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Seventeen of Twenty-Five Selected Hospitals Did Not Comply or May Not Have Complied With the Provider Relief Fund Balance Billing Requirement

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Why OIG Did This Audit

- Congress appropriated $178 billion to HHS to provide funds to eligible providers for health care-related expenses or lost revenue attributable to COVID-19 under the Provider Relief Fund (PRF) program. HHS was responsible for initial PRF program oversight and policy decisions, and HRSA administered the PRF program.
- Under the PRF terms and conditions, if a patient had health insurance and sought COVID-19 treatment from an out-of-network provider that received PRF payments, the provider would not seek to collect out-of-pocket payments greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. (We refer to this as the "balance billing requirement.")
- This audit assessed whether selected hospitals that received PRF payments complied with the balance billing requirement for COVID-19 inpatients.

What OIG Found

- Of the 25 selected hospitals, 17 billed patients an amount that did not comply or may not have complied with the balance billing requirement. For example, one hospital billed a patient $6,000 when the patient's insurance carrier had waived all patient cost-sharing responsibility.
- Hospitals stated that they were uncertain how to comply with the requirement because HRSA did not provide sufficient guidance. If HRSA developed and provided early and detailed guidance, hospitals might not have improperly billed selected patients a total of $637,035 for services provided.

What OIG Recommends

We made two recommendations to HRSA, including that it determine whether the selected hospitals made refunds to patients identified in this audit for billings that did not or may not have complied with the balance billing requirement and perform postpayment reviews of hospitals for compliance with the balance billing requirement as part of its ongoing program integrity procedures. The full recommendations are in the report.

HRSA concurred with both recommendations and described actions that it plans to take in response to the recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Provider Relief Fund (PRF) program provided funds to eligible hospitals and other health care providers (collectively referred to as "providers") for: (1) health care-related expenses or lost revenues (e.g., due to canceled elective services) attributable to COVID-19, (2) COVID-19 testing and treatment for uninsured individuals, and (3) the administration of COVID-19 vaccines. Federal laws appropriated to HHS a combined $178 billion in funds, which were, in part, distributed as direct payments to providers in a series of PRF General and Targeted Distributions.[1, 2, 3]

This audit assessed selected hospitals' compliance with PRF terms and conditions barring hospitals from seeking to collect out-of-pocket payments from COVID-19 inpatients (patients) greater than what the patients would have otherwise been required to pay if their care had been provided by an in-network hospital.[4] (We refer to this as the "balance billing requirement" throughout the report.) It is one of several Office of Inspector General (OIG) audits of various aspects of PRF payments, including: (1) the Department of Health and Human Services' (HHS's) and the Health Resources and Services Administration's (HRSA's) controls related to the requirements for submitting revenue information and attesting to the acceptance or rejection of PRF payments, (2) HHS's and HRSA's controls over PRF payment calculations and provider eligibility determinations, (3) claims for COVID-19 testing and treatment services for uninsured individuals, and (4) whether selected providers complied with terms and conditions and Federal requirements for expending PRF funds. See Appendix B for a list of related OIG reports.

[1] The Coronavirus Aid, Relief, and Economic Security Act, P.L. No. 116-136, signed into law on Mar. 27, 2020, appropriated $100 billion; the Paycheck Protection Program and Health Care Enhancement Act, P.L. No. 116-139, signed into law on Apr. 24, 2020, appropriated $75 billion; and the Consolidated Appropriations Act, 2021, P.L. No. 116-260, signed into law on Dec. 27, 2020, appropriated $3 billion.

[2] Under the General Distributions, PRF payments were distributed in four phases (Phases 1, 2, 3, and 4), and within each phase, a wave number was assigned to a group of payments based on the payment distribution date. For example, under the Phase 1 General Distribution, PRF payments were distributed to eligible Medicare providers that billed Medicare fee-for-service (Medicare Parts A or B) in calendar year (CY) 2019. Under the Targeted Distributions, PRF payments were made to providers to address added COVID-19 challenges, such as high-need and vulnerable populations, including nursing homes and providers serving individuals in rural areas and safety net hospitals.

[3] In June 2023, with the passage of the Fiscal Responsibility Act of 2023, P.L. No. 118-5, Congress rescinded some unobligated PRF funds. In response, HRSA stopped making PRF payments to providers.

[4] In-network providers have contractual agreements with a patient's insurance carrier (carrier) and accept negotiated rates for services. Conversely, out-of-network providers do not have a contractual agreement with an individual's carrier and typically charge more for services than in-network providers.

OBJECTIVE

Our objective was to determine whether selected hospitals that received PRF payments complied with the PRF balance billing requirement for COVID-19 inpatients.

BACKGROUND

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 as a pandemic. Then, on March 13, 2020, the President declared the COVID-19 outbreak a national emergency.[5]

The PRF was established to provide funds to eligible providers for: (1) health care-related expenses or lost revenues attributable to COVID-19, (2) COVID-19 testing and treatment for uninsured individuals, and (3) the administration of vaccines to the uninsured and underinsured.[6] Congress appropriated a combined $178 billion in funding from the Coronavirus Aid, Relief, and Economic Security Act; the Paycheck Protection Program and Health Care Enhancement Act; and the Consolidated Appropriations Act, 2021, of which $145.9 billion was distributed to providers for health care-related expenses attributable to COVID-19.[7]

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

The HHS Office of the Secretary was responsible for initial PRF program oversight and policy decisions. The HHS Office of the Secretary's direct responsibility for the PRF program allowed HHS to meet its mission to expedite the establishment of the PRF and the distribution of funds as quickly as possible for providers' health care-related expenses or lost revenues attributable to COVID-19. Within HHS, HRSA was responsible for providing day-to-day oversight and managed all aspects of the PRF program.[8]

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[5] The national emergency ended on May 11, 2023.

[6] According to HHS's *Instructions for the Distribution for Medicaid, CHIP, and Dental Providers Via Enhanced Provider Relief Fund Payment Portal*, lost revenues 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.

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

[8] HHS and HRSA, *PRF General & Targeted Distribution Cycle Memo,* dated Sept. 30, 2020, and Sept. 30, 2021.

HRSA provided various resources to providers on the proper use and reporting of PRF payments, including issuing a series of Frequently Asked Questions (FAQs), and guidance on the balance billing requirement.[9] In addition, HRSA engaged external audit firms to conduct risk-based audits for a sample of providers to ensure that providers complied with PRF terms and conditions.

Requirements for Hospitals That Received Provider Relief Fund Payments

As a condition of receiving PRF payments, providers, including hospitals,[10] agreed to the PRF terms and conditions.[11] Under the terms and conditions, hospitals were required to comply with various requirements in order to retain and use PRF distribution payments. One of these requirements stipulated that if a patient had insurance and sought treatment for actual or presumptive COVID-19 from an out-of-network hospital, the hospital would not seek to collect out-of-pocket payments greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network hospital.[12, 13] The balance billing requirement was included in the terms and conditions to ensure that COVID-19 patients would not incur financial hardships during the public health emergency because they may have been required to seek care from out-of-network hospitals due to capacity constraints at in-network hospitals.[14]

Due to the variation in in-network cost-sharing[15] responsibility across insurance carriers (carriers) and benefit plans, HRSA established the Affordable Care Act (ACA) Marketplace out-

[9] HRSA, "PRB Provider Relief Fund General Information FAQ." Accessed on Apr. 1, 2025. We note that HRSA initially published this guidance on balance billing on May 6, 2020.

[10] PRF payments were distributed to providers based on providers' Taxpayer Identification Numbers (TINs). We use the term "hospital" to refer to a hospital reporting entity that registered its TIN through HRSA's PRF Reporting Portal to report how it and its associated subsidiaries used PRF payments. A hospital may be a stand-alone hospital, a hospital group, or a parent organization.

[11] Generally, providers were required to sign an attestation confirming receipt of PRF funds and agree to applicable terms and conditions within 90 days of receiving a PRF payment.

[12] HRSA, "Relief Fund Payment from $20 Billion General Distribution Terms and Conditions." Accessed on Apr. 1, 2025.

[13] HRSA, *Provider Relief Programs: Provider Relief Funds and ARP Rural Payments Frequently Asked Questions.* Accessed on Apr. 1, 2025.

[14] The balance billing requirement is unrelated to the No Surprises Act of 2022, which was enacted to protect individuals from financial hardships that could result from large "surprise" medical bills.

[15] Cost-sharing is defined as the share of costs covered by an individual's insurance that is paid by the patient. This generally includes deductibles, co-insurance, and co-payments or similar charges but does not include insurance premiums, balance billing amounts for out-of-network providers, or the cost of noncovered services.

of-pocket limitation[16] as the generally expected threshold for assessing compliance with the balance billing requirement when an out-of-network patient's in-network cost-sharing amount could not be determined.[17]

Hospitals' Compliance With Provider Relief Fund Patient Balance Billing Requirement

Generally, as illustrated in Exhibit 1 (next page), compliance with the PRF balance billing requirement began when a patient was admitted to an out-of-network hospital with a presumptive or actual COVID-19 diagnosis. The hospital should have prepared a claim for submission to the patient's carrier based on the services provided during the patient's stay. The carrier would process the hospital's claim based on the patient's insurance plan and issue a remittance statement, also known as an explanation of benefits (EOB) statement, to the hospital. Generally, the EOB would identify what portion of the submitted claim was: (1) covered by the carrier, (2) the patient's cost-share amount, and (3) the patient's responsibility.[18, 19] Upon receipt of the EOB, the hospital was required, through its acceptance of PRF funding, to first determine if the patient's cost-share amount was based on the carrier's in-network or out-of-network rate. If the patient's responsibility on the EOB was calculated based on the out-of-network rate, the hospital should not have billed the amount shown on the EOB. Instead, the hospital should have attempted to identify the carrier's in-network rate and then billed the patient for this verified amount. If the hospital was unable to identify this amount, the ACA Marketplace out-of-pocket limitation would be the generally expected threshold for assessing compliance with the balance billing requirement.

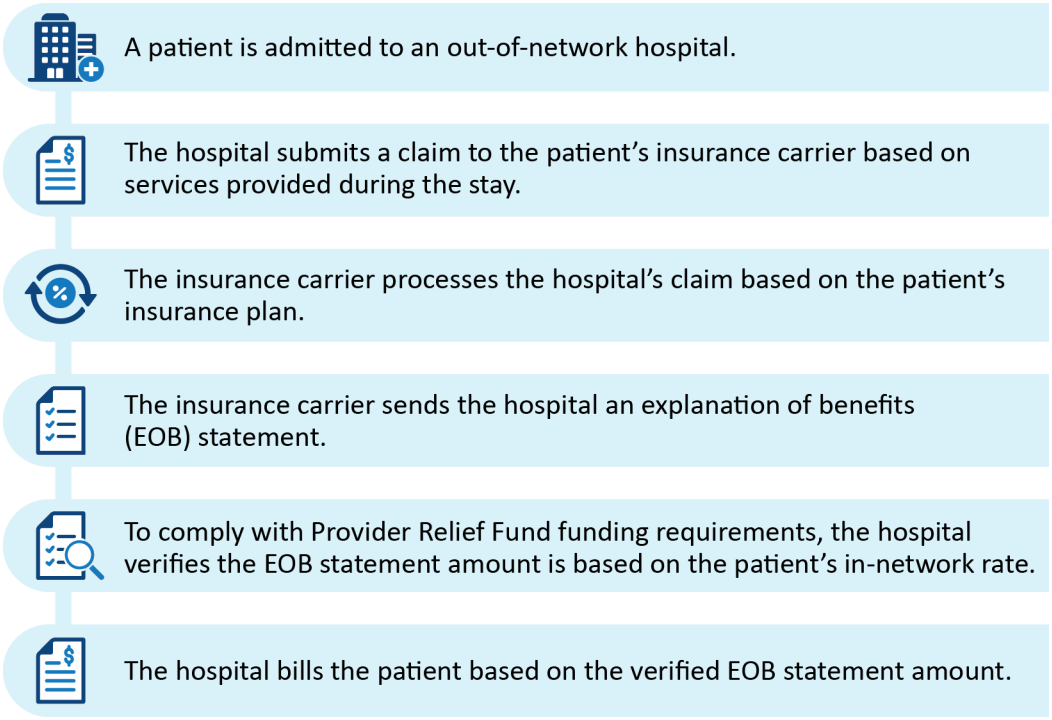
[16] The ACA Marketplace out-of-pocket limit was $8,550 for an individual and $17,100 for a family for the 2021 plan year. For the 2022 plan year, the limits were $8,700 and $17,400, respectively. During our audit, HRSA stated that it established this threshold because out-of-pocket responsibility varied by plan and HRSA could not identify this information. We note that HRSA described the ACA Marketplace out-of-pocket limitation as a compliance threshold as part of a technical update after our audit period on Apr. 6, 2022.

[17] HRSA, *Provider Relief Programs: Provider Relief Funds and ARP Rural Payments Frequently Asked Questions.* Accessed on Apr. 1, 2025.

[18] During the pandemic, many insurers waived—or temporarily waived—out-of-pocket costs for COVID-19 patients enrolled in fully insured plans. For example, Aetna initiated a cost-sharing waiver for some private plans and Medicare Advantage plan members through Jan. 31, 2021, and Cigna initiated a waiver for all COVID-19 treatment through Feb. 15, 2021. We refer to this as a "waiver" throughout the report.

[19] Patient responsibility is what the patient owes after the insurance payment to the hospital and patient's cost-share amount are deducted.

Exhibit 1: Example of Hospital Billing Process for Seeking Reimbursement of COVID-19 Inpatient Services



For hospitals to have complied with the balance billing requirement, they would have issued bills to patients that could have been categorized in one of four ways:

1. The hospital would not bill the patient or would bill the patient for zero dollars because the hospital waived the patient's cost-share amount.

2. The hospital would not bill the patient or would bill the patient for zero dollars because the carrier waived the patient's cost-share amount.

3. The hospital would bill the patient at the patient's in-network cost-share amount.

4. The hospital could not determine the patient's in-network cost-share amount and would bill the patient up to the ACA Marketplace out-of-pocket limitation.

HOW WE CONDUCTED THIS AUDIT

We reviewed selected hospitals for compliance with the PRF balance billing requirement. Our sample included hospitals associated with Taxpayer Identification Numbers (TINs) that kept a

Wave 4 PRF distribution totaling $10,000 or more.[20] From these hospitals, we selected for audit a nonstatistical sample of 25 hospitals (associated with 24 TINs) that admitted 4 or more out-of-network patients with either a positive COVID-19 test result or a COVID-19 diagnosis code.[21] The hospitals were selected based on hospital type (e.g., critical access hospitals [CAHs] and long-term care hospitals), geographic location (i.e., rural or urban), organizational structure (i.e., hospital groups and stand-alone hospitals), and hospital bed count.[22] For each hospital, we nonstatistically selected the hospital billing documentation for four of these patients based on the amount billed and type of insurance coverage (e.g., private health insurance or Medicare Part C). Specifically, we reviewed hospital bills for treatment provided to 100 patients during 2 periods: (1) January 1, 2021, through March 31, 2021, and (2) January 1, 2022, through March 31, 2022 (audit period).[23] We also reviewed HRSA's balance billing guidance to providers and the selected hospitals' policies and procedures for compliance with the balance billing requirement.

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

Of the 25 selected hospitals, 8 complied with the PRF balance billing requirement. However, the remaining 17 hospitals did not comply or may not have complied with the balance billing requirement. Specifically, 9 hospitals improperly billed 18 patients when patients' carriers waived the patients' cost-sharing responsibility, billed the patients' carriers' out-of-network rate instead of the required in-network rate, or billed at a rate above the ACA Marketplace out-of-pocket limitation. In addition, 13 hospitals billed 24 patients an amount that may not have complied with the requirement. These hospitals did not confirm whether: (1) the billed amount was the patients' in-network or out-of-network cost-sharing amount or (2) the patients' carriers

[20] HRSA assigned wave numbers to payments under the General Distributions. Wave 4 automatic PRF payments were part of the Phase 1 General Distribution and were dispersed on Apr. 24, 2020, by HRSA to providers based on revenue data from providers' Medicare cost reports on file with the Centers for Medicare & Medicaid Services for fiscal years 2017 and 2018. One or more hospitals may be associated with a single TIN.

[21] For this audit, two of the selected hospitals were associated with the same TIN.

[22] The selection factors were designed to cover various types and sizes of hospitals nationwide.

[23] We selected the two periods to compare and determine if any changes (e.g., expiration of an insurer's waivers or updated HRSA guidance) impacted the sampled hospitals' ability to comply with the balance billing requirement and did not identify any material differences in the hospitals' compliance between the two periods.

may have waived out-of-pocket costs for COVID-19 services. The total number of hospitals exceeds 17 because we identified 5 hospitals with errors in both categories.

These improper or potentially improper billings occurred because, according to the selected hospitals, they were uncertain of how to comply with the balance billing requirement due to a lack of sufficient guidance from HRSA. For example, HRSA did not provide guidance on the ACA Marketplace out-of-pocket limitation as a compliance threshold until April 6, 2022—after our audit period. If HRSA had developed and provided detailed guidance earlier and the selected hospitals had verified patients' in-network rates, the hospitals might not have improperly billed the selected patients a total of $637,035 for services provided.

Appendix C contains a summary of our findings by hospital and patient.

HOSPITALS DID NOT COMPLY WITH THE BALANCE BILLING REQUIREMENT WHEN BILLING SOME OUT-OF-NETWORK COVID-19 PATIENTS

The PRF terms and conditions required recipients to certify that they would not seek to collect out-of-pocket expenses from patients that exceeded what the patients would have otherwise been required to pay if their care had been provided by an in-network provider.[24]

HRSA's PRF FAQs stated that providers that accepted PRF payments should have submitted claims to patients' carriers for COVID-19 services. Providers could only seek out-of-pocket expenses from patients that were no greater than what the patient would have been required to pay if they were in-network patients. HRSA stated that, generally, "it would be highly unusual for providers to collect" an amount from an out-of-network patient that exceeds the ACA Marketplace out-of-pocket limitation for the calendar year.[25, 26]

Of the 25 selected hospitals, 9 hospitals did not comply with the balance billing requirement when billing out-of-network patients. The hospitals improperly billed 18 patients a total of $601,585 for services provided.[27] Specifically:

[24] HRSA, "Relief Fund Payment from $20 Billion General Distribution Terms and Conditions." Accessed on Apr. 1, 2025.

[25] HRSA, *Provider Relief Programs: Provider Relief Funds and ARP Rural Payments Frequently Asked Questions.* Accessed on Apr. 1, 2025.

[26] This amount is the most an individual would pay for covered services in a plan year. After this amount is spent on deductibles, co-payments, and co-insurance for in-network care and services, the health plan pays all allowable costs of covered benefits.

[27] The total number of hospitals and patients exceed 9 and 18, respectively, because some hospitals made multiple billing errors.

- Seven hospitals billed nine patients a total of $488,926 for services provided despite the patients' carriers having waived the patients' cost-sharing responsibility.[28] For example, one hospital billed a patient $6,000 for services provided; however, for the period in which the services were provided, the patient's carrier waived all patient cost-sharing responsibility. Accordingly, the hospital should not have billed the patient for the services.

- Three hospitals billed eight patients a total of $11,628 for services provided at the patients' carriers' out-of-network rate instead of the required in-network rate. For example, one hospital billed a patient more than $2,000 for services provided. The hospital confirmed that the amount billed was the out-of-network rate for the patient's carrier.

- Two hospitals billed four patients for amounts that exceeded the ACA Marketplace out-of-pocket limitation. For three of these patients, the carrier had waived the patients' cost-sharing responsibility, and the associated improperly billed amounts are included in the respective finding above. For the remaining patient, the hospital billed the patient $101,031 in excess of the out-of-pocket limitation.[29]

As a result, patients in our sample selection received improper hospital bills for services provided, totaling $601,585. We noted that hospitals either: (1) collected payments from patients; (2) wrote off the bills, effectively canceling the debt; (3) classified the bills as outstanding and—as of the end of our fieldwork—continued efforts to collect payment; or (4) transferred the unpaid bills to collection agencies.

HOSPITALS MAY NOT HAVE COMPLIED WITH THE BALANCE BILLING REQUIREMENT WHEN BILLING SOME OUT-OF-NETWORK COVID-19 PATIENTS

The PRF terms and conditions required recipients to certify that they would not seek to collect out-of-pocket expenses from patients that exceeded what the patients would have otherwise been required to pay if their care had been provided by an in-network provider.

Of the 25 selected hospitals, 13 hospitals may not have complied with the balance billing requirement when billing some out-of-network patients. The hospitals billed 24 patients a total of $35,450 when the hospital did not confirm whether: (1) the billed amount was the patient's

[28] Waiving the cost-sharing amount effectively made the patient's in-network responsibility amount zero.

[29] For this patient, the hospital did not verify the patient's in-network cost-sharing amount. To be conservative, we used the highest ACA Marketplace out-of-pocket amount (i.e., $17,100 for the 2021 plan year) to determine the amount in which the billed amount, $118,131, exceeded the limitation.

in-network or out-of-network cost-sharing amount or (2) the patient's carrier may have waived out-of-pocket costs for COVID-19 services.[30] Specifically:

- Nine hospitals billed seventeen patients a total of $20,302 for services provided without confirming whether the patients were billed their in-network or out-of-network cost-sharing amount. We could not determine whether the hospitals complied with the balance billing requirement because hospital billing staff did not verify that the amount on the carrier's EOB was based on the patient's in-network or out-of-network cost-sharing amount.

- Six hospitals billed seven patients a total of $15,148 for services provided without confirming whether the patients' carriers had waived out-of-pocket costs for COVID-19 services.[31] We could not determine whether a waiver was in place because this information was not readily available from the patients' carriers. For example, one patient's carrier may have extended its COVID-19 waiver to cover the period the patient was admitted to the hospital. We could not determine if such a waiver was in place because the carrier's parent company allowed its individual plans to decide whether and how long such a waiver would be effective.

These instances of potential noncompliance with the balance billing requirement resulted in patients in our sample selection receiving hospital bills totaling $35,450 that may have exceeded their in-network cost-sharing amount or waived out-of-network cost. We noted that hospitals either: (1) collected payments from patients, some of which were subsequently refunded; (2) wrote off the bills, effectively canceling the debt; (3) classified the bills as outstanding and—as of the end of our fieldwork—continued efforts to collect payment; or (4) transferred the unpaid bills to collection agencies.

CAUSES FOR IMPROPER AND POTENTIALLY IMPROPER PATIENT BILLINGS

These improper or potentially improper billings occurred because, according to the selected hospitals, they were uncertain how to comply with the balance billing requirement due to a lack of sufficient guidance from HRSA. The hospitals stated that they reviewed HRSA's guidance and

[30] The total number of hospitals exceeds 13 because, for 2 hospitals, we could not determine whether there was a waiver in place *and* the hospital did not confirm whether the billed amount was the patient's in-network or out-of-network cost-sharing amount.

[31] This amount does not include one patient bill, totaling $1,100, because the hospital additionally did not confirm whether the patient was billed their in-network or out-of-network cost-sharing amount, and the billed amount was included in the total for that error category.

FAQs; however, due to the limited nature of the guidance, some hospitals developed billing policies and procedures based on their own interpretations of the requirement.[32]

HRSA's operational objective at the beginning of the public health emergency was to ensure that individuals did not face severe economic hardship during the public health emergency. In addition, the degree of difficulty in implementing and providing oversight over this requirement, intended to protect individuals, could not be anticipated.[33]

RECOMMENDATIONS

We recommend that the Health Resources and Services Administration:

- determine whether the selected hospitals made refunds to the patients identified in this audit for billings that did not or may not have complied with the PRF balance billing requirement and

- as part of its established and ongoing program integrity procedures, perform postpayment reviews of hospitals for compliance with the balance billing requirement, including the hospitals we identified that may not have complied, to ensure that patients were not billed more than their in-network amount and were refunded any improper billed amounts.

HRSA COMMENTS

In written comments on the draft report, HRSA concurred with both recommendations and described corrective actions it plans to address them, including reviewing the selected hospitals' compliance with PRF balance billing requirements and requesting that the hospitals make refunds to patients, as appropriate.

HRSA also provided technical comments on our draft report, which we addressed as appropriate. HRSA's comments, excluding the technical comments, are included as Appendix D.

[32] To prevent against noncompliance with the requirement, some hospitals made the independent decision to waive billing the patient for the balance of the claim not reimbursed by insurance.

[33] Key stakeholders and decisionmakers should use the information included in this report when determining lessons learned from administering PRF distributions during the COVID-19 national emergency.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered a nonstatistical sample of 25 hospitals (associated with 24 TINs) that received and kept PRF payments during calendar year (CY) 2020, and from the 25 selected hospitals, we nonstatistically selected 100 out-of-network patients (4 from each hospital).[34] The hospitals were selected based on payment amount, geographic location, patient count, type of entity, and facility size. The patients were selected based on billed amount and insurance type (e.g., private, Medicare Part C, or Medicaid). The sample unit was a hospital entity associated with a reporting TIN[35] that kept a Wave 4 PRF payment made on April 24, 2020, which was calculated using its submitted cost reports for fiscal years 2017 and 2018. We identified 6,010 hospitals associated with 5,316 TINs that received PRF payments during CY 2020. From the 5,316 TINs, we identified the hospitals that kept Wave 4 PRF distributions totaling $10,000 or more and arrived at 3,414 hospitals associated with 2,939 TINs. We further refined the list based on the PRF payment amount,[36] geographic locations (i.e., urban and rural areas), organizational structure (i.e., hospital groups and stand-alone hospitals), and hospital bed count, leaving us with 265 hospitals associated with 77 TINs.[37] From this list of 265 hospitals, we selected our nonstatistical sample of 25 hospitals that admitted 4 or more out-of-network patients with either a positive COVID-19 test result or a COVID-19 diagnosis code.

To determine the selected hospitals' compliance with the PRF balance billing requirement, we reviewed hospital billing documentation maintained for the selected patients. Specifically, we reviewed bills for treatment[38] provided to the selected 100 patients during 2 periods:

[34] PRF payment recipients had 90 days to return a payment to HHS, otherwise the recipient was deemed to have accepted the terms and conditions. Our sample included PRF payments issued in CY 2020 for which hospitals attested to the payment terms and conditions and/or kept PRF payments after 90 days of receipt.

[35] A reporting TIN is one that is associated with a hospital entity that reports the use of PRF General and/or Targeted Distribution payments received by that TIN and/or its subsidiaries or is associated with a parent organization that is not a hospital entity (e.g., a holding corporation) but reports on the use of PRF payments for one or more of its subsidiaries that are hospital entities. Each selected hospital TIN could be a stand-alone hospital or part of a parent-subsidiary system that may include other provider types (e.g., urgent care facilities, nursing homes, and clinics).

[36] We included a range of payments from $22.8 million to $435.3 million.

[37] The selection factors were designed to cover various types and sizes of hospitals nationwide.

[38] This report refers to bills for treatment as opposed to bills for COVID-19 inpatient services because some patients did not test positive for COVID-19. However, because these patients presented on admission as potentially positive for COVID-19, all services for these patients fell under the balance billing requirement.

(1) January 1, 2021, through March 31, 2021, and (2) January 1, 2022, through March 31, 2022 (audit period).[39]

We did not assess the overall internal control structure of HRSA or the hospitals. We limited our review of HRSA's and the selected hospitals' internal controls to those applicable to our audit objective. Specifically, we reviewed HRSA's guidance to providers related to compliance with the balance billing requirement. We also reviewed selected hospitals' policies and procedures for compliance with the balance billing requirement.[40]

We conducted our audit from July 2022 through June 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance, including the PRF terms and conditions and HRSA's FAQs related to the balance billing requirement;

- interviewed HRSA officials and obtained documentation to gain an understanding of the program's policies and procedures and HRSA's oversight and monitoring of the balance billing requirement;

- conducted an analysis of insurance company waivers for COVID-19 treatment;[41]

- obtained from HRSA a list of hospitals nationwide that received PRF payments;

- created a list of 265 hospitals nationwide that kept PRF payments based on the: (1) type of hospital (e.g., long-term care facility, psychiatric hospital, CAHs), (2) hospital revenues for fiscal years 2017 and 2018, (3) amount of PRF payment kept,[42] (4) geographical location (i.e., urban and rural), and (5) hospital bed count;

- selected a nonstatistical sample of 25 hospitals nationwide (based on payment amount, geographic location, type of entity, and facility size) that received and kept

[39] We selected the two periods to compare and determine if any changes (e.g., expiration of an insurer's waivers or updated HRSA guidance) impacted the sampled hospitals' ability to comply with the balance billing requirement and did not identify any material differences in the hospitals' compliance between the two periods.

[40] The conclusions derived from this audit were based on information provided by hospitals and publicly available information (e.g., websites) from insurance companies. We did not contact insurance carriers or patients for support documentation or to conduct interviews.

[41] Our analysis of insurance company waivers for COVID-19 treatment determined that a vast majority of insurers waived out-of-pocket costs through January 2021.

[42] For this audit, we only considered hospitals that retained PRF payments of $10,000 or more.

PRF payments made to each hospital's TIN and had 4 or more patients with out-of-network insurance coverage with either a positive COVID-19 test result or a COVID-19 diagnosis code;

- obtained hospital questionnaire responses from each selected hospital to identify the policies and procedures used to ensure compliance with the balance billing requirement;

- obtained point-in-time patient census data from each selected hospital to identify out-of-network presumptive and actual COVID-19 patients with Medicare Part C and private insurance during the audit period;[43, 44]

- selected a nonstatistical sample of four out-of-network patients based on billed amount and insurance type (e.g., private, Medicare Part C, or Medicaid) from each hospital (100 patients in total) who were admitted for treatment with a positive COVID-19 test result or a COVID-19 diagnosis and obtained the hospital billing documentation for these selected patients;[45, 46]

- determined, based on the billing documentation provided, whether the hospitals' bills to selected patients treated for COVID-19 complied with the PRF's balance billing requirement, and for each of the 100 patients:

    - obtained and analyzed the hospital's billing documentation and related records;[47]

[43] The patient information obtained included the patient's: personal information (e.g., name, medical identification number, address/contact information), insurance plan and coverage information (i.e., name of carrier, carriers' contact information, and in-network/out-of-network status with the selected hospital), and COVID-19 diagnosis (actual, presumptive, or not applicable). We used this data to identify out-of-network COVID-19 patients with Medicare Part C and private health insurance coverage.

[44] The 25 hospitals identified a total of 783 out-of-network patients admitted with a COVID-19 diagnosis during our audit period.

[45] Preliminary survey work determined that CAHs, primarily located in rural areas, were generally the only health care facility within a large geographic area. As a result, CAHs generally did not have out-of-network patients. Therefore, we excluded CAHs from our sample.

[46] During our fieldwork, we found that for eight of our selected hospitals, the four patients we selected were not billed for the treatment provided because either there was no patient responsibility, or the hospital waived the patient's responsibility. Some hospitals opted to waive billing their patients due to uncertainty with how to comply with the requirement. We note that HRSA established the ACA Marketplace out-of-pocket limitation as a compliance threshold as part of a technical update issued Apr. 6, 2022, which occurred after our audit period.

[47] The hospital billing documentation obtained included, but was not limited to: claim and billing documentation sent to the patient's carrier(s), claim and billing resolution letter(s) from the carrier(s), billing documentation and notifications/correspondence sent to the patient, claim/billing reconciliation of the patient's account, documentation used to determine/calculate the patient's in-network cost, and any other relevant correspondence or documentation regarding the billing or collection of payments for the inpatient stay.

- based on the hospital's documentation, compared the carrier's EOB to the hospital patient payment account and billing statement to determine whether the patient was billed and the amount of the bill;

- confirmed with hospital staff whether the patient's responsibility identified on the EOB was determined based on the in-network or out-of-network rate; and

- determined whether the patient's billed amount exceeded the allowable amount (i.e., the insurance carrier's cost-share waiver [if any], the patient's responsibility, or the ACA Marketplace out-of-pocket limitation).

- discussed the results of our audit with HRSA officials.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Selected Home Health Agencies Complied With Terms and Conditions and Federal Requirements for Provider Relief Fund Payments	A-01-22-00503	11/26/2024
Seven of Thirty Hospices Reviewed Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Provider Relief Fund Payments	A-02-22-01014	11/8/2024
HRSA Made Some Potential Overpayments to Providers Under the Phase 2 General Distribution of the Provider Relief Fund Program	A-09-22-06001	3/4/2024
The Provider Relief Fund Helped Select Nursing Homes Maintain Services During the COVID 19 Pandemic, but Some Found Guidance Difficult To Use	OEI-06-22-00040	12/12/2023
HHS's Oversight of Automatic Provider Relief Fund Payments Was Generally Effective but Improvements Could Be Made	A-02-20-01025	10/30/2023
HRSA Made COVID-19 Uninsured Program Payments to Providers on Behalf of Individuals Who Had Health Insurance Coverage and for Services Unrelated to COVID-19	A-02-21-01013	7/13/2023
Targeted Provider Relief Funds Allocated to Hospitals Had Some Differences With Respect to the Ethnicity and Race of Populations Served	OEI-05-20-00580	7/12/2023
HHS's and HRSA's Controls Related to Selected Provider Relief Fund Program Requirements Could Be Improved	A-09-21-06001	9/26/2022

APPENDIX C: SUMMARY OF FINDINGS

			Errors			Potential Errors				
Hospital	Patient	Patient Amount Billed	Patient Billed When a Waiver Was in Place	Patient Billed Out-of-Network Amount	Patient Bill Exceeded ACA Marketplace Out-of-Pocket Limitation	Hospital Did Not Confirm Amount Billed	Hospital Did Not Confirm if There Was a Waiver	Total Patient Improper and Potentially Improper Amount	Total Hospital Errors and Potential Errors	Total Hospital Improper and Potentially Improper Amount
1	A	$0						$0	2	$7,404
	B	$6,404					X	$6,404		
	C	$0						$0		
	D	$1,000					X	$1,000		
2	A	$1,950		X				$1,950	4	$6,585
	B	$675		X				$675		
	C	$2,010		X				$2,010		
	D	$1,950		X				$1,950		
3	A	$0						$0	0	$0
	B	$0						$0		
	C	$0						$0		
	D	$0						$0		
4	A	$0						$0	2	$6,021
	B	$6,000	X					$6,000		
	C	$21				X		$21		
	D	$0						$0		
5	A	$0						$0	1	$2,240
	B	$0						$0		
	C	$2,240				X		$2,240		
	D	$0						$0		

			Errors			Potential Errors				
Hospital	**Patient**	**Patient Amount Billed**	**Patient Billed When a Waiver Was in Place**	**Patient Billed Out-of-Network Amount**	**Patient Bill Exceeded ACA Marketplace Out-of-Pocket Limitation**	**Hospital Did Not Confirm Amount Billed**	**Hospital Did Not Confirm if There Was a Waiver**	**Total Patient Improper and Potentially Improper Amount**	**Total Hospital Errors and Potential Errors**	**Total Hospital Improper and Potentially Improper Amount**
6	**A**	$0						$0	1	$100
	B	$0						$0		
	C	$0						$0		
	D	$100				X		$100		
7	**A**	$0						$0	0	$0
	B	$0						$0		
	C	$0						$0		
	D	$0						$0		
8	**A**	$2,010		X				$2,010	4	$6,559
	B	$2,674	X					$2,674		
	C	$1,675		X				$1,675		
	D	$200		X				$200		
9	**A**	$0						$0	2	$1,565
	B	$1,158		X				$1,158		
	C	$0						$0		
	D[48]	$407					X	$407		
10	**A**	$1,291	X					$1,291	1	$1,291
	B	$0						$0		
	C	$0						$0		
	D	$0						$0		

[48] During our audit period, Patient D was billed by the sampled hospital for three separate inpatient visits for COVID-19 treatment. The hospital billed the patient for only one of these visits.

			Errors			Potential Errors				
Hospital	**Patient**	**Patient Amount Billed**	**Patient Billed When a Waiver Was in Place**	**Patient Billed Out-of-Network Amount**	**Patient Bill Exceeded ACA Marketplace Out-of-Pocket Limitation**	**Hospital Did Not Confirm Amount Billed**	**Hospital Did Not Confirm if There Was a Waiver**	**Total Patient Improper and Potentially Improper Amount**	**Total Hospital Errors and Potential Errors**	**Total Hospital Improper and Potentially Improper Amount**
11	**A**	$2,592	X					$2,592	3	$7,230
	B	$3,138					X	$3,138		
	C	$2,978						$0		
	D	$1,500	X					$1,500		
12	**A**	$0						$0	0	$0
	B	$0						$0		
	C	$0						$0		
	D	$0						$0		
13	**A**	$0						$0	0	$0
	B	$0						$0		
	C	$0						$0		
	D	$0						$0		
14	**A**	$0						$0	0	$0
	B	$0						$0		
	C	$0						$0		
	D	$0						$0		
15	**A**	$1,000				X		$1,000	6	$550,487
	B	$118,131			X			$101,031		
	C	$296,224	X		X			$296,224		
	D	$152,232	X		X			$152,232		

			Errors			Potential Errors				
Hospital	**Patient**	**Patient Amount Billed**	**Patient Billed When a Waiver Was in Place**	**Patient Billed Out-of-Network Amount**	**Patient Bill Exceeded ACA Marketplace Out-of-Pocket Limitation**	**Hospital Did Not Confirm Amount Billed**	**Hospital Did Not Confirm if There Was a Waiver**	**Total Patient Improper and Potentially Improper Amount**	**Total Hospital Errors and Potential Errors**	**Total Hospital Improper and Potentially Improper Amount**
16	**A**	$1,100				X	X	$1,100	4	$1,956
	B	$225				X		$225		
	C	$0						$0		
	D	$631				X		$631		
17	**A**	$3,112				X		$3,112	3	$6,164
	B	$1,452				X		$1,452		
	C	$7,235						$0		
	D	$1,600				X		$1,600		
18	**A**	$300				X		$300	4	$1,800
	B	$500				X		$500		
	C	$500				X		$500		
	D	$500				X		$500		
19	**A**	$0						$0	1	$5,236
	B	$0						$0		
	C	$0						$0		
	D	$5,236				X		$5,236		
20	**A**	$0						$0	0	$0
	B	$0						$0		
	C	$0						$0		
	D	$0						$0		

			Errors			Potential Errors				
Hospital	**Patient**	**Patient Amount Billed**	**Patient Billed When a Waiver Was in Place**	**Patient Billed Out-of-Network Amount**	**Patient Bill Exceeded ACA Marketplace Out-of-Pocket Limitation**	**Hospital Did Not Confirm Amount Billed**	**Hospital Did Not Confirm if There Was a Waiver**	**Total Patient Improper and Potentially Improper Amount**	**Total Hospital Errors and Potential Errors**	**Total Hospital Improper and Potentially Improper Amount**
21	**A**	$0						$0	2	$25,037
	B	$0						$0		
	C	$0						$0		
	D	$25,037	X		X			$25,037		
22	**A**	$0						$0	0	$0
	B	$0						$0		
	C	$0						$0		
	D	$0						$0		
23	**A**	$0						$0	0	$0
	B	$0						$0		
	C	$0						$0		
	D	$0						$0		
24	**A**	$1,375	X					$1,375	4	$5,980
	B	$1,975				X		$1,975		
	C	$910				X		$910		
	D	$1,720					X	$1,720		
25	**A**	$226						$0	1	$1,380
	B	$86						$0		
	C	$440						$0		
	D	$1,380					X	$1,380		
Total		**$665,100**	**9**	**8**	**4**	**17**	**7**		**45**	**$637,035**

APPENDIX D: HRSA COMMENTS

HRSA
Health Resources & Services Administration
Office of Federal Assistance and Acquisition Management
5600 Fishers Lane
Rockville, MD 20857

DATE: August 6, 2025

TO: Megan Tinker
Chief of Staff

FROM: Cynthia Baugh
Associate Administrator

CYNTHIA R. BAUGH -S
Digitally signed by CYNTHIA R. BAUGH -S
Date: 2025.08.06 09:12:08 -04'00'

SUBJECT: OIG Draft Report: A-02-22-01018

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

Attachments

Draft Report titled *"Seventeen of Twenty-Five Selected Hospitals Did Not Comply or May Not Have Complied With the Provider Relief Fund Balance Billing Requirement, A-02-22-01018"*

General Comments

The Health Resources and Services Administration (HRSA) appreciates the opportunity to comment on the Office of Inspector General's (OIG) draft audit report titled *"Seventeen of Twenty-Five Selected Hospitals Did Not Comply or May Not Have Complied With the Provider Relief Fund Balance Billing Requirement."*

HRSA's responses to the OIG Draft Report recommendations are as follows:

OIG Recommendation 1

The OIG recommended that HRSA determine whether the selected hospitals made refunds to the patients identified in this audit for billings that did not or may not have complied with the PRF balance billing requirement.

HRSA Response

HRSA concurs with the OIG recommendation. HRSA will review the selected hospitals' compliance with the Provider Relief Fund (PRF) balance billing prohibition and request that the hospitals make refunds to patients, as appropriate.

OIG Recommendation 2

The OIG recommended that as part of its established and ongoing program integrity procedures, HRSA perform postpayment reviews of hospitals for compliance with the balance billing requirement, including the hospitals OIG identified that may not have complied, to ensure that patients were not billed more than their in-network amount and were refunded any improper billed amounts.

HRSA Response

HRSA concurs with the OIG recommendation. HRSA will determine if hospital providers selected for a PRF programmatic audit met the Terms and Conditions, including the prohibition of balance billing.

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