Report of the Vermont State Auditor

DOUGLAS R. HOFFER
Vermont State Auditor

Agency of Human Services (AHS)

Of $92.7 Million Reviewed, AHS Overpaid 17 Providers by $7 Million Under the Health Care Provider Stabilization Grant Program

March 18, 2022

Rpt. No. 22-03

Report of the Vermont State Auditor

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Mission Statement

The mission of the Auditor's Office is to hold State government accountable by evaluating whether taxpayer funds are being used effectively and identifying strategies to eliminate waste, fraud, and abuse.

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Dear Colleagues,

In July 2020, the State of Vermont established the Health Care Provider Stabilization Grant Program (HCS program) due to concerns about financial disruptions caused by the COVID-19 pandemic. This program was funded by the Federal government's Coronavirus Relief Fund (CRF) under which Vermont received $1.25 billion in aid.

This is the second of two audits pertaining to Vermont's usage of CRF funds.[1] The objectives of this audit were to (1) assess whether and how the Agency of Human Services (AHS) ensured that only those providers meeting State and Federal requirements received payments under the HCS program and (2) determine whether selected HCS payments were supported and did not duplicate payments made under other government COVID-19 programs.

AHS established an award formula and guidance that addressed State and Federal requirements. The AHS award formula based payments on the total of providers' lost revenue and COVID-19 expenses, reduced by COVID-19 financial assistance providers received under other Federal and State programs.

Providers were required to submit applications that contained relevant financial information and to provide supporting documentation. However, AHS used a risk-based review process in which it paid some awards without reviewing and verifying applications and supporting documentation. **A drawback in the AHS approach is that it did not adjust an application's risk rating based on the potential award amount. This resulted in some HCS payments exceeding $100,000 receiving no review or verification.**

According to AHS financial officials, they developed the risk-based process because the agency did not have the resources to review the volume of applications received and there was a critical need to provide financial relief to health care providers. Another factor was time—AHS paid out most of the funds by the end of calendar year 2020, which was within six months of the Legislature authorizing the HCS program.

We reviewed $92.7 million of the $143.6 million (65 percent) paid during rounds 1-3 of the HCS program (39 awards to 30 providers). More than half of the 39 awards reviewed should not have been made at all or the award amounts were too high. These overpayments, made to 17 providers, totaled $7 million, representing 8 percent of the amount reviewed.

There were a variety of errors that led to these overpayments, such as data in providers' applications that did not agree with their supporting documentation or were inconsistent with Federal or State requirements. In other cases, amounts

[1] *COVID-19 Emergency Economic Recovery Grant Program: Agency of Commerce and Community Development – Some Ineligible Businesses Received Awards and Round 2.0 Awards Increased Profitability for Many of the Businesses Reviewed Instead of Redressing Financial Harm* (SAO Rpt No 21-04, September 21, 2021).

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received from other COVID-19 financial assistance programs were not correctly identified and used to reduce the award. The AHS review process did not catch these errors as it did not always notice when a provider did not submit required documentation or had submitted inconsistent or incomplete data. AHS also sometimes did not follow-up with the provider on issues identified during its review.

AHS is in the process of implementing a post-award data validation review process, which provides the agency with the opportunity to correct the flaws in its original review process. According to AHS, the post-award review process will consider whether (1) the application was filled out in its entirety, (2) required supporting documentation was provided, and (3) the application was consistent with the supporting documentation. However, **the AHS post-award review process has been limited. For example, AHS's post-award review process does not include verifying that providers accurately reported the other COVID-19 financial assistance they had received.**

The AHS post-award data validation review process could identify award overpayments in addition to those we found. The Inspector General of the U.S. Department of the Treasury is authorized to recoup monies from state governments that fail to comply with the allowable uses of CRF funds. Act 136 (2020) states that providers who expended money in good faith reliance on the State's authorization or guidance would not be liable for repayment. Thus, in such circumstances, the State could be required to repay the Federal government for HCS overpayments without the ability to recoup overpayments from awardees.

There is uncertainty about the extent to which the State is at risk of having to repay funds to the Federal government. As of February 17, 2022, AHS had not established a process for addressing HCS award overpayments. According to the Secretary of AHS, any action the Agency decides to take will be contingent on the nature and degree of overpayments found during the post-award data validation review process.

This report is also available on the State auditor's website.

Sincerely,

Doug Hoffer

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The Honorable Jill Krowinski
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The Honorable Becca Balint,
President Pro Tempore of the Senate

The Honorable Phil Scott
Governor

Ms. Kristin Clouser
Secretary, Agency of Administration

Mr. Adam Greshin
Commissioner, Department of Finance and Management

Ms. Jenney Samuelson
Interim Secretary, Agency of Human Services

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Highlights

The Federal government and the State of Vermont took action to mitigate the economic disruptions caused by the Coronavirus Disease 2019 (COVID-19) pandemic. A significant Federal action taken was establishing the Coronavirus Relief Fund (CRF), which provided Vermont with $1.25 billion in funding to cover necessary expenditures incurred due to COVID-19. The Vermont legislature appropriated $175 million of CRF funds to the Agency of Human Services (AHS) to establish the Health Care Provider Stabilization Grant Program[2] (HCS program). The Legislature set up the HCS program because of concerns about providers' COVID-19-related costs and the fiscal impacts of disruptions to their business operations. Health care providers had to change their care delivery models, suspend elective procedures and surgeries, reduce patient volume, acquire additional equipment and supplies, and make other changes to respond to and mitigate the effects of COVID-19.[3]

This is the second of two audits pertaining to Vermont's usage of CRF funds conducted by the State Auditor's Office (SAO).[4] The objectives of this audit were to (1) assess whether and how AHS ensured that only those providers meeting State and Federal requirements received payments under the HCS program and (2) determine whether selected HCS payments were supported and did not duplicate payments made under other government COVID-19 programs. We focused on awards made during Rounds 1, 2, and 3, judgmentally selecting 39 payments totaling $92.7 million[5] (about two thirds of the $143.6 million in awards in our scope) to 30 health care providers for review.[6] Appendix I contains details on our scope and methodology, including the criteria we used to choose the 30 providers. Appendix II contains a list of abbreviations used in this report.

Objective 1 Finding

AHS established an award formula and guidance that addressed State and Federal requirements, but its review and verification process to ensure that providers met these criteria had limitations. The AHS HCS award formula focused on three primary factors: lost revenue, COVID-19 related expenses, and other COVID-19 financial

2 Although the title indicates that this is a grant program, in August 2021 AHS, with approval of the Agency of Administration, determined that the awardees were beneficiaries, not grantees.

3 Memorandum from the Office of Legislative Counsel and Joint Fiscal Office, *Rationales for health care- and human services-related appropriations from the Coronavirus Relief Fund in Act 136 (H.965)*, July 15, 2020.

4 *COVID-19 Emergency Economic Recovery Grant Program: Agency of Commerce and Community Development – Some Ineligible Businesses Received Awards and Round 2.0 Awards Increased Profitability for Many of the Businesses Reviewed Instead of Redressing Financial Harm* (SAO Rpt No 21-04, September 21, 2021).

5 Two awards totaling $69.36 million were paid to one provider. AHS made 37 awards to the other 29 providers totaling $23.38 million.

6 The State issued payments to health care providers using HCS funds not in our scope. For example, we did not review payments authorized by Act 3 (2021) to adult day service providers to ensure their sustainability.

assistance. AHS issued guidance in each of these areas. Providers were required to submit applications that contained relevant financial information and to provide supporting documentation. However, AHS paid some awards without reviewing and verifying applications and supporting documentation. Instead, **AHS used risk-based criteria that considered the percentage revenue loss and amount of expenses incurred to determine which providers' applications would be reviewed and the type of verification that would occur.**

While some level of risk may be acceptable in an emergency, strong internal controls, such as verifying data in applications, help ensure that emergency relief funds are appropriately safeguarded**.** A drawback in the AHS approach is that it did not adjust an application's risk rating based on the potential award amount and some payments made without review and verification were more than $100,000. For example, in a case in which a provider was paid more than $300,000, the provider's revenue loss percentage was seven percent, so it was in the low-risk category even though the amount of its revenue change was $357,000. This amount largely constituted the basis for the award because the provider did not request to be reimbursed for expenses. Because this provider's application was determined to be low risk for both revenue and expenses, AHS did not review and verify the data in the application against supporting documentation.

According to AHS financial officials, they developed their risk-based process because the agency did not have the resources to review the volume of applications received and there was a critical need to provide financial relief to health care providers. In addition, the HCS program was implemented in a short timeframe. Rounds 1 and 2 payments were issued within six months of the Legislature authorizing the program.

Objective 2 Finding

Of the 39 HCS payments reviewed, more than half of the awards should not have been made or the award amounts were too high (see Figure 1). The errors that resulted in these overpayments included data in applications that did not agree with supporting documentation or were inconsistent with Federal or State requirements. In addition, in some cases, the award amount was not reduced by payments from other COVID-19 financial assistance programs.

Figure 1: Summary of Results of SAO Analysis of 39 HCS Awards

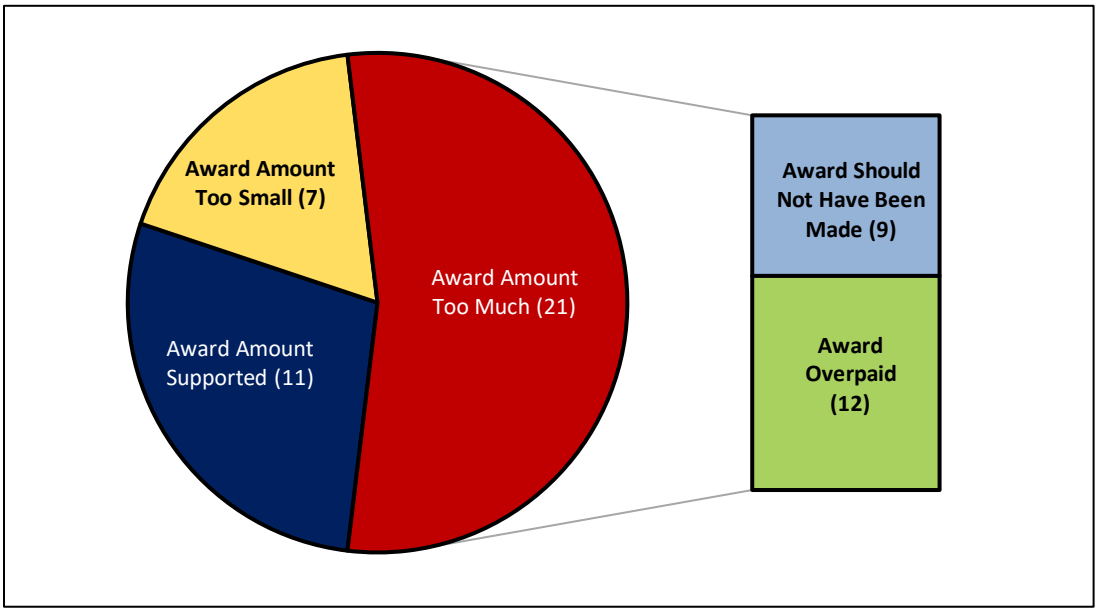


Table 1 summarizes our results by the amount AHS awarded and our recalculation. In total, there were $7 million in overpayments (8 percent of the $92.7 million in payments reviewed) to 17 providers.

Table 1: Comparison of the AHS HCS Payments and SAO's Recalculation by Category of Result

Results Category	AHS Award	SAO Recalculation	Difference[a]
Award Amount too Much[b]	$ 52,731,921	$ 45,407,378	$ 7,324,544
Award Amount too Small[b]	$ 2,817,779	$ 3,295,136	$ (477,357)
Award Amount Supported	$ 37,199,044	$ 37,199,044	0

[a] May not add due to rounding.
[b] There was one provider that was underpaid by $335,851 in Round 1 and overpaid by $902,748 in Round 2 for a net overpayment of $566,898.

Providers were responsible for ensuring that the information submitted in their applications was true, complete, and accurate but they did not always fill out the HCS application in accordance with AHS requirements or guidance. The reasons why AHS did not catch such errors varied and included its risk-based review approach and difficulties in verifying other financial assistance received by the provider. Moreover, while the AHS review process caught some errors prior to payment, this process was inconsistently executed and sometimes flawed.

Other Matters

AHS is in the process of conducting post-award data validation reviews to check the completeness of applications and whether required documents were submitted and consistent with the applications. However, the post-award review process has been limited. For example, AHS's post-award review process does not include verifying whether providers accurately reported other COVID-19 financial assistance, which is information available on Federal websites. In addition, the AHS post-award review process had not been considering whether providers' COVID-19 expenses met Federal and State requirements. In commenting on a draft of this report AHS reported that its post-award review process now includes reviewing whether expenses met such requirements.

The AHS post-award data validation review process could identify award overpayments in addition to those we found. The Inspector General of the U.S. Department of the Treasury is authorized to recoup monies from state governments that fail to comply with the allowable uses of CRF funds. Act 136 (2020) states that providers who expended money in good faith reliance on the State's authorization or guidance would not be liable for repayment. Thus, in such circumstances, the State could be required to repay the Federal government for HCS overpayments without the ability to recoup overpayments from awardees. A mitigating factor is that the Treasury Inspector General could allow the State to demonstrate that it had other eligible expenses that would qualify as allowable.

There is uncertainty about the extent to which the State is at risk of having to repay funds to the Federal government. As of February 17, 2022, AHS had not established a process for addressing HCS award overpayments. According to the Secretary of AHS, any action the Agency decides to take will be contingent on the nature and degree of overpayments found during the post-award data validation process.

Recommendations

We made recommendations to AHS related to its post-award processes, including developing criteria for when it is appropriate to seek to recoup award overpayments from providers.

Background

Establishment of HCS Program

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which funded the HCS program, was enacted in response to concerns over deteriorating economic conditions due to the COVID-19 pandemic.[7] Title V of this law established the CRF, which provided $150 billion in direct assistance to domestic governments, including $1.25 billion to Vermont. The law specifies that the CRF can only be used to cover those costs that:

- are necessary expenditures incurred due to the public health emergency related to COVID-19,
- were not accounted for in the budget most recently passed as of March 27, 2020, and
- were incurred during the period that begins on March 1, 2020 and ends on December 30, 2020 (later changed to December 31, 2021 by P.L. 116-260).

The U.S. Department of the Treasury issued guidance on the use of CRF funds, including answers to frequently asked questions (FAQ).

Any funds not used for eligible expenses during the covered period (i.e., March 1, 2020 – December 31, 2021) must be returned to the Federal government. In addition, the CARES Act authorizes the Inspector General of the Department of the Treasury to recoup funding if a state fails to comply with CRF requirements equal to the amount related to the non-compliance.

Vermont's Act 136 (2020) appropriated a portion of the CRF funds to cover necessary health care and human services-related expenses incurred due to the COVID-19 pandemic.[8] Section 7 of this Act established the HCS program to stabilize Vermont's health care sector and mitigate financial disruptions caused by the pandemic.[9]

[7] P. L. 116-136, approved on March 27, 2020.

[8] Act 136 (2020) appropriated $275 million to the HCS program. Act 154 (2020) reduced this appropriation to $247.5 million. Additional reductions were made and as of January 4, 2022 the amount that was appropriated to this program was $175 million.

[9] Memorandum from the Office of Legislative Counsel and Joint Fiscal Office, *Rationale for health care- and human services-related appropriations from the Coronavirus Relief Fund in Act 136 (H.965)*, July 15, 2020.

Distribution of HCS Awards

AHS distributed HCS funds through multiple rounds of awards. Most of the funds were distributed in rounds 1 and 2. Only designated agencies and specialized service agencies were eligible to apply for another round of payments (Round 3). A wide range of health care providers met the award criteria and received HCS funding.[10] Some providers received awards from more than one of the rounds. About $105 million of the $142.7 million disbursed (74 percent) in Rounds 1 - 2 were paid to Vermont hospitals.

- *Round 1.* Grants awarded in Round 1 were for revenue losses and COVID-19 expenses for the period March 1, 2020 – June 15, 2020. AHS received 351 applications and made 189 awards totaling $84.6 million in September and October 2020. Awards ranged from $719 to $32 million.

- *Round 2.* Grants awarded in Round 2 were for revenue losses and COVID-19 expenses for the period March 1, 2020 – September 15, 2020. AHS received 272 applications and made 129 awards totaling $58.1 million, almost all in December 2020. Awards ranged from $114 to $37 million.

- *Round 3.* Act 154 (2020) authorized AHS to allocate up to $3 million in HCS funds to designated agencies and specialized service agencies for COVID-19 related expenses through December 30, 2020. In March 2021, AHS paid five of these entities about $1 million in total for COVID-19 expenses incurred between September 16, 2020 and December 30, 2020.[11]

Funds from the first two rounds of the HCS program were also used to pay $2.7 million distributed by the Agency of Commerce and Community Development (ACCD) as part of the Emergency Economic Recovery Grant (ERG) program.

[10] Some providers who applied did not receive awards for a variety of reasons. For example, they may have already received State or Federal financial relief that covered their lost revenue and COVID-19 expenses or they did not address AHS's requested changes or corrections.

[11] Act 74 (2021) amended the requirements to allow the funds to be used to cover revenue losses as well as COVID-19 expenses through June 30, 2021. AHS made additional payments to these entities in December 2021. These payments were not in the scope of our audit.

Objective 1: AHS Designed the Program to Meet Federal and State Requirements, but Its Review Process Did Not Verify All Applications or Data

AHS's HCS award formula and related guidance addressed Federal and State requirements, but its review process did not verify some applications or data in the applications prior to payment. The HCS award formula considered a provider's revenue loss, COVID-19 related expenses, and COVID-19 related financial assistance from other sources. AHS issued guidance to providers on submitting applications along with supporting documentation. After receiving provider applications, AHS used a risk-based approach in which it focused its reviews on applications with higher percentage changes in revenues and amount of incurred expenses. As a result, some provider applications and supporting documentation were not reviewed and not all elements of the application were checked against supporting documentation. AHS used this risk-based approach because of resource concerns and to issue payments quickly to relieve the perceived financial stress on health care providers. In addition to the AHS process, $2.7 million in awards approved by ACCD via its ERG program were paid by the HCS fund. These awards were determined by a different formula, application, and review process than AHS used. These differences would have likely resulted in different award amounts, including potentially smaller payments to providers, had awards been made using the AHS HCS criteria.

Award Formula

To address Federal and State requirements that CRF expenditures be limited to those incurred due to COVID-19 and not duplicate funding from other sources, AHS designed a formula that totaled a provider's lost revenue and[12] COVID-19 related expenses, which were then reduced by other COVID-19 financial assistance. Appendix III contains an illustration of the Round 1 formula.

Lost Revenue

Lost revenue refers to revenue a health care or human services provider lost due to COVID-19. This could be because of fewer visits, cancelled procedures, or state-directed shutdowns. To be eligible for coverage, the revenue must be for medical procedures, supplies, products and/or services recognized by the

[12] Round 3 did not include lost revenue as part of the calculation.

American Medical Association and rendered by a provider licensed to render, order, refer, or prescribe those services in Vermont.

To calculate COVID-19 related revenue losses, AHS's award formula compared an applicant's 2019 and 2020 revenue.[13] AHS reduced the revenue loss amount if, during the same timeframe, the applicant also paid less in gross staff wages. According to an AHS financial official, they made this adjustment because a provider would not have a need to backfill revenue if they did not pay salary and wages. This was a noteworthy part of the formula and it stands in contrast with another program that distributed CRF funds based on lost revenue, ACCD's ERG program, which did not make such an adjustment.

COVID-19 Expenses

AHS's formula included the total amount of COVID-19 expenses the applicant incurred during the covered period. Examples of COVID-19 expenses are personal protection equipment, disinfecting supplies, food delivery, information technology and telecommunications to transition to telehealth, and temporary medical facilities. In accordance with the CRF requirements, the beginning of the covered period was March 1, 2020, while the end of the covered period was June 15, 2020 for Round 1 and September 15, 2020 for Round 2. The covered period for the Round 3 payments issued in early 2021 was September 16, 2020 to December 30, 2020.

The HCS award formula allowed providers to be reimbursed for all eligible expenses but the amount was adjusted for certain non-profit applicants eligible to submit costs for reimbursement under Federal Emergency Management Agency's (FEMA) Public Assistance program.[14] In such cases, the AHS formula reduced the amounts to 25 percent of the expenses reported because this was the percentage of eligible expenses not paid by the Public Assistance program.[15]

Other COVID-19 Financial Assistance

Act 136 (2020) prohibited the HCS program from making payments for the same costs or expenses covered by another State or Federal source. Vermont, the Federal government, and others provided such financial assistance to

[13] The HCS program assessed provider's revenue loss and expenses over the covered period. This was 3 1/2 months for Round 1, spanning March 1 - June 15, 2020, and 6 1/2 months for Round 2, spanning March 1 -September 15, 2020.

[14] To be approved for the FEMA Public Assistance program, the provider had to submit documentation supporting its non-profit, tax exempt status. The provider was also required to provide an eligible service, which includes education, utilities, emergency, medical, custodial care, and other essential services. Providers were to submit Public Assistance grant applications if they had more than $3,300 in FEMA-eligible costs.

[15] Subsequent to Round 1 and Round 2, on February 3, 2021, FEMA announced that it would reimburse 100 percent of eligible expenses retroactive to January 20, 2020 and continuing until September 30, 2021.

health care providers. For example, between March – October 2020, the State paid eligible Medicaid providers $37.8 million under programs intended to provide immediate cash flow assistance to health care providers experiencing financial distress due to COVID-19.[16] Federal COVID-19 financial assistance programs included the U.S. Small Business Administration's Paycheck Protection Program[17] and the U.S. Department of Health and Human Service's Provider Relief Fund.[18] Taken together, through April 2021, Vermont heath care providers had received more than $420 million from these Federal programs.

To avoid potential duplication of payments, the AHS formula reduced the HCS award based on other COVID-19 assistance previously received by the applicant from these and other programs. For State of Vermont assistance, the reduction was 100 percent of the prior payment. For Federal assistance sources, AHS prorated amounts covered by the HCS Grant Program (35 percent in Round 1 and 65 percent in Rounds 2 and 3), to account for the differences in coverage periods.

AHS Application and Review Process

Act 136 (2020) required AHS to disburse HCS funds to eligible health care providers as expeditiously as possible. In emergency situations, such as the COVID-19 pandemic, it is understandable, and appropriate, that entities want to get funds out the door quickly. As illustrated in Figure 2, AHS designed and implemented the HCS program in a short timeframe—the Round 1 and Round 2 payments were issued within six months of the program's authorization. This short timeframe was (1) due to the sense of urgency associated with providing the aid to health care and human services providers who experienced financial hardship due to COVID-19 and (2) because use of the Federal CRF funds were initially required to be incurred on or before December 30, 2020. The CRF timeline was later extended to the

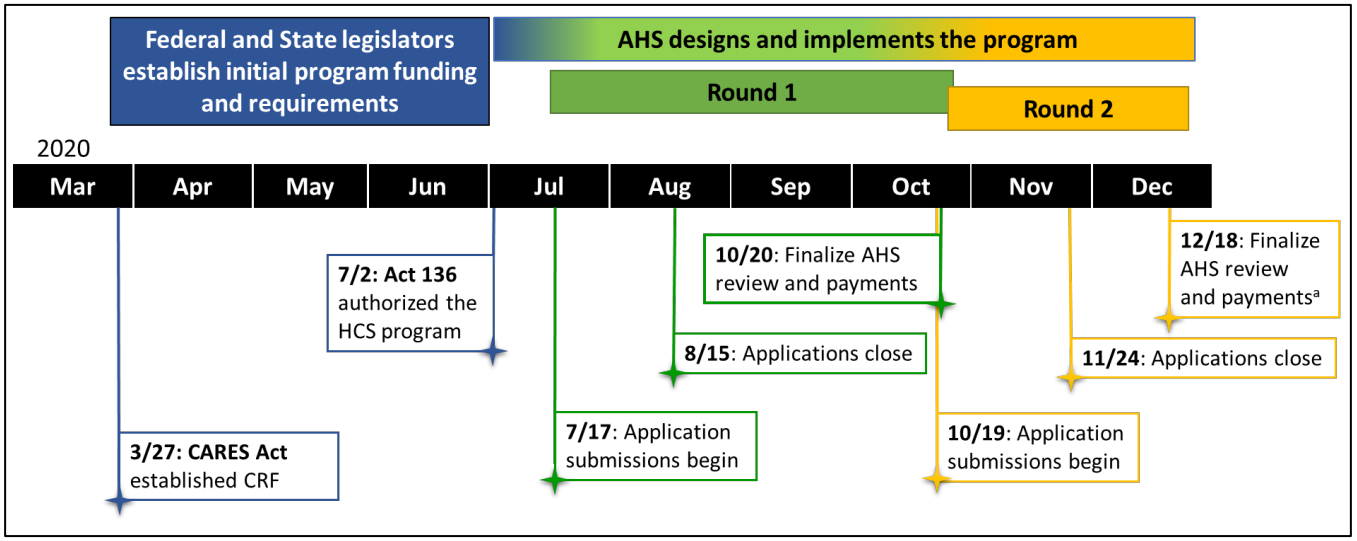
[16] The Department of Vermont Health Access administered Medicaid COVID-19 financial assistance programs labeled as "retainer" programs. For example, the Sustained Monthly Retainer Payment Program combined fee-for-service reimbursement with prospective monthly payments. The prospective payments were to reimburse eligible participating providers for the difference between their long-term average monthly Medicaid fee-for-service revenues and the actual amount of fee-for-service claims payments issued to them for services provided.

[17] The Paycheck Protection Program guaranteed loans to small businesses and other organizations adversely affected by COVID-19. Such loans can be forgiven if a borrower meets certain criteria, such as using at least 60 percent of the proceeds on payroll costs. As of April 7, 2021, Vermont health care providers had been paid $170 million in Paycheck Protection Program loans.

[18] The Provider Relief Fund reimbursed eligible health care providers for health care related expenses or lost revenues that are attributable to COVID-19. As of April 27, 2021, Vermont health care providers had been paid $253 million from the Provider Relief Fund.

end of 2021[19] but not until December 27, 2020, which was after almost all the Round 1 and 2 payments had been made.

Figure 2: Timeline for the Authorization and Execution of Rounds 1 and 2 of the HCS Program



[a] AHS issued a few Round 2 payments after December 18, 2020.

Act 136 required AHS to provide notice and outreach to health care providers regarding the availability of HCS funds. In addition, the Act directed AHS to require applicants to provide only the information necessary to determine their financial need and consistency with the prioritization methodology[20] outlined in the Act.

AHS posted guides and answers to FAQs on its website and held on-line webinars to address provider questions. This guidance explained items such as (1) State eligibility criteria, (2) a definition of the revenue that should be reported and the type of revenue that should not be included in the application, (3) Federal and State criteria and examples of valid and invalid reimbursable COVID-19 expenses, (4) examples of other financial assistance that should be reported, (5) the types of documents that were required to be uploaded into the application portal along with examples of optional documents that could be used to support the application, and (6) the terms and conditions associated with the award.

[19] P.L. 116-260. According to current Federal guidance, a cost associated with a necessary expenditure incurred due to the pandemic is considered to be incurred by December 31, 2021, if the recipient has incurred an obligation with respect to such cost by this same date. Recipients are required to expend funds received from the CRF to cover these obligations by September 30, 2022.

[20] As part of a prioritization methodology, Act 136 (2020) required AHS to consider, for example, the impact of the award amount on the applicant's sustainability and the degree to which the award would provide or support services that would otherwise likely become limited or unavailable as a result of business disruptions caused by COVID-19.

For Rounds 1 and 2,[21] interested health care providers were required to fill out an HCS application through an online portal developed for the HCS program. Among the information requested were 2019 and 2020 revenue and gross staff wages, COVID-19-related expenses, and financial assistance received from other programs. Providers were also directed to upload documentation to the online portal to substantiate their eligibility and support their claims. Examples of required documents are tax returns and billable services summaries. Required documentation for COVID-19 related expenses depended on the amount being requested. All such expenses were supposed to be supported by general ledger data. Providers who submitted total COVID-19 related expenses of $131,100 or greater were also required to submit invoices and receipts.

AHS required providers to sign various attestations. Applicants were required to attest, under penalty of perjury, that all information provided was true, complete and accurate. Examples of other attestations were that (1) the applicant agreed to repay the funds received if incorrect representations were made on the application or to AHS, (2) COVID-19 related expenses submitted for reimbursement only included new costs or marginal costs (amounts above normal operating costs), and (3) the funds awarded would only be used to cover costs and economic support not covered by Federal grants or loans that could be forgiven.

The U.S. Government Accountability Office has acknowledged that some level of risk may be acceptable in an emergency but indicated that strong internal controls help ensure the emergency relief funds are appropriately safeguarded.[22] Without such safeguards, funds may not get to the right organizations or be used for intended purposes. A type of internal control is verification, which is the determination of the completeness, accuracy, authenticity, and/or validity of transactions, events, and information. According to the State's internal control guidance, management should determine what needs to be verified based on the risk to the agency if there was no verification.[23]

AHS applied a risk-based process to determine which providers' applications would be reviewed and the type of verification that would occur. The risk criteria were based on the percentage of applicant revenue loss and the amount of COVID-19 expenses (described in Tables 2 and 3). According to AHS, if an applicant was designated as low risk for both revenue and

[21] Round 3 applications, which could only be submitted by designated agencies and specialized service agencies, were handled outside of the online portal. Applicable providers were asked to fill out a template in a spreadsheet and email it, along with supporting documentation, to AHS. Round 3 funding requests were limited to COVID-19-related expenses incurred between September 16, 2020 – December 30, 2020.

[22] *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts* (U.S. Government Accountability Office, GAO-20-625, June 25, 2020).

[23] *Internal Control Standards: A Guide for Managers* (Edition 2.0, September 3, 2019).

expenses, the application was paid without review. AHS's risk criteria **did not adjust its risk rating based on the potential award amount. Thus, some of the payments made to providers without review and verification of the application were in excess of $100,000.** For example, one provider's revenue loss percentage was seven percent (in the low-risk category) but the amount of its revenue change was $357,000. This amount largely constituted the basis for an award of over $300,000 because the provider did not request to be reimbursed for expenses.[24] Because this provider's application was determined to be low risk for both revenue and expenses, AHS did not review and verify the data in the application against supporting documentation.

Table 2: Revenue Change Risk Levels and Associated Review Requirements

Risk Rating	% Reported Revenue Loss Between 2019 and Covered Period[a]	Review Requirements
Low	less than 17%	No review.[b]
Medium	17% or more but less than 26%	Review backup documentation. If the amount in the backup documentation was within 5% of the application's reported 2019 or covered period revenue, it was approved for payment.[c]
High	26% and above	

[a] Round 1 covered period is March 1, 2020 – June 15, 2020. Round 2 covered period is March 1, 2020 – September 15, 2020.

[b] If a provider was medium or high risk for COVID-19 *expenses* (see Table 3), AHS officials informed us that the reviewer would verify the application revenue amount even if *revenue* had been deemed low risk.

[c] AHS reported that it allowed a 5 percent difference to ensure that minor discrepancies of less than this percentage were not barriers to providers receiving needed relief funds in a timely manner. AHS cited several reasons that differences could arise, including minor data entry errors, partial month documentation, and using a blend of cash and accrual-based inputs and supporting documentation.

Table 3: COVID-19 Expenses Risk Levels and Associated Review Requirements

Risk Rating	Expenses Reported by Applicant	Review Requirements
Low	Less than $25,000	No review.[a]
Medium	$25,000 or more but less than $131,100	Review the general ledger and spot check for reasonability.
High	$131,100 and above	Review the general ledger, invoices, and receipts.

[a] If a provider was medium or high risk for COVID-19 *revenue* (see Table 2), AHS officials informed us that the reviewer would verify the application expense amount even if *expenses* had been deemed low risk.

Also as part of its risk-based approach, AHS did not review or verify the gross staff wages section of the HCS application prior to paying the award. This was

[24] In its determination of the actual award, AHS reduced the lost revenue amount by other financial assistance received by this provider.

an important decision because reductions in an applicant's gross staff wages would result in a lesser award.

According to AHS financial officials, they developed a risk-based process because the agency did not have the resources to review the volume of applications received and there was a critical need to provide financial relief to health care providers. AHS believed that this risk assessment process would identify applications needing a more thorough review and focus on the revenue change and COVID-19 expenses parts of the award formula.

AHS's review and verification process was labor intensive, in part due to technical issues associated with the grant application platform, which was new to AHS. For example, for Round 1, AHS developed and populated a spreadsheet of all applications to calculate awards because the award formula was not working in the grant system at that time.

AHS utilized staff with financial expertise from across the agency to conduct reviews and verification of HCS applications supplemented by a contractor in Round 2. The agency developed review spreadsheets and applications were assessed by multiple reviewers. If the team of reviewers could not find the supporting documentation or had other questions pertaining to the application, an email was sent to the provider to resubmit the application and/or upload required documentation. AHS reported that providers resubmitted over 100 applications with amended information in Round 1.

ACCD Awards Using HCS Funds

Using CRF funding, the State established the ERG program to assist businesses suffering economic harm from the COVID-19 pandemic. Because they are businesses, some health care providers applied for and received COVID-19 assistance through this program, which was managed by ACCD. In September 2020, AHS and ACCD reached agreement to use HCS funds to pay for awards to health care providers made under the ERG program. In total, $2.7 million was awarded to 68 providers via the ERG program and paid using HCS funds.

There were substantial differences in the award criteria and review processes used by ACCD and AHS. In terms of the award criteria, the ACCD-approved awards (1) were based on revenue losses only and did not reimburse applicants for COVID-19 incurred expenses and (2) did not consider reductions in an applicants' gross staff wages. Another difference applied to $1.9 million of the ACCD awards in which ACCD did not reduce the amount of the award by financial assistance from other sources. These differences between the AHS and ACCD process would have likely resulted in

different award amounts, including potentially smaller payments to providers, had awards been made using the AHS criteria.

Objective 2: AHS Overpaid More Than Half the Selected Awards Reviewed

More than half of the 39 HCS award payments we selected for review either should not have been awarded or the amounts awarded were too high. There were a variety of errors, such as data in providers' applications that did not agree with their supporting documentation or were inconsistent with Federal or State requirements. In other cases, payments by other COVID-19 financial assistance programs were not correctly identified and used to reduce the award amount. The AHS review process did not catch these errors as it did not always notice when a provider did not submit required documentation or had submitted inconsistent or incomplete data. AHS also sometimes did not follow-up with the provider on an issue identified during the review.

Of the 39 award payments to 30 organizations that we examined, 21 were too high (see Figure 3), including nine cases in which the payment should not have been made at all. There were also seven awards in which the providers' application had incorrect data that, had it been consistent with the supporting documentation, would have resulted in a *larger* payment. Thus, 72 percent of the awards reviewed were either over or underpaid.

Figure 3: Summary of Results of SAO Analysis of 39 HCS Awards

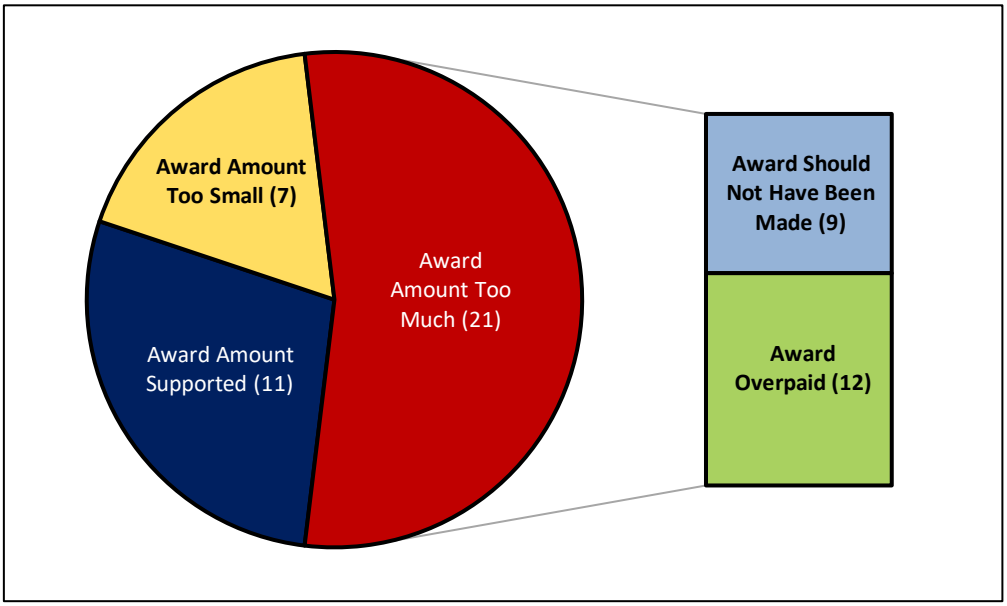


Table 4 summarizes the amount AHS awarded versus our recalculation. In total, there were **$7 million in HCS award overpayments (8 percent of the $92.7 million in payments reviewed)**. Underpayments totaled less than half a million dollars (less than one percent of the payments reviewed). We provided AHS with summaries of our analyses of the under and over payments. AHS agreed with all but one of our recalculations.[25]

Table 4: Comparison of the AHS HCS Payments and SAO's Recalculation by Category of Result

Results Category	AHS Award	SAO Recalculation	Difference[a]
Award Amount too Much[b]	$ 52,731,921	$ 45,407,378	$ 7,324,544
Award Amount too Small[b]	$ 2,817,779	$ 3,295,136	$ (477,357)
Award Amount Supported	$ 37,199,044	$ 37,199,044	0

[a] May not add due to rounding.
[b] There was one provider that was underpaid by $335,851 in Round 1 and overpaid by $902,748 in Round 2 for a net overpayment of $566,898.

Table 5 details the 21 payments made to 17 organizations that were too high. These overpayments ranged from $3,000 to $1.9 million. There was no single type of error that resulted in these overpayments and many awards had errors in more than one of the elements of the formula.

[25] AHS disagreed with our recalculation of an award that we concluded had been overpaid by $11,580. This disagreement pertained to what revenues should be counted.

Table 5: Summary of Excess HCS Round 1 (R1), Round 2 (R2), and Round 3 (R3) Award Payments

Provider	AHS Award Payment	SAO Recalculation of Award	Amount Overpaid		Formula Element with Error		
			In Dollars[a]	As a % of Original Award	Lost Revenue[b]	COVID-19 Expenses	Other COVID-19 Assistance
A (R2 Award)	$ 37,365,717	$ 35,469,834	**$ 1,895,883**	**5%**	X	X	
B (R1 Award)	$ 6,457,920	$ 5,371,327	**$ 1,086,592**	**17%**	X		
C (R2 Award)[c]	$ 1,998,017	$ 1,095,269	**$ 902,748**	**45%**	X	X	X
D (R2 Award)	$ 2,397,135	$ 2,290,962	**$ 106,173**	**4%**		X	
D (R3 Award)	$ 109,281	$ 94,631	**$ 14,650**	**13%**		X	
I (R2 Award)	$ 611,008	Award Would Not Have Been Made	**$ 611,008**	**100%**	X	X	
I (R3 Award)[d]	$ 363,035	Award Would Not Have Been Made	**$ 363,035**	**100%**	X	X	
J (R1 Award)	$ 332,978	Award Would Not Have Been Made	**$ 332,978**	**100%**	X	X	
J (R2 Award)	$ 281,087	Award Would Not Have Been Made	**$ 281,087**	**100%**	X	X	X
J (R3 Award)	$ 96,680	Award Would Not Have Been Made	**$ 96,680**	**100%**			X
K (R1 Award)	$ 574,932	$ 528,161	**$ 46,771**	**8%**	X		X
L (R1 Award)	$ 526,945	Award Would Not Have Been Made	**$ 526,945**	**100%**	X	X	X
N (R2 Award)	$ 369,557	Award Would Not Have Been Made	**$ 369,557**	**100%**	X	X	
P (R2 Award)	$ 323,143	Award Would Not Have Been Made	**$ 323,143**	**100%**	X	X	
Q (R1 Award)	$ 310,495	$ 122,227	**$ 188,268**	**61%**	X	Did not apply for expenses	X
R (R1 Award)	$ 212,327	$ 207,638	**$ 4,689**	**2%**	X		
U (R2 Award)	$ 113,549	$ 98,914	**$ 14,635**	**13%**	X	X	
V (R2 Award)	$ 111,733	$ 108,712	**$ 3,021**	**3%**		X	
W (R1 Award)	$ 100,318	Award Would Not Have Been Made	**$ $100,318**	**100%**	X		
Y (R2 Award)	$ 46,122	$ 1,340	**$ 44,781**	**97%**	X	X	
BB (R1 Award)	$ 29,943	$ 18,363	**$ 11,580**	**39%**	X	Did not apply for expenses	
Total			**$ 7,324,544**				

[a] May not add due to rounding.
[b] This category includes the analysis of changes in gross staff wages.
[c] This provider's Round 1 award was underpaid by $335,851 so the net overpayment for both rounds was $566,898.
[d] The revenue and expense errors in Round 2 for this provider carried forward and caused the Round 3 award overpayment.

There were multiple causes for these errors and their effects varied. While most errors resulted in an overpayment some did not result in a change to the amount of the provider's award[26] or resulted in award amounts that could have been *higher*.

Providers were responsible for ensuring that the information submitted in their applications was true, complete, and accurate. Nevertheless, providers did not always fill out the application in accordance with AHS requirements or guidance. For example,

- Applicants were instructed to report revenue for billable services recognized by the American Medical Association and rendered by a licensed provider. A specialized service agency did not report all its revenue that met this criterion because it misinterpreted AHS's guidance and only reported the revenue associated with programs that experienced revenue losses.

- AHS's guidance listed the types of expenses that were and were not eligible. Nevertheless, two providers included staff bonuses in their applications, which was listed in the ineligible category.[27] In one of these cases, staff bonus expenses totaled $1.1 million. Moreover, some providers submitted expenses that were outside of the period covered by the application (e.g., before March 1, 2020).

- AHS instructed providers to disclose in the HCS application all COVID-19 related financial assistance that was a grant or a loan eligible for forgiveness. Two providers did not disclose that they had received $10,000 payments from the U.S. Small Business Administration's Economic Injury Disaster Loan advance program, which did not have to be repaid.

The emergency nature of the funding and the short timeline for implementing the program and paying the awards left AHS susceptible to missing such errors and making incorrect payments. Nevertheless, AHS could have identified many of the errors had it employed a more robust and consistently applied review process. In addition, the AHS review process was hampered by limited or untimely information available about Federal COVID-19 related financial assistance received by the provider.

[26] One type of error that did not always result in a change in the amount of the provider related to gross staff wages. AHS's guidance and FAQ instructed HCS applicants to include both wages and benefits in reporting gross staff wages. There were providers who only submitted wages. Adding benefits to the calculation of gross staff wages did not always change the amount of the HCS award.

[27] AHS's restrictions on staff bonuses was consistent with U.S. Department of the Treasury CRF guidance, which prohibits workforce bonuses other than hazard pay or overtime (Federal Register Volume 86, No. 10, January 15, 2021, which re-publishes in final form guidance issued in 2020).

AHS Did Not Review Certain Applications

As discussed in the prior section, AHS employed a risk-based approach, which resulted in awards made without AHS reviewing provider documentation. In some cases, this resulted in an incorrect award. For example, a pharmacy received an award of more than $300,000 without an AHS review of its application and supporting documentation. AHS overpaid this provider by about $188,000, primarily due to its inclusion of retail sales in its revenue losses, contrary to AHS guidance. In another case, based on the documentation submitted to AHS, a residential care home whose application was not reviewed understated its 2019 and 2020 revenues.

AHS Did Not Compare Gross Staff Wages in Applications to Supporting Documentation

AHS's review process did not include comparing the gross staff wages in providers' applications to supporting documentation. There were cases in which a review and verification of gross staff wages would have led to a different award amount. For example, an alcohol and drug abuse counseling provider did not include benefits in the gross staff wages sections of its Round 1 application. AHS could have identified this issue had it reviewed the provider's documentation submitted to support the gross staff wages amount. When benefits are included in gross staff wages, this provider's revenue loss and award amount are reduced by $14,000.

AHS's Execution of Reviews was Inconsistent and Sometimes Flawed

In most of the selected applications that underwent an AHS review, the Agency's documentation showed evidence that the reviewer(s) caught errors in provider applications and/or required the provider to submit additional supporting documentation prior to payment. For example, a private non-medical institution removed a $27,753 expense after it was questioned by AHS. In another case, AHS did not process an application from a dental practice until it received documentation that supported the applicant's 2019 paid revenue amount.

Nevertheless, there were several types of deficiencies in the execution of some reviews:

- *Missing provider documentation.* AHS required providers to submit certain documentation along with their application but did not always catch when it was not submitted. For example, providers were required to submit invoices and receipts if they requested reimbursement of COVID-19 related expenses totaling $131,100 or more. The four hospitals in our review did not submit all required invoices for at least one award, even though each requested reimbursement of COVID-19 expenses exceeding this amount. AHS did not ask these hospitals to

supply the required documentation. According to an AHS official, they did not catch this oversight because there was a mix-up over whether AHS or a contractor would be reviewing hospital expenses. One hospital submitted duplicate June 2020 COVID-19 related expenses and made other errors in its expense submission that totaled about $1.5 million.[28]

- *Did not notice inconsistent or incomplete data.* In the case of three providers that received both Round 1 and Round 2 payments, AHS did not notice that the providers submitted different 2019 data in the two rounds. In another case, in their review of a designated agency's Round 2 application, the AHS reviewers missed that the provider's supporting documentation for its 2019 and 2020 revenue amounts stated that it excluded revenue associated with certain programs.[29] Once all the applicable revenue for this provider was taken into account, it no longer had revenue losses and should not have received an award. Similarly, AHS did not notice that pharmacy revenues were not included in the applications of the four hospitals reviewed, which significantly affected the award amount of two of them.

- *Lack of follow-up.* There were cases in which a reviewer noticed a potential problem but there was no evidence of follow-up with the provider, the provider did not submit the additional requested documentation, or the provider submitted the requested documentation, but it was not reviewed. For example, a provider submitted estimated, rather than actual, COVID-19 expenses for medical supplies, which the AHS reviewer noted. However, there was no follow-up with the provider and actual expenses were about $25,000 instead of the $53,000 for which they were paid. In another example, a reviewer noticed that a physical therapy provider's COVID-19 related expenses needed clearer documentation and AHS requested, and received, additional documentation (e.g., invoices). AHS did not review this additional submission and our review of the provider's documentation found costs of about $44,000 that should not have been paid largely because they did not meet the Federal and State requirement to be necessary expenditures incurred due to COVID-19.

Complications Related to Other Financial Assistance Information

In a July 2020 approval of the AHS HCS program, the Deputy Secretary of Administration identified providers receiving other sources of funding as a

[28] FEMA had approved this hospital to be reimbursed for COVID-19 expenses under its Public Assistance program so the HCS program only paid for 25 percent of its expenses. As a result, the effect of this error on the HCS payment was to overstate the award by $385,000.

[29] According to a financial official at this designated agency, revenue from certain programs was excluded because they thought they were supposed to only report programs experiencing revenue loss due to COVID-19 and these programs had experienced caseload and utilization growth and had been protected from revenue loss due to previous actions taken by the State.

potential red flag. AHS directed HCS Round 1 and Round 2 applicants to disclose all COVID-19 related assistance received, which the Agency used to reduce the amount of the HCS awards.

For State assistance, AHS compared the provider's disclosed amounts to data in the State's financial and Medicaid claims systems. However, in two instances AHS did not calculate the State COVID-19 assistance correctly or include all relevant assistance.

In the case of Federal assistance, a staff member in the Department of Vermont Health Access checked the Federal website that contains COVID-19 awards made under the U.S. Department of Health and Human Service's Provider Relief Fund. However, this website did not always have up-to-date information or contain much detail on the assistance. For example, a designated agency received a Federal Provider Relief Fund payment of almost $320,000 in mid-December 2020, but when AHS checked the Federal website in February 2021, before awarding HCS Round 3 payments, the website did not show this payment. Nevertheless, AHS could have discovered this payment by requesting that the provider disclose all COVID-19 related assistance. Unlike in Rounds 1 and 2, AHS did not request Round 3 applicants (restricted to designated agencies and specialized service agencies) provide such information.

In addition, AHS's verification process did not include the Federal Paycheck Protection Program. The U.S. Small Business Administration did not publish the names, addresses, and amounts of all recipients of the Paycheck Protection Program payments until December 2020—several months after the HCS Round 1 payments had been issued and in the same month as when almost all Round 2 payments were made. Thus, if a provider did not disclose the payment from this program, AHS could not check. An alcohol and drug abuse counseling provider's application did not disclose that it had received a Paycheck Protection Program loan (subsequently forgiven) of almost $900,000 in June 2020 even though AHS guidance explicitly stated funding from this program must be disclosed in the HCS application.

Other Matters

Although AHS has made its HCS awards, there remain outstanding issues related to its conduct of post-award data validation reviews, recent payments from HCS funds, and decisions about what to do about overpayments to providers.

AHS Post-Award Data Validation Reviews

In October 2021, AHS began conducting post-award data validation reviews of certain Round 1 and Round 2 payments. According to AHS, they will consider whether (1) the application was filled out in its entirety, (2) required supporting documentation was provided, and (3) the application was consistent with the supporting documentation. In addition, this post-award data validation review includes gross staff wages, which AHS did not verify as part of its pre-award review. If AHS finds exceptions during its comparison of the application and previously provided provider documentation, it is following up with the provider.

AHS is in the process of reviewing payments to the 35 awardees (39 payments) who received payments of $250,000 or greater. AHS has also identified 58 applications that had been deemed low risk in Round 1 (and therefore not reviewed pre-award) and are missing some or all backup documentation. In mid-February 2022, AHS reported that they plan to extend this analysis to Round 2 applications that had been deemed to be low risk. According to AHS, after they complete the review of the payments of $250,000 or greater, they intend to conduct post-award data validation reviews of Rounds 1 and 2 low-risk awards that are missing documentation.

AHS's approach to its post-award data validation reviews has been limited in three areas.

Round 3 Payments to Designated Agencies and Specialized Service Agencies

As allowed by Act 154 (2020) and Act 74 (2021), AHS made $1 million in HCS payments to designated agencies and specialized service agencies in March 2021. At the time of our audit, AHS had not planned to conduct post-award data validation reviews of these payments. The agency stated that "there was no online application for Round 3 so there's nothing to be validated." The absence of an online application should not limit AHS's review. Even though AHS did not use its online application portal, these providers were still required to submit a summary of expenses and supporting documentation. Moreover, all three of the awards we reviewed in this category had errors that resulted in overpayments.

In commenting on a draft of this report, AHS reported that they will include Round 3 payments in their post-award data validation review. According to an AHS financial official, this decision was made on March 3, 2022.

COVID-19 Expenses

At the time of our audit, the AHS post-award review process did not include evaluating whether providers' COVID-19 expenses met Federal and State

requirements. AHS reported they were not conducting a subrecipient[30] monitoring program so verifying the allowability of expenses was "no longer of concern." As previously discussed, our analysis of 39 payments, found that at least a third had unallowable expenses. Such a substantial percentage indicates the need for additional review.

In commenting on a draft of this report, AHS reported that they are now going to evaluate whether providers' COVID-19 expenses met Federal and State requirements in their post-award data validation reviews. According to an AHS financial official, this decision was made on March 3, 2022.

Other COVID-19 Financial Assistance

AHS's post-award review process does not include verifying that providers accurately reported the other financial assistance they had received. AHS stated that it would not be fruitful to review this part of the award formula because the reports they used during their pre-award reviews were cumulative and it is the provider's responsibility to reconcile all sources of funding so not to duplicate benefits. Our analysis of 39 payments found 6 (15 percent) in which either the provider did not report all applicable other assistance and/or AHS made an error in calculating the State's other assistance to these providers. In addition,

- Act 136 (2020), which established the HCS program, states that costs are not compensable under the Act if the same costs or expenses have been or will be covered by insurance or by another State or Federal funding source. This Act also requires that the AHS consider any financial assistance an applicant has received from other sources.

- The reports cited by AHS that were part of its pre-award review process did not include U.S. Small Business Administration payments under the Paycheck Protection Program. In some cases, providers received hundreds of thousands of dollars under this program. This data is readily available on the Small Business Administration's website.

- The Federal government did not always report its Provider Relief Fund payments publicly in a timely manner so the reports cited by AHS may not have shown all applicable payments at the time of the pre-award review. This data is readily available on the Center for Disease Control's website.

[30] Per the Federal Code of Regulations, a subrecipient is a non-Federal entity that receives a subaward from a pass-through entity to carry out part of a Federal program, but does not include an individual that is a beneficiary of a program. Federal CFR guidance states that beneficiaries can also include organizations, such as businesses and non-profits. AHS and the Agency of Administration have determined that HCS awardees are beneficiaries and not subrecipients.

Moreover, as to the responsibility for ensuring that funds are not duplicated, the HCS application required providers to agree that the final determination of whether there has been a duplication of benefits, and the amount to be repaid, will be made by AHS. This seems to contradict AHS's current position that the reconciliation responsibility lies with the provider.

In its comments on a draft of this report, AHS stated that it plans to allow providers that had overpayments the opportunity to identify lost revenue or COVID-19 expenses that may have occurred between the end of the covered periods for each round[31] and December 31, 2021. This expanded timeframe increases the risk that HCS payments could duplicate other COVID-19 assistance because there is now a longer period in which this could occur. We found COVID-19 assistance from Federal and State sources after the original coverage periods of rounds 1 and 2 for providers whose awards had been overpaid. For example, a provider received an HCS award of about a half a million dollars in December 2020 that our analysis showed should not have been made. A month later, in January 2021, this provider received about $700,000 from the Federal Provider Relief Fund that, like the HCS program, was based on lost revenue and expenses attributable to COVID-19.

Payments Made Without Prior Review of Supporting Documentation

Our audit encompassed AHS payments through March 2021 made using the HCS fund in Rounds 1-3. Late in the audit it came to our attention that AHS made HCS fund payments in December 2021 to health care organizations about whom we concluded previous awards were overpaid. Accordingly, we inquired about whether and how AHS had taken the overpayments into account in their decision to award additional amounts. While the payments subsequent to March 2021 were not in our scope, the documentation AHS provided in response to our inquiry indicated a heightened risk that additional overpayments could have occurred.

In mid-December 2021, AHS made $2 million in payments to 18 designated agencies and specialized service agencies. In a justification of these payments, a November 2021 AHS memo to the Agency of Administration stated that staffing issues for crisis beds and emergency services has created fewer options for community-based crisis stabilization and increased emergency department utilization. The December 2021 payments used Federal CRF funds to pay for increases in personal services expenditures in certain job categories (e.g., emergency service clinicians).

[31] The covered period for rounds 1, 2, and 3 ended June 15, 2020, September 15, 2020, and December 30, 2020, respectively.

AHS reported that they derived the award amounts by using a formula based on staffing data provided by the designated agencies and specialized service agencies. However, AHS did not request that the designated agencies and specialized service agencies submit supporting documentation to document increased payroll expenses until January 31, 2022—over a month after paying the award. According to AHS, they will be reviewing this documentation.

Our analysis of prior HCS payments to four designated agencies and specialized service agencies found that all four had been overpaid—in three cases they should not have received awards at all. Moreover, in all four cases, AHS had paid the organizations for expenses that were not allowed by CRF requirements, such as (1) staff bonuses, (2) costs that were not due to COVID-19, and (3) reimbursement for payments to staff or other individuals that had not been made. While AHS acknowledged that these providers were previously overpaid, the agency stated that it deemed it necessary due to emergent circumstances created by the Omicron COVID-19 variant to provide additional fiscal support to these providers to maintain critical mental health and substance abuse disorder services.

In late December 2021, AHS also made a $300,000 payment using CRF funds to another organization that we had determined had received a prior HCS award that was not fully justified. In this case, the AHS award letter links the award to the organization experiencing financial hardship due to COVID-19 but does not require the provider to submit supporting documentation, stating "you do not need to take any action to accept the funding assistance provided." In addition, the documentation provided by the entity prior to AHS making this award was a one-page unaudited balance sheet. While this unaudited balance sheet showed an income loss, it does not link this loss to COVID-19. According to a U.S. Department of the Treasury's Office of the Inspector General (OIG) answer to an FAQ regarding CRF monies being used to provide small businesses assistance, there needs to be documentation that supports that the business was impacted by the public health emergency and therefore eligible for CRF funds. AHS pointed out that it has requested legislative approval to make payments to health care providers to address emergent and exigent circumstances attributable to the pandemic. The applicable section of the subject bill as passed by the legislature would be retroactive to July 1, 2020. This bill was signed by the Governor on March 16, 2022.[32] However, the payment was made prior to receiving legislative approval and the cited bill requires attributing payments to COVID-19.

We acknowledge that the COVID-19 pandemic may have caused health care organizations financial hardships after the end of the March 2021 Round 3

[32] H.679, the fiscal year 2022 budget adjustment act.

payments. Nevertheless, it is riskier for the State to pay organizations without requiring that they provide supporting documentation *prior* to the payment that demonstrate that they meet Federal CRF requirements. Since this was not done, it is important to mitigate this risk by ensuring that the monies paid were used in accordance with these requirements and to seek reimbursement if they were not.

Remedies for Award Overpayments

The HCS application required providers to agree (1) that funds would only be used to cover costs and lost revenue associated with COVID-19 and in accordance with Federal requirements and (2) to repay funds if they are based on incorrect representations made on the application. As discussed previously, our review of 39 HCS awards found overpayments resulting from errors in provider applications and expenses that did not meet Federal requirements. AHS's post-award data validation review may find the same types of overpayments as our audit.

The CARES Act provides the Inspector General of the U.S. Department of the Treasury with the authority to recoup monies from state governments that fail to comply with the allowable uses of CRF funds. All CRF payments to prime recipients (i.e., the State) are subject to audit, which may involve a review of the recipient's beneficiaries (e.g., health care providers). According to a Treasury OIG FAQ, if that office decides after December 31, 2021 that the State did not use CRF monies in accordance with the CARES Act, the OIG may seek recoupment of funds or allow the State to demonstrate that other eligible expenses incurred between March 1, 2020 – December 31, 2021 would qualify as allowable.[33]

Act 136 (2020) includes the following provision:

"Any person who expends monies from the Coronavirus Relief Fund for purposes not eligible under Sec. 5001 of the CARES Act, Pub. L. No. 116-136 and related guidance shall be liable for repayment of the funds to the State of Vermont; provided, however, that a person shall not be liable for such repayment if the person expended the monies in good faith reliance on authorization of the proposed expenditure by or specific guidance from the agency or department administering the grant program."[34]

Thus, if the Treasury OIG determines that Vermont did not use CRF funds in accordance with requirements and the State decides not to seek recoupment

[33] *Department of the Treasury Office of the Inspector General Coronavirus Relief Fund Frequently Asked Questions Related to Reporting and Recordkeeping (revised)* (OIG-CA-20-028R, March 2, 2021).

[34] 1 V.S.A. §128 defines a person as including a corporation, partnership, or other legal entity.

from providers, Vermont could be required to repay the Federal government or it may be allowed to document that it had unreimbursed eligible expenses instead.

There is uncertainty about the extent to which the State is at risk of having to repay funds to the Federal government, since as of February 17, 2022, AHS had not established a process for addressing HCS award overpayments. According to the Secretary of AHS, any action the Agency decides to take will be contingent on the nature and degree of overpayments found during the post-award data validation process. In addition, the decision about overpayments is going to be made in consultation with COVID-19 Financial Office in the Agency of Administration.

Conclusions

AHS faced a challenging task in implementing the HCS program due to the urgency of developing a new program intended to distribute funds to health care providers quickly. In emergency situations such as a pandemic, some level of risk may be acceptable, but it is still important to employ safeguards, such as verifications. AHS implemented a risk-based strategy regarding the extent to which it reviewed and verified the information in provider applications before paying an award. Our determination that 21 of the 39 awards reviewed had been overpaid by a total of $7 million (8 percent of the $92.7 million reviewed) indicates that AHS's verification/review process had flaws. Nevertheless, by implementing a post-award data validation review process, AHS has the opportunity to correct these flaws. However, because AHS had limited the scope of its post-award reviews, this opportunity had been constrained. In addition, AHS has not decided whether to recoup funds from providers whose awards were too high. This is an important decision because the Federal government could seek recoupment from the State for overpayments made to providers under the HCS program.

Recommendations

We make the recommendations in Table 6 to the Secretary of the Agency of Human Services:

Table 6: Recommendations and Related Issues

Recommendation	Report Pages	Issue
1. Conduct post-award data validation reviews of Round 1 and Round 2 providers that had been deemed to be low risk and who are missing required documentation.	21	AHS is in the process of reviewing payments to the 35 awardees (39 payments) who received payments of $250,000 or greater. AHS has also identified 58 applications that had been deemed low risk in Round 1 (and therefore not reviewed pre-award) and are missing some or all backup documentation. In mid-February 2022, AHS reported that they plan to extend this analysis to Round 2 applications that had been deemed to be low risk. According to AHS, after they complete the review of the payments of $250,000 or greater, they intend to conduct post-award data validation reviews of Rounds 1 and 2 low-risk awards that are missing documentation.
2. Conduct post-award data validation reviews of designated agency and specialized service agency HCS payments made in March 2021.	21	AHS made HCS payments to designated agencies and specialized service agencies in March 2021. At the time of our audit, AHS had not planned to conduct post-award data validation reviews of these payments.
3. Include a review of the allowability of expenses during the post-award data validation reviews.	21-22	At the time of our audit, the AHS post-award review process did not include evaluating whether providers' COVID-19 expenses met Federal and State requirements.
4. Verify providers' reported other COVID-19 financial assistance during the post-award data validation reviews.	22-23	AHS's post-award review process does not include verifying that providers accurately reported the other COVID-19 financial assistance they had received.
5. Require and review documentation from organizations that received HCS funding after Round 3 to ensure that the usage of these funds met CRF requirements.	23-24	Late in the audit it came to our attention that AHS made HCS fund payments in December 2021 to health care organizations about whom we concluded previous awards were overpaid. Accordingly, we inquired about whether and how AHS had taken the overpayments into account in their decision to award additional amounts. The documentation AHS provided in response to our inquiry indicated a heightened risk that additional overpayments could have occurred.
6. Develop and apply criteria for when it is appropriate to require providers that received HCS award overpayments to repay the funds.	25-26	Our review of 39 HCS payments found award overpayments and AHS's post-award review could also find overpayments. Providers agreed (1) that HCS funds would only be used to cover costs and lost revenue associated with COVID-19 and in accordance with Federal requirements and (2) to repay funds if they are based on incorrect representations made on the application. Act 136 (2020) states that providers who expended the money in good faith reliance on the State's authorization or guidance would not be liable for repayment.

Recommendation	Report Pages	Issue
7. Report HCS overpayments to the Inspector General of the U.S. Department of the Treasury and seek agreement that would minimize the amount of funds that Vermont would have to repay.	25-26	The CARES Act provides the Inspector General of the U.S. Department of the Treasury with the authority to recoup monies from state governments that fail to comply with the allowable uses of CRF funds. According to a Treasury OIG FAQ, if that office decides after December 31, 2021 that the State did not use CRF monies in accordance with the CARES Act, the OIG may seek recoupment of funds or allow the State to demonstrate that other eligible expenses incurred between March 1, 2020 – December 31, 2021 would qualify as allowable.

Matter for Legislative Consideration

We make the recommendation in Table 7 to the Legislature.

Table 7: Matter for Legislative Consideration

Recommendation	Report Pages	Issue
1. Require AHS to provide periodic reports to the Legislature on (1) the status and results of AHS's post-award data validation reviews and (2) action taken in response to audit recommendations.	20-27	There is uncertainty about the extent to which the State is at risk of having to repay funds to the Federal government. As of February 17, 2022, AHS had not established a process for addressing HCS award overpayments. According to the Secretary of AHS, any action the Agency decides to take will be contingent on the nature and degree of overpayments found during the post-award data validation process.

Management's Comments and Our Evaluation

The Interim Secretary of the Agency of Human Services provided written comments on a draft of this report dated March 7, 2022. These comments are reprinted in Appendix IV. We disagree with some of these comments and our response is in Appendix V.

Appendix I
Scope and Methodology

To address the first objective, we reviewed the Federal[35] and State[36] laws establishing and modifying the requirements for the Federal CRF and the State's HCS program. We reviewed Federal guidance and FAQs issued by the U.S. Department of the Treasury.[37] We also reviewed CRF and HCS guidance documents and FAQs issued by the Agency of Administration and the Agency of Human Services.

We reviewed AHS's reports to the Legislature summarizing the HCS program and funding.

AHS financial officials briefed us on the processes and system AHS used to review HCS applications and supporting documentation. We also interviewed subject matter experts from AHS departments, including the Departments of Disabilities, Aging and Independent Living and Mental Health who were involved in reviewing certain types of providers, such as designated agencies and specialized service agencies.

We reviewed the template containing the formula AHS used to calculate HCS awards along with the summaries of AHS reviews of individual applications when they were performed. In addition, we took into account AHS's explanation of the design of the HCS program that was approved by the Agency of Administration. We also considered the Agency of Administration's remediation plan related to the HCS design.

We calculated the amount of awards paid by the HCS appropriation that were made through ACCD's ERG program. We determined how ACCD processed such awards by reviewing our recent report on the ERG program[38] and identified differences with the AHS process.

For our second objective, we identified all HCS awards made by AHS through a query of VISION, the State's financial system. We judgmentally selected 30 providers who received 39 awards. Our selection was based on the following considerations: (1) awards that were made in all three rounds, (2) the risk levels AHS assigned to an application, (3) examples from a variety of provider types, and (4) primary geographic location (providers were located in 12 of Vermont's 14 counties). We also considered the total amount of payments

[35] P.L. 116-136 and P.L. 116-260.

[36] Act 136 (2020), Act 154 (2020), and Act 74 (2021).

[37] The Department of the Treasury's CRF guidance and FAQs were originally published in mid-2020 and updated several times. The final guidance and FAQs were re-published in the Federal Register on January 15, 2021. *Department of the Treasury Office of the Inspector General Coronavirus Relief Fund Frequently Asked Questions Related to Reporting and Recordkeeping (Revised)* (OIG-CA-20-028R, March 2, 2021). *Coronavirus Relief Fund: Revision to Guidance Regarding When a Cost is Considered Incurred* (December 14, 2021).

[38] *COVID-19 Emergency Economic Recovery Grant Program: Agency of Commerce and Community Development – Some Ineligible Businesses Received Awards and Round 2.0 Awards Increased Profitability for Many of the Businesses Reviewed Instead of Redressing Financial Harm* (SAO Rpt No 21-04, September 21, 2021).

made to an organization, which ranged from $19,657.70 to $69,364,731.22 (see Table 8). The median amount of a payment in our selection was $310,495.

Table 8: Summary of Award Amounts for Selected Providers

Provider	Provider Type	Round 1	Round 2	Round 3[a]	Total
A	Hospital	$ 31,999,014.48	$ 37,365,716.74	Not eligible	$ 69,364,731.22
B	Hospital	$ 6,457,919.57	None	Not eligible	$ 6,457,919.57
C	Nursing home	$ 982,850.44	$ 1,998,017.49	Not eligible	$ 2,980,867.93
D	Designated agency	None	$ 2,397,135.07	$ 109,280.75	$ 2,506,415.82
E	Dentist	$ 2,224,411.77	None	Not eligible	$ 2,224,411.77
F	Hospital	$ 1,277,904.00	None	Not eligible	$ 1,277,904.00
G	Applied behavior analysis	None	$ 1,232,674.62	Not eligible	$ 1,232,674.62
H	Hospital	None	$ 1,051,631.42	Not eligible	$ 1,051,631.42
I	Designated agency	None	$ 611,007.51	$ 363,035.12	$ 974,042.63
J	Designated agency	$ 332,977.67	$ 281,086.82	$ 96,680.39	$ 710,744.88
K	Medical practice	$ 574,931.79	None	Not eligible	$ 574,931.79
L	Alcohol and drug abuse counseling	$ 526,945.17	None	Not eligible	$ 526,945.17
M	Ambulatory surgical center	None	$ 420,107.35	Not eligible	$ 420,107.35
N	Specialized service agency	None	$ 369,556.84	None	$ 369,556.84
O	Medical practice	$ 346,118.54	None	Not eligible	$ 346,118.54
P	Homecare services	None	$ 323,143.03	Not eligible	$ 323,143.03
Q	Pharmacy	$ 310,495.08	None	Not eligible	$ 310,495.08
R	Dentist	$ 212,326.75	None	Not eligible	$ 212,326.75
S	Durable medical equipment, prosthetics, orthotics, and supplies	None	$ 150,713.95	Not eligible	$ 150,713.95
T	Adult day services	$ 142,572.30	None	Not eligible	$ 142,572.30
U	Residential treatment facility	None	$ 113,549.30	Not eligible	$ 113,549.30
V	Private non-medical institution	None	$ 111,733.33	Not eligible	$ 111,733.33
W	Residential care home	$ 100,318.42	None	Not eligible	$ 100,318.42
X	Dentist	$ 44,493.99	$ 25,409.80	Not eligible	$ 69,903.79
Y	Physical therapy	None	$ 46,121.63	Not eligible	$ 46,121.63
Z	Chiropractic services	$ 22,893.32	$ 19,717.20	Not eligible	$ 42,610.52
AA	Psychologist	$ 12,034.38	$ 19,893.74	Not eligible	$ 31,928.12
BB	Emergency medical service	$ 29,943.00	None	Not eligible	$ 29,943.00
CC	Residential mental health treatment services	None	$ 24,724.00	Not eligible	$ 24,724.00
DD	Speech language pathologist	None	$ 19,657.70	Not eligible	$ 19,657.70
Total		$ 45,598,150.67	$ 46,581,597.54	$ 568,996.26	$ 92,748,744.47

[a] Only designated agencies and specialized service agencies were eligible for Round 3 awards.

For each award in our selection, we reviewed (1) the application, supporting documentation, and review notes contained in Salesforce, the system AHS used to process applications, (2) internal and external AHS emails related to the provider and award, (3) AHS reviewer spreadsheets. We recomputed the amount of the award based on the information in the application to confirm the use of the HCS formula. We also traced the following line items in the applications to supporting documentation: (1) 2019 and 2020 revenue, (2) 2019 and 2020 gross staff wages, and (3) expenses. The supporting documentation submitted with the applications varied by provider, but included profit and loss statements, payroll reports, spreadsheets or other types of summaries of expenses, and invoices. To confirm the amount of other financial assistance received by each of these providers, we identified payments made by the State and the Federal government. Payments by the State were identified by querying VISION and the State's Medicaid claims processing system. Payments made by the Federal government were identified by searching data contained in websites that contained awards, such as the U.S. Small Business Administration's Paycheck Protection Program and Economic Injury Disaster Loan advance program and the U.S. Department of Health and Human Services' Provider Relief Fund.

In cases in which we identified missing documentation, a discrepancy between the application and the supporting documentation, or we questioned whether expenses complied with Federal and State requirements or guidance, we contacted the provider to obtain additional documentation or explanations. If the documentation we obtained did not support one or more elements of the application, we recalculated the award amount using the AHS HCS formula. In such cases, we also provided the recalculated award along with relevant documentation to AHS.

Our consideration of internal control was limited to the review of Federal and State requirements and AHS's processes and risk criteria discussed above. We did not review the internal control or reliability of the systems of the providers selected as part of Objective 2.

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 II
Abbreviations

ACCD	Agency of Commerce and Community Development
ACO	Accountable Care Organization
AHS	Agency of Human Services
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
COVID-19	Coronavirus Disease 2019
CRF	Coronavirus Relief Fund
ERG	Emergency Economic Recovery Grant
FAQ	Frequently Asked Questions
FEMA	Federal Emergency Management Agency
HCS Program	Health Care Provider Stabilization Grant Program
OIG	Office of the Inspector General
R1	Round 1
R2	Round 2
R3	Round 3
SAO	State Auditor's Office

Appendix III
Illustration of the Round 1 Formula

Table 9 provides an illustration of the AHS formula for calculating HCS awards in Round 1. The table includes applicant information (orange fields) and formula calculations (blue). The table also includes explanations for specific formula elements. Differences between Round 1 and Round 2 are noted where applicable.

Table 9: Illustration of the HCS Program Formula in Round 1

Ref.	Factor in AHS Formula	Example	Calculation	Notes
	Revenue Loss			
A1	Amount provider billed in 2019	$ 2,000.00	N/A	2019 revenue was collected to establish a baseline for comparison to 2020 revenue.
A2	Amount provider was paid in 2019 for submitted bills	$ 1,000.00		
A3	Percent of 2019 billed services that a provider was paid for	50%	A2 ÷ A1 × 100	The formula calculated a percent of billing that generated revenue for the provider in 2019, to derive a "billed-to-paid factor." This was done anticipating delays in payors processing billing, which would limit applicant's access to their actual 2020 revenue when applying. (Applied in the formula at A8).
A4	Revenue from Accountable Care Organization (ACO) payments in 2019	$ 0.00	N/A	ACO payments are a revenue stream for most Vermont hospitals as well as some other providers. AHS worked with the State's ACO, OneCare Vermont, to establish revenue levels from this funding stream and input this value into the formula for applicable providers.
A5	Average amount provider was paid per month in 2019	$ 83.33	(A2 + A4) ÷12	To compare 2019 and 2020 revenues, the formula converted 2019 annual data into months, and calculated a provider's monthly average revenue.
A6	Average amount provider was paid in 2019 during equivalent number of months to the application period	$ 291.67	A5 × 3.5	The formula adjusted this value to reflect the number of months in the application period: 3.5 months for Round 1 and 6.5 months for Round 2.
A7	Amount provider billed in 2020 (Applicant entered amounts billed for each month in the covered period)	$ 35.00	Sum of monthly billing inputs	The formula calculated how much the provider billed in the application periods: March 1, 2020 – June 15, 2020 for Round 1, and March 1, 2020 – September 15, 2020 for Round 2.
A8	Estimate of amount of 2020 billed income paid during the application period	$ 17.50	A7 × A3	The formula then applied the billed-to-paid factor (derived at A3) so that the data for 2019 and 2020 revenue are comparable.
A9	Revenue from ACO during the application period in 2020	$ 0.00	N/A	AHS worked with OneCare Vermont to assess applicable providers' ACO revenue in 2020. AHS entered this value into the formula.

Appendix III
Illustration of the Round 1 Formula

Ref.	Factor in AHS Formula	Example	Calculation	Notes
A10	**Billable Services Change**	**$ 274.17**	**A6 – (A8 + A9)**	**Calculated to derive revenue loss, without the consideration of wage expenses. In Round 2, if this number indicated that 2020 revenue exceeded 2019 revenue, the formula recorded the amount as zero.**
A11	Gross staff wages in 2019	$ 1,200.00	N/A	Input to establish a baseline for how much a provider paid staff in 2019.
A12	Average monthly gross staff wages in 2019	$ 100.00	A11 ÷12	The formula then estimated monthly wage expense and converted that to reflect the number of months in the application period: 3.5 months for Round 1 and 6.5 months for Round 2.
A13	Gross staff wages paid in 2019 during months equivalent to the application period	$ 350.00	A12 × 3.5	
A14	Gross staff wages in the 2020 application period (applicant input wage expenses in each month of the covered period)	$ 350.00	Sum of monthly wage inputs	The formula summed inputs for wage expenses in each month of the application period: March 1, 2020 – June 15, 2020 for Round 1, and March 1, 2020 – September 15, 2020 for Round 2.
A15	Percent of baseline wage expense incurred during the 2020 application period	100%	A14 ÷ A13 × 100	The formula then calculated any decrease in staff utilization costs from 2019 and 2020 in terms of percentage and dollars to discount the overall revenue loss amount.
A16	Change in gross staff wage expenses between 2019 and 2020 during the application period	$ 0.00	A14 - A13	If A15 was 100 percent or greater, the formula recorded the amount in A16 as zero.
A17	**Base Revenue Change**	**$ 274.17**	**A10 - A16**	**The formula offset revenue loss by reduction in wages.**
	COVID-19 Expenses			
B1	Total amount of COVID-19 related expenses for application period	$ 100.00	N/A	Applicant input COVID-19 expenses incurred between March 1, 2020 – June 15, 2020 for Round 1, and March 1, 2020 – September 15, 2020 for Round 2.
B2	If FEMA-eligible applicant, apply 25 percent match to estimated FEMA-reimbursable expenses[a]	$ 25.00	FEMA-reimbursable costs in B1 × 0.25	Certain non-profits were eligible to obtain FEMA funding for COVID-19 expenses. In these cases, the HCS program only was responsible for the 25 percent of the expense amount that FEMA did not cover.[b]

Appendix III
Illustration of the Round 1 Formula

Ref.	Factor in AHS Formula	Example	Calculation	Notes
	Other Assistance			
C1	Sum of non-State assistance (e.g. Federal programs) (Applicants entered data about individual programs)	$ 70.00	Sum of reported Federal and other assistance	The formula summed amounts of reported Federal and other financial assistance with which to reduce the award. The formula prorated the non-AHS assistance deduction by 35% and 65% in Rounds 1 and 2, respectively, to account for the different coverage periods.
C2	Non-State assistance pro-rated over application period	$ 24.50	C1 × 0.35	
C3	Sum of State of Vermont assistance (AHS entered this amount)	$ 10.00	N/A	This was the amount from Vermont's other relevant COVID-19 assistance programs, as calculated by AHS.
C4	**Deduction from award based on other assistance.**	**$ 34.50**	**C2 + C3**	**Sum of other COVID-19 assistance received by the provider.**
	Total HCS Payout			
	Applicant not eligible for FEMA assistance	**$ 339.67**	**A17 + B1 – C4**	**Revenue change and all of provider's COVID-19 expenses, reduced by other assistance**
	Applicant eligible for FEMA assistance	**$ 264.67**	**A17 + B2 – C4**	**Revenue change and 25 percent of FEMA eligible expenses, reduced by other assistance**

[a] In Round 1 AHS requested that providers submit expenses that are FEMA-eligible separate from other COVID-19 related expenses. In Round 2, AHS did not request that expenses be split and applied the 25 percent to all expenses.

[b] FEMA announced in 2021 that 100 percent of eligible expenses were going to be covered. This was after AHS had made the Round 1 and Round 2 awards.

Appendix IV
Comments from Management

The following is a reprint of management's response to a draft of this report. Our evaluation of these comments is contained in Appendix V.

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

[phone] 802-241-0440
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Jenney Samuelson, *Interim Secretary*
Todd Daloz, *Interim Deputy Secretary*

March 7, 2022

Mr. Doug Hoffer
Office of the Vermont State Auditor
132 State St
Montpelier, VT 05633

Dear Mr. Hoffer,

In response to your Office's draft report, "*Agency of Human Services (AHS): AHS Overpaid Some Providers by $7 Million Under the Health Care Provider Stabilization Grant Program*", please incorporate this enclosed letter as Management's Comments.

The COVID-19 worldwide pandemic has and continues to be a once-in-a-lifetime public health emergency that will have lasting effects on the global landscape. During the early stages of the pandemic, it was critical to stabilize, maintain, and support the health care system so that it could respond during and after the public crisis. The Health Care Provider Stabilization Grant Program was necessary to prevent financial collapse for a system predicated on a non-pandemic payment model which did not account for COVID related lost revenue and public health expenses.

In recognition of the emergent need, AHS stood up the Health Care Provider Stabilization Grant Program authorized by the Legislature under Act 136 in less than six months. As noted in your report, AHS received 623 applications between the two application cycles, and issued 318 awards to 284 providers using the best information available as of the date of application. Overall, AHS views this program as a success: the health care system received critical funding when it needed it most, and all funds were distributed within the federal guidelines. As such, Vermont's healthcare providers were able to play a cornerstone role in one of the most effective COVID responses in the country.

See SAO comment 1 on page 41

There are a few key items which should be noted. During the implementation, the needs of the pandemic response changed, necessitating an evolution of the program. In recognition of this need, the Legislature allowed the flexibility of awards with updated language that can be found in H.679 Sec. 74 retroactive to July 1, 2020. These flexibilities specifically authorize AHS to distribute funds using alternative processes to those set forth in 2020 Acts and Resolves No. 136, Sec. 7, and provide discretion to the Agency to respond to the emergent and exigent circumstances attributed to the COVID-19 pandemic. This flexibility addresses many of the findings outlined in the Report.

See SAO comment 2 on page 41

From the beginning, AHS has planned to do post award validation reviews – this was particularly critical due to the speed at which health care providers and AHS implemented the program. Of the 17 providers you identified as receiving overpayments, our ongoing internal validation process has already found the application issues with 10 of those providers. While there were issues with the applications, consistent with your report, there has been no evidence of fraudulent behavior by providers. We will continue this process to ensure that the program is reviewed per our data validation plan.

See SAO comment 3 on page 41

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See SAO comment 4 on page 42

See SAO comment 5 on page 42

AHS is prepared for any recoupments should that be required, but given that there is no evidence of fraudulent intent, the adherence to US Treasury's guidance for Coronavirus Relief Funds, and flexibilities proposed by the Legislature in H.679, and further documentation from providers documents allowability of expenditures, there has been no evidence of a need for recoupment to date.

We appreciate the thoroughness of your report, and the acknowledgement of the need to implement expeditiously. Yet, it should be noted that the $7M identified in your findings represents approximately 5% of the $143.7M total awards reviewed in this program. The title of report leads readers to believe that a single provider received an overpayment of $7M and that it represents a significant proportion of the funding dispersed. We ask that you please modify the title of the report to reflect the total scope of the review ($143.7M) to clarify the context of these findings.

Thank you for consideration.

Sincerely,

Jenney Samuelson
AHS Interim Secretary

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See SAO comment 3 on page 41 and comment 6 on page 42

See SAO comment 7 on page 43

See SAO comment 8 on page 43

See SAO comment 9 on page 43

Recommendations	Report Pages	Issue	AHS Comments
1. Conduct post-award data validation reviews of Round 1 and Round 2 providers that had been deemed to be low risk and who are missing required documentation.	21	AHS is in the process of reviewing payments to the 35 awardees (39 payments) who received payments of $250,000 or greater. AHS has also identified 58 applications that had been deemed low risk in Round 1 (and therefore not reviewed pre-award) and are missing some or all backup documentation. In mid-February 2022, AHS reported that they plan to extend this analysis to Round 2 applications that had been deemed to be low risk. According to AHS, after they complete the review of the payments of $250,000 or greater, they intend to conduct post-award data validation reviews of Rounds 1 and 2 low-risk awards who are missing documentation.	AHS developed a data validation process beginning in July 2021 that is on-going for Round 1 and 2 providers. Of the 17 providers you identified as receiving overpayments, our ongoing internal validation process has already found application issues with 10 of those providers.
2. Conduct post-award data validation reviews of designated agency and specialized service agency HCS payments made in March 2021.	21	AHS made HCS payments to designated agencies and specialized service agencies in March 2021. AHS does not plan to conduct post-award reviews of these payments.	Act 136 identified $3M as a separate carveout specific to the designated and specialized agencies. The application process for this carveout was administered differently than Round 1 and 2 applications. AHS will conduct data validation review of these awards.
3. Include a review of the allowability of expenses and other financial assistance during the post-award data validation reviews.	22	AHS reported that they do not plan to evaluate whether providers' COVID-19 expenses meet Federal and State requirements, and that all other COVID-19 financial assistance was	For COVID-19 expenses, AHS will be evaluating whether the expenses met Federal and State requirements in accordance with the data validation plan. For other financial assistance, AHS will not be able to accurately evaluate whether the assistance

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See SAO comment 9 on page 43

See SAO comment 10 on page 44

See SAO comment 11 on page 44

		reported as part of the post-award review.	should be factored into the formula as of the date during which the post-award evaluation occurs. Other financial assistance was factored into the award formula using the best information available as of that point in time. It is now incumbent upon the provider to evaluate whether various sources of federal/state funding have been duplicated amongst their financial records.
4. Require and review documentation from organizations that received HCS funding after Round 3 to ensure that the usage of these funds met CRF requirements.	23, 24	Late in the audit it came to our attention that AHS made HCS fund payments in December 2021 to health care organizations about whom we concluded previous awards were overpaid. Accordingly, we inquired about whether and how AHS had taken the overpayments into account in their decision to award additional amounts. The documentation AHS provided in response to our inquiry indicated a heightened risk that additional overpayments could have occurred.	AHS has received and reviewed the supporting documentation to support the $2M payments made to the 18 designated and specialized service agencies. The providers are in compliance with the intent of this targeted beneficiary award. AHS supports the $300,000 payment made to the provider who is a critical component to Vermont's substance use disorder provider network. The provider changed ownership during the middle of the pandemic and did not have a full year's worth of audited financial statements. The unaudited balance sheet shows the operating loss which was directly a result of the public health emergency.
5. Develop and apply criteria for when it is appropriate to require providers that received HCS award overpayments to repay the funds.	24, 25	Our review of 39 HCS payments found award overpayments and AHS's post-award review could also find overpayments. Providers agreed (1) that HCS funds would only be used to cover costs and lost revenue associated with COVID-19 and in accordance with Federal requirements and (2) to repay funds if they are	As discussed in the exit conference, any action AHS implements will be contingent on the nature and degree of overpayments found during the post-award data validation process. Ultimately, AHS will allow providers the opportunity to identify lost revenue or COVID-19 expenses, through December 31, 2021, which may have occurred outside the initial performance period of this program (date dependent on Round) and would therefore comport with the US

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		based on incorrect representations made on the application. Act 136 (2020) states that providers who expended the money in good faith reliance on the State's authorization or guidance would not be liable for repayment.	Treasury's guidance. Additionally, the decision about overpayments will be made in consultation with the COVID-19 Financial Office in the Agency of Administration.
6. Report HCS overpayments to the Inspector General of the U.S. Department of the Treasury and seek agreement that would minimize the amount of funds that Vermont would have to repay.	25	The CARES Act provides the Inspector General of the U.S. Department of the Treasury with the authority to recoup monies from state governments that fail to comply with the allowable uses of CRF funds. According to a Treasury FAQ, if the Inspector General decides after December 31, 2021, that the State did not use CRF monies in accordance with the CARES Act, the OIG may seek recoupment of funds or allow the State to demonstrate that other eligible expenses incurred between March 1, 2020 – December 31, 2021 would qualify as allowable.	If AHS is unable to resolve overpayments described in #5 above, AHS will work with the COVID-19 Financial Office to address the proper notification of overpayments to the OIG.

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Appendix V
SAO Evaluation of Management's Comments

In accordance with generally accepted government auditing standards, the following tables contain our evaluation of management's comments.

Comment #	Management's Response	SAO Evaluation
1	*Overall, AHS views this program as a success: the health care system received critical funding when it needed it most, and all funds were distributed within the federal guidelines.*	As demonstrated by the overpayments we found in our analyses of HCS awards, it is inaccurate to state that all funds were distributed within Federal guidelines. The following are examples of non-compliance with Federal requirements: • Two providers were reimbursed for staff bonuses totaling $1.3 million. Staff bonuses are explicitly not allowed in the Treasury guidance. • A provider overstated its COVID-19 expenses by $1.5 million, which was almost all due its submission of duplicate June 2020 COVID-19 related expenses. • A provider did not report other Federal assistance that it received totaling almost $900,000. The U.S. Department of the Treasury FAQ states that payments from the CRF cannot be used to cover expenditures for which other reimbursement will be received.
2	*During the implementation, the needs of the pandemic response changed, necessitating an evolution of the program. In recognition of this need, the Legislature allowed the flexibility of awards with updated language that can be found in H.679 Sec. 74 retroactive to July 1, 2020. These flexibilities specifically authorize AHS to distribute funds using alternative processes to those set forth in 2020 Acts and Resolves No. 136, Sec. 7, and provide discretion to the Agency to respond to the emergent and exigent circumstances attributed to the COVID-19 pandemic. This flexibility addresses many of the findings outlined in the Report.*	The AHS response references a bill passed during the 2022 legislative session. Our audit covered the formulas and review processes AHS used to award providers HCS payments made between September 2020 and March 2021. H.679 was passed by the legislature a year later. This bill, which was signed by the Governor on March 16, 2022, would allow AHS to retroactively change its award criteria for the HCS program. As to the comment that the bill will address many of the findings in our report, it is yet to be seen the extent to which retroactive changes to the HCS program will address the overpayments found. According to the U.S. Office of Management and Budget, the CARES Act criteria on the use of CRF payments as interpreted in Treasury guidance and FAQs applies to both prime recipients and beneficiaries. Under the CRF, Vermont is the prime recipient and the HCS awardees are beneficiaries.
3	*Of the 17 providers you identified as receiving overpayments, our ongoing internal validation process has already found application issues with 10 of those providers.*	As we completed analyses of payments to individual providers that had been overpaid, we shared our observations with AHS along with supporting documentation. By November 1, 2021, we had sent about 60 percent of our analyses of the 17 providers with overpayments to AHS. AHS began its post-award data validation reviews in October 2021.

Appendix V
SAO Evaluation of Management's Comments

Comment #	Management's Response	SAO Evaluation
4	*AHS is prepared for any recoupments should that be required, but given that there is no evidence of fraudulent intent, the adherence to US Treasury's guidance for Coronavirus Relief Funds, and flexibilities proposed by the Legislature in H.679, and further documentation from providers documents allowability of expenditures, there has been no evidence of a need for recoupment to date.*	Our report found that certain providers did not comply with Federal or State requirements and does not suggest that these errors were due to fraud. In addition, the flexibilities in H.679 cited by AHS do not negate the State's responsibility to comply with Federal requirements for CRF funding. As noted in comment 1, there were HCS award overpayments due to non-compliance with Federal requirements. All CRF payments to prime recipients (i.e., the State) are subject to audit by the U.S. Department of the Treasury's OIG, which may involve a review of the recipient's beneficiaries (e.g., health care providers) as part of an audit of the State. According to a Treasury OIG FAQ, if that office decides after December 31, 2021 that the State did not use CRF monies in accordance with the CARES Act, the OIG may seek recoupment of funds or allow the State to demonstrate that other eligible expenses incurred between March 1, 2020 – December 31, 2021 would qualify as allowable. Thus, H.679 will not shield AHS from the Federal government possibly seeking recoupment from the State for such overpayments if AHS does not obtain reimbursement from the provider. Moreover, neither the CARES Act nor the Treasury OIG FAQ limit possible Federal recoupment to non-compliance with requirements that is due to fraud.
5	*It should be noted that the $7M identified in your findings represents approximately 5% of the $143.7M total awards reviewed in this program. The title of report leads readers to believe that a single provider received an overpayment of $7M and that it represents a significant proportion of the funding dispersed. We ask that you please modify the title of the report to reflect the total scope of the review ($143.7M) to clarify the context of these findings.*	AHS's statements are misleading. Our overall audit covered the AHS process for paying rounds 1-3 awards, which totaled $143.6 million. However, as stated on page 1 of the report and several times thereafter, we reviewed 39 payments that totaled $92.7 million of which there were $7 million in overpayments (8 percent). Since AHS misinterpreted the title of the report, we changed it to add the amount of payments reviewed and the number of providers with overpayments.
6	*AHS developed a data validation process beginning in July 2021 that is on-going for Round 1 and 2 providers.*	AHS hired a staff member to perform this work in mid-July 2021 but did not finalize its data validation plan until October 2021. According to the individual performing the post-award data validation reviews, this is the same month in which the reviews were started.

Appendix V
SAO Evaluation of Management's Comments

Comment #	Management's Response	SAO Evaluation
7	*Act 136 identified $3M as a separate carveout specific to the designated agencies and specialized agencies. The application for this carveout was administered differently than Round 1 and 2 applications. AHS will conduct data validation review of these awards.*	AHS provided us with a revised data validation plan that included reviewing Round 3 awards. An AHS financial official stated that AHS decided to conduct reviews of Round 3 payments on March 3, 2022, which is after we sent them a draft of this report. We will assess AHS's implementation of this recommendation when we conduct our post-audit recommendation follow-up.
8	*For COVID-19 expenses, AHS will be evaluating whether the expenses met Federal and State requirements in accordance with the data validation plan.*	AHS provided us with a revised data validation plan that included reviewing COVID-19 expenses. An AHS financial official stated that AHS made the decision to evaluate whether expenses met Federal and State requirements on March 3, 2022, which is after we sent them a draft of this report. We will assess AHS's implementation of this recommendation when we conduct our post-audit recommendation follow-up.
9	*For other financial assistance, AHS will not be able to accurately evaluate whether the assistance should be factored into the formula as of the date during which the post-award evaluation occurs.*	We disagree. In the case of the U.S. Small Business Administration's Paycheck Protection Program, AHS could check its publicly available website. This website contains data on the organizations that received these funds, including loan approval dates and amounts and the extent to which the loan amounts were forgiven. Another public Federal website specifies the amount that individual health care organizations received under the Provider Relief Fund. While this website does not contain the dates of awards, AHS could identify HCS program awardees that received such funding from this website and ask the provider to submit documentation of when the assistance was received, such as bank deposits. These are the procedures we used to identify other COVID-19 financial assistance that was not included in AHS's award calculations for two providers of several hundred thousand dollars each. In addition, in another section of its comments, AHS stated that it plans to allow providers the opportunity to identify lost revenue or COVID-19 expenses that may have occurred between the covered periods and December 31, 2021. This decision increases the risk that AHS could duplicate other COVID-19 assistance because there is now a longer period in which this could occur thus makes checking for other financial assistance even more important.

Appendix V
SAO Evaluation of Management's Comments

Comment #	Management's Response	SAO Evaluation
10	*AHS has received and reviewed the supporting documentation to support the $2M payments made to the 18 designated and specialized service agencies. The providers are in compliance with the intent of this targeted beneficiary award.*	We have not audited AHS's assertion that this work has been completed so we are not expressing an opinion about whether our recommendation has been implemented. We will assess AHS's implementation of this recommendation when we conduct our post-audit recommendation follow-up.

11	*AHS supports the $300,000 payment made to the provider who is a critical component to Vermont's substance use disorder provider network. The provider changed ownership during the middle of the pandemic and did not have a full year's worth of audited financial statements. The unaudited balance sheet shows the operating loss which was directly a result of the public health emergency.*	In October 2021 we informed AHS that this provider should not have received an HCS award of about a half a million dollars. AHS agreed with our analysis in November 2021. As we stated in the report, AHS used a one-page unaudited balance sheet to support an additional December 2021 $300,000 payment to this provider. In addition, the purported loss recorded on this balance sheet does not include evidence that it is linked to COVID-19, which is a requirement to receive Federal CRF funds.