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HRSA Made $658 Million in Potential Overpayments to Selected Providers Under Phase 3 of the Provider Relief Fund Program

REPORT HIGHLIGHTS

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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 revenues attributed to COVID-19. These funds were distributed under the Provider Relief Fund (PRF) program. HRSA administered the PRF program and distributed the funds in multiple phases. HRSA calculated providers' Phase 3 PRF payments based on the greater of 2 percent of the providers' patient care revenue or 88 percent of the providers' reported net revenue losses. HRSA distributed about $19.3 billion to 64,048 providers in the Phase 3 General Distribution.
- This audit is part of a series reviewing various aspects of PRF payments. Specifically, this audit assessed whether Phase 3 PRF payments that HRSA made to providers were correctly calculated, properly supported, and were made to eligible providers in accordance with PRF terms and conditions and Federal requirements. We reviewed a statistical sample of 150 providers and a nonstatistical sample of 15 providers who received Phase 3 PRF payments.

What OIG Found

- For all 150 providers in our statistical sample and all 15 providers in our nonstatistical sample, HRSA made PRF payments to providers who met Federal eligibility requirements. However, for 65 of the 150 providers in our statistical sample, HRSA made PRF payments that were not correctly calculated or supported by appropriate documentation. For 7 of the 15 providers in our nonstatistical sample, HRSA made PRF payments that were not correctly calculated.
- HRSA made $655.7 million in potential overpayments to 39 providers and $131.3 million in potential underpayments to 26 providers in our statistical sample. In addition, HRSA made $2.3 million in potential overpayments to six providers and $1.1 million in potential underpayments to one provider in our nonstatistical sample.

What OIG Recommends

We made two recommendations to HRSA, including that it conduct a review of the providers in our statistical sample that had potential overpayments of $655.7 million and the providers in our nonstatistical sample that had potential overpayments of $2.3 million and determine the amount of and seek from these providers repayment of any overpayments, up to $658 million. The full recommendations are in the report.

HRSA did not indicate concurrence or nonconcurrence with our recommendations but described actions it plans to take in response to our recommendations.

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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, including the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which the President signed into law. These Federal laws appropriated to the Department of Health and Human Services (HHS) a combined $178 billion in funds, which HHS used to establish the Provider Relief Fund (PRF).[1] The PRF provided payments 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. HHS distributed PRF funds, in part, as direct payments to providers in a series of PRF General and Targeted Distributions.[2] As of October 2024, the Health Resources and Services Administration (HRSA) had distributed $145.9 billion of the PRF to providers.[3]

In November 2020, HRSA began distributing PRF payments under the Phase 3 General Distribution to new providers, behavioral health providers, and some providers that previously received a PRF payment.[4, 5] As of March 2023 (the end of our audit period), HRSA had distributed about $19.3 billion to 64,048 providers in Phase 3 PRF payments.

HRSA calculated a provider's Phase 3 PRF payment based on the greater of two amounts: (1) 2 percent of the provider's annual revenue from patient care (referred to as "patient care

[1] Specifically, the CARES 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). 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 Phase 2 General Distribution, PRF payments were distributed to Medicaid and Children's Health Insurance Program (CHIP) providers, dental providers, and assisted living facilities. Under the Targeted Distributions, PRF payments were made to eligible providers or specific provider types to address added COVID-19 challenges, such as high-need populations, including nursing facilities and providers serving individuals in rural areas and safety net hospitals.

[3] This dollar figure is based on latest PRF distribution data provided by HRSA. As of June 2023, with the passage of the Fiscal Responsibility Act of 2023, P.L. No. 118-5, Congress rescinded unobligated PRF funds, notwithstanding limited funding Congress directed be used for program oversight and administration. In response, HRSA stopped making PRF payments to providers.

[4] HRSA used the term "new providers" to describe providers that delivered patient care for the first time during CY 2019 or the first quarter of CY 2020.

[5] Providers that received previous PRF payments under the Phase 1 or Phase 2 General Distributions or through a Targeted Distribution may have been eligible to apply for additional PRF payments under the Phase 3 General Distribution.

revenue") or (2) up to 88 percent of the provider's reported losses—defined as lost revenue and health care-related expenses attributable to coronavirus and incurred during the first half of 2020 (referred to as "provider's net revenue losses"). To receive a Phase 3 PRF payment, a provider was required to submit an application and documentation (e.g., Federal income tax return [referred to as "Federal tax return"] and internally generated financial statements) to support the revenues and expenses reported on the application. Providers were also required to meet certain eligibility requirements, such as not being excluded from participating in Medicaid or Medicare.

This audit assessed whether Phase 3 PRF payments that HRSA made to providers were made in accordance with PRF terms and conditions and Federal requirements.[6] These PRF payments were disbursed from November 16, 2020, through March 1, 2023 (audit period). Further, this audit is one of several Office of Inspector General (OIG) audits that examined various aspects of PRF payments, including HHS's and HRSA's oversight of payment calculations and provider eligibility, as well as providers' compliance with Federal requirements for reporting and using PRF payments.[7]

OBJECTIVE

Our objective was to determine whether Phase 3 PRF payments were correctly calculated, properly supported, and made to eligible providers in accordance with PRF terms and conditions and Federal requirements.

BACKGROUND

The Provider Relief Fund

As a result of the COVID-19 public health emergency, 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.[8] Many providers reported that their cash reserves were quickly depleted, which could have disrupted ongoing provider operations. Many of these providers requested financial assistance, including loans and grants.

[6] The Phase 3 General Distribution included certain payments made to providers who received a Phase 1 General Distribution PRF payment. These payments were included in another OIG audit; therefore, we excluded these payments from this review.

[7] Other OIG audits have examined various aspects of the PRF payments.

[8] On Jan. 31, 2020, the Secretary of Health and Human Services declared the COVID-19 outbreak a public health emergency. Then, on Mar. 13, 2020, the President declared the COVID-19 outbreak a national emergency. Both the COVID-19 public health and national emergencies ended on May 11, 2023.

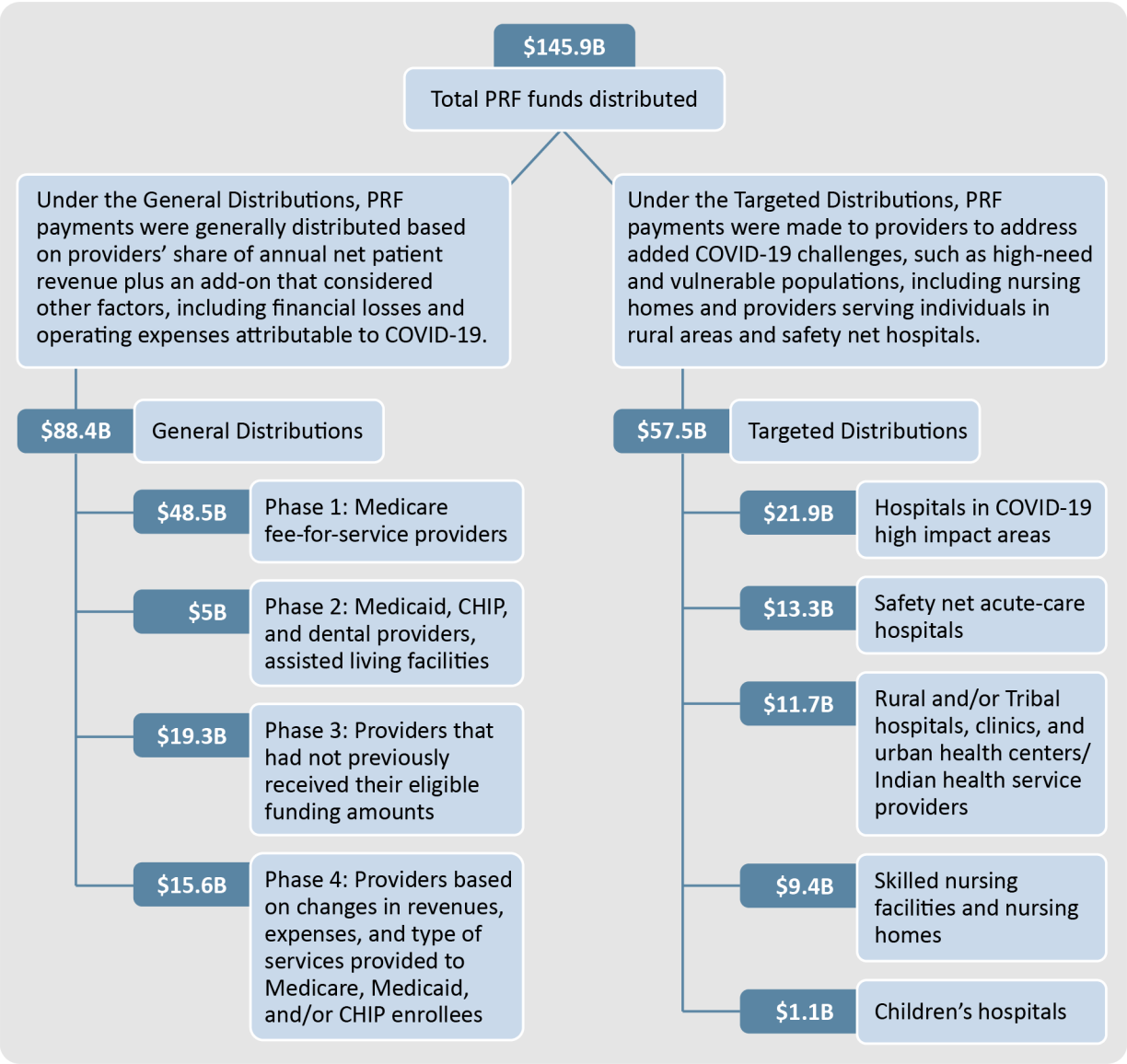
In response to the public health emergency, the PRF was established to provide funds to eligible providers for health care-related expenses or lost revenue attributable to COVID-19.[9] HHS received a combined $178 billion in funding, of which $145.9 billion was distributed via PRF payments to providers.[10] Under the CARES Act, Congress directed that PRF payments be distributed to "eligible healthcare providers" using the "most efficient payment systems practicable to provide emergency payment."

The Exhibit on the next page details the PRF distributions to health care providers.

[9] 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 reimbursement for treatment)." This lost revenue may include revenue losses associated with fewer outpatient visits or canceled elective procedures or services. (In August 2020, HRSA removed from the instructions the field for lost revenue and the definition of "lost revenue attributable to COVID-19.")

[10] Congress 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 was administered by HRSA and had similar limitations and requirements as the PRF but was not part of the PRF.

Exhibit: Provider Relief Fund Distributions to Health Care Providers



Notes: Amounts for the Targeted Distributions do not add to $57.5 billion due to rounding. CHIP stands for the Children's Health Insurance Program.

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 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 management of all aspects of the PRF program.[11]

HRSA provided various resources to providers on the proper use and reporting of PRF payments, including issuing a collection of evolving Frequently Asked Questions (FAQs), and other guidance on allowable expenses and lost revenue calculations.[12] HRSA also conducted technical assistance webinars on the reporting process. In addition, HRSA engaged external audit firms to conduct risk-based audits for a sample of providers to ensure that providers used PRF payments in accordance with PRF terms and conditions.

Provider Relief Fund Payments Under the Phase 3 General Distribution

HRSA began distributing Phase 3 PRF payments in November 2020 to new providers, behavioral health providers, and some providers that previously received a PRF payment. The payments were based on completed applications submitted through the PRF Application and Attestation Portal.

The following sections describe how HRSA: (1) calculated Phase 3 PRF payments, (2) reviewed applicants' supporting documentation, and (3) determined whether providers were eligible for the payments.

HRSA's Calculation of Phase 3 Provider Relief Fund Payments

HRSA worked with a contractor to calculate Phase 3 PRF payments using a six-step calculation described below. According to HHS's *Provider Relief Programs: Provider Relief Fund and ARP Rural Payments Frequently Asked Questions* (PRF FAQs), a provider was paid the greater of 2 percent of the provider's patient care revenue or 88 percent of its reported net revenue losses.[13] HRSA adjusted a provider's payment if HRSA determined that the provider's application included: (1) nonpatient care revenues and expenses, (2) unsupported revenues and

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

[12] HRSA, *Provider Relief Programs: Provider Relief Fund and ARP Rural Payments Frequently Asked Questions* (PRF FAQs). Accessed on July 24, 2025. HRSA, *Provider Relief Fund Distributions and American Rescue Plan Rural Distribution Post-Payment Notice of Reporting Requirements* (PRF Reporting Requirements). Accessed on July 24, 2025. As of March 2026, HRSA has substantially revised these websites.

[13] According to HRSA's "Instructions for Phase 3 – General Distribution Application Via Provider Relief Fund Application and Attestation Portal," patient care revenue does not include revenue such as grants, insurance, investment, or real estate revenue. Patient care expenses do not include expenses such as costs incurred on rental property (exception for nursing and assisted living facilities) and gains or losses on investments.

expenses, or (3) revenues or expenses that were extreme outliers in comparison to other providers of the same provider type.[14]

Providers were required to enter the following information on the PRF application: (1) gross revenue, (2) percentage of revenue from patient care, (3) operating revenues from patient care, (4) operating expenses from patient care, and (5) provider type (e.g., behavioral health provider or acute-care hospital).[15] As described in HRSA's *Provider Relief Fund Phase 3: Payment Calculation Methodology*, HRSA's process for calculating Phase 3 PRF payments included six steps:

1. **Calculate 2 percent of the provider's patient care revenue.** HRSA multiplied the provider's gross revenue for the most recent complete tax year by the percentage of revenue from patient care to get the provider's patient care revenue and multiplied the result by 0.02.[16]

2. **Calculate initial loss ratio and the provider-type loss ratios.** HRSA calculated the provider's initial loss ratio by dividing the provider's losses (i.e., the provider's lost revenue minus its change in expenses) by its patient care revenue. The provider-type loss ratios were calculated using the provider's self-selected provider type.[17]

3. **Adjust loss ratios and make other pre-payment value adjustments.** HRSA adjusted the provider's initial loss ratio to the provider-type loss ratio if one of the reported quarter revenues or expenses was greater than 50 percent of the patient care revenue or made other pre-payment value adjustments if certain conditions were met.

4. **Calculate 88 percent of the provider's net revenue losses.** HRSA multiplied the provider's patient care revenue in step 1 by the provider's initial loss ratio or an adjusted loss ratio (e.g., mean loss ratio for the provider type) if step 3 conditions were met to calculate the provider's net revenue losses. The provider's net revenue losses were then

[14] Providers who believed that their PRF Phase 3 payment was not calculated correctly according to the Phase 3 payment methodology had an opportunity to request reconsideration of their payment amounts. However, as of June 2023, with the passage of the Fiscal Responsibility Act of 2023, P.L. No. 118-5, Congress rescinded unobligated PRF funds, except for limited funding Congress directed be used for program oversight and administration. In response, HRSA stopped making PRF payments to providers.

[15] HRSA instructed providers to report the revenue amount from their most recent Federal tax return for 2017, 2018, or 2019 if in operation before Jan. 1, 2020. If a provider was a new provider, the provider was instructed to enter its operating revenues from patient care for the portion of time during which the provider was delivering patient care.

[16] These revenue calculations were used in later steps; therefore, any errors made in step 1 impacted the payment made to the provider.

[17] Based on the self-selected provider type, the provider-type loss ratios (i.e., mean, median, and mean plus one standard deviation of the loss ratio) were calculated for the provider type.

multiplied by 0.88.

5. **Select the greater of 2 percent of the provider's patient care revenue or 88 percent of the provider's net revenue losses.**

6. **Deduct all prior PRF payments made to the provider and its subsidiaries from the amount selected in step 5.**

Provider Submission of Supporting Documentation

Providers that applied for Phase 3 PRF payments were required to submit a PRF application and documentation supporting the gross revenue and operating revenues and expenses from patient care (i.e., providers' reported operating revenues and operating expenses for 2019 and 2020 calendar quarters 1 and 2, which we refer to as "quarterly figures") reported on the application.[18] Documentation supporting quarterly figures included internally generated financial statements. However, HRSA did not require providers to submit documentation supporting the self-reported percentage of revenue from patient care as part of gross revenue. Finally, providers were required to report their organization tax identification number (TIN) and any subsidiary TINs on the PRF application to show the parent-subsidiary relationship, if any.

HRSA instructed its contractor to manually review providers' applications and associated supporting documentation if certain conditions were met (referred to as "manual review"). HRSA stated that these conditions included missing or incomplete information, potential payments greater than $1 million, or suspicious information (e.g., a suspicious email domain or phone number). During its manual review of applications, HRSA's contractor was instructed to validate applicants' gross revenue and quarterly figures by reviewing a tax return, financial statements, or other documentation the provider submitted. If necessary, the contractor was also instructed to adjust the gross revenue or quarterly figure amounts to match the documentation and exclude potential nonpatient care revenue. The contractor would send the results of its review to HRSA to make the final payment determination. According to HRSA, if there was no support for a provider's gross revenue, a payment should not have been made.

Provider Eligibility for Phase 3 PRF Payments

The CARES Act stated that PRF payments shall be made to eligible providers with a valid TIN. To be eligible for Phase 3 PRF payments, providers must not have been terminated from participation in Medicare, Medicaid, or other Federal health care programs.[19] To validate a TIN, HRSA verified whether a provider's name and TIN were found in Internal Revenue Service (IRS)

[18] Documentation for gross revenue included the provider's most recent Federal tax return for 2017, 2018, or 2019.

[19] Specifically, providers must not have been terminated from participation in Medicare or precluded from receiving payments through Medicare Part C (managed care) or Part D (prescription drug insurance); must not have been excluded from participation in Medicare, Medicaid, and other Federal health care programs; and must not have had Medicare billing privileges revoked.

databases. To determine a provider's eligibility, HRSA checked whether a provider's TIN was included on several lists of sanctioned providers (e.g., the Centers for Medicare & Medicaid Services' [CMS's] list of individuals or entities barred from participation in Medicare and OIG's list of individuals and entities excluded from participation in Federal health care programs). HRSA also checked whether a provider's TIN or its subsidiary TIN (if any) was included in HRSA's curated lists of eligible providers (e.g., providers that participated in Medicare and Medicaid) to receive payment. If a TIN was not found on a curated list, HRSA shared the TIN with other agencies (e.g., State Medicaid agencies) for further authentication.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $19 billion in Phase 3 PRF payments to 50,168 providers that received total Phase 3 PRF payments of $10,000 or more from November 16, 2020, through March 1, 2023.[20] We selected for review a stratified random sample of 150 providers that received Phase 3 PRF payments totaling $5,201,260,313 and a nonstatistical sample of 15 providers that received Phase 3 PRF payments totaling $8,995,515 (each represented by a tax-filing TIN).[21, 22]

To determine whether PRF payments were supported by appropriate documentation as identified in HHS's instructions for the PRF application, we reviewed providers' supporting documentation (e.g., a Federal tax return). In addition, we determined whether the PRF payments were correctly calculated based on the providers' supporting documentation. We also reviewed CMS and OIG lists to determine whether providers were eligible for PRF payments.

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.

[20] HRSA's payment data covered 66,072 Phase 3 payments made to 64,048 unique TINs from November 2020 through March 2023 (audit period). Throughout this report, we use the term "tax-filing TIN" to refer to a TIN that a provider entered on its Federal tax return or annual information returns, which included parent organizations that filed returns on behalf of themselves and their subsidiary organizations. For the purposes of this report, we refer to a provider's tax-filing TIN as a "provider."

[21] During our audit, members of Congress requested that OIG review PRF applications submitted by Planned Parenthood providers to determine whether they provided false or misleading information to obtain access to PRF funds. To accommodate the request, we reviewed a nonstatistical sample of these providers as part of this audit. Specifically, we reviewed PRF applications and supporting documentation submitted by these Planned Parenthood providers for Phase 3 PRF payments and did not identify that any of these providers submitted false or misleading information to obtain access to PRF funds.

[22] We limited our review to the provider eligibility requirements for receiving PRF payments. Providers' compliance with PRF terms and conditions and Federal requirements for reporting and using PRF payments was outside the scope of this audit.

Appendix A describes our audit scope and methodology, and Appendix B contains our statistical sampling methodology.

FINDINGS

For all 150 providers in our statistical sample and all 15 providers in our nonstatistical sample, HRSA made PRF payments to providers who met Federal eligibility requirements. However, for 65 of the 150 providers in our statistical sample, HRSA made PRF payments that were not correctly calculated (56 providers) or supported by appropriate documentation (9 providers). For 7 of the 15 providers in our nonstatistical sample, HRSA made PRF payments that were not correctly calculated.

Specifically, for the 56 providers in our statistical sample and 7 providers in our nonstatistical sample for which PRF payments were not correctly calculated, HRSA made payments:

- Without subtracting prior PRF payments made to providers' subsidiary organizations (1 provider in our statistical sample)

- Based on incorrect information entered on providers' PRF applications (2 providers in our statistical sample)

- Based on incorrect patient care revenues, expenses, or both (39 providers in our statistical sample and 4 providers in our nonstatistical sample)

- Based on the incorrect loss ratio (14 providers in our statistical sample and 3 providers in our nonstatistical sample)

For the remaining nine providers in our statistical sample, HRSA made payments that were not supported by appropriate documentation.

As a result of these deficiencies, HRSA made $657,938,721 in potential overpayments to providers under the PRF Phase 3 General Distribution.[23] Specifically, HRSA made $524,332,601

[23] We have chosen not to report any estimates of potential net overpayments in the sampling frame because the lower limit of the two-sided 90-percent confidence interval was less than the known potential net overpayments in the sample.

in potential net overpayments to 65 providers in our statistical sample and $1,181,914 in potential net overpayments to 7 providers in our nonstatistical sample.[24, 25]

These potential net overpayments occurred because certain HRSA procedures for processing and reviewing providers' PRF applications and supporting documentation did not ensure that PRF payments were correctly calculated and supported. HRSA stated that it received more than 100,000 Phase 3 applications and had to create an efficient payment process to provide what it described as emergency PRF payments. HRSA used providers' self-reported gross revenue and quarterly figures to calculate Phase 3 PRF payments without reviewing the supporting documentation for approximately 95 percent of PRF applications. HRSA relied on its safeguards (e.g., manual review) to account for significant deviations reported for gross revenue and quarterly figures and to adjust payments to providers. However, approximately 5 percent of applications went through the manual review. HRSA stated that the manually reviewed applications represented approximately 73 percent of Phase 3 PRF payments distributed, or $14.7 billion. Nevertheless, we found that the contractor's manual review did not always ensure that payments were correctly calculated or supported. For example, HRSA made payments based on incorrect patient care revenues or expenses for manually reviewed applications.

HRSA MADE PROVIDER RELIEF FUND PAYMENTS TO ELIGIBLE PROVIDERS

Federal requirements stated that PRF payments shall be made to eligible providers with a valid TIN. To be eligible for Phase 3 PRF payments, providers must not have been terminated from participation in Medicare, Medicaid, or other Federal health care programs.

For all 150 providers in our statistical sample and all 15 providers in our nonstatistical sample, HRSA made PRF payments to providers who met Federal eligibility requirements.

[24] For the $524,332,601 in potential net overpayments, HRSA made $655,651,947 in potential overpayments to 39 providers and $131,319,346 in potential underpayments to 26 providers in our statistical sample. For the $1,181,914 in potential net overpayments, HRSA made $2,286,774 in potential overpayments to six providers and $1,104,860 in potential underpayments to one provider in our nonstatistical sample. We consider these potential overpayments because HRSA could have accounted for overpayments or underpayments made to these providers in subsequent distributions that were outside the scope of our audit. However, with the passage of the Fiscal Responsibility Act of 2023, P.L. No. 118-5, Congress rescinded unobligated PRF funds, and HRSA stopped making PRF payments to providers.

[25] Three of the sampled providers for which we identified potential underpayments submitted payment reconsideration requests to HRSA. HRSA approved two of these payment reconsiderations and made additional payments. We reviewed these additional payments as part of our audit and found that HRSA incorrectly calculated the payments. HRSA denied the remaining provider's payment reconsideration; therefore, the provider's original payment remained unchanged. We maintain that HRSA incorrectly calculated the original payment. According to HRSA, none of the remaining sampled providers requested a payment reconsideration.

HRSA MADE PROVIDER RELIEF FUND PAYMENTS THAT WERE NOT CORRECTLY CALCULATED

HRSA made PRF payments that were not correctly calculated to 56 providers in our statistical sample and 7 providers in our nonstatistical sample. Specifically, HRSA made payments: (1) without subtracting prior payments made to providers' subsidiary organizations; (2) based on incorrect information entered on providers' PRF applications; (3) based on incorrect patient care revenues, expenses, or both; and (4) based on the incorrect loss ratio.

HRSA Made a Payment to a Provider Without Subtracting Prior Payments Made to the Provider's Subsidiary Organizations

HRSA instructed providers applying on behalf of subsidiaries to list their TIN and the TINs of their subsidiaries on its Phase 3 application (PRF FAQs). Providers could list up to 1,200 subsidiary TINs. Step 6 of HRSA's process for calculating Phase 3 payments stated that all prior PRF payments—including payments received by both the provider's filing TIN and its listed subsidiaries' TINs—were to be deducted.[26] HRSA stated that it deducted prior payments made to all subsidiaries listed in an application, regardless of whether a subsidiary was listed on multiple applications.

HRSA made a payment to one provider in our statistical sample without subtracting prior PRF payments made to the provider's subsidiary organizations. The sampled provider (a medical group consisting of physicians and specialists) received a PRF payment of $19,803,996 after submitting a PRF application and supporting documentation that included gross revenue for three subsidiary organizations.[27] The provider did not list the three subsidiary organizations on its application, and the HRSA contractor's manual review did not identify them. We found that HRSA subtracted PRF payments previously made to only the sampled provider—not payments previously made to the three subsidiaries' TINs included in the supporting documentation. As a result, HRSA made a potential overpayment of $2,643,817 to the provider.

The contractor's manual review process had steps to identify whether an application was for a single provider or a provider with subsidiaries. However, this process lacked steps to identify whether prior PRF payments were made to the provider or its subsidiaries that would have allowed HRSA to account for all prior PRF payments when calculating a Phase 3 payment.

HRSA did not subtract prior payments made to all subsidiaries because it obtained subsidiary TINs from providers' applications, which were subject to data entry errors and incomplete information. For example, we identified 1,313 other TINs in our sampled providers' documentation to support their PRF applications (i.e., potential subsidiary TINs). We could not determine: (1) whether prior payments made to these potential subsidiaries should have been

[26] Prior PRF payments were deducted to ensure that PRF payments were prioritized for providers who had not received funding or at least 2 percent of the providers' patient care revenue.

[27] The sampled provider included a total of 35 TINs in its supporting documentation. We determined that, in its PRF application, the provider claimed revenue for three of these TINs.

deducted or (2) whether the providers claimed the revenues and expenses for these potential subsidiaries on their applications. We determined that HRSA did not verify the accuracy of subsidiary TINs or lack thereof reported by the providers.

HRSA Made Payments to Providers Based on Incorrect Information Entered on Providers' Provider Relief Fund Applications

According to HRSA's instructions for completing the PRF application, providers were to enter their operating revenues and operating expenses from patient care for each required period (i.e., quarterly figures).

As described earlier, HRSA used this information as part of its calculation of PRF payments.

HRSA made payments to two providers in our statistical sample based on incorrect information entered on providers' PRF applications for operating revenues from patient care. This mistake led to large potential overpayments, as described in the example below. Specifically:

- For one sampled provider (an acute-care hospital), HRSA's contractor noted incorrect operating revenues from patient care entered on the provider's PRF application for the first two quarters of 2020. HRSA's contractor corrected the amount for the second quarter of 2020 but used the incorrect amount for the first quarter of 2020. Specifically, rather than using the correct amount of $755,497,000 for the provider's operating revenues from patient care, the contractor used $755,497, which led to erroneous increased losses. As a result, HRSA made a potential overpayment of $166,030,734 to this provider.

- For another sampled provider (an acute-care hospital), HRSA's contractor noted an incorrect quarterly figure entered on the provider's PRF application as a typo and adjusted the amount to match the provider's financial statement. However, instead of using the adjusted amount of $888,417,812 to calculate the provider's PRF payment, HRSA used the incorrect amount of $88,417,812, which led to erroneous increased losses. As a result, HRSA made a potential overpayment of $137,637,092 to this provider.

These potential overpayments occurred because the contractor's manual reviews did not always ensure that payments were correctly calculated. Further, even when the contractor adjusted the providers' quarterly figures, HRSA did not always use the adjusted amount. As a result, HRSA made potential overpayments of $303,667,826 to these two providers in our statistical sample.

HRSA Made Payments Based on Incorrect Patient Care Revenues, Expenses, or Both

HRSA's instructions for completing the PRF application defined "operating revenues from patient care" as revenues that represented amounts received for the delivery of health care services

directly to patients. These included revenues for patient services delivered and pharmacy revenue derived through HRSA's 340B Drug Pricing Program.[28] Nonpatient care revenue such as insurance, grants or tuition, contractual adjustments from all third-party payors, charity care adjustments, bad debt, and pharmacy revenues not derived through the 340B Drug Pricing Program were to be excluded from providers' figures. HRSA stated that operating revenues, including fundraising and interest income, were considered to be nonpatient care revenue. In addition, HRSA's policies and procedures stated that "nonpatient care dining services, parking services, capitation, education, and administrative service fees" were revenues that were excludable for calculating patient care revenue.

HRSA officials stated that certain other revenues (e.g., miscellaneous income and research income) required an audit to determine whether these revenues could be considered as part of patient care operating revenues. For the purposes of this audit, we deemed these revenues as potentially nonpatient care revenues.

In addition, HRSA stated that donations and grant expenses were not considered part of patient care operating expenses. HRSA noted that certain expenses (e.g., gifts, entertainment, and travel) would require an audit to determine whether these expenses could be considered as part of patient care operating expenses. Accordingly, we considered these expenses as potentially nonpatient care expenses.[29]

HRSA made PRF payments to 39 providers in our statistical sample and 4 providers in our nonstatistical sample based on incorrect patient care revenues, expenses, or both. In general, HRSA calculated these payments based on providers' gross revenue and quarterly figures that included nonpatient care or potentially nonpatient care revenues, expenses, or both. For example:

- One sampled provider (an acute-care hospital) reported patient care revenue of $2,116,708,489. We found that the provider's revenue included nonpatient care revenues such as: (1) pharmacy revenues not derived from the 340B Drug Pricing Program, (2) third-party activity revenues, and (3) capitation revenues. After excluding these nonpatient care revenues, we determined that the patient care revenue should have been $1,943,845,310. In addition, the provider's reported operating revenues from patient care did not exclude bad debt to arrive at net patient service revenues. Also, it reported operating expenses from patient care that included collection agency costs, advertising costs, credit card fees, miscellaneous other expenses, and travel and

[28] Entities enrolled in the 340B Drug Pricing Program could purchase discounted outpatient drugs from manufacturers.

[29] In addition to these expenses, we considered other general expenses categories that are not generally or not reasonably associated with patient care, such as advertising, miscellaneous, and alcohol expenses.

entertainment that were potentially nonpatient care expenses.[30] HRSA made a Phase 3 PRF payment to the provider totaling $71,163,755. Based on our payment recalculation, we determined that HRSA made a potential overpayment of $14,234,527 to the provider.

- One sampled provider (a multispecialty practice) reported figures for operating expenses from patient care that included donations and contributions that should have been excluded as nonpatient care expenses. In addition, the provider's reported operating expenses from patient care included potentially nonpatient care expenses (e.g., advertising, gifts, travel expenses, and alcoholic beverages).[31] HRSA made a Phase 3 PRF payment to the provider totaling $25,816,677. Based on our payment recalculation, we determined that HRSA made a potential overpayment of $1,667,331 to the provider.

The incorrectly calculated PRF payments occurred, in part, because HRSA did not require providers to submit documentation to support their figures for the percentage of revenues from patient care. Nevertheless, HRSA used this percentage to calculate patient care revenue. If a provider's application was manually reviewed, the contractor would have reviewed the provider's supporting documentation (e.g., tax form) to determine whether a revenue was related to patient care before calculating patient care revenue. HRSA stated that if the contractor was unable to determine whether an expense or revenue was related to patient care, HRSA assumed that it was related to patient care. HRSA also stated that it appeared that most providers consistently included nonpatient care in their quarterly figures. Even if the manual review identified a nonpatient care revenue or expense, HRSA stated that it may have been within the margin of error it had established and therefore acceptable for payment calculation. As a result, HRSA made $158,154,511 in potential overpayments to 20 providers and $65,298,182 in potential underpayments to 19 providers in our statistical sample. In addition, HRSA made $790,699 in potential overpayments to three providers and $1,104,860 in potential underpayment to one provider in our nonstatistical sample.

HRSA Made Payments to Providers Based on Incorrect Loss Ratio

As described earlier, HRSA's Phase 3 calculation methodology stated that, for each application, HRSA's contractor calculated an initial loss ratio using a provider's self-reported patient care revenue and quarterly figures. HRSA compared the provider's initial loss ratio to the provider-type loss ratios for potential adjustments. For example, HRSA adjusted the provider's initial loss ratio to the mean loss ratio for the provider type if one of the provider's reported quarterly figures was greater than 50 percent of its patient care revenue. This same adjustment occurred when unknown differences (e.g., missing or illegible information) were found between the

[30] The provider's supporting documentation did not include information to justify these expenses as related to patient care. Therefore, we excluded these expenses from our payment recalculation.

[31] The provider's supporting documentation did not include information to justify these expenses as related to patient care. Therefore, we excluded these expenses from our payment recalculation.

provider's reported quarterly figures and its supporting documentation. In general, a higher loss ratio resulted in a provider receiving a higher payment.

HRSA made PRF payments to 14 providers in our statistical sample and 3 providers in our nonstatistical sample because it used the incorrect loss ratio when it calculated the providers' payment. For example:

- For one sampled provider (an acute-care hospital), HRSA erroneously relied on the provider's self-reported quarterly figures to calculate the provider's losses, which resulted in an initial loss ratio of 6.59 percent for the provider's Phase 3 payment. The contractor's manual review stated that the provider's supporting documentation for its quarterly figures had dates that were cut off, making it unclear what periods were covered by the documentation. We also could not validate the provider's reported quarterly figures to its supporting documentation. Given the inadequate supporting documentation, HRSA should have adjusted the provider's initial loss ratio to the mean loss ratio (5.26 percent) for acute-care hospitals to calculate the provider's payment. Based on our payment recalculation, we determined that HRSA made a potential overpayment of $23,387,123 to the provider.

- For another sampled provider (a multispecialty practice), HRSA incorrectly adjusted the provider's initial loss ratio to the mean loss ratio for the provider type (4.59 percent) when it calculated the provider's payment. The contractor's manual review provided no comments for this sampled provider but recommended that the mean loss ratio be applied. However, we validated the provider's reported quarterly figures to the supporting documentation and recalculated the provider's initial loss ratio to be 4.27 percent. We also found that no quarterly figure was greater than 50 percent of the provider's patient care revenue, so the mean loss ratio should not have been applied for the provider. Based on our payment recalculation, we determined that HRSA made a potential overpayment of $1,115,582 to the provider.

The incorrectly calculated PRF payments occurred, in part, because the contractor's manual reviews did not always ensure that payments were correctly calculated using correct loss ratios. As a result, HRSA made $36,148,722 in potential overpayments to seven providers and $66,021,164 in potential underpayments to seven other providers in our statistical sample. In addition, HRSA made $1,496,075 in potential overpayments to three providers in our nonstatistical sample.

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

In general, a provider's reported gross revenue had to be supported with appropriate documentation because this revenue was a required component for step 1 of HRSA's payment calculation process. Specifically, a provider's reported gross revenue was used to determine patient care revenue, which was necessary for determining whether the provider received a

Phase 3 payment based on 2 percent of its patient care revenue or 88 percent of its reported net revenue losses.

According to HRSA's instructions for completing the PRF application, providers were to enter revenues from their most recent Federal tax return (i.e., 2017, 2018, or 2019). Providers were also required to submit specific tax forms based on their Federal tax classification.[32] Providers exempted from filing Federal tax returns (e.g., a State-owned hospital) or who did not file a Federal tax return were required to enter a net patient care revenue or equivalent from their most recent audited financial statements or management-prepared financial statements and submit these documents with their application.

As part of its quality controls processes, HRSA instructed its contractor to validate providers' reported revenue amounts by first checking if their application included a tax return. If no tax return was included, the contractor was to check for financial statements. If no financial statements were included, the contractor was to check whether any other documentation could be used to validate the reported revenue amounts. According to HRSA, if no documentation was provided, the provider was not paid.

HRSA instructed new 2020 providers (i.e., providers that began delivering patient care during the first quarter of 2020) to enter $0 for revenue on their applications. These providers were instructed to upload a cover letter explaining that they were a new provider to support their reason for not including a Federal tax return and supporting documents. To determine the 2 percent of patient care revenue for new 2020 providers, HRSA used 2 percent of the sum of the providers' operating revenue amounts from patient care for the first two quarters of 2020.

HRSA made payments to nine providers in our statistical sample whose applications were not supported by appropriate documentation (i.e., tax returns, audited financial statements, or management-prepared financial statements). For example:

- One sampled provider (an outpatient specialty provider operating as an S corporation) entered $5,718,876 as its gross revenue amount on its PRF application. To support this amount, the provider submitted a 2019 IRS Form 1040 Federal tax return (an individual's income tax return) instead of an IRS Form 1120-S (an income tax return for an S corporation). Therefore, the provider's reported revenue was not supported by appropriate documentation. Nevertheless, HRSA paid the provider $323,794—a potential overpayment.

- One sampled provider (a new 2020 home health provider) entered $195,652 and $275,635 as its quarterly operating revenues from patient care for the first two quarters of 2020, respectively. However, the provider did not submit the appropriate documentation (i.e., internally generated financial statements) to support these

[32] For example, an S corporation was required to enter amounts from certain lines on its IRS Form 1120-S, U.S. Income Tax Return for an S Corporation.

amounts. Instead, the provider submitted a 2019 IRS Form 1065 Federal tax return (a U.S. partnership income tax return), Form 941 for 2019 and 2020 Employer's Quarterly Federal Tax Returns, and a 2019 State tax return, none of which supported the quarterly operating revenues from patient care.[33] HRSA paid the provider $10,281—a potential overpayment.

The unsupported PRF payments occurred because HRSA used the providers' self-reported gross revenue and quarterly figures for payment calculation without reviewing the supporting documentation for approximately 95 percent of submitted applications. HRSA instructed its contractor to perform a manual review of the supporting documentation only under certain conditions (e.g., potential payments greater than $1 million).

HRSA's procedures did not ensure that providers uploaded all required documentation or correct documentation for their applications. HRSA stated that its instructions for new providers did not require providers to submit supporting documentation for operating revenues and expenses from patient care for 2020 calendar quarters 1 and 2 because this information was not critical in preventing overpayments. However, HRSA used this information for its payment calculation. HRSA determined that, given the small amount of potential overpayments, the burden of requiring providers to submit supporting documentation was not justified. Nevertheless, we believe that it was unreasonable for HRSA to accept providers' self-reported revenue without any supporting documentation. If providers did not submit supporting documentation for revenue, there was a higher risk of overpayments.

As a result, HRSA made potential overpayments of $155,037,071 to the providers in our statistical sample.

CERTAIN HRSA PROCEDURES LED TO POTENTIAL OVERPAYMENTS TO PROVIDERS

HRSA made $655,651,947 in potential overpayments to 39 providers in our statistical sample and $2,286,774 to 6 providers in our nonstatistical sample.

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

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

[33] Form 941, Employer's Quarterly Federal Tax Return, is used to report taxes withheld from employee's paychecks and to pay the employer's portion of Social Security or Medicare tax. The form does not include information on quarterly operating revenues from patient care.

RECOMMENDATIONS

- We recommend that HRSA conduct a review of the providers in our statistical sample that had potential overpayments of $655,651,947 and the providers in our nonstatistical sample that had potential overpayments of $2,286,774 and determine the amount of and seek from these providers repayment of any overpayments, up to $657,938,721.[34]

- We recommend that HRSA confirm with the sampled providers whether the potential subsidiary TINs in the supporting documentation are subsidiary organizations that received prior PRF payments and whether the providers claimed the revenues and expenses for these subsidiaries on its application. Then, seek from these providers repayment of any overpayments.

HRSA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, HRSA did not indicate concurrence or nonconcurrence with our recommendations but described actions it plans to take in response to our recommendations. Also, HRSA indicated that there are errors in OIG's calculations and provided additional documentation related to sampled providers that returned PRF payments.

After considering HRSA's comments and additional documentation, we revised our findings and potential overpayment amounts. We maintain that our recommendations, as revised, are valid.

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

HRSA COMMENTS

Regarding our first recommendation, HRSA stated that there are errors in OIG's calculations due to 1 error and 10 cases of what it described as "rounding early." HRSA also stated that two sampled providers returned overpayments in full, which reduced the potential overpayment.[35] Further, HRSA stated that, pending available resources, it will review supporting documentation for the remaining 46 sampled providers to determine whether the OIG decision is consistent with HRSA policy and seek repayment, as appropriate.

[34] HRSA made $655,651,947 in potential overpayments to 39 providers and $131,319,346 in potential underpayments to 26 providers in our statistical sample. HRSA made $2,286,774 in potential overpayments to six providers and $1,104,860 in potential underpayments to one provider in our nonstatistical sample. Providers that believed their payment calculation was incorrect could have requested a payment reconsideration. However, with the passage of the Fiscal Responsibility Act of 2023, P.L. No. 118-5, Congress rescinded unobligated PRF funds, and HRSA stopped making PRF payments to providers. As a result, we only recommend that HRSA focus on reviewing the potential overpayments and seek repayment of any overpayments.

[35] HRSA also provided documentation for a third sampled provider that returned a portion of its payment.

Regarding our second recommendation, HRSA stated that, pending available resources, it will review the applications of the Phase 3 sampled providers to identify if those applications included subsidiary organizations' revenue, in line with the recommendation, and seek repayment, as appropriate.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding HRSA's comments on our first recommendation, we disagree with HRSA's assertion that we made calculation errors and note that HRSA did not provide any documentation to support how it determined our calculation for one sampled provider was in error. When calculating potential overpayment amounts, we followed HRSA's guidance documents, including its PRF FAQs and Phase 3 calculation methodology. HRSA provided recalculated payment totals for the 10 sampled providers for which it contended we "rounded early" but did not provide its calculation steps; therefore, we could not verify HRSA's assertion. Nevertheless, we compared the payment total differences for these sampled providers and found the average difference to be less than one-tenth of 1 percent (i.e., 0.07 percent). Finally, after reviewing additional documentation provided by HRSA, we verified that the sampled providers had returned overpayments prior to the start of our audit and revised our findings and potential overpayment amount.[36]

Regarding HRSA's comments on our second recommendation, we acknowledge that HRSA will review the applications of the Phase 3 sampled providers, pending available resources.

[36] We also revised our description of a payment made by HRSA to one provider in our statistical sample for which HRSA did not subtract prior PRF payments made to the provider's subsidiary organizations (page 11).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 50,168 tax-filing TINs for each provider that received a total payment of $10,000 or more from November 16, 2020, through March 1, 2023, under the Phase 3 General Distribution of the PRF.[37] HRSA disbursed total payments of $18,959,584,563 to these providers. We selected for review a stratified random sample of 150 providers totaling $5,201,260,313 and a nonstatistical sample of 15 providers (each represented by a tax-filing TIN) totaling $8,995,515.[38, 39, 40]

We limited our review of HRSA's internal controls to those that were significant to our audit objective. We did not assess HRSA's overall internal control structure. Specifically, we reviewed the PRF FAQs, the Phase 3 General Distribution terms and conditions, and instructions for the PRF application to obtain an understanding of HRSA's policies and procedures for the Phase 3 General Distribution payment calculation and the requirements for supporting documentation and provider eligibility. We also interviewed HRSA officials to obtain an understanding of controls related to the Phase 3 General Distribution payment calculation and the requirements for supporting documentation and provider eligibility.

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

We conducted our audit from July 2023 through June 2026.

METHODOLOGY

We took the following steps to accomplish our objective:

[37] The Phase 3 General Distribution included certain payments made to providers who received a Phase 1 General Distribution PRF payment. These payments were included in another OIG audit; therefore, we excluded these payments from this review.

[38] Specifically, we reviewed all PRF applications by Planned Parenthood providers for Phase 3 PRF payments.

[39] During our audit, members of Congress requested that OIG review PRF applications submitted by Planned Parenthood providers to determine whether they provided false or misleading information to obtain access to PRF funds. To accommodate the request, we reviewed a nonstatistical sample of these providers as part of this audit. Specifically, we reviewed PRF applications and supporting documentation submitted by these Planned Parenthood providers for Phase 3 PRF payments and did not identify that any of these providers submitted false or misleading information to obtain access to PRF funds.

[40] We limited our review to the provider eligibility requirements for receiving PRF payments. Providers' compliance with PRF terms and conditions and Federal requirements for reporting and using PRF payments was outside the scope of this audit.

- Reviewed applicable Federal laws, regulations, and guidance

- Reviewed the PRF FAQs, the Phase 3 General Distribution terms and conditions, and instructions for the PRF application to obtain an understanding of HRSA's policies and procedures for the Phase 3 General Distribution payment calculation and the requirements for supporting documentation and provider eligibility

- Met with HRSA officials to gain an understanding of controls related to the Phase 3 General Distribution payment calculation and the requirements for supporting documentation and provider eligibility

- Reviewed HRSA's policies and procedures related to the requirements for payment calculation, supporting documentation, and provider eligibility

- Reviewed HRSA's contractor's methodology memos to obtain an understanding of the Phase 3 General Distribution payment calculation

- Obtained from HRSA and analyzed the payment, subsidiary, and attestation data for the Phase 3 General Distribution

- Created a sampling frame that consisted of 50,168 provider tax-filing TINs, each of which received a total of $10,000 or more during our audit period, for which HRSA disbursed payments totaling $18,959,584,563 (Appendix B)

- Selected a stratified random sample of 150 providers and nonstatistical sample of 15 providers from our sampling frame[41]

- For each sampled provider, obtained from HRSA the supporting documentation (e.g., the PRF application and Federal tax return submitted by the provider) to determine whether the PRF payments were correctly calculated, properly supported, and made to an eligible provider[42]

- Reviewed each sampled provider's supporting documentation to identify potential subsidiaries not listed on the provider's PRF application

- Analyzed PRF payment data to determine whether each sampled provider had received prior PRF payments and, if so, whether those payments should have been subtracted when HRSA calculated the PRF payment under the Phase 3 General Distribution

[41] See footnote 21.

[42] We limited our review to the provider eligibility requirements for receiving PRF payment. Providers' compliance with PRF terms and conditions and Federal requirements for reporting and using PRF payments was outside the scope of this audit.

- 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: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 50,168 provider tax-filing TINs for which each provider received a total payment of $10,000 or more from November 16, 2020, through March 1, 2023, under the Phase 3 General Distribution of the PRF and for which HRSA disbursed total payments of $18,959,584,563.

SAMPLE UNIT

The sample unit was a provider tax-filing TIN total payment.[43]

SAMPLE DESIGN AND SAMPLE SIZE

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

Table 1: Strata for Our Sample

Stratum	Dollar Range of Total Payments Received	Frame Size	Value of Frame	Sample Size
1	Total payments equal to or greater than $10,000 but less than $300,000	45,176	$3,104,001,737	30
2	Total payments equal to or greater than $300,000 but less than $3,000,000	4,240	3,133,459,926	30
3	Total payments equal to or greater than $3,000,000 but less than $17,000,000	575	4,036,481,886	30
4	Total payments equal to or greater than $17,000,000 but less than $65,000,000	147	4,599,139,957	30
5	Total payments equal to or greater than $65,000,000	30	4,086,501,057	30
	Total	**50,168**	**$18,959,584,563**	**150**

[43] For the purposes of this report, we refer to a provider's tax-filing TIN as a "provider."

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We sorted the providers in each stratum based on the provider's tax-filing TIN. We then consecutively numbered the providers in each stratum of the sampling frame. After generating the random numbers for our sample according to our sample design, we selected the corresponding frame items for review. We also selected a nonstatistical sample of 15 providers for review.

ESTIMATION METHODOLOGY

We have chosen not to report any estimates of potential net overpayments in the sampling frame because the lower limit of the two-sided 90-percent confidence interval was less than the known potential net overpayments in the sample. Therefore, we are recommending recovery of only the potential overpayments for the items in our sample.

APPENDIX C: HRSA COMMENTS

HRSA
Health Resources & Services Administration

5600 Fishers Lane
Rockville, MD 20857

DATE: August 14, 2026

TO: T. March Bell
Principal Deputy Inspector General

FROM: Cynthia Baugh
Associate Administrator

SUBJECT: OIG Response Memo: A-09-23-01006

Attached are 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.

Attachment

Draft Report titled *"HRSA Made Nearly $1 Billion in Potential Overpayments to Selected Providers Under Phase 3 of the Provider Relief Fund Program, A-09-23-01006*
OIG Draft Report Dated June 30, 2026

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 "*HRSA Made Nearly $1 Billion in Potential Overpayments to Selected Providers Under Phase 3 of the Provider Relief Fund Program.*"

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

OIG Recommendation 1

The OIG recommended that HRSA conduct a review of the providers in our statistical sample that had potential overpayments of $980,655,496 and the providers in our nonstatistical sample that had potential overpayments of $2,286,774 and determine the amount of and seek from these providers repayment of any overpayments, up to $982,942,270.

HRSA Response

HRSA believes there are errors in OIG's calculations (irrespective of agreement with OIG conclusions) due to one error and 10 cases of rounding early. Based on HRSA's recalculations, Recommendation 1 (Draft Report, PDF page 23) should read:

> *We recommend that HRSA conduct a review of the providers in our statistical sample that had potential overpayments of* ***$980,722,022*** *and the providers in our nonstatistical sample that had potential overpayments of* ***$2,287,725*** *and determine the amount of and seek from these providers repayment of any overpayments, up to* ***$983,009,746.75****.*

In addition, 2 providers (Samples 90 and 121) have returned the amounts in full ($9,128,686 and $314,874,863, respectively), reducing the potential overpayment (irrespective of HRSA agreement with OIG conclusions) by $324,003,549. See files titled *"Sample 90 - Return.xlsx"* and *"Sample 121 - Return.xlsx"*.

Draft Report titled *"HRSA Made Nearly $1 Billion in Potential Overpayments to Selected Providers Under Phase 3 of the Provider Relief Fund Program, A-09-23-01006 OIG Draft Report Dated June 30, 2026*

General Comments

			HRSA Recalculation of OIG-Calculated Unallowable Amounts	
OIG Finding Category	**OIG Samples Identified**	**OIG-Calculated Unallowable Amount**	**Adjusted for Errors and Rounding**	**Additionally Adjusted for Offsets and Returns**
Documentation - *Payments Not Supported by Documentation*	9	$156,037,070.82	$156,037,070.82	$155,037,070.83
Incorrectly Calculated – *Incorrect Loss Ratio Used*	11	$46,773,482.87	$46,822,548.17	$37,632,898.19
	1	-$164,358.91	$20,277.94	$20,277.94
Incorrectly Calculated - *Patient Care Revenues and/or Expenses*	23	$158,945,210.55	$158,943,343.59	$158,861,061.60
Incorrectly Calculated - *Revenue and/or Expenses Entered*	2	$303,667,826.24	$303,667,826.24	$303,667,826.24
Incorrectly Calculated - *Payments to Subsidiaries Not Subtracted*	2	$317,518,679.99	$317,518,679.99	$2,643,816.56
Total	**48**	**$982,777,911.56**	**$983,009,746.75**	**$657,862,951.36**

Pending available resources, HRSA will review supporting documentation for the remaining 46 sampled providers to determine whether the OIG decision is consistent with HRSA policy, and seek repayment, as appropriate.

OIG Recommendation 2

The OIG recommended that HRSA confirm with the sampled providers whether the potential subsidiary TINs in the supporting documentation are subsidiary organizations that received prior PRF payments and whether the providers claimed the revenues and expenses for these subsidiaries on its application. Then, seek from these providers repayment of any overpayments.

HRSA Response

Pending available resources, HRSA will review the applications of the Phase 3 sampled providers to identify if those applications included subsidiary organizations' revenue, in-line with the OIG recommendation, and seek repayment, as appropriate.

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330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov