Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PAYMENTS MADE TO PROVIDERS UNDER THE COVID-19 ACCELERATED AND ADVANCE PAYMENTS PROGRAM WERE GENERALLY IN COMPLIANCE WITH THE CARES ACT AND OTHER FEDERAL REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Inspector General

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Report in Brief
Date: October 2022
Report No. A-05-20-00053

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

Payments Made to Providers Under the COVID-19 Accelerated and Advance Payments Program Were Generally in Compliance With the CARES Act and Other Federal Requirements

Why OIG Did This Audit

The Centers for Medicare & Medicaid Services (CMS) can provide temporary relief loans through the accelerated payment program for certain Part A providers and through the advance payment program for certain Part B providers and suppliers when these providers and suppliers face cashflow challenges due to circumstances beyond their control. The Coronavirus Aid, Relief, and Economic Security (CARES) Act, which Congress passed on March 27, 2020, expanded these programs to more providers to relieve pandemic-caused financial strain. CMS referred to this expansion as the COVID-19 Accelerated and Advanced Payments (CAAP) Program and issued eligibility criteria on March 28, 2020. As of September 17, 2020, CMS, through the Medicare Administrative Contractors (MACs), disbursed more than $100 billion in CAAP Program payments to more than 46,000 providers. These CAAP Program payments were issued in a short period of time, thus increasing the risk of improper payments.

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

Our objective was to determine whether CAAP Program payments were made to providers in compliance with the CARES Act and other Federal requirements.

How OIG Did This Audit

Our audit covered $103.1 billion in total CAAP Program payments made to 46,373 providers. We selected a stratified random sample of 109 providers and reviewed CAAP Program payments totaling $4.1 billion made to those providers. Of those 109 providers, 100 providers were randomly selected, and 9 providers were under bankruptcy when the CAAP Program payments were made.

What OIG Found

CMS generally made CAAP Program payments to providers in compliance with the CARES Act and other Federal requirements. Of the 109 providers in our sample, CMS appropriately made CAAP Program payments to all 100 providers that we randomly selected. For the nine providers under bankruptcy, CMS did not send a CAAP Program payment to six of the providers; however, CMS did make a CAAP program payment to three of the providers.

The CAAP Program payments made to the three providers under bankruptcy occurred because two MACs did not correctly match the provider's request against their bankruptcy databases, and one MAC did not update its bankruptcy database based on bankruptcy information that was provided by CMS prior to approving the CAAP Program payment request.

For the three CAAP Program payments made to providers under bankruptcy, the MACs immediately identified their errors after the payment and recovered the improper payments.

What OIG Recommends

Based on our sample, we found that CMS and its MACs generally made CAAP Program payments to providers in compliance with the CARES Act and other Federal requirements. Although the MACs erroneously approved CAAP Program payments to nine providers under bankruptcy, the MACs immediately identified their errors, stopped payments to six providers, and recovered improper payments made to the other three providers. Therefore, we do not have any recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) can provide temporary relief loans through the accelerated payment program for certain Part A providers and through the advance payment program for certain Part B providers and suppliers when these providers and suppliers face cashflow challenges due to circumstances beyond their control. These rarely used programs, which have existed for decades, are collectively referred to as the Accelerated and Advance Payments (AAP) Program.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, which Congress passed on March 27, 2020, expanded the AAP Program to more providers to relieve pandemic-caused financial strain. CMS has referred to this expansion as the COVID-19 Accelerated and Advance Payments (CAAP) Program.

CMS then expanded the CAAP Program to a broader group of Part A providers and Part B suppliers and issued new CAAP Program eligibility criteria on March 28, 2020. The term "providers" used throughout the rest of this report refers to "providers and suppliers."

As of September 17, 2020, CMS, through the Medicare Administrative Contractors (MACs), disbursed more than $100 billion in CAAP Program payments to more than 46,000 providers. These CAAP Program payments were issued in a short period of time, thus increasing the risk of improper payments.

COVID-19 has created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for HHS, the Office of Inspector General (OIG) oversees HHS's COVID-19 response and recovery efforts. This audit is part of OIG's COVID-19 response strategic plan.[1]

OBJECTIVE

Our objective was to determine whether CAAP Program payments were made to providers in compliance with the CARES Act and other Federal requirements.

BACKGROUND

Medicare

Under Title XVIII of the Act, the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare has

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

different parts that help cover specific medical services. Medicare Hospital Insurance, known as Part A, helps pay for inpatient hospitals, home health, skilled nursing facilities, and hospice care. Medicare Supplementary Medical Insurance, known as Part B, helps pay for physicians, outpatient hospitals, home health, durable medical equipment, and other services.[2]

CMS uses MACs to, among other things, process and pay Medicare claims submitted for medical services. In addition, CMS utilizes Unified Program Integrity Contractors (UPICs) to investigate instances of suspected fraud, waste, and abuse in Medicare claims.

COVID-19 Accelerated and Advance Payments Program

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

On March 28, 2020, CMS expanded the CAAP Program to a broader group of Part A providers and Part B suppliers and issued new CAAP Program eligibility criteria in a document titled "Fact Sheet: Expansion of the Accelerated and Advance Payments Program for Providers and Suppliers During COVID-19 Emergency" (Fact Sheet).[3] On April 6, 2020, CMS incorporated CAAP Program criteria for Part B suppliers in 42 CFR § 421.214.[4] The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. No. 116-159) clarified that the CARES Act expansion of the AAP Program also applied to all other Part A providers and Part B providers.

To receive a CAAP Program payment, the CARES Act required providers to submit a request. CMS required the MACs to review the requests to determine whether the providers qualified for a CAAP Program payment.[5] To qualify for a CAAP Program payment, the Fact Sheet required providers to meet four criteria. Specifically, a provider must: (1) not be under bankruptcy,[6] (2) have billed Medicare for claims within 180 days immediately before the date

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

[3] The Fact Sheet, updated as of October 8, 2020, available online at https://www.cms.gov/files/document/accelerated-and-advanced-payments-fact-sheet.pdf. Accessed on July 27, 2022.

[4] This change was effective March 31, 2020, and was applicable beginning March 1, 2020.

[5] The CMS Technical Direction Letter number 200324, dated March 27, 2020 (Technical Direction Letter).

[6] When a MAC gets information that a provider is under bankruptcy, the MAC updates CMS' Healthcare Integrated General Ledger Accounting System (HIGLAS) to indicate the provider's bankruptcy status. HIGLAS is the centralized accounting system for the Federal financial accounting functions for all of CMS' programs. In addition to updating

of signature on the provider's request form, (3) not be under active medical review or program integrity investigation, and (4) not have any outstanding delinquent Medicare overpayments.[7]

CMS also required the MACs to determine the maximum CAAP Program payment a provider could request based on the provider type and Medicare payment history. Specifically, inpatient acute care hospitals, children's hospitals, and certain cancer hospitals could request up to 100 percent of their Medicare payment amount for a 6-month period; critical access hospitals could request up to 125 percent of their Medicare payment amount for a 6-month period, and all other providers could request up to 100 percent of their Medicare payment amount for a 3-month period. CMS referred to these 3-month and 6-month periods, which ended on December 31, 2019, as "look-back periods."[8]

COVID-19 Accelerated and Advance Payments Program Request Processing and Payments

CMS required the MACs to issue CAAP Program payments to the providers within 7 days from receiving a provider's request.[9] For requests where the MACs determined the provider met the eligibility criteria for a CAAP Program payment, MACs entered invoices in the Healthcare Integrated General Ledger Accounting System (HIGLAS).[10, 11] HIGLAS processed the invoices and sent an electronic remittance advice interface file to the Medicare Shared System.[12] Using

HIGLAS, each of the MACs maintains its own database that reflects the providers' bankruptcy status (bankruptcy database).

[7] The *Medicare Financial Management Manual*, chapter 4 § 70.4, states that, "Per…[The Debt Collection Improvement Act of 1996]…referral criteria, 'delinquent' is defined as debt: (1) that has not been paid (in full) by the date specified in the agency's initial written notification (i.e., the agency's first demand letter), unless other payment arrangements have been made, or (2) that at any time thereafter the debtor defaults on a repayment agreement." The *Medicare Financial Management Manual*, chapter 3, describes the minimum requirements that the MACs must follow for collecting the Medicare overpayments and templates for MACs' demand letters.

[8] Technical Direction Letter.

[9] Technical Direction Letter.

[10] From HIGLAS, CMS extracted the data containing all invoices that MACs entered in HIGLAS for CAAP Program payments (CAAP Program payment database) and provided it to us. This CAAP Program payment database included, among other things, MAC jurisdiction, provider number, provider tax identification number, invoice number, invoice amount, and invoice date.

[11] The CAAP Program payment dates we state throughout this report refer to the invoice dates in HIGLAS.

[12] The Medicare Shared System includes Fiscal Intermediary Shared System (FISS), Multicarrier System (MCS), and Viable Information Processing Systems Medicare Systems (VMS). The FISS is a processing system for Medicare Part A claims (such as claims for hospital inpatient care and skilled nursing facility care) and certain Medicare Part B claims (such as claims for hospital outpatient care). The MCS is a processing system for certain Part B claims (such as claims of physicians and those of labs that are not part of a hospital). The VMS is a processing system for Medicare durable medical equipment claims (such as claims for non-implantable durable medical equipment, prosthetics, orthotics, and supplies).

the electronic remittance advice interface file, the Medicare Shared System created and sent electronic fund transfer information files to the MAC's bank for depositing the CAAP Program payment into the provider's bank account. There is a timelag, often 2 days, between the entry of the invoice in the HIGLAS and the MAC's bank's deposit into the provider's bank account.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $103.1 billion in total CAAP Program payments made to 46,373 providers.[13] We selected a stratified random sample of 109 providers and reviewed CAAP Program payments totaling $4.1 billion made to those providers.[14] One of our sample strata included nine providers that were under bankruptcy when the CAAP Program payments were made.[15]

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

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

FINDING

CMS generally made CAAP Program payments to providers in compliance with the CARES Act and other Federal requirements. Of the 109 providers in our sample, CMS appropriately made CAAP Program payments to all 100 providers in the first 3 strata of our sample. For the nine providers under bankruptcy, CMS did not send a CAAP Program payment to six of the providers; however, CMS did make a CAAP Program payment to three of the providers.

The CAAP Program payments made to the three providers under bankruptcy occurred because two MACs did not correctly match the provider's request against their bankruptcy databases, and one MAC did not update its bankruptcy database based on bankruptcy information that was provided by CMS prior to approving the CAAP Program payment request.

[13] The total CAAP Program payments were $103,093,506,435.

[14] The payment total was $4,059,528,270.

[15] Based on a news article found during the audit planning stage, we identified that Quorum Health Corporation (Quorum) and 134 entities related to Quorum (Quorum entities), which included several health care providers, filed bankruptcy petitions in Federal court on April 7, 2020. We found seven Quorum entities in the HIGLAS CAAP Program payment database that CMS provided us, and CMS informed us that two non-Quorum entities under bankruptcy also received CAAP Program payments. We selected all nine providers as part of our sample.

PROVIDERS UNDER BANKRUPTCY

To qualify for a CAAP Program payment, the provider must not be under bankruptcy.[16] The CAAP Program payment database obtained from CMS included nine providers under bankruptcy. These nine providers were included in the database because the MACs incorrectly determined these providers were eligible for a CAAP Program payment and thus entered invoices in HIGLAS for processing. Based on bankruptcy information that CMS subsequently provided to the MACs, one MAC identified its error and stopped the payments before the bank deposited the CAAP Program payment into the bank accounts of six of the nine providers.[17] However, three MACs identified their errors only after the CAAP Program payments were deposited into the bank accounts of the three remaining providers.

COVID-19 Accelerated and Advance Payments Program Payments Made to Three Providers Under Bankruptcy

Three providers under bankruptcy received a CAAP Program payment, as explained below:

- One provider filed for bankruptcy on August 22, 2017. The provider submitted a CAAP Program payment request on April 9, 2020. This provider was in the MAC's bankruptcy database. The MAC erroneously approved the request and entered an invoice for $460,240 in HIGLAS on April 10, 2020. The MAC subsequently identified the error, informed CMS of the improper payment, and initiated recovery prior to the start of our audit.[18] The recovery was completed on May 23, 2022.

- One provider filed for bankruptcy on July 27, 2017. The provider submitted a CAAP Program payment request on April 3, 2020. This provider was in the MAC's bankruptcy database. The MAC erroneously approved the request and entered an invoice for $270,908 in HIGLAS on April 8, 2020. The MAC subsequently identified the error, informed CMS of the improper payment, and initiated recovery beginning on October 29, 2020. The recovery was completed on December 1, 2020.

- One provider filed for bankruptcy on April 7, 2020.[19] The provider submitted a CAAP Program payment request on April 10, 2020. This provider was not in the MAC's bankruptcy database. CMS informed the MAC on April 10, 2020, that this provider filed for bankruptcy. The MAC erroneously approved the CAAP Program payment request and entered an invoice for $431 into HIGLAS on April 15, 2020. The MAC subsequently

[16] Fact Sheet and Technical Directions Letter.

[17] These six providers were Quorum entities.

[18] We issued our audit start notice to CMS on August 7, 2020.

[19] This provider was a Quorum entity.

identified the error, informed CMS of the error, and then recovered the payment prior to the start of our audit.

The CAAP Program payments made to three providers under bankruptcy occurred because two MACs did not correctly match the providers' requests against their bankruptcy databases, and one MAC did not update its bankruptcy database based on the bankruptcy information that CMS provided prior to approving the CAAP Program payment request.

CONCLUSION

Based on our sample, we found that CMS and its MACs generally made CAAP Program payments to providers in compliance with the CARES Act and other Federal requirements. Although the MACs erroneously approved CAAP Program payments to nine providers under bankruptcy, the MACs immediately identified their errors, stopped payments to six providers, and recovered improper payments made to the other three providers. Therefore, we do not have any recommendations.

We provided CMS with a draft report for review. CMS elected not to provide formal comments; however, it provided technical comments, which we addressed as appropriate.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $103,093,506,435 in total CAAP Program payments made to 46,373 providers. We selected a stratified random sample of 109 providers and reviewed CAAP Program payments totaling $4,059,528,270 made to those providers. Of those 109 providers, 100 providers were randomly selected, and 9 providers were under bankruptcy when the CAAP Program payments were made.

During our audit, we did not assess the overall internal control structure of CMS. Instead, we limited our review to CMS' internal controls for ensuring compliance with CAAP Program payment requirements.

We conducted our audit from August 2020 to August 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed the CARES Act, other applicable Federal requirements, and CMS guidance;
- interviewed MAC officials to obtain an understanding of the CAAP Program;
- selected a stratified random sample of 109 providers (Appendix B) that received a total of $4,059,528,270 in CAAP Program payments,
- determined the eligibility to receive CAAP Program payments for each of the 109 sampled providers by performing the following:
    - obtained from the MACs the CAAP program requests submitted by the providers;
    - obtained from the MACs the HIGLAS Reports reflecting Medicare payments to providers to determine whether the providers billed Medicare during the 180 days preceding the date of signature on their requests;

- obtained from the MACs the Provider Alert Lists that the MACs received from the UPICs to determine whether providers under program integrity investigations or medical review received a CAAP Program payment;[20]

- obtained from the MACs the Receivable Balance Detail Extract to determine whether the providers had delinquent Medicare debts more than 180 days old;[21] and

- obtained from the MACs their bankruptcy databases and the bankruptcy filing records from the Federal courts and used that information to determine whether the MACs made CAAP Program payments to providers who were under bankruptcy;

- determined that the CAAP Program payments made to eligible providers did not exceed their maximum allowable amount by performing the following:

  - obtained from the MACs the HIGLAS Reports showing the Medicare payments during the look-back periods for each of the 109 sampled providers;

  - used CMS' provider certification numbers (provider numbers) to distinguish acute care hospitals, children's hospitals, and critical access hospitals from all other types of providers;[22] and

  - compared the CAAP Program payments with HIGLAS Reports showing each provider's Medicare payment during the look-back period and determined whether the CAAP Program payments exceeded the provider's maximum payable amount; and

[20] CMS requires UPICs to record all investigations into a national database called "Unified Case Management System," a system of records for the UPICs. CMS also requires UPICs to document in the Unified Case Management System all activities (such as medical reviews) they are performing to substantiate any allegations of potential fraud, waste, or abuse. UPICs generate a file referred to as "Provider Alert List" from the Unified Case Management System every month and send it to the MACs. The Provider Alert List includes updated information about all providers in the Unified Case Management System. MACs use the Provider Alert List to identify providers under investigation.

[21] Once a MAC determines an overpayment to a provider has been made, it must create an account receivable in HIGLAS and attempt to recover overpayments. The MAC also records recovery of overpayments in HIGLAS. MACs can generate a report referred to as "Receivable Balance Detail Extract" from HIGLAS on any day. The Receivable Balance Detail Extract provides details about the debts that the providers owe Medicare, and MACs use this extract, among other things, to identify providers with delinquent debts.

[22] The inpatient provider number has six digits. The first two digits identify the State in which the provider is located. The last four digits identify the type of facility (*State Operations Manual*, Pub. No. 100-07, ch. 2, The Certification Process, § 2779A1).

- discussed the results of our audit with CMS 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: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 46,373 providers that CMS indicated received CAAP Program payments totaling $103,093,506,435.

SAMPLE UNIT

The sample unit was a provider.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing four strata as shown in Table 1:

Table 1: Sample Design and Sample Sizes

Stratum	Dollar Range of Sample Units		Number of Sample Units	Dollar Value of Sample Units	Sample Size
	Minimum	Maximum			
1	$4.90	$4,947,830.00	43,651	$19,021,723,342	33
2	4,959,240.00	51,862,424.52	2,261	39,822,013,317	33
3	51,877,170.00	522,801,000.00	452	44,242,357,938	34
4	[redacted]		9	7,411,838	9
		Totals	46,373	$103,093,506,435	109

Strata 1 through 3 were created based solely on the dollar value of the sample unit, and 100 providers were randomly selected from them as shown in Table 1. Stratum 4 consisted of providers under bankruptcy when the CAAP Program payments were made, and all of them were selected.

SOURCE OF THE RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

We found that CMS made CAAP Program payments in compliance with the CARES Act and other Federal requirements to all 100 providers that we randomly selected; as a result, we made no estimates.