U.S. Department of Health and Human Services

Office of Inspector General

The Provider Relief Fund Helped Select Nursing Homes Maintain Services During the COVID-19 Pandemic, but Some Found Guidance Difficult to Use

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Inspector General

December 2023, OEI-06-22-00040

U.S. Department of Health and Human Services

Office of Inspector General

Report in Brief

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Why OIG Did This Review

Nursing homes and their residents have been among the hardest hit by the COVID-19 pandemic, partly because of longstanding challenges with staffing and infection control. To help nursing homes and other health care providers respond to the pandemic, Congress appropriated $178 billion and designated HHS to oversee Provider Relief Fund (PRF) and related distributions to providers. HHS made approximately $9.4 billion in targeted PRF distributions to nursing homes and skilled nursing facilities (SNFs).

How OIG Did This Review

We conducted this evaluation in conjunction with a series of Pandemic Response Accountability Committee (PRAC) studies examining COVID-19 funding in six select locations. We examined how 11 nursing homes in those locations used PRF payments during 2020 and 2021 to improve their responses to the COVID-19 pandemic. We also examined Health Resources and Services Administration (HRSA) oversight of the funds. We based our findings on document reviews, an analysis of PRF payment data, and 33 interviews with leadership, staff, residents, and residents' family members from the selected nursing homes. We also conducted two group interviews with HRSA officials. We collected the documents and data in early 2022 to prepare for conducting interviews from May through December concurrently with the PRAC's site visits.

The Provider Relief Fund Helped Select Nursing Homes Maintain Services During the COVID-19 Pandemic, but Some Found Guidance Difficult to Use

Key Takeaway

HHS and HRSA quickly distributed PRF payments to nursing homes. Nursing homes reported that payments were integral to maintaining services during the COVID-19 pandemic, but that guidance from HRSA about the payments and reporting requirements was often difficult to use.

What OIG Found

After receiving congressional appropriations in March 2020, HHS quickly worked with HRSA and other stakeholders to develop PRF and began distributing general relief payments to health care providers the following month. HHS began the first targeted distribution payments to nursing homes in May. Although leaders for the nursing homes in our sample appreciated how quickly the payments were disbursed, they sometimes faced challenges with PRF distribution and attestation processes.

HRSA distributed nearly $15 million in PRF payments to the 11 nursing homes in our sample in 2020 and 2021, including more than $5 million from targeted distributions to nursing homes and SNFs. Nursing home leaders reported that HRSA's broad guidance on allowable uses was initially unclear and difficult to use. As a result, some were hesitant to use the funds for fear they would use the money incorrectly and be forced to pay it back later. Regardless of the challenges, the nursing homes had used and reported about $12 million of the $15 million when we began our site visits in May 2022. Nursing home leaders reported using the funds for expenses and lost revenue, and reported that PRF payments were integral to maintaining services during the pandemic.

HRSA required nursing homes to submit reports about PRF use. The nursing homes in this review generally complied with the reporting requirements, but some appeared to misreport data or had to resubmit information. Nursing home leaders reported that it was difficult to find time to review lengthy reporting guidance, and that completing the reports was a burden. Although HRSA reported plans to assess nursing home use of PRF, the agency had not yet begun conducting audits at the time we conducted our review.

What OIG Recommends and How the Agency Responded

We recommend that HRSA: (1) create a document to record lessons learned from managing PRF and submit the document to HHS leadership and (2) expedite audits of provider use of PRF payments. HRSA did not concur with the first recommendation and concurred with the second.

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BACKGROUND

OBJECTIVES

1. To assess how select nursing homes used Provider Relief Fund (PRF) payments during calendar years (CYs) 2020 and 2021 to improve their responses to the COVID-19 pandemic.
2. To evaluate the Health Resources and Services Administration's (HRSA's) management and oversight of PRF payments distributed to nursing homes.

Background

The COVID-19 pandemic has had a devastating effect on nursing homes and their residents, partly because of longstanding challenges related to infection control and staffing.[1, 2, 3] To reimburse nursing homes and other health care providers for health care-related expenses and lost revenues attributable to COVID-19, Congress appropriated $178 billion to the Department of Health and Human Services (HHS) during 2020 and 2021.[4] HHS administered the funds through PRF and related programs.[5] This review includes only funding administered through PRF distributions, of which there were two types: general distributions and targeted distributions to categories of health care providers that had added COVID-19 challenges.[6] HHS made approximately $9.4 billion in targeted PRF distributions to skilled nursing facilities (SNFs) and nursing homes, and obligated approximately $54.7 billion in total to SNFs and nursing homes across all PRF distributions.[7] HHS stopped making PRF payments in June 2023 following passage of the Fiscal Responsibility Act of 2023.[8]

COVID-19 and Nursing Homes

The nation's nursing home residents have been hard hit by the COVID-19 pandemic. Residents' advanced ages, underlying medical conditions, and close living quarters have made residents especially vulnerable.[9] As of January 1, 2023, more than 1.4 million nursing home residents in the United States had already had a confirmed case of COVID-19, with approximately 160,000 deaths.[10] Previous HHS Office of Inspector General (OIG) work found that almost 1,000 more nursing home residents enrolled in Medicare died per day in April 2020 than in April the previous year.[11]

Nursing homes have faced longstanding infection control and other challenges that continued during the pandemic. From 2013 through 2017, the Centers for Medicare & Medicaid Services (CMS) and State surveyors cited 82 percent of nursing homes with infection control deficiencies, and cited half of those homes in consecutive years.[12] During COVID-19 surges in the spring and fall of 2020, more than

1,300 nursing homes had infection rates of 75 percent or more among residents enrolled in Medicare.[13] Nursing homes also experienced inadequate access to personal protective equipment (PPE) and staffing shortages, which may have further contributed to infection control problems.[14, 15] In July 2021, the American Health Care Association and National Center for Assisted Living released survey results that found 94 percent of nursing homes reported recently experiencing staffing shortages.[16] According to media reports, nursing homes also faced ongoing financial hardships throughout the pandemic.[17, 18]

PRF Overview

During CYs 2020 and 2021, Congress appropriated $178 billion to HHS's Public Health and Social Services Emergency Fund to reimburse eligible health care providers for health care-related expenses or lost revenues attributable to COVID-19.[a, b] HHS administered $136.6 billion of that funding through PRF. HHS administered further funding through related programs.[19, c]

PRF included two funding distribution types: general and targeted. General distributions were broadly available to health care providers, while targeted distributions were for health care providers with added COVID-19 challenges, such as providers highly impacted by COVID-19 or serving high-need and vulnerable populations (e.g., nursing homes).[20, 21] HHS disbursed the general distributions—totaling $81.4 billion—in four phases.[22, 23] Targeted distributions were made to specific provider types, including providers in COVID-19 high-impact areas, rural providers, Indian Health Service and Tribal providers, safety net hospitals, children's hospitals, SNFs, and nursing homes. Targeted distributions made to these provider types varied in amount, with totals ranging from $494 million to $20.7 billion.[24] (See Exhibit 1 for PRF distribution type summaries.) Allocation levels differ from the amounts HHS originally planned and announced due to the number of applicants for some general distributions, returned funds, and other factors.[d] HHS stopped making PRF payments in June 2023.[25]

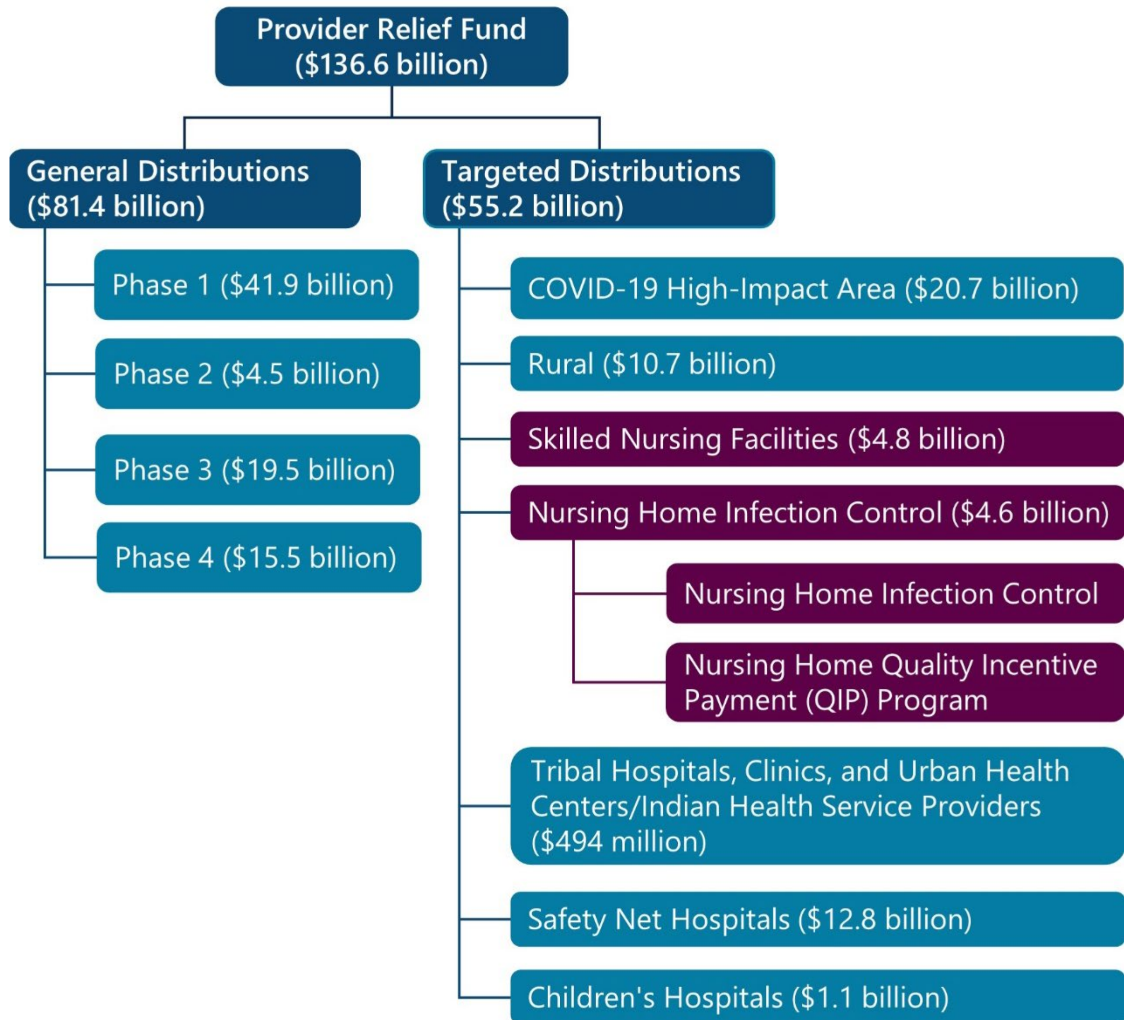
[a] HHS uses the Public Health and Social Services Emergency Fund to improve preparedness against naturally occurring and man-made health threats, as well as threats that interfere with HHS's function. See HHS, *Fiscal Year 2020 Public Health and Social Services Emergency Fund, Justification of Estimates for Appropriations Committee*, p. 11. Accessed at https://www.hhs.gov/sites/default/files/fy-2020-cj-phssef-final-print.pdf on Jan. 30, 2023.

[b] The Coronavirus Aid, Relief, and Economic Security (CARES) Act appropriated $100 billion; the Paycheck Protection Program and Health Care Enhancement (PPPHCE) Act appropriated $75 billion; and the Consolidated Appropriations Act, 2021, appropriated $3 billion. See CARES Act, P.L. No. 116-136, Division B, Title VIII, (Mar. 27, 2020); PPPHCE Act, P.L. No. 116-139, Division B, Title I (Apr. 24, 2020); and Consolidated Appropriations Act, 2021, P.L. No. 116-260, Division M, Title III (Dec. 27, 2020).

[c] For more information about related programs funded using these and other appropriations, see footnotes e and f on page 4 of this report.

[d] For example, HHS initially announced $18 billion for Phase 2 of the General Distribution but only allocated $4.5 billion. See HRSA, *Past General Distributions,* November 2022. Accessed at https://www.hrsa.gov/provider-relief/past-payments/general-distribution on Dec. 16, 2022.

Exhibit 1: PRF Distribution Types



Sources: HRSA, *Past General Distributions*, November 2022. Accessed at https://www.hrsa.gov/provider-relief/payments-and-data/past-payments/general-distribution on Dec. 16, 2022. HRSA, *Phase 4 and ARP Rural Distributions*, September 2023. Accessed https://www.hrsa.gov/provider-relief/payments-and-data/phase4-arp on Sept. 18, 2023. HRSA, *Past Targeted Distributions*, November 2022. Accessed at https://www.hrsa.gov/provider-relief/payments-and-data/past-payments/targeted-distribution on Dec. 16, 2022.
Note: Purple boxes indicate targeted distributions for nursing homes and SNFs. HRSA does not publicly report total amounts from other PRF distributions that may have gone to nursing homes or SNFs.

HRSA Management of PRF

HRSA is the HHS agency responsible for administering the PRF program. HRSA operates programs that provide health care to people who are geographically isolated or economically or medically vulnerable. Its mission is to improve health outcomes and achieve health equity through access to quality services; a skilled health workforce; and innovative, high-value programs.[26] The agency has served several critical functions during the pandemic, including investing in the public health workforce using National Health Service Corps programs; expanding vaccine access in health centers, rural health clinics, and community-based organizations; operating the

COVID-19 Coverage Assistance Fund, which covers costs associated with administering COVID-19 vaccines to patients whose health insurance would not fully cover those costs; and administering claims reimbursement to health care providers for COVID-19 testing, treatment, and vaccinations for uninsured patients through the COVID-19 Uninsured Program.[27, 28, 29, e, f]

HRSA manages the PRF program through its Provider Relief Bureau by overseeing provider application reviews and operating the PRF Reporting Portal, among other efforts.[30, 31, 32] HRSA has contracted with external organizations to assist with some functions, such as collecting information through the application portal, facilitating the distribution of PRF payments, and auditing provider use of PRF.[33, 34, 35]

Targeted PRF Distributions to Nursing Homes and SNFs

HRSA distributed approximately $9.4 billion in targeted PRF payments directly to SNFs and nursing homes.[36, g] HRSA distributed $4.8 billion of this amount to 12,806 SNFs which provide complex nursing and therapy care that can only be safely and effectively performed by, or under the supervision of, skilled nursing and therapy professionals.[37] HRSA used a fixed-payment approach for this SNF distribution; SNFs with at least six CMS-certified beds qualified for $50,000 plus $2,500 per bed.[38] The terms and conditions required that recipients use the payments to prevent, prepare for, and respond to COVID-19, and only for health care-related expenses or lost revenues attributable to COVID-19.[39]

[e] Within PRF, HHS and HRSA used a portion of the funding Congress appropriated to support health care-related expenses attributable to the COVID-19 pandemic in order to support the Coverage Assistance Fund and the COVID-19 Uninsured Program. See Centers for Disease Control and Prevention (CDC), *Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration of the Uninsured*, updated Mar. 3, 2022. Accessed at https://data.cdc.gov/Administrative/Claims-Reimbursement-to-Health-Care-Providers-and-/rksx-33p3 on Jan. 30, 2023; and CDC, *COVID-19 Coverage Assistance Fund: Claims Reimbursement to Health Care Providers and Facilities for Services to the Underinsured*, updated Nov. 16, 2022. Accessed at https://data.cdc.gov/Administrative/COVID-19-Coverage-Assistance-Fund-Claims-Reimburse/xgy8-wnft on Jan. 30, 2023.

[f] HRSA administered funds for other programs alongside PRF. HHS used $8.5 billion that Congress appropriated through the American Rescue Plan (ARP) Act of 2021 to establish the ARP Rural Distribution to administer payments to providers and suppliers who serve rural enrollees in Medicaid, the Children's Health Insurance Program, and Medicare. The Rural Health Clinic COVID-19 Testing (RHCCT) and Rural Health Clinic COVID-19 Testing and Mitigation (RHCCTM) programs supported Rural Health Clinics in maintaining and increasing COVID-19 testing and mitigation efforts. See HHS press release, "Biden-Harris Administration Begins Distributing American Rescue Plan Rural Funding to Support Providers Impacted by Pandemic," Nov. 23, 2021. Accessed at https://public3.pagefreezer.com/browse/HHS.gov/30-12-2021T15:27/https:/www.hhs.gov/about/news/2021/11/23/biden-admin-begins-distributing-arp-prf-support-to-providers-impacted-by-pandemic.html on Aug. 10, 2023; and HRSA, *Rural Health Clinic COVID-19 Testing and Mitigation (RHCCTM) Program,* August 2022. Accessed at https://www.hrsa.gov/coronavirus/rural-health-clinics/testing on Oct. 27, 2022.

[g] In addition to the targeted distributions, some nursing homes also qualified for additional funding through general and other PRF distributions. In June 2023, HRSA reported to OIG that HHS had obligated approximately $54.7 billion total to SNFs and nursing homes across all PRF distributions.

HHS distributed the remaining $4.6 billion to nursing homes through the Nursing Home Infection Control (NHIC) distribution. The NHIC distribution included two types of allocations: infection control payments and the Quality Incentive Payment (QIP) program. HRSA distributed infection control payments to 12,787 nursing homes using a per-facility formula: $10,000 per home plus $1,450 per certified bed. HRSA distributed QIP to 11,819 nursing homes in amounts that varied by facility and month. HHS developed a complex formula using COVID-19 infection and mortality rates to determine whether nursing homes qualified for QIP. HRSA distributed QIP four times following monthly assessments between September and December 2020.[40, h] (See Exhibit 2 for information about SNF and NHIC payment calculations.) The terms and conditions for the NHIC distribution required that recipients spend the funds on infection control-related expenses, such as COVID-19 testing and hiring staff.[41]

Exhibit 2: Targeted PRF Distributions to SNFs and Nursing Homes

SNF Distribution

One-time:
$50,000 + $2,500/bed

NHIC Distribution

One-time:
$10,000 + $1,450/bed

NHIC Distribution, QIP

Up to four times:
Determined by
COVID-19-related metrics

Source: HRSA, *Past Targeted Distributions*, November 2022. Accessed at https://www.hrsa.gov/provider-relief/payments-and-data/past-payments/targeted-distribution on Dec. 16, 2022.

HRSA automatically distributed SNF and NHIC payments directly to eligible nursing homes electronically or by check.[42] HRSA directed providers to attest to accepting the associated terms and conditions upon receiving the funds.[i] The terms and conditions required nursing homes to allow public disclosure of the payments and to fully cooperate with audits, in addition to other requirements.[43, 44] HRSA requires

[h] HHS and HRSA calculated the infection and mortality measures using data from sources such as CDC's National Healthcare Safety Network and COVID-19 community profile reports. See HRSA, *Nursing Home Quality Incentive Program Methodology*, Dec. 7, 2020. Accessed at https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/nursing-home-qip-methodology.pdf on Jan. 31, 2023.

[i] HRSA deemed providers that did not attest to the terms and conditions as having attested if they retained a payment for 90 days. Providers use the CARES Act PRF Payment Attestation Portal or the PRF Application and Attestation Portal to attest to the terms and conditions. See HRSA, *PRB Provider Relief Fund General Information FAQ*. Accessed at https://www.hrsa.gov/provider-relief/faq/general on Jan. 31, 2023.

providers with unused funds at the end of a relevant period of availability to return the funds.[j]

Timelines and Reporting Requirements

HHS began issuing PRF payments in April 2020 and, for reporting purposes, established periods during which PRF recipients must use and report on the funds.[45] HRSA required all recipients that received PRF payment(s) exceeding $10,000 in the aggregate during any given payment-received period (i.e., a time period in which a health care provider received one or more PRF payments) to report use of the funds during the applicable reporting period. Those recipients reported use in broad categories, by lost revenue, or by general or health care-related expense.[46, k]
In general, PRF recipients must use the funds within 1 year after the payment-received period ends and report on use during a subsequent 3-month period. HRSA has revised the periods since developing its initial timelines. In May 2023, HRSA added Periods 8 and 9 that extend reporting through fiscal year 2025.[47] (See Exhibit 3 for a list of the payment-received, use, and reporting periods.)

[j] Providers return unused PRF payment amounts to HRSA through the Return Unused PRF Funds Portal. See HRSA, *PRB Provider Relief Fund General Information FAQ*. Accessed at https://www.hrsa.gov/provider-relief/faq/general on Jan. 31, 2023.

[k] HRSA required providers to report use of NHIC payments and all other payments separately.

Exhibit 3: Timelines for Provider Receipt, Use, and Reports of PRF Payments

	Payment-Received Period[*]	Deadline for Using Funds	Reporting Time Period
Period 1	From Apr. 10 to June 30, 2020	June 30, 2021	July 1 to Sept. 30, 2021[**]
Period 2	From July 1 to Dec. 31, 2020	Dec. 31, 2021	Jan. 1 to Mar. 31, 2022
Period 3	From Jan. 1 to June 30, 2021	June 30, 2022	July 1 to Sept. 30, 2022
Period 4	From July 1 to Dec. 31, 2021	Dec. 31, 2022	Jan. 1 to Mar. 31, 2023
Period 5	From Jan. 1 to June 30, 2022	June 30, 2023	July 1 to Sept. 30, 2023
Period 6	July 1 to Dec. 31, 2022	Dec. 31, 2023[***]	Jan. 1 to Mar. 31, 2024
Period 7	Jan. 1 to June 30, 2023	June 30, 2024[***]	July 1 to Sept. 30, 2024
Period 8	July 1 to Dec. 31, 2023	Dec. 31, 2024[***]	Jan. 1 to Mar. 31, 2025
Period 9	Jan. 1 to June 30, 2024	June 30, 2025[***]	July 1 to Sept. 30, 2025

Source: HRSA, Important Dates for Reporting, May 2023. Accessed at https://www.hrsa.gov/provider-relief/reporting-auditing/important-dates on May 11, 2023.

[*] These periods are not the same as the general distribution phases. HHS used the general distribution phases to distribute funding as the Department received and allocated it; these periods were established for reporting purposes.

[**] HRSA allowed a grace period for this reporting time period, which ended on Nov. 30, 2021.

[***] PRF payments not fully expended on expenses attributable to COVID-19 may only be applied to lost revenue up to the end of the quarter in which the Public Health Emergency ended (i.e., June 30, 2023). See HRSA, *How to Calculate Lost Revenues for PRF and ARP Rural Reporting*, February 2023. Accessed at https://www.hrsa.gov/provider-relief/reporting-auditing/lost-revenues on Mar. 20, 2023.

Related Work

This study expands on OIG's body of work focused on the health and well-being of nursing home residents, as well as OIG's oversight of HHS's COVID-19 response and recovery. Prior evaluations found that nursing home residents enrolled in Medicare were hard-hit by COVID-19, with 2 in 5 diagnosed with either COVID-19 or likely COVID-19 in 2020, and that more than 1,000 nursing homes experienced "extremely high" infection rates and an average overall mortality rate approaching 20 percent during COVID-19 surges in 2020.[48, 49] A July 2023 evaluation found some differences in targeted PRF funds allocated to hospitals with respect to the race and ethnicity of

the populations the hospitals served.[50] OIG has an ongoing evaluation examining nursing home strategies to mitigate pandemic-related challenges.[51]

OIG has an ongoing, three-part approach to auditing PRF. In the first part, OIG found that HHS's oversight of automatic general distribution Phase 1 PRF payments was generally effective but improvements could be made.[52] In the second, OIG is conducting several additional audits of PRF general distributions, including audits of controls for provider submission of information, provider eligibility, and other items.[53] In one of these audits, OIG found that HHS's and HRSA's controls related to selected PRF program requirements could be improved.[54] In the third part of its audit strategy, OIG is auditing provider expenditures of PRF funding and compliance with program requirements.[55, 56] One of those audits will include a larger sample of SNFs to determine whether PRF recipients complied with certain terms, conditions, and Federal requirements for spending and reporting on PRF payments.

See the OIG COVID-19 Portal for more information about OIG's oversight work related to COVID-19 and the OIG nursing home site for more information about OIG's efforts to protect nursing home residents, strengthen oversight, and promote emergency preparedness.

Joint Work With the PRAC

We conducted this evaluation in conjunction with a series of studies led by the Pandemic Response Accountability Committee (PRAC)—a committee of 20 Inspectors General created by Congress to oversee pandemic relief spending—that examined Federal COVID-19 funding. The PRAC released the first report in July 2023 and plans to release the remaining reports in 2024.[57]

The PRAC divided its project into two phases:

1) Phase 1 provides an overview of Federal COVID-19 funding to 6 geographic locations, which was distributed by programs overseen by 10 participating Federal OIGs.
2) Phase 2 will detail funding distributed to each location for specific programs chosen by each OIG. The PRAC and participating OIGs visited each selected location, virtually or in person, and conducted interviews with community officials and others to examine the use and effect of pandemic relief funding in the selected programs.

Methodology

Scope of Inspection

We examined the use of PRF payments to 11 nursing homes during CYs 2020 and 2021, and HRSA management and oversight of those funds.[l] We conducted our data collection concurrently with the PRAC's Phase 2 site visits to its selected locations from May through December 2022. We used virtual interviews, documents, and payment data to identify how the nursing homes used PRF payments and whether they experienced any challenges using these funds. To assess HRSA management and oversight of PRF payments, we interviewed HRSA officials and nursing home leaders about PRF distribution processes and the agency's efforts to collect and review related data and documentation.

As noted, we conducted this evaluation in conjunction with a series of studies led by the PRAC that examined Federal COVID-19 funding. The PRAC selected six geographic locations as the subject of its studies. The PRAC chose the 6 by randomly selecting 10 locations within each of 3 area types: small to-mid-sized cities, rural communities, and Tribal reservations. From each group of 10, the PRAC then selected 2 locations based on the highest total number of COVID-19 cases. The PRAC also considered additional factors, such as total funding provided to each location and geographic distribution across the United States.

The 11 sample nursing homes include all nursing homes located in the PRAC's 6 selected geographic locations that received PRF payments through the SNF and NHIC distributions.[m] (See Exhibit 4 for a list of the geographic locations selected by the PRAC and the number and size of nursing homes within each location.) One of the six PRAC-selected locations did not include any nursing homes that directly received PRF funds and was not included as part of this evaluation. Because of data constraints, we did not include 2 nursing homes that did not receive direct PRF payments in our sample of 11 nursing homes, although they may have received PRF funds as subrecipients of distributions to their owners. We also excluded a third nursing home. That nursing home's Taxpayer Identification Number (TIN) was associated with an outdated location in the PRF payment data, which was located within study boundaries. However, a representative for the company identified by the TIN reported that the company no longer operated a facility within those boundaries.

[l] For purposes of our review, we used the term "nursing homes" to refer to all facilities in our sample regardless of technical status (i.e., nursing facility and/or SNF) according to common use. We use the term "SNF" throughout only when referring to HRSA's targeted distribution allocated to SNFs.

[m] To determine the sample of nursing homes, we filtered data about PRF payments to nursing homes using ZIP Codes for each location provided by the PRAC. We also verified the sample by using mapping tools to identify any additional nursing homes located within the ZIP Codes but included in the PRF data under another location, such as the location of facility owners.

Exhibit 4: Number and Size of Sample Nursing Homes in Each Location

Location Selected by the PRAC	Number of Nursing Homes	Average Number of Beds per Nursing Home*
Springfield, MA	1**	120
Coeur d'Alene, ID	5	86
Sheridan County, NE	3	56
Marion County, GA	1	70
White Earth Nation Indian Reservation (MN)	1	32
Jicarilla Apache Nation Reservation (NM)	-	-
All Locations	**11**	**75**

Source: OIG analysis of PRF data and OIG analysis of supplemental National Healthcare Safety Network COVID-19 nursing home data from August 2022.
* Numbers rounded to the nearest whole number.
** The three nursing homes that we did not include in our sample were located in Springfield.

Although we determined our sample by selecting the nursing homes in each location that received PRF payments through the SNF and NHIC distributions, our findings include a discussion about the nursing homes' use of all types of PRF payments received. In addition to SNF and NHIC payments, the nursing homes in our sample received payments from other PRF distributions, including general distributions and targeted distributions to other types of health care providers.[n, o] We chose to include the nursing homes' broader PRF payments because interview respondents often did not distinguish SNF and NHIC payments from other payments. In addition, use of SNF payments is reported together with the use of other payment types to HRSA.

Data Collection

[n] Some of the nursing homes in our sample are part of facilities that also serve as hospitals, health centers, or other facility types.

[o] We refer to all non-NHIC or SNF payments the nursing homes in our sample received as "other" throughout this report.

Interviews: To evaluate nursing home use of PRF payments, we held interviews virtually with leadership, staff, and a small number of residents and family members from the selected nursing homes concurrently with the PRAC's onsite visits.[p] We also conducted two virtual group interviews with relevant HRSA officials. We employed adaptable interview protocols that allowed us to modify questions, as needed, and follow up on additional issues as we identified key issues.

Nursing Home Interviews: We conducted 33 individual or group interviews with 131 leaders, staff, residents, and family members at the selected nursing homes. Leaders included nursing home administrators and directors of nursing; corporate executives; representatives from contracted management and audit groups; health care system leaders; and others. Staff interviews included clinical and nonclinical staff. During interviews, we discussed nursing home experiences in using the funds and reporting the information to HRSA, including any challenges and interactions with HRSA. We conducted interviews with residents and/or family members at some of the nursing homes to gather supplementary insights about nursing home care during COVID-19. We used these insights for the PRAC's corresponding location-specific reports described on page 8 of this report.

HRSA Interviews: We conducted two group interviews with representatives from HRSA's Provider Relief Bureau and Office of Planning, Analysis, and Evaluation. Interviewees included 13 officials who responded during one or both interviews, as well as 6 other attendees. During the interviews, we discussed HRSA's efforts to manage and oversee PRF, including the agency's efforts related to PRF payment distribution, provider reporting processes, audits, and recovery of improper or unintended payments. We also asked about any coordination regarding nursing homes with CMS and other Federal or State agencies. We discussed any challenges that HRSA experienced with oversight, and any actions it took to assist nursing homes in overcoming challenges.

Document Review: We collected available funding receipt attestations and reports to HRSA about how the sample nursing homes used PRF payments. OIG extracted the documents during April and June 2022 in preparation for the PRAC's series of location site visits. At that time, only two of four required reporting periods had passed, so the nursing homes had not yet reported on their use of all PRF payments. They had, however, reported on most of the payments they received through the SNF and NHIC distributions.[q] We also requested and reviewed summary documentation from the nursing homes supporting expenses and lost revenue outlined in those

[p] In addition to conducting our own interviews, we attended 13 PRAC interviews with leadership and health or related departments in the 5 locations containing nursing homes that received PRF payments directly. We did not include information from those interviews in our findings. We did, however, confirm that the local departments did not have any role in helping nursing homes determine how to use PRF.

[q] During the first two reporting periods, the nursing homes in our sample were required to report about their use of 61 of 80 PRF payments received during 2020 and 2021, including 43 of 57 SNF and NHIC payments.

reports. Additionally, we requested any correspondence between HRSA officials and the nursing homes about PRF money and the reports, as well as any documentation of HRSA's oversight actions related to the use of the funds. As of June 8, 2022, HRSA had no documentation of oversight actions related to the nursing homes.

PRF Payment Data: To summarize PRF payments the nursing homes received and kept, we reviewed PRF payment data from HRSA for the 11 selected nursing homes. We collected PRF payment data in preparation for the PRAC's series of location site visits; the data were extracted on February 28, 2022, and, depending on whether the payments were made electronically or by check, were current through the beginning of January or February 2022. The data therefore included all payments made during our timeframe, which included CYs 2020 and 2021.

Data Analysis

We conducted a qualitative analysis of interview data and documentation from the nursing homes and HRSA. We used our analysis to gain a deeper understanding of PRF program strengths and weaknesses from the perspective of HRSA and the 11 nursing homes. This analysis also helped us to determine how the selected nursing homes used targeted payments to improve infection control and address health care expenses and lost revenue related to the pandemic. We identified themes and challenges related to the disbursement and use of the funds, and PRF oversight processes.

We conducted a quantitative review of PRF payment data and of the nursing homes' reports and supporting financial documentation. We used our analysis of the data to briefly summarize the types and amounts of PRF payments each nursing home received and how the funds were used.

Limitations

We focused only on the experiences of the 11 selected nursing homes. Our findings cannot be generalized to all nursing homes that received PRF payments.

Although HHS-OIG compared the nursing home reports to HRSA against supporting documentation and PRF terms and conditions to assess appropriateness, we did not conduct an audit of the nursing homes' financial documentation to verify their reports and supporting material.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

After receiving congressional appropriations, HHS quickly developed PRF and began distributing payments to nursing homes

HRSA officials described PRF development as an urgent and difficult endeavor. Officials said that it was an "extraordinary" challenge to balance the urgency to distribute the payments with the large amount of information, guidance, and requests the agency received from stakeholders. One official explained that HHS and HRSA's goal in developing PRF was to invest in entities that would have the highest pandemic-related lost revenues and increased expenses, such as hard-hit nursing homes. Another official added that HHS and HRSA sought to use QIP distributions to reward nursing homes that created and maintained safe environments for residents.

HHS and HRSA quickly developed PRF policies and processes and began distributing general distribution Phase 1 payments to health care providers on April 10, 2020, within 1 month after the enactment of the CARES Act on March 27. HRSA began the SNF and NHIC distributions shortly thereafter. (See Exhibit 5 for a timeline of PRF development and initial distribution to nursing homes.) As OIG has recognized, distributing PRF quickly during unprecedented circumstances was a substantial challenge.[58]

Exhibit 5: PRF Development and Distribution Timeline

Sources: CARES Act, P.L. No. 116-136, (Mar. 27, 2020); and data from HRSA officials, June 2022.

HHS worked with HRSA, other HHS agencies, and contractors to rapidly develop PRF policies and processes

HHS collaborated with HRSA and a wide range of other stakeholders to develop and manage PRF. According to HRSA officials, the HHS Office of the Secretary led program and policy development including the development of payment methodologies, terms and conditions, oversight processes, and determining eligibility

standards. HHS sought feedback from HRSA and other agencies about the distributions. For example, one official reported that HHS convened agencies including CMS, CDC, and others to coordinate HHS infection control activities, including NHIC QIP. HHS and HRSA also sought feedback from two nursing home associations about QIP.

Following PRF development, HRSA became responsible for program management and worked with HHS on provider communication. HHS and HRSA worked with contractors to develop payment methodologies, portals for applications and attestations, and other efforts.

One official reported that HHS and HRSA developed broad PRF terms and conditions so that providers could "use [the] money in any way they saw fit" to address health care-related expenses and lost revenue attributable to COVID-19 in accordance with the PRF appropriations statutes. The official further confirmed that, according to the NHIC terms and conditions, NHIC payments could be used for COVID-19-related infection control expenses but could not be used for lost revenue.

HRSA used a variety of methods to distribute payments to providers, but had some difficulty issuing automatic payments to nursing homes because of data lags

To quickly distribute PRF payments, HRSA relied on various payment techniques. HRSA officials reported that the agency used automatic push payments during the first phase of the general distribution and for targeted distributions. To distribute automatic payments, HRSA used data such as bank account information and provider addresses from other HHS agencies, including CMS and the Indian Health Service. For example, HRSA was able to distribute many of the targeted payments to nursing homes using banking information CMS had for Medicare- and Medicaid-participating facilities. HRSA used application processes to gather information about providers for which it did not already have necessary data. HRSA distributed general distribution Phase 2, 3, and 4 and some Phase 1 payments using information providers submitted through those applications.

Officials reported that the timing of data on changes in nursing home ownership affected payment distribution. Specifically for general distribution Phase 1 and SNF targeted distribution payments, officials said that lags in ownership data that HRSA received from other HHS agencies resulted in a small number of payments distributed to prior owners. To remedy this, HRSA allowed providers that did not receive correct general distribution Phase 1 payments to apply for funds during Phase 2 and required incorrect recipients to return the funds. HRSA also reissued targeted distribution payments to the correct providers.

Nursing homes in our sample sometimes faced challenges with PRF distribution and attestation processes

Nursing home leaders appreciated the efficiency of payment disbursement but were sometimes unsure of or disagreed with PRF distribution processes. Some said they had little or no notice regarding when they would receive the funds, and sometimes they had to retroactively determine which distributions the payments came from after receiving them. Some leaders were unsure of, or disagreed with, the methods HRSA used to determine the payment amounts. For example, one nursing home administrator disagreed with the use of QIP to incentivize quality. The administrator stated that most nursing homes continually strive for quality, but that it is harder for facilities with less funding to meet quality benchmarks, which results in ineligibility for payments determined by quality measures and can lead to a cycle of underfunding.

A leader for two nursing homes in our sample said the nursing homes were initially unable to access some PRF funds. The nursing homes were in a chain and had difficulty accessing NHIC payments because the chain was going through bankruptcy and therefore had been deemed ineligible for PRF funds.[r]

HHS and HRSA required nursing homes and other providers to attest to the associated terms and conditions upon receiving payments, but the nursing homes in our sample often did not complete attestations.[s] One leader reported that the attestation process was tedious, required "a lot of clicks," and that sometimes information did not save correctly. The leader added that every payment required separate attestations, which meant completing the same process repeatedly. As noted in footnote i (on page 5), HRSA deemed providers that did not attest to the terms and conditions as having attested if they retained a payment for 90 days.

Nursing homes in our sample used $12 million in PRF payments to address COVID-19-related expenses and lost revenue, and said that the funds were integral to maintaining services during the pandemic

At the time of our review, the sample nursing homes had been required to report to HRSA about the use of approximately $12 million of nearly $15 million in total PRF payments they had received. Nursing home leaders reported gathering input from personnel about facility and staff needs, and using the funds to cover lost revenue, general and administrative expenses, and health care-related expenses. Specific costs

[r] HRSA told us that it later changed its policy so that bankruptcy was no longer a consideration when determining eligibility and paid these facilities during subsequent payment waves.

[s] During CYs 2020 and 2021, the 11 nursing homes in our sample had attested to receiving 49 of 80 PRF payments. The nursing homes had either taken no action or had not yet been required to respond about the remaining payments.

included health care-related equipment and supplies, such as PPE, and staffing. Nursing home leaders reported that use of the funds allowed them to maintain operations, infection control, and resident care during the pandemic.

The 11 nursing homes in our sample received nearly $15 million in total PRF payments

As of December 2021, the 11 nursing homes in our sample had received a total of $14.8 million from general and targeted PRF distributions.[t] Targeted payments included $2.6 million from the SNF distribution and $2.5 million from the NHIC distribution (see Exhibit 6). The nursing homes also received payments from general and other types of distributions.

Exhibit 6: PRF Payments to Nursing Homes*

Distribution	Total Payments Distributed to Nursing Homes Nationally	Total Payments Distributed to Sample Nursing Homes
SNF	$4.8 billion	$2,625,000
NHIC	$4.6 billion	$2,498,150
Other**	$45.3 billion	$9,666,953
Total	**$54.7 billion**	**$14,790,103**

Sources: HRSA, *Past Targeted Distributions*, November 2022, accessed at https://www.hrsa.gov/provider-relief/past-payments/targeted-distribution on Dec. 16, 2022; and OIG analysis of PRF payment data.

* HRSA last reviewed the web page that lists the targeted distribution totals in November 2022 and stated that the totals were current through September 2022. PRF payment data for our sample nursing homes are current through December 2021.

** "Other" includes all other payments to nursing homes (i.e., PRF payments made through distributions that are not SNF and NHIC distributions). HRSA reported to OIG in June 2023 the total amount paid to nursing homes, but does not publicly report total amounts distributed to specific provider types for general distributions. HRSA also does not publicly report total amounts from other PRF distributions—other than the SNF and NHIC distributions—that may have gone to those facilities.

HRSA's methods for determining payment amounts, which were sometimes based on the number of beds in a facility, meant that each nursing home received different general and targeted distribution payment amounts. Additionally, some nursing homes were part of small health centers or health systems that included hospitals and other provider types that were also eligible for other types of targeted distributions. (See Exhibit 7 for the number of nursing homes within each location and associated PRF payments.)

[t] The nursing homes also received an additional $893,300 from the ARP Rural Distribution and the RHCCT and RHCCTM programs. These programs are separate from PRF but are related in that HRSA administered them and included their data alongside PRF.

Exhibit 7: The 11 sample nursing homes in locations selected by the PRAC received nearly $15 million in total PRF payments, including more than $5 million from the SNF and NHIC distributions.

Location Selected by the PRAC	Number of Nursing Homes	Total PRF Payments	Total PRF Payments from SNF and NHIC Distributions
Springfield, MA	1	$919,454	$698,532
Coeur d'Alene, ID	5	$4,572,004	$2,615,091
Sheridan County, NE	3	$4,961,682	$1,099,614
Marion County, GA	1	$504,617	$411,958
White Earth Nation Reservation (MN)	1	$3,832,346	$297,955
Jicarilla Apache Nation Reservation (NM)	-	-	-
Total	**11**	**$14,790,103**	**$5,123,150**

Source: OIG analysis of PRF data.

Sample nursing homes reported that guidance on allowable PRF uses was initially unclear and difficult to use

Nursing home leaders reported that they used HRSA's terms and conditions, emails, and FAQ resources for guidance about what was allowable, but said the guidance was broad and unclear. Although intended by HRSA to be helpful, the broad guidance and allowable uses of funding (i.e., for expenses and lost revenue attributable to COVID-19) made some leaders hesitant to make decisions about how to use funds for fear that they would use the money incorrectly and be forced to pay it back later. One administrator stated, "There wasn't a lot of clear-cut, black and white writing about 'This is what you can spend it on.'" The administrator explained that the nursing home had to purchase things such as extra dumpsters due to increased waste, but worried that such use would "backfire" and that funds would need to be returned. The CEO for a health center that included one of the nursing homes said that sometimes it was even unclear whether payments were for the nursing home or for the hospital. A few leaders reported that guidance about allowable uses improved over time, with one saying allowable uses were not clear until reporting guidance came out in summer 2021, prior to the first reporting deadline.

"It would have been nice to have more knowledge upfront in the terms and conditions to know exactly what we could use it for, instead of the overhanging fear of, 'Are we doing this correctly?'" – Corporate Accountant

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Leaders also reported that the large amount of guidance and information, including frequent updates, was difficult to keep up with, leading to additional uncertainty. One leader said, “It seemed like the guidance changed so often. You weren’t really sure. Maybe you could use it for wages, maybe not. Maybe you could only use it for infection prevention, maybe you couldn’t. That’s where it got really difficult for us.” Although some nursing homes found supplemental information such as FAQs useful, one leader said that the FAQs were difficult to monitor: “Some FAQs would be there, then they would disappear, including questions on costs. It was hard to keep up.”

Leaders sought additional information to clarify guidance but had difficulty obtaining guidance. Some leaders said they used the helpline to seek supplemental guidance but that it was sometimes difficult to reach a helpline operator and that some operators knew little more about PRF than the leaders did. Leaders reported sometimes relying on outside sources such as nursing home or health care associations, consultants, or other experts for clarification about guidance. One corporate leader reported gathering information from multiple sources that was then “cobble[d] together” to determine what was allowable.

Nursing homes reported using PRF payments to address COVID-19-related expenses and lost revenue

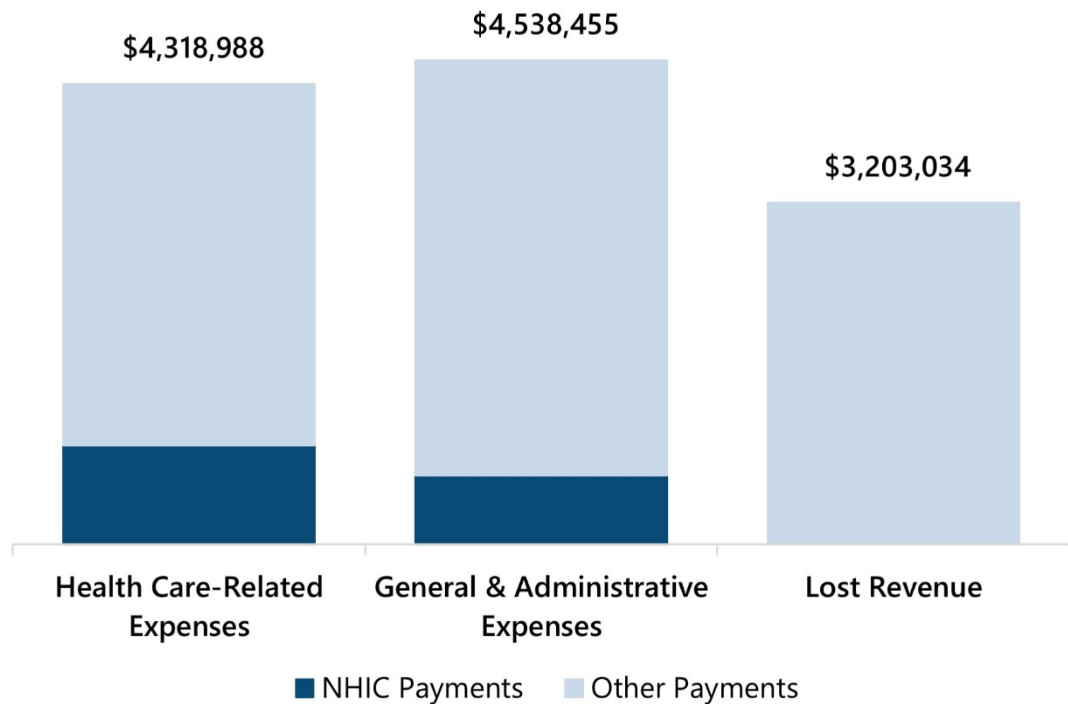
Leaders reported that nursing homes used or returned all funds received during the first two periods.[u, v] Specifically, the 11 nursing homes reported about $12.2 million in total PRF payments, including $4.3 million in payments targeted for nursing homes ($2.6 million in SNF payments and $1.7 million in NHIC payments) and $10,969 in interest earned on PRF payments.

How the 11 nursing homes used funds to respond to the pandemic varied. Four nursing homes used payments they had reported on for lost revenue and for general or health care-related expenses, four used payments only for expenses, and three used payments only for lost revenue. As required, the nursing homes reported use of NHIC payments and all other payments separately. (See Exhibit 8 for a summary of how nursing homes reported using funds.)

[u] At the time we began the virtual site visits, the nursing homes were only required to have used and reported on PRF payments received during the first two periods. For that reason, we included only those two reporting periods in this review.

[v] The nursing homes were required to use and report about the funds within the timeframes defined in Exhibit 3. If the nursing homes had not met the deadlines, they would have been considered out of compliance with PRF terms and conditions, and funds may have been recouped. See HRSA, *Important Dates for Reporting*, May 2023. Accessed at https://www.hrsa.gov/provider-relief/reporting-auditing/important-dates on May 11, 2023.

Exhibit 8: Nursing homes used most of the PRF payments reported on, including NHIC payments, for pandemic-related health care and administrative expenses.



Source: OIG analysis of nursing home reports to HRSA about PRF use.
Notes: "Other Payments" includes reported use of all non-NHIC payments. HRSA required nursing homes to report the use of NHIC payments and all other payments (including SNF payments) separately. The total of all payments in this exhibit does not equal $12.2 million because one nursing home returned an NHIC payment.

Despite initial hesitation over broad guidance, nursing home leaders reported the guidance allowed for discretion in using the funds to meet facility needs. Nursing home leaders said they were conservative in using the funds, especially early on, partly due to fear that they might have been required to return the funds if used incorrectly. One nursing home returned a $97,000 NHIC payment because its leaders did not feel they could use the money appropriately during the given time period. Leaders for other nursing homes described using funds for items that were clearly pandemic-related, such as lost revenue, staffing, PPE, or tests. Some leaders said they later became more comfortable using the funds for broader purposes to address specific needs. For example, one nursing home used PRF to replace facility flooring with flooring material that was easier to disinfect as an infection control measure. Another nursing home reported using PRF to replace its heating, ventilation, and air conditioning system for the same reason.

Nursing homes reported that PRF payments were integral to maintaining services during the pandemic, but that financial challenges were ongoing

Leaders and staff across the nursing homes reported that PRF payments were instrumental in continuing operations and maintaining infection control and quality of care during the pandemic. Corporate leaders noted that the payments provided a "huge financial relief," and had both immediate and longer-term positive effects. Staff in one nursing home explained that their facility was one of the last in their community to experience a COVID-19 case, and that PRF payments played a "big part [in] keeping [COVID-19] out." Leaders and staff also described the long-term, positive effects of the payments, explaining that they helped nursing homes improve infection control practices and better prepare for other emergencies.

Nursing home leaders described how using the funds for specific expense types was beneficial. For example, some said using the money for increased wages and pay bonuses allowed them to retain and support staff who were working in difficult conditions. Leaders also said they expended the money on equipment they would not have otherwise been able to obtain, such as screening, disinfection, and air filtration devices. Finally, leaders and staff said that using the funds for resident care expenses, such as tablets for communicating with family members remotely, helped nursing homes better provide services during the pandemic.

"Things were getting bad and dangerous . . . then this new money showed up that we weren't expecting but allowed us to address things . . . . Thank God this money came through." – CEO, Contracted Management Group

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Sample nursing homes reported that they were unable to fully address ongoing COVID-19-related expenses using PRF. Nursing home leaders said that PRF payments were not sufficient to offset COVID-19-related expenses, some of which were ongoing. One nursing home reported to HRSA that, after the first two payment and use periods, it had hundreds of thousands of dollars remaining in unreimbursed expenses.[w] We conducted interviews with that nursing home in June 2022 after it had received hundreds of thousands of dollars of PRF more than what had been included in the first two reports. At that point, its leaders reported that they had used all the funds received and still had remaining COVID-19-related

[w] HRSA defines "unreimbursed expenses" as expenses that remain unreimbursed after considering all assistance received by HRSA and all other sources. See HRSA, *User Guide: Provider Relief Fund (PRF) Reporting Portal—Reporting*, p. 64, Dec. 30, 2022. Accessed at https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/prf-reporting-portal-user-guide.pdf on Jan. 31, 2023.

costs that had not been reimbursed by PRF. One chief financial officer explained that although PRF payments were adequate for addressing the nursing home's needs at the time received, the nursing home could not have anticipated that expenses for contracted labor and other costs would continue to increase.

Nursing homes in our sample generally complied with PRF reporting requirements but reported that HRSA guidance was difficult to use

HRSA required any nursing home or other provider that received more than $10,000 in PRF payments in the aggregate during a given payment-received period to submit reports about how the funds were used (see page 6). The form required nursing homes to report information specific to PRF payments, including the amount distributed to the recipient during the relevant period, any interest earned on relevant payments, and how those PRF payments were used. Reports required information about remaining unreimbursed expenses, and the financial and clinical care effects of PRF payments. For example, respondents ranked the amount to which they agreed with the statement "The PRF payment(s) had a significant impact on overall operations," with options ranging from "Strongly Agree" to "Strongly Disagree." The form also had fields for identifying the provider and for general information not specific to PRF, such as personnel and patient metrics.

The nursing homes in our sample generally complied with HRSA's reporting requirements, but some misreported or were required to resubmit information

At the time we collected our data, 9 of the 11 nursing homes in our sample had completed reports about how they used PRF funds during the first 2 periods by the required deadline. Two nursing homes, however, initially submitted reports incorrectly and had to resubmit information. During the first reporting period, the corporate office that owned the two nursing homes incorrectly reported use of the facilities' targeted PRF payments at the corporate level rather than at the facility level. To resolve the error, HRSA allowed the nursing homes to resubmit the reports after the deadline had passed.[x]

During our review, we observed that information the nursing homes reported to HRSA was generally supported by underlying facility data and appeared to align with allowable uses of the general and targeted distributions. One nursing home's documentation, however, appeared to show that funds it reported using for general

[x] The two nursing homes that incorrectly reported information during the first period were also the facilities that had difficulty accessing the NHIC payments due to bankruptcy (see page 15). Because of the delay in the NHIC payments, the two nursing homes received no PRF payments during the second period and were therefore not required to submit reports for that period.

and administrative expenses were actually used for lost revenue, which would mean that the facility incorrectly used NHIC payments. Other nursing homes appeared to be unable to support minor items in their reports, such as the use of small amounts of interest earned on PRF payments or small PRF expenses. Another reported use of funds during fiscal quarters not supported by expense-incurred dates on supporting documentation.

Nursing home leaders found that HRSA's reporting guidance was difficult to use and that completing the reports was difficult

Nursing home leaders found that HRSA's reporting guidance, like the guidance on allowable uses, was sometimes difficult to review. An administrator at one nursing home stated that reporting resources were not readily available and that it was difficult to find time to review the material and complete the reports given conflicting obligations. A chief financial officer for a chain supported that sentiment, saying that "a 90- or 100-page manual [is] a perfect example of . . . saying, 'Here's your manual; it's here to help.'" Specific challenges included interpreting nuances about how costs should be applied to PRF payments and classified in the reports, and difficulties defining or calculating lost revenue.

Additionally, leaders for many of the nursing homes reported that tracking their expenses and entering the information into the reporting portal was stressful, time-consuming, and labor intensive. One corporate officer explained that supplemental information, such as personnel metrics, was tedious to enter because each statistic had to be entered manually and separately. Leaders said that the information had to be reported by quarter, which was not explained ahead of time and was difficult to do. An administrator at a nursing home described technical challenges, such as the report website timing out if they stepped away for another task. Leaders for one nursing home stated that PRF reporting amplified the burden of what was already an "incredible" amount of other COVID-19-related data tracking and reporting.

Some nursing homes reported having to seek supplemental guidance from the PRF help desk or from outside organizations or accountants. A leader for one nursing home said trying to get technical support regarding the reporting portal was difficult: "There was not a direct line to people who actually programmed the website. We had to run through the intermediaries assigned to make the payments, and they would determine whether they can answer your question or not, then would transfer you to HHS technical support . . . . It was time consuming."

Some leaders said that reporting challenges were heightened for small or independently owned nursing homes that did not have extra resources to devote to PRF processes. A corporate officer for a regional nursing home chain explained, "As what I would call a small regional operator, I can only imagine the true mom-and-pops trying to . . . maneuver through applying for funds . . . and the reporting . . . . We had resources to manage the process; I'm sure there's a lot of

people who don't." An administrator for a small city-owned nursing home, who was almost solely responsible for managing PRF payments that the facility received, stated, "I'm just dreading [submitting the next report] because it's like a weeklong process for me."

HRSA developed plans to assess nursing home use of PRF but had not yet begun auditing nursing homes at the time we conducted our review

HRSA reported developing processes to review provider reports ongoing and following the reporting periods, using data checks, audits, and evaluations of data. One official reported that, as a first step of review, the PRF reporting system checks information for inconsistencies throughout the report preparation and submittal process. It requires a provider to address any identified errors and attest to accuracy before submitting a report.

We collected information from HRSA about its audit plans in June and July 2022, after the close of two reporting periods. During that time, HRSA officials reported that they had not yet begun auditing nursing homes to assess use of PRF payments and recoup improperly used funds. HRSA officials described the plans for conducting audits. For each reporting period, HRSA planned to select a sample of health care facilities, including nursing homes, to be audited according to a risk-based strategy to verify compliance with the terms and conditions of the program and recoup any inappropriately used funds. In summer 2022, HRSA had not yet determined the number of providers whose reports the agency would audit or assess, but had contracted with several entities to help with the audits and assessments.[y, z]

HRSA officials reported that the agency would also conduct an ongoing analysis of providers' reported spending, seeking to identify trends in how providers spent PRF payments to provide services during the pandemic. One official explained that HRSA plans to highlight the impact of the program on service provision and financial circumstances using data pulled from report fields about the ways in which funds allowed respondents to continue or expand operations.

Agency officials said they felt it was a weakness of the PRF program that it relied largely on self-reported information, rather than on supporting documents or other

[y] In October 2023, HRSA reported to OIG that it was nearing completion of 35 audits of reporting period 1 providers and had initiated 200 additional audits, which included 7 nursing homes, to be completed by the end of the fiscal year 2024.

[z] Any nursing home that spends a total of $750,000 or more in Federal funds, including PRF payments, during a given fiscal year is subject to Single Audit requirements in accordance with 45 CFR 75 Subpart F. In addition to conducting its own PRF audits, HRSA is responsible for resolving single audit findings pertaining to all HRSA programs. For more information, see HRSA, *Audit Requirements*, June 2023. Accessed at https://www.hrsa.gov/provider-relief/reporting-auditing/audit-requirements on June 26, 2023.

evidence, about how funds were used. Officials reported that they considered requiring providers to submit documentation (e.g., receipts) but decided against it because they thought it would be too onerous on providers. The decision to use only self-reported information, however, makes audits and other controls more important.

CONCLUSION AND RECOMMENDATIONS

The COVID-19 pandemic has had a devastating effect on health care providers, including hard-hit nursing homes. To help nursing homes and other health care providers respond to the pandemic, Congress appropriated funding to HHS for PRF. HHS quickly worked with HRSA, other HHS agencies, and other stakeholders to develop PRF and began distributing payments to providers in April 2020.

The nursing homes in our sample reported that the nearly $15 million PRF they received was critical for maintaining services, but many reported challenges throughout the attestation, use, and reporting processes. Leaders also reported that HRSA guidance on allowable uses was unclear and that reporting how they used the funds was difficult. HRSA officials recognized difficulties related to reporting, and had not yet begun auditing the reports at the time we conducted our review.

To address the issues identified in this report and prepare for potential future emergencies, we recommend that HRSA:

Create a document to record lessons learned from managing PRF and submit the document to HHS leadership

To relieve providers from the financial effects of the pandemic, HHS and HRSA had to act quickly to develop the PRF program and begin administering payments. Nursing homes in our sample reported that PRF payments were critical to their operations, but that they sometimes had difficulty interacting with the program. HRSA should record (e.g., in an after-action report or other document) its experiences and lessons learned from its responsibilities in managing PRF. The document will serve as an accounting of HRSA's actions in administering these Federal funds and as a road map for future HHS emergency funding distributions. In developing the document, HRSA should seek feedback from nursing homes and other stakeholder groups, as appropriate, to gain insights about how processes could be improved.

OIG is not prescriptive about the timeframe or the content to include in the document. However, the document should be written while staff with relevant experience are available to contribute. HRSA should consider including lessons learned from our findings, such as potential policy or process improvements for:

- collecting and sharing data across HHS to ensure timely and accurate funding to providers;
- quickly generating, updating, and communicating clear and concise program guidance;

- creating user-friendly reporting portals, which HHS agencies can quickly activate in case of emergencies; and
- developing and enacting program integrity safeguards, such as audits, for recovering improperly used funds.

It is likely that, similar to PRF, responsibility for any future emergency funding distributions to health care providers will be directed by HHS leadership. Following completion, HRSA should submit the document to the HHS Office of the Secretary.

Expedite audits of provider use of PRF payments

As of mid-2023, HRSA was nearing completion of its initial audits. However, when we conducted our data collection in mid-2022, after two reporting periods had passed, the agency and its contractors had not yet begun auditing provider reports to assess use. The automatic checks for inconsistencies and other efforts to pre-emptively address issues in PRF reports likely helped ensure that the reports were complete, but further assessment is necessary to provide proper oversight and safeguard Federal dollars. As such, HRSA should work with urgency to assess appropriateness of PRF use. Moving forward, the agency should work to select its samples and conduct audits sooner after reporting period completion. Doing so will help ensure that improperly used funds are recovered.

AGENCY COMMENTS AND OIG RESPONSE

HRSA provided both technical and formal comments to our draft report. We have, where appropriate, added additional context from the technical comments to this report. In its formal comments, HRSA concurred with one recommendation and did not concur with the other.

HRSA did not concur with our first recommendation, which was originally for it to create an after-action report about lessons learned from managing PRF and submit the report to HHS leadership. HRSA stated that it is unable to produce an after-action report due to resource constraints. OIG continues to recommend that HRSA produce a document recording its lessons learned from managing PRF and submit the document to HHS leadership. To note, OIG is not prescriptive about the timeframe or the content to include in the document. We revised the recommendation to make this clear and to no longer specify that the document be an after-action report.

HRSA concurred with our second recommendation, which was for it to expedite audits of provider use of PRF payments. HRSA reported that the agency is prioritizing its remaining resources to expedite those audits. HRSA stated that it has defined an audit sample for the first five reporting periods, and will complete those audits over the next 12 months. HRSA also stated that it will initiate additional audits as the remaining reporting periods close.

For the full text of HRSA's comments, see the Agency Comments appendix at the end of the report.

APPENDIX

Agency Comments

Following this page are the official comments from HRSA.

HRSA
Health Resources & Services Administration

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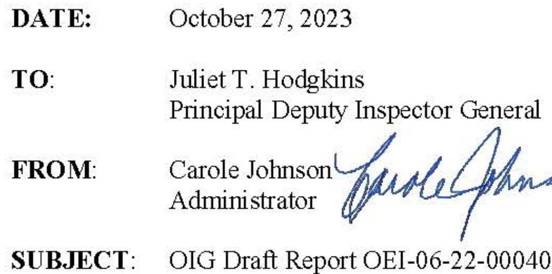
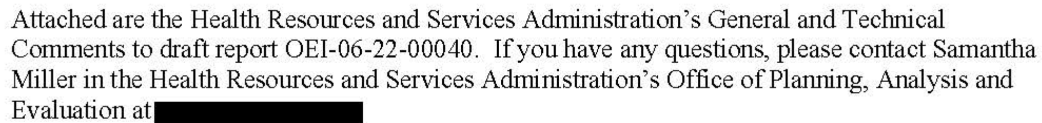

DATE: October 27, 2023

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Carole Johnson
Administrator

SUBJECT: OIG Draft Report OEI-06-22-00040


Attached are the Health Resources and Services Administration's General and Technical Comments to draft report OEI-06-22-00040. If you have any questions, please contact Samantha Miller in the Health Resources and Services Administration's Office of Planning, Analysis and Evaluation at [redacted]

Attachments

Health Resources and Services Administration
www.hrsa.gov

GENERAL COMMENTS FROM THE HEALTH RESOURCES AND SERVICES ADMINISTRATION ON THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' OFFICE OF INSPECTOR GENERAL DRAFT REPORT OEI-06-22-00040

Office of Inspector General (OIG) Recommendation

OIG recommended creating an after-action report about lessons learned from managing the Provider Relief Fund (PRF) and submitting the report to Department of Health and Human Services leadership.

Health Resources and Services Administration (HRSA) Response

While HRSA appreciates the intent of the recommendation, the Fiscal Responsibility Act of 2023 recission of program funds has dramatically limited HRSA's resources, and the agency is dedicating every available remaining administrative dollar to the critical program integrity work of oversight and appropriate recovery of payments. Therefore, the agency must non-concur.

OIG Recommendation

OIG recommended expediting audits of provider use of PRF payments.

HRSA Response

HRSA concurs and is prioritizing its remaining resources to expedite audits of providers' use of PRF payments. HRSA has a defined audit sample for the first five reporting periods that will be completed over the next 12 months. As the remaining reporting periods close, additional audits will be initiated.

Page 1 of 1

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Savanna Thielbar served as the team leader for this study. Others in the Office of Evaluation and Inspections Dallas Regional Office who conducted the study include Sarah Lee, Emma Steyaert, and John Van Der Schans. Office of Evaluation and Inspections headquarters staff who provided support include Chris Galvin, Althea Hosein, and Michael Novello.

We would also like to acknowledge the contributions of other Office of Inspector General staff, including Mandy Brooks, Miranda Fanning, Logan Kingma, Karen Lowe, and Jennifer Wagner.

This report was prepared under the direction of Petra Nealy, Regional Inspector General for Evaluation and Inspections in the Dallas Regional Office, and Marshall Allen, Assistant Regional Inspector General.

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ABOUT THE OFFICE OF INSPECTOR GENERAL

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

ENDNOTES

[1] Government Accountability Office (GAO), *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic*, GAO-20-576R, May 20, 2020.

[2] Lauren Weber, "Nursing Homes Keep Losing Workers," *The Wall Street Journal*, Aug. 25, 2021. Accessed at https://www.wsj.com/articles/nursing-homes-keep-losing-workers-11629898200 on Jan. 30, 2023.

[3] *COVID-19 Had a Devastating Impact on Medicare Beneficiaries in Nursing Homes During 2020* (OEI-02-20-00490), June 22, 2021.

[4] The $178 billion was appropriated across multiple pieces of legislation. See Coronavirus Aid, Relief, and Economic Security (CARES) Act, P.L. No. 116-136, Division B, Title VIII, (Mar. 27, 2020); Protection Program and Health Care Enhancement (PPPHCE) Act, P.L. No. 116-139, Division B, Title I (Apr. 24, 2020); and Consolidated Appropriations Act, 2021, P.L. No. 116-260, Division M, Title III (Dec. 27, 2020).

[5] For more information about HRSA's administration of PRF, see HRSA, *About*. Accessed at https://www.hrsa.gov/provider-relief/about/ on Jan. 31, 2023. For more information about related programs, see footnotes e and f on page 4 of this report.

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[13] *More Than a Thousand Nursing Homes Reached Infection Rates of 75 Percent or More in the First year of the COVID-19 Pandemic; Better Protections Are Needed for Future Emergencies* (OEI-02-20-00491), Jan. 19, 2023.

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[16] AHCA and NCAL press release, "Survey: 94 Percent of Nursing Homes Face Staffing Shortages," June 23, 2021. Accessed at https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Survey-94-Percent-of-Nursing-Homes-Face-Staffing-Shortages.aspx on Jan. 30, 2023.

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[19] HRSA publicly reports amounts distributed through each PRF distribution, which total $136.6 billion. See HRSA, *Past General Distributions*, November 2022, accessed at https://www.hrsa.gov/provider-relief/payments-and-data/past-payments/general-distribution on Dec. 16, 2022; HRSA, *Phase 4 and ARP Rural Distributions*, September 2023, accessed at https://www.hrsa.gov/provider-relief/payments-and-data/phase4-arp on Sept. 18, 2023; and HRSA, *Past Targeted Distributions*, November 2022, accessed at https://www.hrsa.gov/provider-relief/payments-and-data/past-payments/targeted-distribution on Dec. 16, 2022.

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