Department of Health and Human Services
Office of Inspector General
Office of Audit Services

June 2025 | A-02-22-01003

# Eleven of Thirty Selected Hospitals Did Not Comply With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments

# REPORT HIGHLIGHTS

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## Why OIG Did This Audit

- Congress appropriated $178 billion to HHS for the Provider Relief Fund (PRF), which provided reimbursement to eligible providers for health care-related expenses or lost revenue attributable to COVID-19. HHS was responsible for initial PRF program oversight and policy decisions, and HRSA administered the PRF program.
- Providers receiving PRF payments were to ensure that the payments were: (1) used to prevent, prepare for, or respond to COVID-19; (2) used for health care-related expenses or lost revenues attributable to COVID-19; (3) not used to cover expenses or losses reimbursed by other funding sources; and (4) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities.
- This audit is part of a series reviewing PRF payments to various provider types. Specifically, this audit assessed whether 30 selected hospitals expended taxpayer funds in accordance with Federal and program requirements.

## What OIG Found

- Of the 30 selected hospitals we reviewed, 10 hospitals claimed a total of $63 million of unallowable PRF expenditures and 2 hospitals inaccurately reported $645.6 million of lost revenues. These hospitals (11, including 1 hospital that had more than 1 deficiency) received a total of $3.8 billion in PRF payments. The remaining hospitals used PRF funds for allowable expenditures and lost revenues.
- These deficiencies occurred because although hospitals attested to the PRF terms and conditions and HRSA provided continuously updated guidance to PRF recipients, the hospitals made clerical errors in their reporting of expenditures and did not always correctly interpret HRSA guidance, maintain documentation to support reported expenditures, or have procedures to verify the accuracy of lost revenue calculations.

## What OIG Recommends

We made two recommendations to HRSA, including that it require the selected hospitals to return any unallowable expenditures and lost revenue amounts to the Federal Government or ensure that the hospitals properly account for these expenditures and lost revenues. HRSA concurred with 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, 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 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]

This audit assessed selected hospitals' compliance with terms and conditions and Federal requirements for expending PRF payments. It is one of several Office of Inspector General (OIG) audits of various aspects of PRF payments, including: (1) HHS's and 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, and (3) claims for COVID-19 testing and treatment services for uninsured individuals. See Appendix B for a list of related OIG reports.

[1] Specifically, 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). 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 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.

## OBJECTIVE

Our objective was to determine whether selected hospitals that received PRF payments complied with terms and conditions and Federal requirements for expending PRF funds.

## 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.[4] Hospitals throughout the Nation reported that ceasing elective procedures and other services decreased revenues while their costs increased as they prepared for a potential surge of patients.[5] Many hospitals reported that their cash reserves were quickly depleted, which could have disrupted ongoing hospital operations. Additionally, all types of hospitals, and especially small rural hospitals, requested financial assistance, including loans and grants. Smaller, independent hospitals, such as rural hospitals and critical access hospitals, reported that they were at greater financial risk than those in larger systems and faced more financial uncertainty.

In response to the public health emergency, the PRF was established to provide funds to eligible providers for health care-related expenses or lost revenues attributable to COVID-19.[6] HHS received a combined $178 billion in funding, of which $145.9 billion was distributed via PRF payments to providers.[7] PRF funds were distributed as direct payments to providers in a series of General and Targeted Distributions.

The Exhibit on the next page details the PRF distributions to health care providers. For further details on how PRF payments were distributed, see Appendix C.

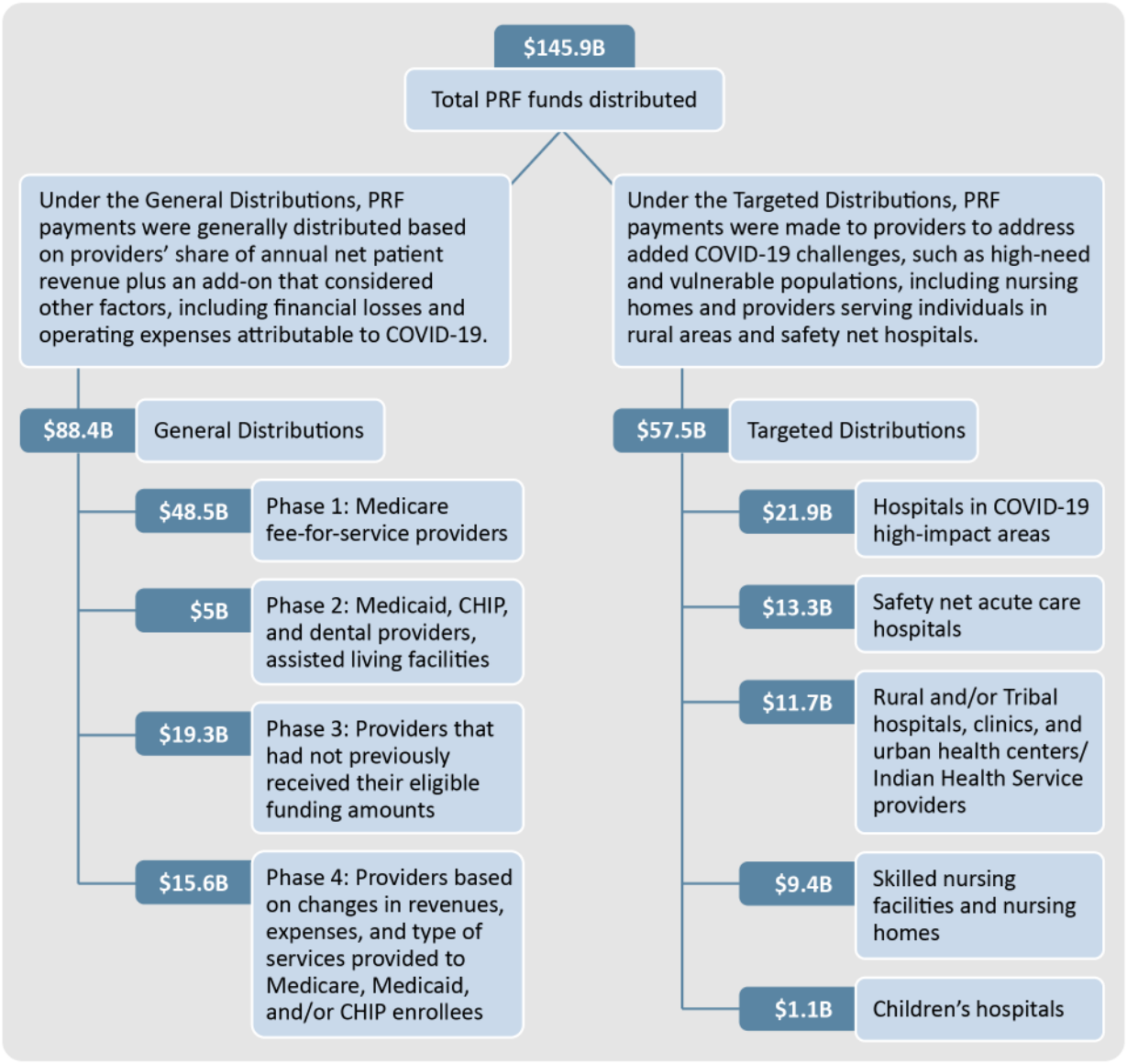
[4] On Jan. 31, 2020, the Secretary of Health and Human Services declared the COVID-19 outbreak a public health emergency. Then, on Mar. 13, 2020, the President declared the COVID-19 outbreak a national emergency. Both the COVID-19 public health and national emergencies ended on May 11, 2023.

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

[6] Providers had up to the end of the quarter in which the public health emergency ended (June 30, 2023) to use PRF payments for any health care-related expenses or lost revenues attributable to COVID-19, if any.

[7] Congress also appropriated $8.5 billion of COVID-19-related relief for rural providers enrolled in 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 is 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 managed all aspects of the PRF program.[8]

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 revenues calculations.[9] 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.

**Requirements for Hospitals That Received Provider Relief Fund Payments**

Providers, including hospitals, may have been eligible to receive PRF payments from multiple distributions. For example, a hospital could have received PRF payments through the General Distribution as well as the Targeted Distribution for high-impact areas and rural providers.[10, 11] Hospitals that received PRF payments had to comply with certain provisions of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR part 75). Specifically, the hospitals had to comply with 45 CFR § 75.302 (Financial management and standards for financial management systems) and 45 CFR §§ 75.361 through 75.365 (Record retention and access).

As a condition of receiving PRF payments, providers agreed to the PRF terms and conditions, including meeting eligibility criteria; filing expenditure reports; and ensuring that payments were: (1) used to prevent, prepare for, or respond to COVID-19; (2) used for health care-related

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

[9] HRSA, *Provider Relief Programs: Provider Relief Fund and ARP Rural Payments Frequently Asked Questions* (PRF FAQs). Accessed on Mar. 26, 2025. HRSA, *Provider Relief Fund Distributions and American Rescue Plan Rural Distribution Post-Payment Notice of Reporting Requirements* (PRF Reporting Requirements). Accessed on Mar. 26, 2025.

[10] PRF payments were distributed to providers based on providers' taxpayer identification numbers (TINs). Hospitals and other providers were required to report on their PRF payments if they received $10,000 or more during a specified timeframe (i.e., payment period). For providers to meet this requirement, HRSA established reporting periods, which specified when providers had to report on the use of PRF payments and were based on the payment period(s). For example, reporting periods 1 and 2 covered PRF payments received during CY 2020. We use the term "hospital" to refer to a hospital reporting entity. A hospital reporting entity may have registered its TIN through the PRF Reporting Portal to report to HRSA on the use of PRF payments received by that TIN and TINs associated with the entity's subsidiary entities (e.g., individual hospitals). A hospital may be a stand-alone hospital, a hospital group, or a parent organization.

[11] For details on General and Targeted Distribution payments, see Appendix C. In addition to PRF payments, hospitals may have received COVID-19-related assistance from other sources such as the Federal Emergency Management Agency, the Department of the Treasury, and the Small Business Administration, as well as from grants and donations from other local and State governments or private sources.

expenses or lost revenues (i.e., patient care revenues) attributable to COVID-19;[12] (3) not used to reimburse expenses or losses already reimbursed from other funding sources; and (4) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities (e.g., lobbying).[13]

*Provider Relief Fund Expenditures and Lost Revenues*

For reporting purposes, HRSA established periods during which providers were required to use and report on PRF payments.[14] Providers, including hospitals, were required to report on their use of PRF payments in broad categories (i.e., lost revenues, health care-related expenses, or general and administrative expenses). For expenses, hospitals were required to report their use of PRF payments for health care-related expenses (e.g., expenses for purchasing equipment such as ventilators and sanitizing supplies for infection control) and general and administrative expenses (e.g., salaries, utilities, rent), including expenses incurred prior to receipt of PRF payments (i.e., pre-award costs dated back to January 1, 2020).[15] Hospitals were required to follow their basis of accounting (cash or accrual basis) to determine expenses and only use PRF payments for eligible expenses or lost revenues during what is known as the period of availability.[16]

For lost revenues, hospitals could apply their PRF payments toward lost revenue amounts during a period of availability calculated using one of the following three options:

1. the difference between actual patient care revenues from 2019 and actual patient care revenues during the period of availability,

2. the difference between budgeted patient care revenues (approved by hospital officials prior to March 27, 2020) and actual patient care revenues, or

[12] Patient care means health care, services, and supports as provided in a medical setting, at home, via telehealth, or in the community. Items not considered patient care revenue include nonpatient care dining services, grants, bad debt, any gains or losses on investments, and contractual adjustments.

[13] Recipients were not allowed to use PRF payments to pay any salary at a rate in excess of Executive Level II, which was set at $197,300 for 2020 and $199,300 for 2021.

[14] HRSA required all providers that received PRF payments exceeding $10,000 in the aggregate during any of these periods to report on their use of the payments during the applicable reporting period.

[15] HRSA, PRF Reporting Requirements.

[16] The period of availability ends 1 year after the end of the quarter or semiannual period in which the payment was received. The first payment receipt period was Apr. 10, 2020, through June 30, 2020. Subsequent payment receipt periods were 6 months.

3. any reasonable method of estimating revenues.[17]

HRSA guidance for the treatment of unallowable or ineligible expenditures of PRF funds stated that providers were allowed to replace unallowable or ineligible expenditures allocated to PRF payments in a closed reporting period with unreimbursed lost revenues in subsequent reporting periods. Providers are not required to return PRF payments used for unallowable purposes (e.g., lobbying) to the Federal Government if they have sufficient unreimbursed lost revenues to offset unallowable amounts. See Appendix D for a detailed description of how providers could choose to calculate lost revenues.

## HOW WE CONDUCTED THIS AUDIT

Our audit covered $6.6 billion in PRF payments and related interest to a nonstatistical sample of 30 hospital taxpayer identification numbers (TINs) during calendar year (CY) 2020.[18] (We refer to these sample units throughout the report as "hospitals.")[19] The selected hospitals reported that they used $3.8 billion of their PRF payments to offset lost revenues, $1.6 billion for general and administrative expenses, and the remaining $1.2 billion for health care-related expenses.[20] Appendix E contains details on how the selected hospitals used PRF payments issued in CY 2020.

We selected hospitals based on an analysis that considered the amount of PRF payments received, geographic location (i.e., areas most impacted by COVID-19, urban and rural areas), and organizational structure (e.g., hospital groups and stand-alone hospitals).[21] We reviewed the hospitals' PRF payments used to offset lost patient care revenues or cover general and administrative and health care-related expenses. Specifically, for each of the selected hospitals that reported expenditures, we reviewed a nonstatistical sample of expenses that we selected

[17] For payments received in Periods 5, 6, or 7, the period of availability to use PRF payments for lost revenues attributable to COVID-19 ended June 30, 2023, the end of the quarter in which the COVID-19 public health emergency ended (HRSA, PRF Reporting Requirements).

[18] Some hospitals kept their PRF payments in an interest-bearing account and included interest in the amounts reported on expenditure reports submitted to HRSA.

[19] The sampling frame consisted of 649 hospitals that received and kept 1 or more PRF payments totaling approximately $23.1 billion. 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 hospitals that received PRF payments issued in CY 2020 and for which hospitals attested to the payment terms and conditions or were deemed to have accepted the terms and conditions.

[20] Hospitals reported these amounts on expenditure reports submitted to HRSA for reporting periods 1 and 2.

[21] Our sample unit was a hospital that reported the use of PRF General and Targeted Distribution payments. Each sampled hospital could be a stand-alone hospital or part of a parent-subsidiary system that may include a parent company and various provider types (e.g., hospitals, clinics, urgent care facilities, and physician groups). The 30 selected hospitals each received more than $10 million in PRF payments during CY 2020 and are located in 9 States. Three of the hospitals are stand-alone hospitals and 27 are part of hospital systems.

based on materiality and expense descriptions (e.g., salaries, supplies, equipment). For the selected hospitals that reported lost revenues, we reviewed the hospitals' lost revenues calculations.[22]

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 30 selected hospitals, 19 used the funds for allowable general and administrative and health care-related expenditures and to offset lost revenues attributable to COVID-19. However, the remaining 11 hospitals did not comply with Federal requirements. Specifically, 10 hospitals used PRF payments for unallowable expenditures and 2 hospitals inaccurately calculated lost revenues.[23] These deficiencies occurred because although hospitals attested to the PRF terms and conditions and HRSA provided continuously updated guidance to PRF recipients, the hospitals made clerical errors in their reporting of expenditures and did not always correctly interpret HRSA guidance, maintain documentation to support reported expenditures, or have procedures to verify the accuracy of lost revenue calculations.

As a result of these deficiencies, 11 of the 30 selected hospitals used PRF payments for unallowable expenditures totaling $63 million and inaccurately calculated lost revenues totaling $645.6 million. These funds could have been used to offset allowable lost revenues or to support other activities related to the COVID-19 public health emergency, including preventing, preparing for, and responding to COVID-19.

Appendix F contains a summary of our audit results for the sampled hospitals.

[22] Of the 30 hospitals, 23 hospitals reported both expenses and lost revenues, 5 hospitals reported only lost revenues, and 2 hospitals reported only expenses.

[23] The total number of hospitals with deficiencies exceeds 11 because 1 hospital had more than 1 deficiency.

## SOME HOSPITALS USED PROVIDER RELIEF FUND PAYMENTS FOR UNALLOWABLE EXPENDITURES AND INACCURATELY CALCULATED LOST REVENUES

### Salary Costs Exceeded the Federal Executive Level II Salary Limit

The PRF terms and conditions specified that PRF recipients could not use PRF payments to pay the salary of an individual at a rate in excess of Executive Level II salary levels.[24] The Federal Executive Level II salary level was $197,300 in CY 2020 and $199,300 in CY 2021.

Four hospitals used PRF payments for salary for executives and other employees that exceeded the Executive Level II salary levels for CYs 2020 and 2021 by a total of $4.6 million.[25] Specifically, one hospital used PRF payments to cover salary and fringe benefit costs for 33 executives and 16 employees based on a methodology tied to monthly percentages of COVID-19 discharges or COVID-19 patient days. As a result, the hospital charged salary and associated fringe benefit costs for the executives and employees that exceeded the Executive Level II salary levels for CYs 2020 and 2021 by a total of $2.9 million.[26] Another hospital used PRF payments to cover salary costs for certain employees who worked more than 2,080 hours (the equivalent of a full-time appointment) in CY 2020.[27] As a result, the hospital reported salaries for these employees that exceeded the Executive Level II salary level by $1.6 million. The remaining two hospitals used PRF payments to cover salary costs for certain employees whose salaries exceeded the Executive Level II threshold for CYs 2020 and 2021. As a result, the hospitals reported salaries for these employees that exceeded the Executive Level II salary level by $80,349.[28]

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[24] PRF General and Targeted Distribution payments terms and conditions.

[25] This amount included fringe benefit costs (e.g., health insurance, group-life insurance, retirement plan) associated with unallowable salary amounts. We excluded COVID-19-related incentive payments (e.g., hazard pay, retention and hiring bonuses) to calculate the unallowable amount.

[26] For example, one hospital employee's annual salary for 2020 was $365,709. Their biweekly pay amount was $13,659 for the pay period ending Apr. 23, 2020. The COVID-19 patient discharge rate at the hospital for April 2020 was 63 percent. Based on this rate, the hospital charged $8,585 (63 percent of $13,659) of the employee's salary to PRF. If the hospital based its calculation on the Federal Executive Level II for 2020, which was $197,300, the employee's biweekly pay amount charged to PRF for this employee would have been $4,781.

[27] A full-time appointment is 2,080 hours per year. (HRSA, "External Grants Policy Bulletin – 2020 Salary Cap Limitation" [2020-03E]. Accessed on Mar. 26, 2025.) In its calculation of salary cap amounts, the hospital incorrectly increased the Executive Level II salary level for employees who worked more than 2,080 hours. For example, if an employee worked 2,264 hours in CY 2020, the hospital calculated a ratio by dividing an employee's actual hours worked (2,264 hours) by 2,080 hours, then multiplied the resulting ratio by the Executive Level II salary level to calculate the employee's salary cap. As a result, the hospital calculated an employee's salary cap to be $214,753, which was higher than the applicable salary cap of $197,300 for CY 2020.

[28] During our audit, one hospital indicated that it had incorrectly used PRF payments for $65,497 of salaries that exceeded the Executive Level II salary level. The hospital stated that it would replace the unallowable amount with unreimbursed lost revenues in the subsequent reporting period.

**Costs Not Adequately Supported**

PRF recipients must comply with certain Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR part 75). The financial management system of each PRF recipient must provide accurate, current, and complete disclosure of the financial results of each Federal award or program. The PRF recipient's records must identify the source and application of funds for federally funded activities and be supported by source documentation (45 CFR §§ 75.302(b)(2) and (3)).

Three hospitals did not maintain adequate documentation to support the use of PRF payments to cover salary and fringe benefit costs totaling $52.5 million. Specifically, two hospitals used PRF payments totaling $52.1 million to cover salary and fringe benefit costs for which the hospitals did not provide payroll records.[29] The remaining hospital used PRF payments to cover $364,405 in salary costs without underlying work hours inputted into the hospital's timekeeping system. The hospital stated that it should not have used PRF payments for these costs.

**Costs Charged but Not Incurred**

PRF recipients must comply with certain Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR part 75). The financial management system of each PRF recipient must provide accurate, current, and complete disclosure of the financial results of each Federal award or program. The PRF recipient's records must identify the source and application of funds for federally funded activities and be supported by source documentation (45 CFR §§ 75.302(b)(2) and (3)).

Three hospitals used PRF payments for $143,881 in costs that were not incurred. Specifically, two hospitals used PRF payments to cover expenses based on amounts detailed in purchase orders; however, the actual invoices and payment amounts were $100,448 less than the amounts detailed in the purchase orders. The remaining hospital used PRF payments to cover fringe benefit costs that exceeded actual costs by $43,433 because it used an incorrect percentage to calculate fringe benefit costs.[30]

**Duplicate Expenses**

PRF recipients must comply with certain Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR part 75). The financial management system of each PRF recipient must provide accurate, current, and complete disclosure of the financial

[29] The two hospitals are part of the same parent-subsidiary system. One of the hospitals is the parent organization. The hospitals stated that they provided OIG all the available supporting information.

[30] The hospital stated that, due to a clerical error, it used an incorrect fringe benefit rate of 62 percent instead of 47 percent, which was its actual fringe benefit rate.

results of each Federal award or program. The PRF recipient's records must identify the source and application of funds for federally funded activities and be supported by source documentation (45 CFR §§ 75.302(b)(2) and (3)). Additionally, PRF payments may not be applied to the same expenses and lost revenues that were reported on in prior reporting periods.[31]

Two hospitals used PRF payments to cover duplicate expenses totaling $5.8 million. Specifically, one hospital used PRF payments to cover expenses (i.e., personnel, supplies, and equipment) totaling $5.7 million during PRF reporting period 2 that it already reported in reporting period 1. The other hospital used PRF payments to cover employee salary deductions totaling $105,675 that it also included in its gross salaries charges.

**Inaccurate Lost Revenue Calculations**

PRF payment amounts not fully expended on health care-related expenses attributable to COVID-19 may be applied to lost revenues. Lost revenues can be calculated by one of three options, including determining the difference between actual 2019 patient service revenues and actual patient care revenues during the period of availability.[32, 33] In addition, HRSA's guidance for lost revenues calculations provided recipients flexibility in the reconciliation of lost revenues among parent entities and subsidiaries. However, HRSA's FAQs stated that expenses and lost revenues may not be duplicated, and payments may not be applied to the same expenses and lost revenues that were reported on in prior reporting periods.

Two hospitals inaccurately calculated and reported lost revenues totaling $645.6 million. Specifically, one hospital (a parent hospital) reported lost revenues totaling $643.2 million that were also reported by four of its subsidiary hospitals.[34] The other hospital overstated its lost revenues by $2.4 million because the hospital used incorrect 2019 actual patient service revenues as the baseline to calculate its 2020 lost revenues.

## CAUSES OF UNALLOWABLE EXPENDITURES AND INACCURATELY CALCULATED LOST REVENUES

These deficiencies occurred because although hospitals attested to the PRF terms and conditions and HRSA provided continuously updated guidance to PRF recipients, the hospitals made clerical errors in their reporting of expenditures and did not always correctly interpret

[31] HRSA, PRF FAQs.

[32] HRSA, PRF Reporting Requirements.

[33] HRSA, "How to Calculate Lost Revenues for PRF and ARP Rural Reporting." Accessed on Mar. 26, 2025.

[34] The parent hospital calculated lost revenues on a consolidated basis totaling $1.2 billion. That total included lost revenues for four of its subsidiary hospitals that had separately calculated and reported lost revenues totaling $643.2 million that duplicated the parent hospital's reported lost revenues.

HRSA guidance, maintain documentation to support reported expenditures, or have procedures to verify the accuracy of lost revenue calculations.

Further, in the context of extraordinary challenges from the COVID-19 public health emergency, HRSA's operational objective at the beginning of the public health emergency was to rapidly disburse PRF payments to support providers facing severe economic hardship. In addition, some hospitals indicated they had a lack of staffing resources and unusually high staff turnover. These and other unprecedented challenges of the pandemic may have contributed to clerical errors when reporting PRF expenditures or caused staff to misinterpret HRSA's guidance.

In addition to the recommendations below, key stakeholders and decisionmakers should use the information included in this report when determining lessons learned from administering PRF distributions during the COVID-19 public health emergency and look for additional ways to safeguard Federal funds when rapidly disbursing assistance payments to providers in response to future public health emergencies.

## RECOMMENDATIONS

We recommend that the Health Resources and Services Administration:

- require the 10 hospitals that we determined as having used PRF payments for unallowable expenditures totaling $63 million to return the unallowable amounts to the Federal Government or ensure that the hospitals properly replace the unallowable expenditures with allowable unreimbursed lost revenues or eligible expenses, if any, and

- require the 2 hospitals that we determined as having inaccurately calculated and reported lost revenues totaling $645.6 million to identify and return to the Federal Government any PRF payments used to offset inaccurately calculated lost revenues or replace them with allowable unreimbursed lost revenues or eligible expenses, if any.

## OTHER MATTERS

PRF payment amounts not fully expended on health care-related expenses attributable to COVID-19 may be applied to patient care lost revenues. As noted previously, recipients could choose to apply PRF payments toward lost revenues using one of the following three options:

1. the difference between actual patient care revenues from 2019 and actual patient care revenues during the period of availability,

2. the difference between budgeted patient care revenues (approved by hospital officials prior to March 27, 2020) and actual patient care revenues, or

3. any reasonable method of estimating revenues.

HRSA's guidance allowed recipients to calculate lost revenues as a stand-alone quarterly calculation and consider only those quarters with lost revenues to determine total loss amounts for each reporting period.[35] Option 3 provided reporting entities additional flexibility in the reconciliation of lost revenues among parent and subsidiary entities, including the application of lost revenues as the reporting entity saw fit.

Twenty-eight of the thirty selected hospitals reported lost revenues totaling $6.9 billion. For these hospitals, we recalculated lost revenues to determine what these amounts would have been on an annual basis under option 1 (i.e., comparing 2019 actual patient care revenues to 2020 and 2021 actual patient care revenues).[36] Based on our analysis, we determined that the methodologies prescribed by HRSA resulted in hospitals reporting higher lost revenue amounts and did not always result in an efficient use of PRF payments.

If HRSA had required reporting entities to use option 1 and annualize their revenues, 27 of the 28 selected hospitals would not have been able to report a total of $3.5 billion in lost revenues and would not be able to apply PRF payments to offset this amount. For any PRF payments applied against these excess lost revenue amounts, the PRF payments could have been used for other purposes that supported hospitals' activities (e.g., upgrading HVAC systems, purchasing cleaning supplies and personal protective equipment) related to the COVID-19 public health emergency. In addition, instead of refunding the PRF payment amounts used for unallowable expenditures, HRSA allowed hospitals to offset unallowable amounts against amounts calculated for lost revenues.[37] For further details, see Appendix G.

## HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, HRSA concurred with our recommendations and indicated that it will review the relevant records and seek repayment, as appropriate.

Regarding our Other Matters section, HRSA noted that it was legally required to allow providers to use "any reasonable" method to determine revenue losses, and OIG's analysis and conclusion were at odds with flexibilities afforded to providers.

[35] HRSA, PRF FAQs.

[36] The PRF expenditure reports for the payment period ending June 30, 2020, were due on Sept. 30, 2021, with a grace period ending on Nov. 30, 2021. The expenditure reports for the payment period ending Dec. 31, 2020, were due on Mar. 31, 2022. Therefore, actual patient care revenues for CY 2020 would have been available prior to the PRF report due dates.

[37] In its FAQs, HRSA indicated that the reporting entities could replace unallowable expenses with unreimbursed lost revenues.

We acknowledge that certain flexibilities were available to providers for lost revenue calculations. However, we maintain that calculating revenue losses by comparing year-over-year actual patient service revenues would have resulted in a more efficient use of PRF payments.

HRSA also provided technical comments, which we addressed as appropriate. HRSA's comments, excluding the technical comments, are included as Appendix H.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We identified 4,725 hospitals that received and kept 1 or more PRF payments totaling approximately $74.1 billion during CY 2020. We selected for audit a nonstatistical sample of 30 hospitals that received PRF payments from General and certain Targeted Distributions totaling $6.6 billion during CY 2020.[38] We selected hospitals based on a risk analysis that included geographic location (i.e., COVID-19 high-impact areas, urban and rural areas), total PRF payment amounts, and organizational structure (hospital groups and stand-alone hospitals).[39] We reviewed the selected hospitals' use of PRF payments received from General and certain Targeted Distributions, including COVID-19 high-impact, rural, and safety net hospital distributions.

We limited our review of HRSA's and the selected hospitals' internal controls to those applicable to our audit objective. We did not assess HRSA's or the hospitals' overall internal control structure. Specifically, we reviewed HRSA's policies and procedures for reviewing expenditure information submitted by providers and its guidance to providers on the use and reporting of PRF payments. We also reviewed selected hospitals' policies and procedures for monitoring, tracking, and expending PRF payments.

We established reasonable assurance of the authenticity and accuracy of the PRF payment data by reconciling it with PRF expenditure reports submitted by the hospitals through HRSA's PRF Reporting Portal.

We conducted our audit from November 2021 through December 2024.

### 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 providers' use of PRF payments;

[38] The sampling frame consisted of 649 hospitals that received and kept 1 or more PRF payments totaling approximately $23.1 billion. 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 hospitals that received PRF payments in CY 2020 for which hospitals attested to the payment terms and conditions or were deemed to have accepted the terms and conditions.

[39] COVID-19 high-impact area payments were made to hospitals that had large numbers of COVID-19 inpatient admissions. In addition, using publicly available data from USAFacts.org and HRSA websites, we identified 45 urban and 5 rural counties with the highest per capita number of COVID-19 cases as of Dec. 31, 2020. These counties are located in 19 States.

- met with HRSA officials to gain an understanding of the PRF's payment terms and conditions, reporting requirements, and HRSA's monitoring and oversight activities;

- reviewed HRSA's policies and procedures related to its oversight of recipients' reporting on the use of PRF funds and compliance with the terms and conditions for PRF payments;

- obtained from HRSA a list of hospitals that received a payment through Targeted Distributions, including COVID-19 high-impact, rural, Tribal, safety net hospital, and children's hospital distributions;

- obtained PRF payments data for General and Targeted Distributions;

- compiled a list of hospitals that received PRF General and Targeted Distributions;[40]

- created a list of hospitals[41] in areas most impacted by COVID-19 that received PRF payments from General Distributions and certain Targeted Distributions, including COVID-19 high-impact, rural, and safety net hospital distributions;

- selected a nonstatistical sample of 30 hospitals that received PRF payments based on the amount of PRF payments received, geographic locations (areas most impacted by COVID-19, urban and rural areas), and organizational structure (hospital groups and stand-alone hospitals);[42]

- for each hospital selected for audit, interviewed hospital officials; reviewed its expenditure reports submitted to HRSA and a nonstatistical sample of expenses based on materiality and expense descriptions; and analyzed supporting accounting, personnel, and other records to determine whether:

    - payments were used only to prevent, prepare for, and respond to COVID-19;

    - payments were used for health care-related or general and administrative expenses or were applied to offset eligible lost revenues attributable to

[40] We obtained from HRSA lists of TINs associated with hospitals that received PRF payments from the Targeted Distributions; we then extracted PRF payments (from the General and Targeted Distributions) for these TINs from the PRF payments attestation file provided by OIG's Division of Data Analytics.

[41] To create a comprehensive list of hospitals in areas most impacted by COVID-19, we also used the following datasets: (1) a list of hospitals registered with Medicare, (2) hospital revenue report data for fiscal years 2017 and 2018 from Acumen (a consulting firm that HRSA had engaged for the development and construction of certain PRF payment files), and (3) a hospital COVID-19 coverage report from the HealthData.gov website.

[42] The sampling frame consisted of 649 hospitals that received and kept 1 or more PRF payments totaling approximately $23.1 billion.

COVID-19, and whether the amount for any lost revenues applied toward PRF payments was accurately calculated;[43]

- payments were not used to pay for expenses or losses reimbursed or eligible for reimbursement from other funding sources (e.g., reimbursements from the Federal Emergency Management Agency, Medicare/Medicaid or commercial health insurance, the Paycheck Protection Program, and assistance from State or local government agencies); and

- payments were not used to pay salaries at a rate in excess of certain thresholds or for other prohibited activities.

- 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.

[43] We recalculated lost revenue amounts using the same option that the entity used for determining lost revenues.

## 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: PROVIDER RELIEF FUND GENERAL AND TARGETED DISTRIBUTION PAYMENTS

As of October 2024, HRSA distributed $145.9 billion of the $178 billion appropriated to HHS for the PRF. Of the $145.9 billion, $88.4 billion was distributed in General Distributions and $57.5 billion was distributed in several Targeted Distributions. A portion of the remaining $32.1 billion was distributed or allocated for HRSA's program for uninsured individuals, the COVID-19 Coverage Assistance Fund, and Phase 4 General Distribution payments.[44]

### General Distributions

HRSA made General Distributions in four phases to health care providers, including Medicare providers; providers participating in Medicaid, Children's Health Insurance Program (CHIP), or Medicaid managed care plans; dentists; assisted living facilities; and behavioral health providers.

- *Phase 1 General Distribution:* HRSA distributed $48.5 billion to providers in two rounds under the Phase 1 General Distribution for eligible providers that billed Medicare fee-for-service. These funds were allocated proportional to providers' share of annual patient service revenues.

- *Phase 2 General Distribution:* HRSA distributed $5 billion in the Phase 2 General Distribution to Medicaid, CHIP, and dental providers, as well as assisted living facilities and certain Medicare providers who did not receive a Phase 1 General Distribution payment equal to 2 percent of their total patient care revenue or had a change in ownership in 2019 or 2020. Providers were required to apply for funding and included in their applications certain financial information related to documenting revenue necessary to determine the amount that a facility would receive.

- *Phase 3 General Distribution:* HRSA distributed $19.3 billion in the Phase 3 General Distribution to providers that had not received funding in prior distributions (i.e., because they were new or because they were behavioral health providers not included in a prior allocation). Providers that had previously received PRF payments but had not received the full 2 percent of their annual patient revenue in PRF assistance were also eligible to apply for additional funds. Providers were required to apply for these funds.

- *Phase 4 General Distribution:* HRSA distributed approximately $15.6 billion in the Phase 4 General Distribution to providers based on changes in revenues and expenses, as well as the amount and type of services provided to Medicare, Medicaid, and CHIP patients. Providers were required to apply for these funds.

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

**Targeted Distributions**

HRSA also distributed PRF funds to certain types of providers that had high needs due to COVID-19. These included the following:

- *COVID-19 High-Impact Area Providers:* HRSA distributed nearly $22 billion in COVID-19 high-impact area payments to hospitals that had large numbers of COVID-19 inpatient admissions.[45]

- *Safety Net Hospitals and Children's Hospitals:* HRSA distributed $13.3 billion to safety net and acute care hospitals and $1.1 billion to children's hospitals.

- *Rural Providers:* HRSA distributed $11.2 billion in rural payments to rural hospitals, including rural acute care general hospitals and critical access hospitals; rural health clinics; and Federally Qualified Health Centers located in rural areas, including specialty rural hospitals, urban hospitals with certain rural Medicare designations, and hospitals in small metropolitan areas.

- *Tribal Hospitals, Clinics, and Urban Health Centers/Indian Health Service Providers:* HRSA distributed $540 million in relief funds to Tribal hospitals, clinics, and urban health centers. These payments were based on operating expenses.

- *Skilled Nursing Facilities and Nursing Homes:* HRSA distributed $4.9 billion in skilled nursing facility distribution payments. Additionally, to help combat the devastating effects of COVID-19, HRSA distributed $4.5 billion to skilled nursing facilities and nursing homes nationwide, which included payments for infection control and quality incentive payments to nursing homes that created and maintained safe environments for their residents.

[45] Hospitals that treated 100 or more COVID-19 patients between Jan. 1 and Apr. 10, 2020, were eligible for the first round of high-impact distributions. Hospitals that treated more than 160 COVID-19 patients between Jan. 1 and June 10, 2020, were eligible for the second round of high-impact distributions.

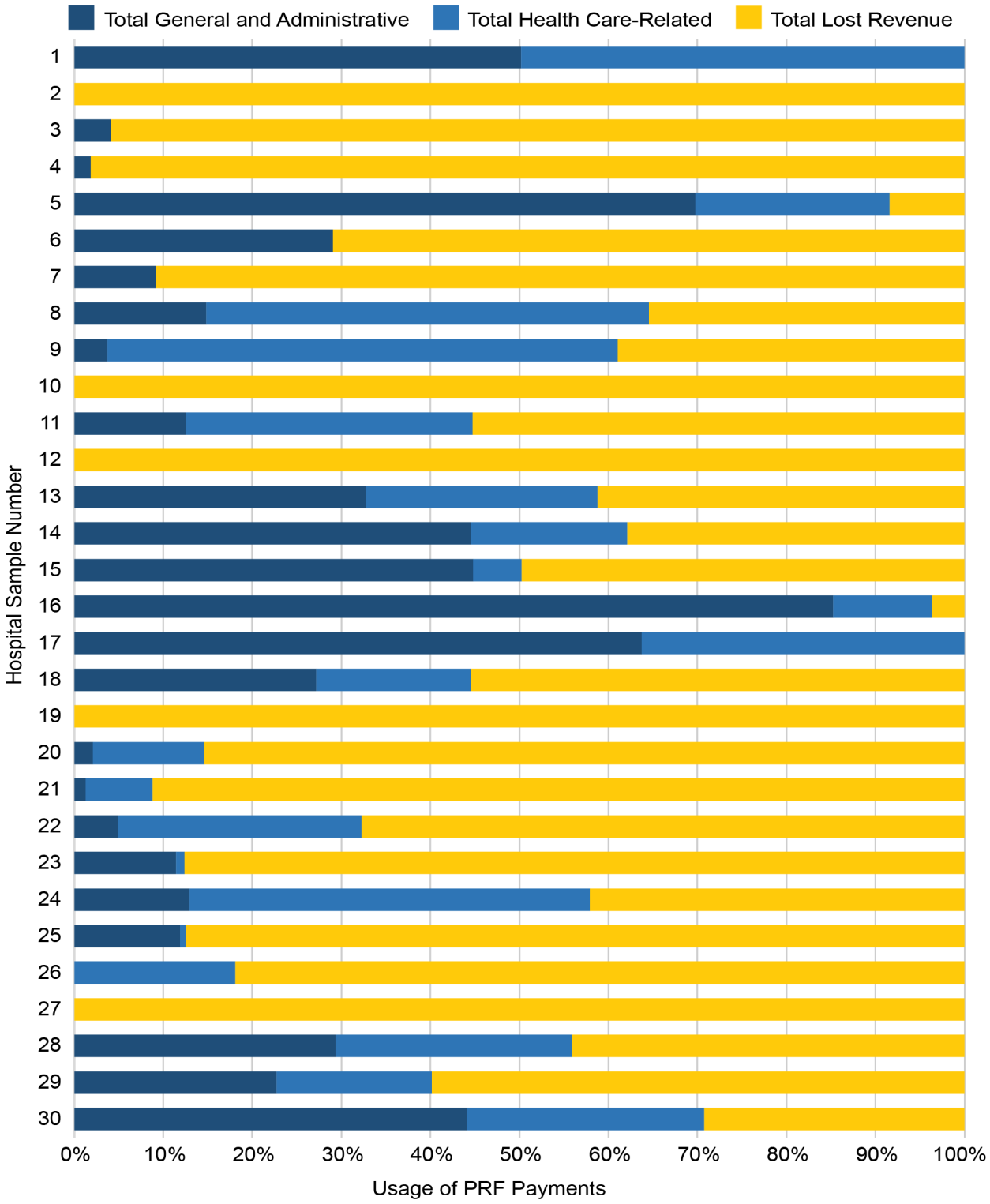
## APPENDIX D: OPTIONS FOR CALCULATING LOST REVENUES

Providers, including hospitals, could use one of the following options to calculate their lost revenues.

| Lost Revenues Options | Option 1 | Option 2 | Option 3 |
|---|---|---|---|
| *Definition of Option* | *The difference between actual patient care revenues from 2019 and actual patient revenues during the period of availability* | *The difference between budgeted and actual patient care revenues* | *Any reasonable method of estimating revenues* |
| **PRF Reporting Portal Option** | 2019 Actual Revenue | 2020 Budgeted Revenue | Alternate Reasonable Methodology |
| **Base Period for Calculation** | 2019 | 2020 or 2021 | Not prescribed |
| **Calculation Method** | Actuals vs. Actuals (e.g., Q1 2020 vs. Q1 2019) | Budget vs. Actuals | Not prescribed |
| **Frequency of Calculation** | Quarterly | Quarterly | Quarterly |
| **Duration of Lost Revenues Period** | Each quarter during the period of availability | Each quarter during the period of availability | Each quarter during the period of availability in which lost revenues were determined |
| **Service Lines To Include in Revenues** | All patient care services | All patient care services | All patient care services (as appropriate for methodology) |
| **Budget Approval Date** | Not applicable | Before March 27, 2020 | Not prescribed |

Source: HRSA, *Provider Relief Fund Lost Revenues Guide – Reporting Period 1*. Accessed on Mar. 26, 2025.

## APPENDIX E: SELECTED HOSPITALS' REPORTED USE OF CY 2020 PROVIDER RELIEF FUND PAYMENTS



## APPENDIX F: SUMMARY OF SAMPLED HOSPITALS' UNALLOWABLE EXPENDITURES AND INACCURATELY CALCULATED LOST REVENUE AMOUNTS

| Sample Hospital No. | Total PRF Payments Hospital Reported in Periods 1 and 2 | Unallowable Expenditures and Inaccurately Calculated Lost Revenue Amount | Reason(s) for Unallowable Expenditures and Inaccurately Calculated Lost Revenue Amount |
|---|---|---|---|
| 1 | $1,197,231,926 | $91,948 | Costs charged but not incurred |
| 2 | $633,073,890 | - | |
| 3 | $467,977,273 | $2,901,904 | Salary costs exceeded Federal salary limit |
| 4 | $408,913,562 | - | |
| 5 | $317,447,996 | - | |
| 6 | $90,027,314 | $10,718,789 | Costs not adequately supported |
| 7 | $673,336,086 | $684,577,381* | Costs not adequately supported<br>Inaccurately calculated lost revenues |
| 8 | $198,859,422 | $43,433 | Costs charged but not incurred |
| 9 | $124,871,770 | - | |
| 10 | $35,744,177 | - | |
| 11 | $183,018,381 | $1,625,133 | Salary costs exceeded Federal salary limit |
| 12 | $173,227,425 | - | |
| 13 | $135,083,813 | - | |
| 14 | $45,472,721 | - | |
| 15 | $313,670,033 | - | |
| 16 | $288,615,514 | $14,853 | Salary costs exceeded Federal salary limit |
| 17 | $31,100,000 | - | |
| 18 | $325,817,736 | $429,902 | Salary costs exceeded Federal salary limit<br>Costs not adequately supported |
| 19 | $231,167,516 | $2,368,313 | Inaccurately calculated lost revenues |
| 20 | $66,058,129 | - | |
| 21 | $36,715,276 | - | |
| 22 | $124,260,647 | - | |
| 23 | $99,508,592 | - | |
| 24 | $169,916,040 | - | |
| 25 | $80,421,707 | $105,675 | Duplicate expenses |
| 26 | $63,500,000 | - | |
| 27 | $20,263,721 | - | |
| 28 | $14,085,765 | - | |
| 29 | $63,027,573 | - | |

| Sample Hospital No. | Total PRF Payments Hospital Reported in Periods 1 and 2 | Unallowable Expenditures and Inaccurately Calculated Lost Revenue Amount | Reason(s) for Unallowable Expenditures and Inaccurately Calculated Lost Revenue Amount |
|---|---|---|---|
| 30 | $16,123,028 | $5,713,487 | Duplicate expenses<br>Costs charged but not incurred |
| **Total** | **$6,628,537,034†** | **$708,590,817†** | |

* We reviewed the hospital's total lost revenues calculation for periods 1 and 2, which exceeded the total PRF payments the hospital reported for the same periods. These inaccurately calculated revenues could be used to offset PRF payments in future reporting periods.
† Amounts do not add up to the total due to rounding.

## APPENDIX G: OTHER MATTERS – POTENTIAL SAVINGS CALCULATIONS

| (A) | (B) | (C) | (D) | (E) | (F) | (G) | (H) |
|---|---|---|---|---|---|---|---|
| **OIG Sample Number** | **Option Hospital Used To Calculate Lost Revenues (1, 2, 3, or N/A)** | **Total PRF Payments Hospital Reported in Periods 1 and 2** | **Total Lost Revenues Hospitals Calculated and Reported** | **Total PRF Payment Hospitals Applied To Offset Lost Revenues in Periods 1 and 2** | **Total Lost Revenues Remained After Reporting Periods 1 and 2**<br><br>**(D) - (E) = (F)** | **Recalculated Lost Revenues if Hospitals Used Option 1 and Annualized Loss Calculation** | **Total Potential Savings if Hospitals Used Option 1 and Annualized Loss Calculation**<br><br>**(D) - (G) = (H)** |
| 1 | N/A | $1,197,231,926 | Did not use PRF to offset lost revenues | $0 | $0 | $0 | N/A |
| 2 | 3 | $633,073,890 | $1,214,923,000 | $633,073,890 | $581,849,110 | $688,791,000 | $526,132,000 |
| 3 | 3 | $467,977,273 | $737,679,709 | $448,997,381 | $288,682,328 | $335,272,000 | $402,407,709 |
| 4 | 3 | $408,913,562 | $422,345,167 | $401,423,682 | $20,921,485 | $118,770,000 | $303,575,167 |
| 5 | 1 | $317,447,996 | $378,426,396 | $26,687,322 | $351,739,074 | $267,165,428 | $111,260,968 |
| 6 | 2 | $90,027,314 | $470,585,010 | $63,863,461 | $406,721,549 | $306,264,556 | $164,320,454 |
| 7 | 2 | $673,336,086 | $1,199,282,186 | $611,795,195 | $587,486,991 | $746,154,066 | $453,128,120 |
| 8 | 1 | $198,859,422 | $155,958,173 | $70,475,628 | $85,482,545 | $108,456,095 | $47,502,078 |
| 9 | 3 | $124,871,770 | $148,437,554 | $48,684,686 | $99,752,868 | $31,354,529 | $117,083,025 |
| 10 | 2 | $35,744,177 | $41,469,203 | $35,744,177 | $5,725,026 | $0 | $41,469,203 |
| 11 | 1 | $183,018,381 | $101,900,792 | $101,155,593 | $745,199 | $22,968,349 | $78,932,443 |
| 12 | 3 | $173,227,425 | $179,286,726 | $173,227,425 | $6,059,302 | $0 | $179,286,726 |
| 13 | 1 | $135,083,813 | $137,364,825 | $55,659,185 | $81,705,640 | $130,445,369 | $6,919,456 |
| 14 | 1 | $45,472,721 | $69,261,731 | $17,249,015 | $52,012,717 | $57,189,953 | $12,071,778 |
| 15 | 1 | $313,670,033 | $156,108,037 | $156,108,037 | $0 | $0 | $156,108,037 |
| 16 | 1 | $288,615,514 | $213,859,580 | $10,547,761 | $203,311,819 | $56,826,157 | $157,033,423 |

| (A) | (B) | (C) | (D) | (E) | (F) | (G) | (H) |
|---|---|---|---|---|---|---|---|
| **OIG Sample Number** | **Option Hospital Used To Calculate Lost Revenues (1, 2, 3, or N/A)** | **Total PRF Payments Hospital Reported in Periods 1 and 2** | **Total Lost Revenues Hospitals Calculated and Reported** | **Total PRF Payment Hospitals Applied To Offset Lost Revenues in Periods 1 and 2** | **Total Lost Revenues Remained After Reporting Periods 1 and 2**<br><br>**(D) - (E) = (F)** | **Recalculated Lost Revenues if Hospitals Used Option 1 and Annualized Loss Calculation** | **Total Potential Savings if Hospitals Used Option 1 and Annualized Loss Calculation**<br><br>**(D) - (G) = (H)** |
| 17 | N/A | $31,100,000 | Did not use PRF to offset lost revenues | $0 | $0 | $0 | N/A |
| 18 | 3 | $325,817,736 | $352,311,522 | $180,718,246 | $171,593,276 | $39,956,880 | $312,354,641 |
| 19 | 3 | $231,167,516 | $231,167,516 | $231,167,516 | $0 | $201,427,464 | $29,740,052 |
| 20 | 1 | $66,058,129 | $107,447,792 | $56,416,214 | $51,031,578 | $59,330,035 | $48,117,758 |
| 21 | 1 | $36,715,276 | $42,556,357 | $33,488,663 | $9,067,694 | $13,046,610 | $29,509,747 |
| 22 | 1 | $124,260,647 | $100,110,853 | $84,192,914 | $15,917,939 | $100,110,853 | $0* |
| 23 | 3 | $99,508,592 | $140,617,742 | $87,187,793 | $53,429,949 | $49,215,436 | $91,402,306 |
| 24 | 3 | $169,916,040 | $71,541,904 | $71,541,904 | $0 | $0 | $71,541,904 |
| 25 | 3 | $80,421,707 | $70,342,667 | $70,342,666 | $1 | $27,095,799 | $43,246,868 |
| 26 | 2 | $63,500,000 | $52,023,235 | $52,023,234 | $1 | $0 | $38,523,235 |
| 27 | 3 | $20,263,721 | $34,754,947 | $20,263,721 | $14,491,226 | $6,019,151 | $28,735,796 |
| 28 | 1 | $14,085,765 | $11,086,294 | $6,211,061 | $4,875,233 | $1,688,489 | $9,397,805 |
| 29 | 1 | $63,027,573 | $64,527,315 | $37,740,382 | $26,786,933 | $0 | $64,527,315 |
| 30 | 3 | $16,123,028 | $26,950,100 | $4,713,054 | $22,237,046 | $4,713,054 | $22,237,046 |
| **Total** | | **$6,628,537,034†** | **$6,932,326,333** | **$3,790,699,806** | **$3,141,626,527†** | **$3,372,261,273** | **$3,546,565,060** |

* The hospital used option 1 and suffered revenue losses in all eight quarters.

† Amounts do not add up to totals due to rounding.

## APPENDIX H: HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS

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

**DATE**: March 5, 2025

**TO**: Juliet T. Hodgkins
Principal Deputy Inspector General

**FROM**: Cynthia Baugh
Associate Administrator

CYNTHIA R. BAUGH -S

Digitally signed by CYNTHIA R. BAUGH -S
Date: 2025.03.05 17:39:57 -05'00'

**SUBJECT**: OIG Draft Report: A-02-22-01003

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

## Eleven of Thirty Selected Hospitals Did Not Comply With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments, A-02-22-01003

**HRSA 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 *"Eleven of Thirty Selected Hospitals Did Not Comply With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments."*

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

**OIG Recommendation 1**

The OIG recommended that HRSA require the 10 hospitals that it determined had used PRF payments for unallowable expenditures totaling $63 million to return the unallowable amounts to the Federal Government or ensure that the hospitals properly replace the unallowable expenditures with allowable unreimbursed lost revenues or eligible expenses, if any.

**HRSA Response**

HRSA concurs with OIG's recommendation. HRSA will review these records and seek repayment, as appropriate.

**OIG Recommendation 2**

The OIG recommended that HRSA require the 2 hospitals that it determined had inaccurately calculated and reported lost revenues totaling $645.6 million to identify and return to the Federal Government any PRF payments used to offset inaccurately lost revenues or replace with allowable unreimbursed lost revenues or eligible expenses, if any.

**HRSA Response**

HRSA concurs with OIG's recommendation. HRSA will review these records and seek repayment, as appropriate.

**OIG Other Matters**

The OIG conducted an analysis and determined that the methodologies prescribed by HRSA resulted in hospitals reporting higher lost revenue amounts and did not always result in an efficient use of PRF payments. If HRSA had required reporting entities to use "option 1" and annualize their revenues, 27 of the 28 selected hospitals would not have been able to report a total of $3.5 billion in lost revenues and would not be able to apply PRF payments to offset this amount.

**HRSA Response**

While acknowledging OIG's analysis and conclusion, HRSA notes that the OIG analysis and conclusion are at odds with the flexibility afforded providers in statute by Congress. OIG is contemplating scenarios that HRSA does not have statutory authority to accomplish as HRSA was legally bound to allow providers to use "any reasonable method" to document lost revenue in accordance with the Consolidated Appropriations Act, 2021 (P.L. 116-260) (134 STAT. 1920). As OIG notes, HRSA has allowed hospitals to offset unallowable expenditures with amounts calculated for lost revenues but only to the extent that those lost revenues were not already reimbursed ***or obligated to be reimbursed by another funding source***.

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