# Hot Topic: What's Next For Providers After PRF Reports are Submitted?

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**PROFESSIONAL**

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The U.S. Department of Health and Human Services (HHS) requires providers who received $10,000 or more from the Provider Relief Fund (PRF) to report on their use of the funds and requires providers who spent $750,000 or more in annual total federal awards to complete and submit a timely Single Audit report or, in some cases, either a program-specific audit or a financial related audit of the award(s) conducted in accordance with Generally Accepted Government Auditing Standards.

The PRF reporting process is already underway – the first two PRF Reporting Periods (of five) have already closed, and the third Reporting Period opened on July 1, 2022 and will remain open through September 30, 2022. Meanwhile, Single Audit reports must typically be submitted by the earlier of 30 days after receipt of the auditor's report or 9 months after the fiscal year end. For fiscal years ending on or before June 30, 2021, however, the Single Audit submission deadline was extended by six months (*i.e.*, due no later than the earlier of approximately seven months after receipt of the auditor's report or 15 months after the fiscal year end), but organizations taking advantage of this flexibility are advised to maintain documentation of the reason for the delayed filing. For Provider Relief Fund payments received in either Period 1 (before June 30, 2020) or Period 2 (between July 1, 2020 and December 31, 2020), Single Audits must be uploaded to the Federal Audit Clearinghouse by September 30, 2022.

Providers who have already submitted Single Audit Reports should be on the lookout for the following communication provided by the Health Resource and Services Administration (HRSA) in the months following submission of their reports:

- **Providers *will* receive a Management Decision Letter within six months of HRSA' s receipt of the Report.** The Management Decision Letter will include information on whether or not HRSA agrees with each audit finding, the reason for HRSA's decision, whether or not HRSA will require the provider to repay any questioned expenditures that are disallowed (and instructions for returning disallowed costs if so). This letter will also explain the provider's right to present an appeal to the Departmental Appeals Board, should the provider disagree with a determination that certain expenditures should be disallowed and, consequently, that grant funds must be returned.
- **Providers *may* receive follow up communications from HRSA during the first six months after submission while HRSA is reviewing the Report**. These communications may request additional information necessary for HRSA to resolve any procedural questions, monetary questions (e.g., disallowed costs), or questions

regarding the adequacy of any corrective action plans submitted in connection with grant funding. Examples of documentation that HRSA may request includes provider policies and procedures or additional explanations or documentation to support questioned costs.

If a provider wishes to contest any questioned expenditures that are disallowed in the Management Decision Letter, **the provider must submit a Notice of Appeal to the HHS Departmental Appeals Board within 30 days of receiving the Letter.** The Notice of Appeal must include a copy of the Management Decision Letter, a statement of the amount in dispute in the appeal, and a brief statement regarding why the decision is wrong. Within 10 days of receiving the Notice of Appeal, the Board will send the provider an Acknowledgement of receipt of Notice. **Once a provider receives an Acknowledgement of Notice from the Board, the provider must submit an appeal file to the Board (with a copy to HRSA) within 30 days,** along with a written statement of the provider's argument**.**

When submitting an appeal, providers should consider the following:

- A appeal may only be submitted after a provider has received a final written decision and has exhausted any required preliminary appeal process. It appears that, for Single Audits the Management Decision Letter constitutes a final written decision and there are no other preliminary appeal processes required before an appeal may be submitted. However, providers should refer to the specific language within the Management Decision Letter to confirm there are no additional preliminary appeal requirements for their particular case.
- The Board strictly applies the 30-day deadline for submitting an appeal, and has only very rarely accepted review of an appeal filed beyond that timeframe.
- There do not appear to be any procedural disadvantages to filing an appeal; therefore, it may be in a provider's best interest to always file a Notice of Appeal when it is even considering contesting questioned expenditures that are disallowed.
- While the initial Notice of Appeal only requires a brief statement contesting the decision, the initial appeal file requires significantly more documentation. The Board recommends the initial appeal file be "as complete a documentary record as possible" as the Board may make a decision based on just the initial appeal and HRSA's response, without any further development of the record or hearing. While the Board does not require an appeal brief to follow any particular format, the Board recommends a brief include a thorough statement of the facts giving rise to the dispute and legal arguments on the issues raised by the facts which cite to relevant Board decisions, statutes, regulations and administrative materials. The page limit for an appeal brief is 40 pages.
- The Board has set a goal for review of an appeal to take no more than 6 months, and for cases involving a hearing to take no more than 9 months. However, Board regulations note that "[t]hese are goals, not rigid requirements."

Beyond the Single Audit process, PRF fund recipients are required to submit timely PRF reports through the portal detailing their use of PRF funds. Noncompliance with the requirements for Provider Relief Funds (e.g., retention of funds by an ineligible entity or the misuse of funds), may expose PRF fund recipients to recoupment or other enforcement actions.

For further questions regarding Provider Relief Fund audits or appeals, please contact Mark Reagan, Katrina Pagonis, or Maydha Vinson in San Francisco, Nina Marsden in Los Angeles or any member of the Hooper, Lundy, and Bookman team to determine how best to proceed in this new, and rapidly changing, regulatory environment.

**Key Resources:**

- HRSA guidance regarding PRF reports and audits can be found within HRSA PRF Reporting Requirements and Auditing and HRSA Provider Relief Fund Reporting and Auditing Questions
- Regulatory Requirements regarding Single Audits are located within 45 C.F.R. Part 75
- Regulatory Requirements regarding HHS Departmental Appeals Board Procedures are located within 45 C.F.R. Part 16, with further guidance on the Board found within the HHS Appellate Division Practice Manual

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