calculated and (2) disbursed only to eligible providers.

How OIG Did This Audit

Our audit covered approximately $39 billion in automatic PRF payments that were disbursed to 319,468 providers during our audit period. We performed audit procedures, including interviewing HRSA officials and contractors and analyzing payment data.

What OIG Found

HHS allocated PRF funds in a series of distributions in several phases. Of relevance to this audit, HHS allocated $50 billion to distribute to providers in two rounds under the Phase 1 General Distribution for eligible providers that billed Medicare fee-for-service. Most of these payments were automatically made to these providers (i.e., providers did not need to take action to receive payments).

Generally, HHS's oversight was effective in ensuring that most of the approximately $39.3 billion in automatic PRF payments were properly calculated and disbursed to eligible providers. However, HHS did not ensure that approximately $2.16 billion (5.5 percent) in automatic PRF payments were properly calculated as intended. Also, HHS did not prevent more than $247 million in payments (less than 1 percent) from being disbursed to ineligible providers and did not utilize all readily available lists to identify these providers. Specifically, we found that HHS did not ensure that all round 1 automatic PRF payments to Medicare providers were properly calculated as intended. Additionally, HHS did not ensure that calculations for round 2 automatic PRF payments were properly made to Medicare providers. Finally, HHS did not identify all ineligible providers and exclude them from receiving PRF payments.

We understand that HHS and HRSA's operational objective at the beginning of the COVID-19 national emergency was to rapidly disburse PRF payments to support providers facing severe economic hardship during the national emergency. We also understand that HHS prioritized the rapid distribution of PRF payments and did not focus its activities on lowering the risk of improper payments because those activities would have delayed the disbursement of PRF payments. However, as HRSA fully develops and implements postpayment review processes, it should consider the information and recommendations included in this report.

What OIG Recommends and HRSA Comments

We made a series of recommendations to HRSA, including that it perform postpayment quality control reviews of selected providers and recoup any overpayments. (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 has taken or plans to take to address them.

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SELECTED ACRONYMS AND ABBREVIATIONS

CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CCW	Chronic Conditions Data Warehouse
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
FAQ	Frequently Asked Question
FFS	fee-for-service
GAO	Government Accountability Office
HHA	home health agency
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
LEIE	List of Excluded Individuals/Entities
MCO	managed care organization
NPR	net patient revenue
OIG	Office of Inspector General
PECOS	Provider Enrollment, Chain, and Ownership System
PPS	Prospective Payment System
PRF	Provider Relief Fund
SNF	skilled nursing facility
TIN	taxpayer identification number
TPR	total patient revenue

INTRODUCTION

WHY WE DID THIS AUDIT

On March 13, 2020, the President 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) 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 were 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 funds in a fast, fair, and transparent manner and to provide immediate financial relief to providers on the front lines of the COVID-19 response. Within 1 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 automatic PRF payments to Medicare providers under the Phase 1 General Distribution.[4] As of April 24, 2020, HHS had distributed approximately $39 billion to 319,468 Medicare providers.[5]

During our audit period (April 10 through April 24, 2020), HHS was responsible for PRF program oversight and policy decisions, and the Health Resources and Services Administration (HRSA) within HHS provided day-to-day oversight and management of the program. Providers that received PRF payments under the Phase 1 General Distribution were subject to several program requirements, such as the requirement that a provider must not have had their Medicare billing

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

[2] Under the General Distributions, PRF payments were distributed in four phases (Phases 1, 2, 3, and 4). For example, under the Phase 1 General Distribution, PRF payments were distributed to eligible Medicare providers that billed Medicare fee-for-service (FFS) (Medicare Parts A or B) in calendar year 2019. Under the Targeted Distributions, PRF payments were distributed to eligible providers or specific provider types 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 Phase 1 General Distribution consisted of automatic and nonautomatic payments.

[5] The payment data the Health Resources and Services Administration (HRSA) provided included payments made to 319,468 unique taxpayer identification numbers (TINs) from Apr. 10 through Apr. 24, 2020 (our audit period). For the purposes of this report, we refer to a provider's Medicare billing TIN or tax filing TIN as a "provider."

privileges revoked. To ensure that providers received the correct PRF payments from the Phase 1 General Distribution, HHS and HRSA established oversight procedures related to these requirements. For example, HHS and HRSA developed guidance for providers to attest to their acceptance or rejection of PRF payments they received. HHS and HRSA also developed procedures to identify ineligible providers prior to disbursing PRF payments.

This audit assessed HHS's and HRSA's oversight of automatic PRF payments disbursed under the Phase 1 General Distribution. These PRF payments were disbursed during our audit period. This audit is the second of several Office of Inspector General (OIG) audits that will examine various aspects of PRF payments, including HHS's and HRSA's oversight over payment calculations and provider eligibility, COVID-19 diagnostic testing and treatment services under HRSA's COVID-19 Uninsured Program[6] and Coverage Assistance Fund, and providers' compliance with Federal requirements for reporting and using PRF payments.[7]

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.[8]

OBJECTIVE

Our objective was to determine whether HHS ensured that Phase 1 General Distribution automatic PRF payments were: (1) properly calculated and (2) disbursed only to eligible providers.

BACKGROUND

COVID-19 National Emergency and the Provider Relief Fund

On January 30, 2020, the World Health Organization declared the COVID-19 outbreak a public health emergency of international concern, and on March 11, 2020, it characterized COVID-19

[6] Under the COVID-19 Uninsured Program, formally known as the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, HHS reimbursed 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] 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.

[8] OIG's COVID-19 response and recovery strategic plan and oversight activities can be accessed at https://oig.hhs.gov/coronavirus/index.asp.

as a pandemic.[9] Then, on March 13, 2020, then-President Trump declared the COVID-19 outbreak a national emergency.

As a result of the COVID-19 pandemic, many States ordered health care facilities, physicians, and other providers and professionals to delay elective or nonurgent procedures to conserve personal protective equipment and free up staff and facilities for COVID-19 patients. In April 2020, OIG issued the results of a survey[10] in which hospitals throughout the Nation reported that ceasing elective procedures and other services decreased revenues at the same time that their costs increased as they prepared for a potential surge of patients. Many hospitals reported that their cash reserves were quickly depleting, which could disrupt ongoing hospital operations. Additionally, all types of hospitals, and especially small rural hospitals, reported that they requested financial assistance.

In response to the national emergency, the PRF was established to provide funds to eligible hospitals and other providers for: (1) health care-related expenses or lost revenue attributable to COVID-19, (2) COVID-19 testing and treatment for uninsured individuals, and (3) the administration of vaccines to the uninsured and underinsured.[11] 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.[12] Under the CARES Act, Congress directed that PRF payments be distributed to "eligible health care 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 funds 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

[9] 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.

[10] HHS-OIG, *Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020* (OEI-06-20-00300) Apr. 3, 2020.

[11] 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.

[12] 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).

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

Phase 1 General Distribution Under the Provider Relief Fund

To support hospitals and other 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 PRF funds in a series of distributions in several phases. Of relevance to this audit, HHS allocated $50 billion to distribute to providers in two rounds under the Phase 1 General Distribution for eligible providers that billed Medicare fee-for-service (FFS).[13] Most of these payments were automatically made to these providers (i.e., providers did not need to take action to receive payments). The two rounds of the Phase 1 General Distribution consisted of:

- *Round 1 (Automatic Payments)*. Beginning April 10, 2020, HHS distributed round 1 automatic PRF payments to providers. Approximately $30.1 billion in payments were distributed automatically to 319,468 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.[14] We refer to these payments as "automatic PRF payments."

- *Round 2 (Automatic and Nonautomatic Payments)*. On April 24, 2020, HHS began distributing round 2 automatic PRF payments to providers who received a round 1 automatic PRF payment. Approximately $9.2 billion in automatic PRF payments were distributed to 14,834 of those providers under wave 4 based on revenue data from providers' Medicare cost reports on file with the Centers for Medicare & Medicaid Services (CMS).[15] Later, HHS distributed about $8.6 billion in nonautomatic payments to 85,956 providers under waves 5 and 13 based on completed applications submitted through HHS's online application portal.[16] In total, approximately $18.4 billion in round 2 PRF payments had been distributed to 102,975 providers, as of October 3, 2022.

[13] For each round, HHS or HRSA assigned a wave and subwave number to a group of payments based on the payment distribution date.

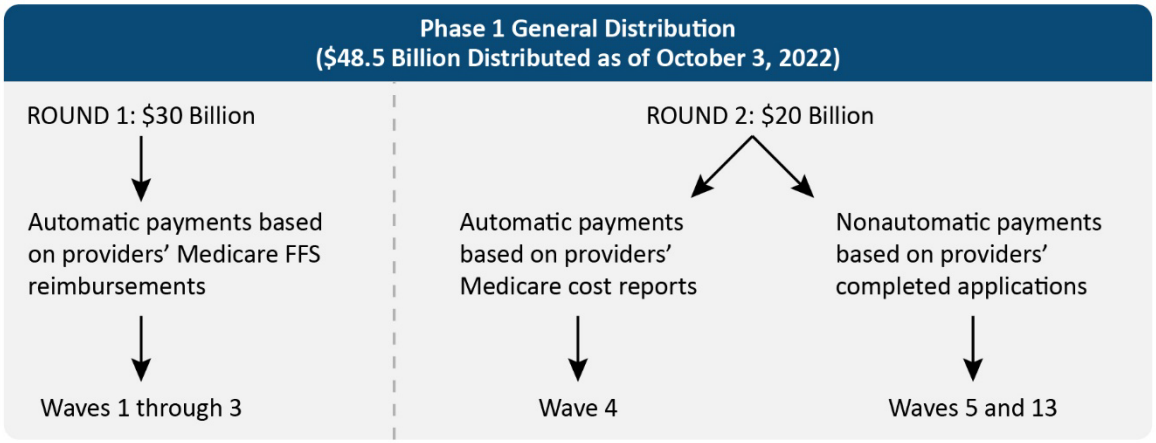
[14] HHS and HRSA assigned waves 1 through 3 and their related subwaves (1a, 1b, 2a, and 3a) to round 1 payments under the Phase 1 General Distribution. The totals do not include subwave 1b payments totaling approximately $23.4 million disbursed to 3,386 providers on July 2, 2020, which occurred after our audit period (Apr. 10 through Apr. 24, 2020).

[15] Wave 4 did not have any related subwaves. These payments were made only to providers who received a round 1 automatic PRF payment.

[16] HHS and HRSA assigned waves 5 and 13 and their related subwaves (5a through 5p and 13a through 13i) to round 2 payments. 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.

Figure 1 below illustrates how payments under the Phase 1 General Distribution were disbursed in two rounds and in designated waves.

Figure 1: Disbursement of Payments Under Phase 1 General Distribution



Dollar figures may not reflect exact amounts in report due to rounding.

As of April 24, 2020, approximately $39.3 billion in automatic PRF payments had been distributed to 319,468 Medicare providers. Figure 4 (see Appendix B) details the payment distribution date, total number of taxpayer identification numbers (TINs), and total PRF payments distributed for selected waves and subwaves under round 1 and round 2 automatic PRF payments from the Phase 1 General Distribution.

Calculation of Automatic Payments Under the Phase 1 General Distribution

HHS calculated automatic PRF payments made during waves 1 through 4. Specifically, HHS worked with an HHS contractor (Contractor A) to calculate round 1 automatic PRF payments (i.e., waves 1 through 3) by using a provider's proportionate share of Medicare FFS reimbursements in calendar year 2019. Round 2 automatic PRF payments (i.e., wave 4) were generally determined based on 2 percent of a provider's 2018 or most recent complete tax year's gross receipts. If a provider received a round 1 automatic PRF payment equal to or more than 2 percent of its gross receipts for 2018 or its most recent complete tax year, the provider could not receive a round 2 automatic PRF payment.[17]

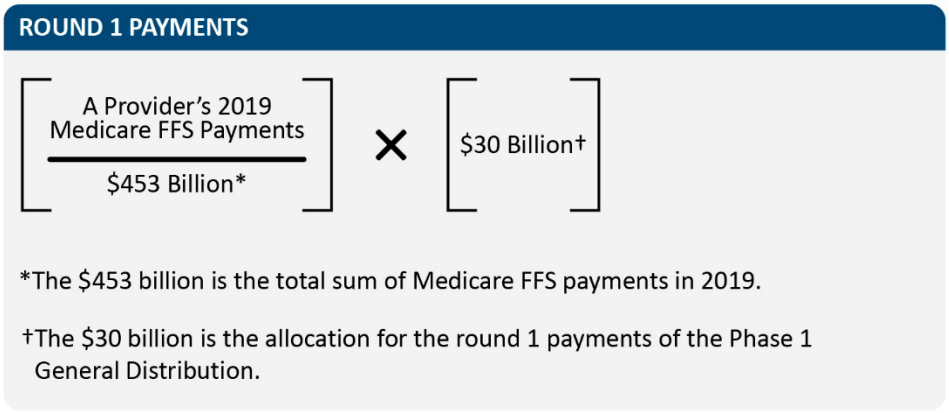
Providers that received and kept these payments were required to meet PRF program requirements, such as not having been terminated from participation in Medicare. Furthermore, each phase of the General Distribution had its own provider-eligibility requirements. For example, to be eligible for a Phase 1 General Distribution payment, providers must have billed the Medicare FFS program in 2019.

[17] 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.

Calculation for Round 1 Automatic Provider Relief Fund Payments

Round 1 automatic PRF payments were calculated by determining a provider's share (i.e., percentage) of their 2019 Medicare FFS reimbursements out of the total of all providers' 2019 Medicare reimbursements[18] and multiplying that percentage by $30 billion (an approximate total of all round 1 automatic PRF payments). Figure 2 below shows the payment calculation methodology for round 1 automatic payments.

Figure 2: Payment Calculation Methodology for Round 1 Automatic Payments



In its formula for calculating payments, HHS used the sum of a provider's 2019 Medicare FFS payments in the numerator. Because Medicare reimbursement amounts are set forth in several Prospective Payment Systems (PPSs) and fee schedules, these reimbursements may have been made through different payment systems (e.g., an acute care hospital could have received payments under the Inpatient PPS and the Outpatient PPS). Payments by Medicare Advantage Plans were not to be included in the calculation because they are not FFS payments. The denominator—the total of *all* providers' 2019 Medicare FFS reimbursements—was $453 billion, the sum of 2019 FFS payments to the following provider types: (1) inpatient hospital, (2) home health agency (HHA), (3) skilled nursing facility (SNF), (4) hospice, (5) outpatient hospital, (6) durable medical equipment (DME) supplier, and (7) Part B physician/supplier (i.e., carrier provider).[19]

The following factors were to be included when calculating Medicare FFS payments:[20]

[18] According to HHS, the total sum of Medicare FFS reimbursements in calendar year 2019 was $453 billion.

[19] Provider types as defined by CMS's Provider Enrollment, Chain, and Ownership System (PECOS).

[20] These factors are costs and different variables used in Medicare claims' payment files from the Research Data Assistance Center (ResDAC) and Chronic Conditions Data Warehouse (CCW). ResDAC is a CMS contractor that helps researchers interested in CMS data. CMS's CCW provides researchers with Medicare and Medicaid beneficiary, claims, and other data linked by beneficiary across the continuum of care.

- *Payments Made by Medicare (Inpatient)*: This amount was derived by adding claim payment amounts to a field known as "claim pass-through per diem payment amount" and multiplying the result for each claim by the number of days the enrollee was hospitalized, plus the payment made by the primary insurance payor.

- *Payments Made by Medicare (Outpatient)*: This amount was composed of all claim payment amounts for an enrollee.

- *Payments Made by Beneficiaries*: This amount included enrollees' coinsurance liability amounts and deductibles paid by enrollees.

Payments made by Medicare were to factor in the 2-percent sequestration reduction initially required by the Budget Control Act of 2011 (P.L. No. 112-25) and in effect during our audit period.[21]

Calculation for Round 2 Automatic Provider Relief Fund Payments

Round 2 automatic PRF payments were calculated using net patient revenue (NPR) amounts reported on a Medicare Part A provider's fiscal year 2018 cost report. NPR amounts are calculated by taking a provider's total patient revenue (TPR) and subtracting its contractual allowances.[22] HHS multiplied the NPR amount by 2 percent to determine the maximum PRF payment amount a provider was eligible to receive. HHS then subtracted the provider's round 1 payment from this amount to determine the amount the provider was eligible to receive in round 2.[23]

Eligibility Requirements for Provider Relief Fund Payments

The Terms and Conditions for the Phase 1 General Distribution (PRF Terms and Conditions) state that PRF payments shall reimburse recipients for health care-related expenses or lost revenues attributable to COVID-19. To be eligible for a PRF payment, a provider must not: (1) be terminated from participating in Medicare or precluded from receiving payment through

[21] The Budget Control Act of 2011 requires mandatory across-the-board reductions in Federal spending, known as the 2-percent sequestration reduction amount. See also: Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. No. 99-177) and Section 901 of the American Taxpayer Relief Act of 2012 (P.L. No. 112-240).

[22] TPR is the total income generated from hospitals, other health care facilities, and Medicare-approved clinical laboratories. It includes nonpatient care revenues, for which the PRF does not reimburse, per the PRF Terms and Conditions. In providers' cost reports, reductions in revenue due to contractual allowances (e.g., contractual adjustments, policy and charity discounts, and teaching allowances) are subtracted from TPR to determine the providers' NPR.

[23] Any providers with a zero or negative amount were not eligible for the supplemental payment.

Medicare Advantage or Part D;[24] (2) be excluded from participating in Medicare, Medicaid, or other Federal health care programs; or (3) have its Medicare billing privileges revoked (PRF Terms and Conditions). For example, providers that are terminated or had billing privileges revoked are prohibited from receiving payments from the Medicaid and Medicare programs (42 CFR §§ 424.535 and 424.540) and are therefore ineligible for PRF payments.

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

The HHS Office of the Secretary was responsible for PRF program oversight and policy decisions so that the program could meet its mission to establish the PRF and 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.[25]

In late March 2020, HHS began developing prepayment validation processes to help ensure that correct Phase 1 General Distribution payments would be disbursed to eligible providers.[26] For example, HHS developed a process to determine whether providers were included on CMS's list of individuals or entities barred from participation in Medicare or OIG's list of individuals and entities excluded from participation in Federal health care programs. If providers were included on either list, HHS took steps to remove the providers from the payment files used to disburse automatic PRF payments (waves 1 through 4) to providers. For subsequent PRF payment waves, beginning in May 2020, HRSA worked with Contractor A to calculate payments and prepare payment files.

Standards for Internal Control in the Federal Government and Risk Tolerance

Internal control is a process that management uses to help an entity achieve its objectives. 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), which 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 (Green Book, "Control Activities," paragraph 10.01).

In addition to GAO's Green Book, the Office of Management and Budget's Circular No. A-123, discusses risk. Specifically:

[24] CMS maintains a list of precluded providers (e.g., providers convicted of a felony under Federal or State law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program (42 CFR §§ 402.1(e) and 402.200-308)).

[25] HHS and HRSA, *PRF General & Targeted Distribution Cycle Memo,* Sept. 30, 2020.

[26] HHS had prepayment validation processes for payments made under waves 1 through 4 (automatic PRF payments) and subwaves 5a through 5c (nonautomatic PRF payments).

> 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.[27]

HHS's and HRSA's Oversight of the Provider Relief Fund Program Requirements

Within 1 month of the President declaring the COVID-19 outbreak a national emergency, HHS established oversight procedures related to the methodologies for determining provider eligibility and calculating automatic PRF payments before transferring the program to HRSA.

Provider Relief Fund Terms and Conditions

As part of their oversight procedures, HHS and HRSA established the PRF Terms and Conditions as a programmatic requirement for providers to receive and retain PRF payments. By attesting to the PRF Terms and Conditions, providers agreed to meet reporting requirements and be subject to potential audits of how they used PRF payments. Also, HHS reserved the right to administer penalties for noncompliance. Providers that are not in compliance may be subject to enforcement actions, including repayment and debt collection.

Provider Relief Fund Program Guidance

HHS and HRSA developed Provider Relief Fund Frequently Asked Questions (PRF FAQs) to help providers understand how PRF payments were calculated and distributed, and who was eligible to receive them.[28] These included:

- An initial PRF FAQ that stated that, to be eligible for a General Distribution, a provider must have billed Medicare in 2019 and provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 after January 31, 2020. HHS broadly viewed every patient as possibly needing care for COVID-19.

- A PRF FAQ added May 12, 2020, stated that PRF payments were being made to providers (e.g., a sole proprietor) or groups of providers that were organized within a TIN (e.g., a parent company and its subsidiary organizations).

[27] OMB, Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control (July 15, 2016), page 28.

[28] The PRF FAQs were amended on several occasions. Many FAQs were added and numerous revised over time.

- A PRF FAQ added June 15, 2020, stated that payments to providers and practices that were part of a larger medical group went to the group's central billing office. It further stated that if a provider TIN for which HHS intended to issue an automatic PRF payment identified both a Social Security number of an individual Medicare provider and a Medicare provider's employer identification number, the TIN was removed from the automatic payment files. Providers were also removed from these payment files if HHS could not obtain a provider's complete banking information and/or personal contact information.

- A PRF FAQ added June 16, 2020, stated that, in general, providers could estimate payments from the Phase 1 General Distribution of approximately 2 percent of their 2018 (or most recent complete tax year) gross receipts or sales/program service revenue by using this equation: (Individual Provider Revenues/$2.5 Trillion) x $50 Billion = Expected Combined General Distribution.

Procedures for Calculating Payments, Verifying Information Submitted by Providers, and Determining Provider Eligibility

HHS developed procedures for calculating PRF payments and determining whether providers were eligible for automatic PRF payments. HHS used Contractor A to implement some of these procedures.[29] For example, Contractor A was tasked to identify providers who were potentially ineligible for automatic PRF payments because their:

- TIN was associated with at least one provider whose enrollment in Medicare was revoked or no providers associated with the TIN were enrolled in CMS's Medicare provider enrollment system (Provider Enrollment, Chain, and Ownership System [PECOS]);

- TIN was associated with a provider who, according to PECOS, had died;

- TIN matched both a Social Security number and an employer identification number in PECOS; and

- CMS-assigned certification number was listed in PECOS as terminated; therefore, they were no longer eligible to provide Medicare services.

After Contractor A identified these potentially ineligible providers, HHS constructed the PRF payment files for the waves related to round 1 and round 2 automatic PRF payments. For subsequent waves, beginning in May 2020, Contractor A assisted HRSA in calculating PRF payments and developing PRF payment files.

[29] HHS officials requested that its Office of the Assistant Secretary for Planning and Evaluation (ASPE) use ASPE's existing contract with Contractor A to initially support HHS's work for distributing PRF payments. In June 2020, Contractor A's work was moved to a direct contract with HRSA.

For the round 1 and round 2 automatic PRF payments, HHS identified provider types that filed Medicare claims in calendar year 2019 using available data as of March 2020 from: (1) CMS's Common Working File, (2) PECOS, and (3) CMS's National Plan and Provider Enumeration System to calculate the total Medicare FFS reimbursement for each provider type.

Contractor A identified Medicare Part A provider types (inpatient hospitals, HHAs, hospices, and SNFs) and calculated their total reimbursements by summing the payments that the providers received for all Part A claims for 2019. Ultimately, HHS utilized these data in its final payment calculations. For Medicare Part B provider types (outpatient hospitals, carriers,[30] and DME suppliers), Contractor A utilized 2019 Medicare FFS claims and calculated their total reimbursements by summing the providers' allowed charge amount.

HHS developed and provided payment files to HRSA, which then sent the files to Contractor B to disburse PRF payments to providers.[31] As described earlier, Contractor A also included data fields that HHS could use for its validation methodology, which HHS developed, to identify providers potentially ineligible for PRF payments.

HOW WE CONDUCTED THIS AUDIT

Our audit covered approximately $39 billion in PRF payments that were disbursed to 319,468 providers from April 10 through April 24, 2020. We obtained payment data from HRSA for our audit period as well as data on whether providers attested to and accepted, rejected, or returned their PRF payments.

HHS's and HRSA's control objective for the PRF program was to ensure that providers received correct PRF payments from the Phase 1 General Distribution in a fast, fair, and transparent manner. We assessed the implementation of HHS's and HRSA's controls related to automatic PRF payment calculations and provider eligibility and determined whether these controls achieved HHS's and HRSA's control objective. We also determined whether automatic PRF payments were calculated as intended and whether HHS's payments were correct or incorrect. We did not assess how HHS and HRSA designed their controls related to automatic PRF payments.

[30] Throughout this report, we use terms for providers that differ from our use of the same terms in other OIG reports because these terms for providers were included in the data fields used by Contractor A and HHS. For example, in this report, the term "Medicare Part B carrier provider" refers to professional providers (e.g., physicians, physician assistants, clinical social workers, and nurse practitioners) that submit FFS claims and some organizational providers, such as freestanding radiology centers. Also, we use the terms "Part A hospital inpatient providers" and "Part B hospital outpatient providers" to identify specific provider types included in the data fields used by Contractor A and HHS.

[31] Contractor A issued methodology memos to HHS to document Contractor A's process for developing the payment files.

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 ensured that most of the approximately $39.3 billion in automatic PRF payments were properly calculated and disbursed to eligible providers. Nearly all providers received correct automatic PRF payments from the Phase 1 General Distribution. However, we identified several deficiencies in HHS's calculations of rounds 1 and 2 automatic PRF payments that resulted in some provider types receiving incorrect payments. As a result, HHS did not ensure that $2.16 billion (5.5 percent) of the automatic PRF payments were properly calculated. Specifically:

- When calculating providers' round 1 automatic PRF payments, HHS did not always: (1) apply a 2-percent sequestration reduction amount, (2) exclude managed care claim amounts, (3) include pass-through per diem amounts for Part A hospital inpatient providers, and (4) include beneficiary coinsurance liability and deductible amounts when it calculated Part B hospital outpatient providers' 2019 Medicare FFS reimbursements.

- For automatic PRF payments disbursed as part of round 2, HHS did not calculate payments to one provider type (renal dialysis providers) as intended and did not identify certain providers whose cost reports had data irregularities (the providers submitted duplicate NPR amounts), resulting in higher automatic PRF payments than intended.

Additionally, HHS did not prevent more than $247 million in payments (less than 1 percent) from being disbursed to ineligible providers and did not utilize all readily available lists to identify these providers.

Based on our interviews with HHS officials and contractors, we believe HHS accepted the risk of providing less oversight of the PRF program than it would for a similar program under normal circumstances because of the unprecedented challenge to provide emergency financial assistance to providers in a timely manner. As a result, some providers received improper or unallowable payments. Additionally, because HHS did not have certain procedures, some providers may not have received the correct PRF payments.

We understand that HHS's 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 directive HHS prioritized the rapid distribution of PRF payments and did not focus its activities on lowering the risk of improper payments because those activities would have delayed the disbursement of PRF payments. However, HRSA continues to develop and implement postpayment review processes and should consider the information included in this report. For example, HRSA should consider reviewing randomly selected providers and their PRF payments, reviewing eligibility lists, and performing reconciliations to ensure proper execution of payment calculations.

Finally, to prepare for a possible future public health emergency, HHS should use the information 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 providers in response to future national emergencies.

HHS DID NOT ENSURE THAT ALL AUTOMATIC PROVIDER RELIEF FUND PAYMENTS WERE CALCULATED AS INTENDED

HHS Did Not Ensure That All Round 1 Payments Were Calculated as Intended

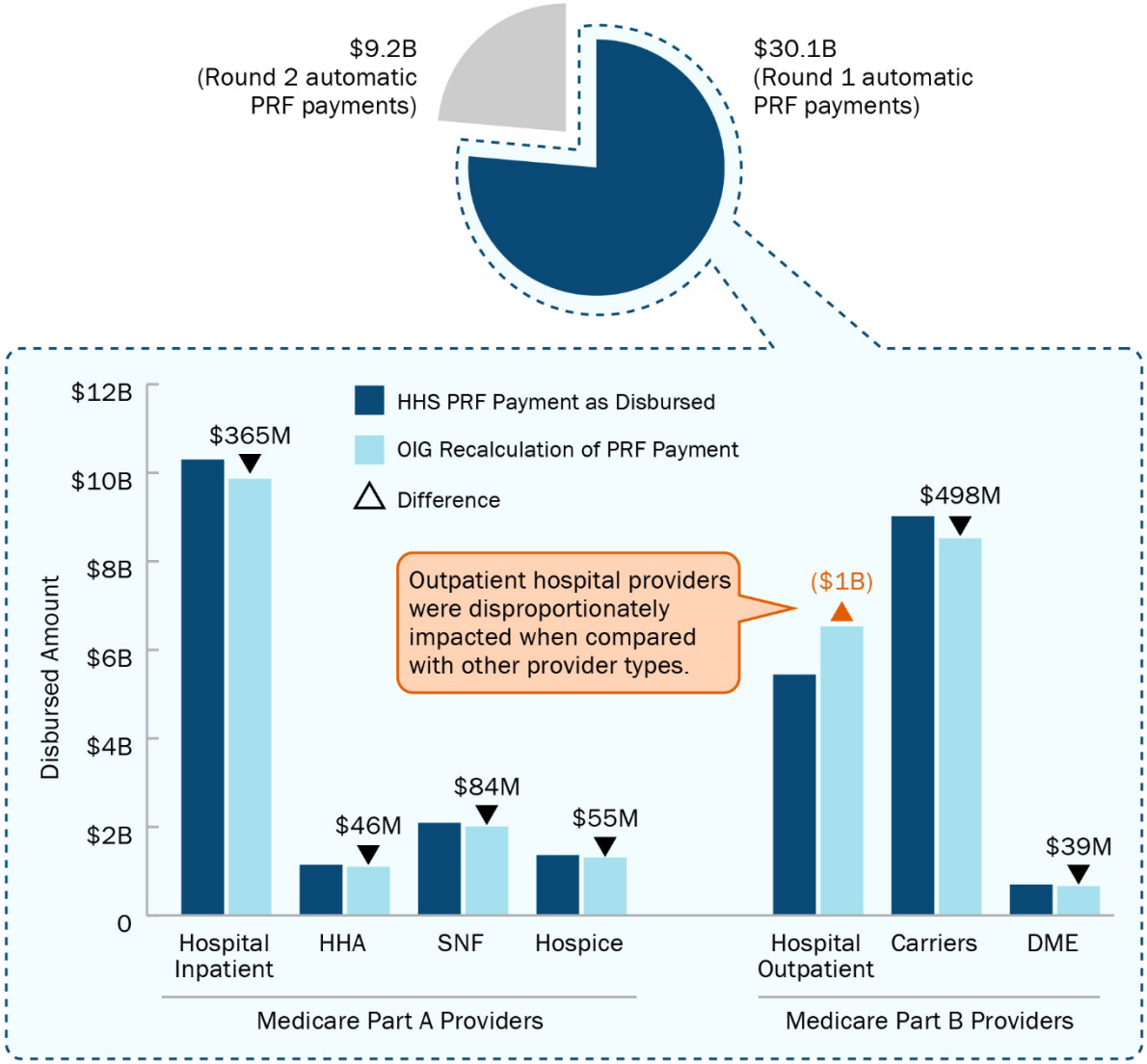
HHS did not ensure that all round 1 automatic PRF payments to Medicare providers were calculated as intended. Specifically, in its automatic PRF payment calculations, HHS understated providers' total 2019 Medicare FFS reimbursements by a net amount of $19 billion (see Figure 5 in Appendix C[32]). As detailed in Figure 2 (page 6), HHS used this understated figure in its automatic PRF payments calculations. As a result, most providers received larger PRF payments whereas Part B outpatient providers (mostly hospitals) received collectively $1.1 billion less in PRF payments.

HHS did not ensure that all round 1 automatic PRF payments were calculated as intended. Specifically, HHS accepted the risk of providing less oversight of the PRF program than it would for a similar program under normal circumstances due to the unprecedented challenge to quickly distribute emergency financial assistance to providers so the providers could continue their efforts to prevent, prepare for, and respond to the COVID-19 pandemic. For example, HHS did not implement procedures such as independently verifying Contractor A's work. Additionally, personnel in the HHS Immediate Office of the Secretary did not adequately coordinate with personnel (e.g., CMS data analysts) with a deep understanding of Medicare FFS claims payment data for different provider types.

[32] Figure 5 details OIG's recalculation of the total, adjusted for provider types and associated disbursements. The net understatement of $19 billion in Medicare FFS reimbursements is the result of the following issues we identified: (1) an overstatement of $2.3 billion for Part B carrier providers and DME suppliers, (2) an overstatement of approximately $4 billion for Part A hospital inpatient providers, (3) an understatement of $4.7 billion for Part A hospital inpatient providers, and (4) an understatement of $20.5 billion for Part B outpatient providers.

As depicted in Figure 3 below, HHS's 2019 Medicare FFS reimbursement calculations resulted in $1.1 billion more in round 1 automatic PRF payments (April 10 through April 17, 2020) to most provider types (e.g., inpatient hospitals, HHAs, SNFs, and hospices) than HHS intended. The figure also illustrates the impact of the calculations on automatic PRF payments disbursed to Part B outpatient providers, which also includes hospitals. Hospitals bill the Medicare FFS program for both inpatient and outpatient services. While hospitals represent a small number of Medicare outpatient providers, approximately 82 percent of the $20.5 billion understatement (see footnote 33) was attributable to Part B hospital outpatient services. We refer to these providers as "outpatient hospital providers" in the figure and throughout the report.[33]

Figure 3: Comparison of Round 1 PRF Payments—HHS Disbursements and OIG Recalculations



Dollar figures may not reflect exact amounts in report due to rounding.

[33] Provider types associated with the remaining 18 percent of the $20.5 billion understatement included home health providers and physical and occupational therapists.

"Outpatient hospital providers" received $1.1 billion *less* in round 1 automatic PRF payments than HHS intended primarily because these providers' total 2019 Medicare FFS reimbursements were understated by $20.5 billion. This understatement disproportionately impacted hospitals when compared with other provider types.[34, 35] Figure 6 (see Appendix C) summarizes the results of OIG's recalculation of the automatic PRF payments for all Medicare provider types.

HHS's Calculations Did Not Apply a 2-Percent Sequestration Reduction Amount for Medicare Part B Carrier Providers and Durable Medical Equipment Suppliers

Medicare FFS claims made by all provider types incur a 2-percent reduction in Medicare payment; however, when calculating automatic PRF payment amounts, HHS did not ensure that this 2-percent sequestration was applied to all providers' 2019 Medicare FFS reimbursements. Specifically, HHS applied this amount to calculations for all Medicare providers except for Part B carrier providers (e.g., ambulance services) and DME suppliers. As a result, reimbursements for Part B carrier providers and DME suppliers were overstated by $2.1 billion and $165 million, respectively. Figure 5 (see Appendix C) summarizes the results of OIG's recalculation of 2019 Medicare FFS reimbursements, including these providers. In our recalculation, we applied the sequestration reduction to providers' 2019 Medicare FFS reimbursements.

As shown in Figure 3, if HHS had applied a 2-percent sequestration for Medicare Part B carrier providers and DME suppliers when it calculated automatic PRF payments, Part B carrier providers would have received $498 million less in automatic PRF payments, and DME suppliers would have received $39 million less.

HHS's Calculations Did Not Exclude Managed Care Claim Amounts for Medicare Part A Hospital Inpatient Providers

Claims for managed care services are covered under managed care plans and therefore not paid on an FFS basis under Medicare Part A or Part B. When calculating automatic PRF payment amounts, HHS did not ensure that certain Medicare managed care claim amounts and managed care claim pass-through per diem amounts were excluded from providers' 2019 Medicare FFS reimbursements. Specifically, for the round 1 automatic PRF payments, HHS excluded these amounts from calculations for all Medicare providers except Part A hospital inpatient providers.

[34] We note that, as part of the round 2 automatic PRF payments, HHS took steps to disburse supplemental payments to Part A providers (including hospitals) whose round 1 automatic PRF payments were less than 2 percent of their 2018 gross receipts.

[35] Hospitals bill the Medicare FFS program for both inpatient and outpatient services. While hospitals represent a small number of Medicare outpatient providers, approximately 82 percent of the $20.5 billion understatement was attributable to Part B hospital outpatient services. We multiplied this percentage by the $1.1 billion in underpayments to Medicare outpatient providers and then subtracted the $365 million in overpayments to hospital inpatient providers to determine the net effect on hospital providers. We determined that hospitals received $530 million less in PRF payments than HHS intended.

The claim amounts—used for determining the sum of allowable Medicare FFS reimbursements—were actually paid by managed care organizations (MCOs), not through CMS's Medicare FFS program.[36] The claims are submitted for "Information Only" billing to CMS so that CMS can collect data on beneficiaries' inpatient stays. Therefore, the claim amounts should not have been included in HHS's calculations. By including these amounts, HHS overstated Medicare Part A hospital inpatient providers' reimbursements by nearly $4 billion.

As shown in Figure 3, if HHS had excluded managed care claims from Medicare Part A hospital inpatient providers' 2019 Medicare FFS reimbursements when it calculated automatic PRF payments, these providers would have received $365 million less in automatic PRF payments.

HHS's Calculations Did Not Include All Pass-Through Reimbursement Amounts for Medicare Part A Hospital Inpatient Providers

Medicare FFS reimbursements for Part A hospital inpatient claims are calculated using a formula that includes several claims data fields, including a field known as "claim pass-through per diem payment amount," which relates to capital expenditures, direct medical education, and organ acquisition costs. When calculating automatic PRF payment amounts for Part A hospital inpatient providers, HHS did not include the "claim pass-through per diem payment amount" when determining the providers' 2019 Medicare FFS reimbursements.[37] As a result, the providers' Medicare FFS reimbursements were understated by $4.7 billion.

As shown in Figure 3, if HHS had included claim pass-through per diem amounts in the sum of Medicare Part A hospital inpatient providers' reimbursements when it calculated automatic PRF payments, these providers would have received $365 million[38] less in automatic PRF payments.

[36] MCOs offer Medicare Advantage plans to Medicare beneficiaries as a way for beneficiaries to receive both Medicare Part A and Part B coverage under a single plan. Claims for managed care services are covered under these managed care arrangements and therefore not paid on an FFS basis under Medicare Part A or Part B. CMS requires MCOs that bill inpatient claims for reimbursement through the Part A cost report to submit "no pay" claims to Medicare Administrative Contractors to collect information on beneficiaries' inpatient hospital stays covered by Medicare Advantage plans. This type of billing is often referred to as "shadow billing" because claims are submitted to both a Medicare Advantage plan for payment and a Medicare Administrative Contractor as "Information Only" billing.

[37] Specifically, the total Medicare FFS reimbursement for inpatient claims is calculated by adding the payments made by Medicare, the enrollee (e.g., deductible), and the primary insurance payor and then subtracting the 2-percent sequestration reduction amount. (For this formula, the payment made by Medicare is calculated by multiplying the claim pass-through per diem amount by the claim utilization day count and then adding the claim payment amount.)

[38] The inclusion of "no pay" claims resulted in an overstatement of $3.8 billion and the inclusion of managed care claim pass-through per diem amounts resulted in an overstatement of $147.5 million in Medicare FFS reimbursements. When combined with an inpatient claim pass-through per diem amount understatement of $4.7 billion, the result is a net understatement of $724 million in Medicare FFS reimbursements for the providers. The combined effect of these calculation issues resulted in $365 million less in automatic PRF payments to Medicare Part A hospital inpatient providers.

HHS's Calculations Did Not Include Beneficiary Coinsurance Liability and Deductible Amounts for Medicare Part B Hospital Outpatient Providers

Medicare payments to providers generally account for beneficiary coinsurance liability and deductible amounts. When calculating automatic PRF payment amounts, HHS included beneficiary coinsurance liability and deductible amounts in all providers' 2019 Medicare FFS reimbursements except when calculating Part B hospital outpatient providers' reimbursements.[39] As a result, the hospital outpatient providers' reimbursements were understated by almost $20 billion for coinsurance and $706 million for deductible amounts.

As shown in Figure 3, if HHS had included beneficiary coinsurance liability and deductible amounts for Medicare Part B hospital outpatient providers when it calculated automatic PRF payments, these providers would have received $1.1 billion more in automatic PRF payments.

HHS Did Not Ensure That All Round 2 Payments Were Calculated as Intended

According to HHS, round 2 automatic PRF payment amounts were calculated using NPR amounts for Medicare Part A providers' fiscal year 2018 cost reports. NPR amounts are determined by taking a provider's TPR amount and subtracting its contractual allowances. HHS multiplied a provider's NPR amount by 2 percent to determine the maximum PRF payment amount the provider was eligible to receive. HHS then subtracted the provider's round 1 automatic PRF payment to determine the provider's round 2 automatic PRF payment.

HHS did not ensure that all calculations for Round 2 automatic PRF payments were properly made to Medicare providers. Specifically, HHS did not calculate payments to renal dialysis providers as intended and did not identify certain providers whose cost reports had data irregularities (the providers submitted duplicate NPR amounts), resulting in higher automatic PRF payments than intended. This resulted in: (1) renal dialysis providers receiving overpayments totaling $912 million based on TPR rather than NPR and (2) potentially overstated NPR amounts by $8.4 billion when HHS calculated round 2 automatic PRF payments. This occurred because HHS accepted the risk of providing less oversight of PRF payment calculations than it would for a similar program under normal circumstances due to the unprecedented challenge to quickly distribute emergency financial assistance to providers so the providers could remain in business and continue their efforts to prevent, prepare for, and respond to the COVID-19 pandemic.

If HHS had calculated automatic PRF payments for renal dialysis providers by using NPR instead of TPR, these providers would have received $912 million less in automatic PRF payments.

[39] According to CMS's CCW, with the exception of using pass-through per diem amounts and claim utilization day counts, Medicare FFS reimbursements for Part B hospital outpatient claims are calculated the same way as those for Part A hospital inpatient claims, including beneficiary deductible and coinsurance amounts.

Additionally, if HHS had validated CMS cost report data prior to disbursing round 2 automatic PRF payments, certain providers with multiple subsidiary organizations that may have overstated their NPR amounts by $8.4 billion because they reported duplicate NPR amounts would have not received up to $165 million in potential overpayments.

HHS Improperly Calculated Automatic Provider Relief Fund Payments to Renal Dialysis Providers

HHS used TPR rather than NPR when it calculated round 2 automatic PRF payment amounts for 950 renal dialysis providers (see Figure 7A in Appendix D). By using renal dialysis providers' TPR, HHS incorrectly calculated and paid $937 million in automatic PRF payments[40] (see Figure 7B in Appendix D). However, HHS should have calculated PRF payments using NPR, which would have resulted in these providers receiving $25 million. As a result, HHS made overpayments to renal dialysis providers totaling $912 million.[41]

According to our interviews with HRSA and Contractor A, HHS staff may have inadvertently selected TPR instead of NPR when performing PRF payment calculations for renal dialysis providers.[42]

If HHS had used NPR to calculate payments to renal dialysis providers, total round 2 automatic PRF payments to these providers would have been $25 million. By using TPR, HHS made overpayments totaling $912 million to 950 renal dialysis providers. Of these 950 providers, 218 kept $138 million. Of this amount, 108 renal dialysis providers received overpayments totaling $58 million.[43] Figure 7C (see Appendix D) summarizes the results of OIG's recalculation of the renal dialysis providers' automatic PRF payments.

[40] The 950 providers received $1.7 billion of round 2 automatic PRF payments. Of these providers, 14 with multiple subsidiary organizations had at least 2 different provider types (e.g., hospitals and renal dialysis providers). For these 14 providers, HHS correctly used NPR when it calculated $784 million in round 2 automatic PRF payments for non-renal dialysis provider types.

[41] During our audit, HRSA conducted a review of renal dialysis providers (completed in December 2020) through their Post-Pay Quality Control Review process and identified 117 providers with $60.6 million in overpayments. After further analysis, HRSA concluded that 17 providers received overpayments totaling $15.1 million and issued a repayment letter to these providers in December 2020.

[42] TPR is the total amount of income generated from hospitals, other health care facilities, and Medicare-approved clinical laboratories. It includes nonpatient care revenues, for which the PRF does not reimburse. NPR does not include charity care, bad debt, and other discounts or adjustments derived from nonhospital operations because they are not considered gross receipts or sales/program service revenue. In providers' cost reports, reductions in revenue due to contractual allowances are subtracted from TPR to determine the providers' NPR.

[43] Based on our recalculation, we determined that the remaining 110 renal dialysis providers received underpayments totaling $5 million.

HHS Did Not Identify Providers That Had Provided Duplicate Net Patient Revenue Amounts Before It Calculated Automatic Provider Relief Fund Payments

HHS did not identify certain providers that had irregularities in their CMS cost report data. Specifically, HHS did not identify providers with subsidiary organizations that submitted duplicate NPR amounts on their CMS cost reports prior to calculating their round 2 automatic PRF payments. (For example, a parent company reported $653,072,040 in NPR and its four subsidiary organizations each reported $163,268,010 in NPR.) As a result, HHS disbursed $241 million in automatic PRF payments, of which $165 million were potential overpayments, to 67 providers with NPR amounts that were potentially overstated by at least $8.4 billion (see Figure 8A, Appendix D). Nine of the 67 providers returned a total of $111 million in round 2 automatic PRF payments to HHS. The remaining 58 providers kept their automatic PRF payments totaling $130 million.

HHS accepted the risk of providing less oversight of PRF payment calculations than it would for a similar program under normal circumstances due to the unprecedented challenge to quickly distribute emergency financial assistance to providers so the providers could remain in business and continue their efforts to prevent, prepare for, and respond to the COVID-19 pandemic. This resulted in relying on existing data sources (i.e., CMS cost reports) and data that could be accessed and utilized quickly. However, HHS did not establish procedures to identify irregularities in CMS cost report data.

If HHS had developed procedures to identify subsidiary organizations that submitted duplicate NPR amounts in CMS cost report data, HHS may have identified the 67 providers with overstated NPR amounts.[44] HHS could have delayed making payments to these providers and evaluated the accuracy of the providers' (i.e., the parent's and subsidiary organizations') reported NPR amounts. If HHS had determined that the providers' NPR amounts were inaccurate, the providers would not have received $165 million in round 2 automatic PRF payments.[45] We recalculated the automatic PRF payments with duplicate amounts removed from 63 providers' reported NPR amounts (see Figure 8B, Appendix D).

[44] During our audit, HRSA conducted a review of providers with subsidiary organizations. As of March 2021, HRSA identified 585 providers with potential overpayments of $148 million. HRSA stated it is currently validating this particular group of providers and anticipates that it will seek to recoup overpayments of $15.7 million from 138 providers. HRSA will conduct a comparison of the wave 5 providers to the providers with multiple subsidiary organizations we identified to determine if further analysis needs to be performed or if all overpayments were remediated.

[45] Specifically, we recalculated round 2 automatic PRF payments for 63 of the 67 providers by removing duplicate NPR amounts and determined that they may have received up to $165 million in overpayments. Of this amount, providers returned $70 million ($95 million remains outstanding). For the remaining four providers, which received a total of approximately $700,000 in round 2 automatic PRF payments, we could not determine an overpayment effect because we were unable to reconcile their round 2 payment amounts.

HHS DID NOT ENSURE THAT AUTOMATIC PROVIDER RELIEF FUND PAYMENTS WERE DISBURSED ONLY TO ELIGIBLE PROVIDERS

Provider Relief Fund Eligibility Requirements

To be eligible for a PRF payment, a provider must not: (1) be terminated from participating in Medicare or precluded from receiving payment through Medicare Advantage or Part D; (2) be excluded from participating in Medicare, Medicaid, and other Federal health care programs; or (3) have its Medicare billing privileges revoked (PRF Terms and Conditions for the Phase 1 General Distribution).

Providers, suppliers, or eligible professionals that are terminated or had billing privileges revoked are prohibited from receiving payments from the Medicaid and Medicare programs (42 CFR §§ 424.535 and 424.540). CMS's list of precluded providers, known as the Preclusion List, comprises any individual or entity that: (1) is currently revoked from Medicare,[46] (2) was engaged in behavior for which CMS could have revoked the individual or entity, or (3) has been convicted of a felony under Federal or State law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program.[47] Additionally, excluded providers cannot receive payments made by Medicare, Medicaid, or any of the other Federal health care programs for any item or service furnished, on or after the effective date specified in the notice period (42 CFR § 1001.1901(a)–(b)).

Pursuant to section 1128 of the Social Security Act (the Act), OIG may exclude individuals and entities from participation in Medicare and Medicaid (e.g., individuals convicted of Medicare fraud). OIG maintains a database of all excluded providers known as the List of Excluded Individuals/Entities (LEIE).[48] Federal law prohibits payment under Medicare for services provided or prescriptions written by excluded providers when the person furnishing such items or service knows or has reason to know of the exclusion (§ 1862(e) of the Act).[49]

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[46] CMS may revoke a currently enrolled provider for reasons such as: (1) noncompliance with enrollment requirements, (2) provider or supplier conduct, (3) felonies or false or misleading information, or (4) abuse of billing privileges (42 CFR § 424.535).

[47] The Preclusion List is to be used by Medicare Advantage and Part D plans to preclude providers from those programs. It initially consisted of "certain individuals and entities that are currently revoked from the Medicare program under 42 CFR § 424.535 and are under an active reenrollment bar, or have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that led, or would have led, to the revocation is detrimental to the best interests of the Medicare program." See 83 Fed. Reg. 16440, 16441 (Apr. 16, 2018). CMS added felony convictions 1 year later. See 84 Fed. Reg. 15680, 15783 (Apr. 16, 2019).

[48] HHS-OIG, *LEIE Downloaded Database*. Available online at https://oig.hhs.gov/exclusions/exclusions_list.asp.

[49] OIG has the authority to waive a provider's exclusion from Medicare when the excluded provider is the sole community physician or the sole source of essential specialized services in a community and the exclusion would impose a hardship on Medicare beneficiaries. Each waiver is subject to the limitations described in the provider's waiver letter (42 CFR § 1001.1801).

HHS Disbursed Provider Relief Fund Payments to Ineligible Providers

HHS disbursed automatic PRF payments totaling $247 million[50] ($221 million from round 1 and $25 million from round 2) to ineligible providers. Specifically, although HHS obtained from CMS a list of providers whose Medicare billing privileges were revoked (known as the CMS Revocation List) and the OIG LEIE (a list of providers excluded, by OIG, from participating in Medicare and Medicaid), it disbursed PRF payments to 321 ineligible providers. Additionally, if HHS had obtained and used other readily available CMS-maintained lists, it would have prevented an additional 666 ineligible providers from receiving automatic PRF payments[51, 52] (see Figure 9, Appendix E). Specifically, HHS did not obtain three lists (CMS's Preclusion and Medicaid Termination lists, as well as CMS's Compliance Hold [another list composed of individuals ineligible for PRF payments]) that would have identified additional ineligible providers prior to disbursing automatic PRF payments.

HHS accepted the risk of providing less oversight of provider eligibility than it would for a similar program under normal circumstances because of the unprecedented challenge to quickly distribute emergency financial assistance to providers so the providers could remain in business and continue their efforts to prevent, prepare for, and respond to the COVID-19 pandemic.

As a result, 987 providers received automatic PRF payments totaling $247 million despite being on the CMS Revocation List, the OIG LEIE, or another readily available list of ineligible providers. Of the $247 million disbursed, $82 million was rejected or returned by providers; however, 642 providers attested to and kept the remaining $165 million in automatic PRF payments. If HHS had utilized all available data, it could have prevented these payments to ineligible providers.[53] See Figures 9 through 12 (Appendix E) for details on automatic PRF payments made to ineligible providers.

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[50] This amount is higher than the sum of round 1 and 2 automatic PRF payments due to rounding.

[51] The lists included a CMS list known as the Preclusion List that includes providers and prescribers who have been or could have been revoked from the Medicare program for conduct that CMS determines is detrimental to the best interest of the Medicare program. Other lists included: (1) a CMS list of providers who can bill Medicare but will not receive any payments until a "compliance hold" is lifted (42 CFR § 401.613), and (2) a CMS list of providers terminated from participating in the Medicaid program.

[52] HHS developed the round 1 and 2 payment files and determined which lists of excluded providers should be used. HRSA added information from CMS's Compliance Hold and Medicaid Termination lists to its catalog of excluded providers in June 2020 and is in the process of updating its data use agreement with CMS to include the Preclusion List.

[53] During our audit, HRSA began finalizing the review of ineligible providers through the Post-Pay Quality Control Review Process to include CMS Medicare revocations, OIG LEIE, CMS Compliance Holds, and CMS Medicaid terminations. As of July 2023, HRSA was in the process of analyzing ineligible providers for these discrepancies.

CONCLUSION

In the context of unprecedented challenges from the COVID-19 national emergency, HHS and HRSA oversight of the PRF payments was designed to ensure that providers received the correct automatic PRF payments from the Phase 1 General Distribution in a fast, fair, and transparent manner. However, we determined that some of their oversight efforts could be improved.

HHS and HRSA did not have certain oversight procedures to ensure that payments were properly calculated and made only to eligible providers. For example, HHS's willingness to accept the risk of providing less oversight than it would for a similar program under normal circumstances led to an error that caused the use of an incorrect data variable when renal dialysis payments were calculated.

We understand that HHS's 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. We also understand that HHS did not focus its activities on lowering the risk of improper payments because to do so would have likely delayed the disbursement of PRF payments. However, as HRSA fully develops and implements postpayment review processes, it should consider the information included in this report.

In addition, to prepare for a possible public health emergency in the future, HHS should use the information 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 providers in response to future national emergencies.

RECOMMENDATIONS

We recommend that the Health Resources and Services Administration:

- perform postpayment reviews of:

    - 108 renal dialysis providers that attested to and kept automatic PRF payments totaling $58 million and recoup any outstanding overpayments from these providers;

    - 58 providers with multiple subsidiary organizations that attested to and kept automatic PRF payments totaling $130 million and recoup any outstanding overpayments from these providers;

    - 642 providers that attested to and kept $165 million in automatic PRF payments for which they were not eligible and recoup any outstanding overpayments from these providers; and

- commit to strengthening its procedures that may apply to future programs of a similar nature to better ensure that:

    - providers receive their intended share of financial assistance;

    - financial assistance payments are properly calculated;

    - data and data sources are appropriate, current, complete, and accurate, and revisions are made when necessary for calculating financial assistance; and

    - all available data sources are utilized to identify ineligible providers and prevent them from receiving financial assistance.

HRSA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, HRSA concurred with all of our recommendations and provided information on actions that it has taken or plans to take to address them.[54] 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 F.

Regarding our first recommendation, HRSA stated that it completed its review of renal dialysis providers as part of its ongoing postpayment quality control review process in December 2020. As a result of this process, HRSA stated that it sent out repayment notices to providers and will continue to seek repayment for overpayments, as appropriate. Additionally, HRSA is conducting reviews of providers with multiple subsidiary organizations and ineligible providers and anticipates finalizing these reviews by the end of the 2023 calendar year. HRSA will seek repayment for overpayments, as appropriate.

Regarding our second recommendation, HRSA stated that it has reviewed and, on an ongoing basis, updated its pre- and postpayment policies and procedures. HRSA stated that it will continue to use its established program integrity procedures to identify and address payment issues.

We commend HRSA for its actions in response to our recommendations and acknowledge that the PRF program was designed to be responsive to the pandemic and expeditiously reimburse providers.

[54] 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 decided not to provide us with any written comments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered approximately $39 billion in PRF payments that were disbursed to 319,468 providers from April 10 through April 24, 2020. We obtained payment and eligibility data from HRSA for our audit period as well as data on whether providers attested to and accepted, rejected, or returned their PRF payments. We assessed the reliability of the payment, attestation, and eligibility data by: (1) performing electronic testing, (2) reviewing existing information about the data and the system that produced them, and (3) interviewing HHS officials knowledgeable about the data. We determined that the data were sufficiently reliable for the purposes of this report.

HHS's and HRSA's control objective for the PRF program was to ensure that providers received correct PRF payments from the Phase 1 General Distribution in a fast, fair, and transparent manner. We assessed the implementation of HHS's and HRSA's controls related to automatic PRF payment calculations and provider eligibility and determined whether these controls achieved HHS's control objective by:

- performing audit procedures detailed in the Methodology section that follows and
- recalculating all automatic PRF payments made to the 319,468 providers.[55]

Because this audit assessed HHS's and HRSA's oversight of the PRF payments, we determined whether the payments made to providers were properly calculated and made only to eligible providers. We determined for each finding whether these payments were made as HHS intended. However, we did not calculate the impact on payments for future distributions of the PRF, as these payments may take previous PRF payments into account.

We conducted fieldwork for our audit from April 2020 to May 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed generally accepted government auditing standards to determine their significance to our audit objective;

[55] We recalculated providers' Medicare FFS reimbursements using data from CMS's Integrated Data Repository, which allowed us to utilize point-in-time provider payment data to determine whether round 1 automatic PRF payments were distributed as intended. We recalculated round 2 automatic PRF payments using reported revenue information on each provider's CMS cost report.

- reviewed the PRF FAQs and the Terms and Conditions to obtain an understanding of HHS's and HRSA's policies and procedures related to calculating automatic PRF payments;

- interviewed officials from HRSA and its contractors to obtain an understanding of how they intended to calculate automatic PRF payments;

- obtained and analyzed the payment and attestation data from HRSA to determine:

    - the total payments disbursed as of April 24, 2020; and

    - the attestation status of the payment (e.g., whether the provider attested to acceptance of the payment and kept the payment);

- reviewed Contractor A's methodology memos to obtain an understanding of the calculation of payments under the Phase 1 General Distribution;

- obtained lists of providers ineligible for Medicare and Medicaid reimbursement (see Appendix E);

- reviewed all 319,468 providers that received automatic PRF payments totaling $39,319,824,349, and for each provider, reviewed:

    - the claims data on the provider's CMS cost report and supporting documentation,

    - the subsidiary TINs reported on the provider's cost report (for providers with any related subsidiary TINs) and the subsidiary TINs used when the provider's payments were calculated, and

    - whether they were listed as ineligible for Medicare or Medicaid reimbursement; and

- discussed the results of our audit with HHS and 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 AUTOMATIC PROVIDER RELIEF FUND PAYMENT DISTRIBUTIONS

Figure 4 details the payment distribution date, total number of TINs (i.e., providers), and total PRF payments for each wave or subwave under round 1 and 2 automatic payments from the Phase 1 General Distribution. Please note that all amounts listed below are rounded to the nearest dollar.

Figure 4: Automatic PRF Payments Disbursed During Our Audit Period

Round 1 Payments				Round 2 Payment			
Wave	**Distribution**	**Providers**	**Total Dollars**	**Wave**	**Distribution**	**Providers**	**Total Dollars**
1	4/10/2020	144,173	$26,143,124,405	4	4/24/2020	14,834	$9,177,151,026
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				
Total		**319,468**	**$30,142,673,323**	**Total**		**14,834***	**$9,177,151,026**

* Round 2 automatic PRF payments were made only to providers who received a round 1 automatic PRF payment.

APPENDIX C: ROUND 1 AUTOMATIC PROVIDER RELIEF FUND PAYMENT RECALCULATIONS

Figure 5 depicts the reimbursement allocation based on the respective allocation rate used by HHS and summarizes the results of OIG's recalculations. Figure 6 summarizes the results of OIG's recalculations based on our findings for round 1 automatic payments. Please note that all amounts listed below are rounded to the nearest dollar.

Figure 5: OIG Summary of Round 1 Medicare Reimbursement Calculations By Issues and Provider Type

Provider Type	HHS Calculation of Reimbursements (A)	OIG Recalculation of Reimbursements (B)	Difference (C) = A – B	Issues
Medicare Part A				
Hospital Inpatient	$154,581,340,545	$155,305,397,206	($724,056,661)	"No Pay" Managed Care Claims and Pass-Through Reimbursement
HHA	17,356,629,151	17,356,629,151	-	-
SNF	31,646,440,046	31,646,440,046	-	-
Hospice	20,653,385,736	20,653,385,736	-	-
Medicare Part B				
Hospital Outpatient	82,237,430,059	102,788,620,749	(20,551,190,690)	Coinsurance Liability and the Deductible Amount
Carriers	136,272,880,185	134,130,348,848	2,142,531,337	Sequestration Reduction Amount
DME	10,576,843,801	10,412,015,434	164,828,368	Sequestration Reduction Amount
Total 2019 Medicare FFS	**$453,324,949,523**	**$472,292,837,170**	**($18,967,887,646)**	

Figure 6: OIG Recalculations of the Round 1 Automatic PRF Payments Made During Our Audit Period

Provider Type	HHS PRF Payment Disbursed (A)	OIG Recalculation of PRF Payment (B)	Difference (C) = A – B
Medicare Part A			
Hospital Inpatient	$10,229,836,724	$9,864,985,343	$364,851,381
HHA	1,148,621,701	1,102,491,576	46,130,124
SNF	2,094,288,440	2,010,179,123	84,109,317
Hospice	1,366,793,451	1,311,901,268	54,892,182
Medicare Part B			
Hospital Outpatient	5,442,283,519	6,529,124,263	(1,086,840,744)
Carriers	9,018,225,028	8,519,948,110	498,276,918
DME	699,951,137	661,370,316	$38,580,821
Total	**$30,000,000,000**	**$30,000,000,000**	**-**

APPENDIX D: ROUND 2 AUTOMATIC PROVIDER RELIEF FUND PAYMENT RECALCULATIONS

Figures 7 and 8 summarize the results of OIG's recalculations based on our findings for round 2 automatic payments for renal dialysis providers and providers with multiple subsidiary organizations. Please note that all amounts listed below are rounded to the nearest dollar.

Figure 7A: OIG Recalculation of Round 2 Automatic PRF Payments to Renal Dialysis Providers—Including Payments to All Provider Types Associated With Renal Dialysis Providers

Provider Type	Provider Count	HHS Payment Second Round Payment (A)	OIG Recalculations of Second Round Payment Using NPR (B)	Difference in PRF Payment (C) = A – B
Renal Dialysis	936	$935,148,741	$27,329,286	$907,819,455
Renal Dialysis Associated With Other Provider Types	14	785,759,687	781,854,654	3,905,032
Total	**950**	**$1,720,908,428**	**$809,183,940**	**$911,724,487**

Figure 7B: OIG Recalculation of Round 2 Automatic PRF Payments—Only Payments to Renal Dialysis Providers

Provider Type	Provider Count	HHS Payment Second Round Payment (A)	OIG Recalculations of Second Round Payment Using NPR (B)	Difference in PRF Payment (C) = A – B
Renal Dialysis	936	$935,148,741	$27,329,286	$907,819,455
Renal Dialysis Associated With Other Provider Types	14	1,571,519	(2,333,513)	3,905,032
Total	**950**	**$936,720,260**	**$24,995,773**	**$911,724,487**

Figure 7C: OIG Recalculations of Round 2 Automatic Payments—Renal Dialysis Providers' Kept Net Payment

Providers	Kept Payment (A)	Overpayment (B)	Underpayment (C)	Net Overpayment (D) = (B – C)
218	$138,337,301	$57,506,122	$4,638,154	$52,867,968

Figure 8A: Duplicate NPR Amounts for Providers With Multiple Subsidiary Organizations—Differences in NPR

Provider Type	Providers Identified	HHS Calculation of NPR (A)	OIG Recalculation of NPR (B)	Total Duplicative NPR (C) = A – B
CMHC*	1	$86,617,599	$28,872,533	$57,745,066
Hospice	1	70,760,802	34,925,408	35,835,394
RDF†	2	274,336,942	33,071,229	241,265,713
SNF	2	387,872,248	99,507,866	288,364,382
Hospital	7	7,211,251,290	3,442,357,635	3,768,893,655
HHA	17‡	3,438,481,723	1,368,401,991	2,070,079,732
FQHC**	37	3,655,911,068	1,674,263,934	1,981,647,134
Total	**67**	**$15,125,231,672**	**$6,681,400,596**	**$8,443,831,075**

* CMHC = Community Mental Health Center.

† RDF = renal dialysis facility.

‡ Out of the 17 providers identified with duplicate NPRs for HHA providers, 4 providers were excluded from our analysis because we were unable to reconcile their round 2 payment amounts.

** FQHC = Federally Qualified Health Center.

Figure 8B: Duplicate NPR Amounts for Providers With Multiple Subsidiary Organizations—Potential Overpayments

Provider Type	OIG 2% of NPR (D) = B (See Figure 8A) x .02	Round 1 Payment (E)	Round 2 Payment (F)	Potential Overpayment (G) = (E + F) – D	Payment > 2% (H)	Adjusted Potential Overpayment (I) = G – H
CMHC*	$577,451	$120,489	$1,611,866	$1,154,904	-	$1,154,904
Hospice	698,508	925,070	490,167	716,729	$226,562	490,167
RDF†	661,425	460,866	5,025,884	4,825,325	103,628	4,721,697
SNF	1,990,157	556,359	7,201,099	5,767,300	-	5,767,300
Hospital	68,847,153	38,770,952	105,454,952	75,378,752	-	75,378,752
HHA‡	27,368,040	17,376,522	50,330,169	40,338,650	2,686,651	37,652,000
FQHC**	33,485,279	2,619,857	70,498,424	39,633,002	-	39,633,002
Total	**$133,628,012**	**$60,830,114**	**$240,612,560**	**$167,814,662**	**$3,016,840**	**$164,797,822**

* CMHC = Community Mental Health Center.

† RDF = renal dialysis facility.

‡ Out of the 17 providers identified with duplicate NPRs for HHA providers, 4 providers were excluded from our analysis because we were unable to reconcile their round 2 payment amounts.

** FQHC = Federally Qualified Health Center.

APPENDIX E: AUTOMATIC PROVIDER RELIEF FUND PAYMENTS MADE TO INELIGIBLE PROVIDERS

Figures 9 through 12 summarize the results of OIG's analysis of the CMS Revocation and the OIG LEIE lists and all readily available lists. Please note that all amounts listed below are rounded to the nearest dollar.

Figure 9: Eligibility Lists That HHS Used, or Could Have Used, To Identify Ineligible Providers

List	HHS Applied	HRSA Applied	Date Applied	Ineligibility Category (PRF Terms and Conditions)
OIG LEIE (updated monthly)	Yes	Yes	April 2020	Excluded
CMS Medicare Revocation (updated weekly)	Yes	Yes	April 2020	Revoked
CMS Compliance Hold* (updated biweekly)	No	Yes	June 2020	Revoked
CMS Medicaid Termination (updated monthly)	No	Yes	June 2020	Terminated
CMS Preclusion	No	No	-	Precluded

* This is a CMS list of providers who can bill Medicare but will not receive any payments until a "compliance hold" is lifted, per Federal regulations.

Figure 10: OIG Analysis of Round 1 Automatic PRF Payments Made to Ineligible Providers

List	Ineligible Providers	OIG Recalculated Payments
CMS Medicare Revocation and OIG LEIE	321	$16,869,844
CMS Compliance Hold, Preclusion, and Medicaid Termination	666	204,467,631
Total	**987**	**$221,337,475**

Figure 11: OIG Analysis of Round 2 Automatic PRF Payments Made to Ineligible Providers

List	Ineligible Providers	OIG Recalculated Payments
CMS Medicare Revocation and OIG LEIE	4	$366,662
CMS Compliance Hold, Preclusion, and Medicaid Termination	31	24,884,573
Total	**35**	**$25,251,235**

Figure 12: OIG Recalculation of Available Lists Total Impact

Automatic PRF Payment Distribution	Sum of Payments	Provider Count
Round 1	$221,337,475	987
Round 2	25,251,235	35*
Total	**$246,588,710**	**987**

* Round 2 automatic PRF payments were made only to providers who received a round 1 automatic PRF payment. Accordingly, all 35 ineligible providers that received a round 2 automatic PRF payment were included in the count of ineligible providers that received a round 1 automatic PRF payment.

APPENDIX F: HRSA COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville, MD 20857

DATE: August 18, 2023

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Carole Johnson
Administrator

SUBJECT: OIG Draft Report: *HHS's Oversight of Automatic Provider Relief Fund Payments Was Generally Effective but Improvements Could Be Made* (A-02-20-01025)

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

Health Resources and Services Administration's Comments on OIG Draft Report A-02-20-01025

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 1 General Distribution automatic payments made during a defined period in 2020, entitled *"HHS's Oversight of Automatic Provider Relief Fund Payments Was Generally Effective But Improvements Could be Made."*

The audit reviewed whether the Department of Health and Human Services (HHS) and HRSA ensured that Phase 1 General Distribution automatic PRF payments were: (1) properly calculated and (2) disbursed only to eligible providers. The audit covered $39.3 billion in automatic PRF payments that were disbursed to 319,468 providers from April 10 through April 24, 2020.

The PRF played a critical role in the federal government's response to the COVID-19 pandemic. Phase 1, which occurred in 2020, represented the first and largest distribution of the PRF. It was developed and launched just weeks after the passage of the CARES Act, during the early days of the pandemic. The authorizing statute instructed HHS to implement the most efficient payment systems practicable to provide emergency payments to providers. As a result, HHS used provider data that was readily available and that could quickly and consistently be collected to facilitate payments. The goal 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.

HRSA agrees with OIG's primary finding that, generally, HHS' oversight was effective in ensuring that PRF automatic payments were properly calculated and disbursed. HRSA acknowledges OIG's other findings but notes that the Agency has always been committed to post-payment review while taking appropriate action to support the nation's health care infrastructure at a time of crisis.

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

Recommendation #1

The OIG recommended post-payment reviews of specific renal dialysis providers, certain providers with multiple subsidiary organizations, and a subset of providers who attested to and kept automatic PRF payments for which they were not eligible and to recoup any outstanding overpayments from these providers.

HRSA Response #1

HRSA concurs with OIG's recommendation and has already taken action to address this recommendation.

The three groups of providers identified in this recommendation are included in HRSA's ongoing post-payment quality control review (PPQCR) process. The PPQCR of all renal dialysis providers, inclusive of the 108 renal dialysis providers identified in OIG's sample, was

completed in December 2020. HRSA sent repayment notices to 17 providers with overpayments totaling $15.1 million. As of July 2023, HRSA has recouped $14.6 million from 16 of the 17 providers. HRSA will continue to seek repayment for overpayments, as appropriate. Additionally, HRSA is conducting PPQCRs of providers with multiple subsidiary organizations and the subset of providers that received payments for which they were not eligible, inclusive of the providers identified in OIG's samples. HRSA anticipates finalizing these reviews by the end of the calendar year and will seek repayment for overpayments, as appropriate.

Recommendation #2

The OIG recommended strengthening procedures that may apply to future programs of a similar nature (including issues such as completeness of data sources and identifying all available data sources to validate provider eligibility).

HRSA Response #2

HRSA concurs with OIG's recommendation. HRSA's pre- and post-payment policies and procedures have been reviewed and updated on an ongoing basis over the three years the Agency has implemented the program. After the Phase 1 General Distribution automatic payments, HRSA deployed an application-based approach and had an iterative process to strengthen internal controls in each subsequent application cycle. HRSA continues to use its established program integrity procedures to identify and address payment issues.