Department of Health and Human Services
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June 2025 | A-05-22-00012

Ten of Thirty Selected Nursing Facilities Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments

REPORT HIGHLIGHTS

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Ten of Thirty Selected Nursing Facilities Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments

Why OIG Did This Audit

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

What OIG Found

- Of the 30 selected nursing facilities we reviewed, 8 nursing facilities used $2.3 million in PRF payments for unallowable expenditures or lost revenues, and 3 nursing facilities used $333,000 in PRF payments for expenditures that may not have been allowable. These nursing facilities (10, including 1 nursing facility that had more than 1 deficiency) received a total of $178 million in PRF payments. The remaining nursing facilities used PRF payments for allowable expenditures and lost revenues.
- These deficiencies occurred because although nursing facilities attested to the PRF terms and conditions and HRSA provided continuously updated guidance to PRF recipients, the nursing facilities did not always maintain documentation to support reported expenditures, may have misinterpreted HRSA's guidance, made clerical errors, or did not effectively track expenses funded by PRF payments.

What OIG Recommends

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

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INTRODUCTION

WHY WE DID THIS AUDIT

On March 13, 2020, the President declared the COVID-19 outbreak a national emergency. In response, Congress passed three bills, which the President signed into law. These Federal laws appropriated to the Department of Health and Human Services (HHS) a combined $178 billion in funds, which HHS used to establish the Provider Relief Fund (PRF).[1] The PRF provided payments to eligible hospitals and other health care providers (collectively referred to as "providers") for: (1) health care-related expenses or lost revenue (e.g., due to canceled elective services) attributable to COVID-19, (2) COVID-19 testing and treatment for uninsured individuals, and (3) the administration of vaccines. HHS distributed PRF funds, in part, as direct payments to providers in a series of PRF General and Targeted Distributions.[2] As of October 2024, the Health Resources and Services Administration (HRSA) had distributed $145.9 billion of the PRF to providers.[3]

This audit assessed selected nursing facilities' compliance with terms and conditions and Federal requirements for expending PRF payments. It is one of several Office of Inspector General (OIG) audits of various aspects of PRF payments, including: (1) HHS's and HRSA's controls related to the requirements for submitting revenue information and attesting to the acceptance or rejection of PRF payments, (2) HHS's and HRSA's controls over PRF payment calculations and provider eligibility determinations, and (3) claims for COVID-19 testing and treatment services for uninsured individuals. See Appendix B for a list of related OIG reports.

OBJECTIVE

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

[1] Specifically, the Coronavirus Aid, Relief, and Economic Security Act, P.L. No. 116-136, signed into law on Mar. 27, 2020, appropriated $100 billion; the Paycheck Protection Program and Health Care Enhancement Act, P.L. No. 116-139, signed into law on Apr. 24, 2020, appropriated $75 billion; and the Consolidated Appropriations Act, 2021, P.L. No. 116-260, signed into law on Dec. 27, 2020, appropriated $3 billion.

[2] Under the General Distributions, PRF payments were distributed in four phases (Phases 1, 2, 3, and 4). For example, under the Phase 1 General Distribution, PRF payments were distributed to eligible Medicare providers that billed Medicare fee-for-service (Medicare Parts A or B) in calendar year (CY) 2019. Under the Targeted Distributions, PRF payments were made to eligible providers or specific provider types to address added COVID-19 challenges, such as high-need populations, including nursing facilities and providers serving individuals in rural areas and safety net hospitals.

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

BACKGROUND

The Provider Relief Fund

As a result of the COVID-19 public health emergency, many States ordered health care facilities, physicians, and other providers and professionals to delay elective or nonurgent procedures to conserve personal protective equipment (PPE) and free up staff and facilities for COVID-19 patients.[4] Nursing facilities subsequently experienced decreased admissions in addition to increased costs (e.g., for staffing, PPE and other supplies, routine testing, and other expenses). Nursing facilities and their residents were among the hardest hit by the COVID-19 pandemic, due in part to the residents' advanced age and underlying medical conditions, close living quarters, and nursing facilities' longstanding staffing and infection control challenges.[5, 6] During COVID-19 surges in the spring and fall of 2020, more than 1,300 nursing facilities had infection rates of 75 percent or more among residents enrolled in Medicare.[7]

In response to the public health emergency, the PRF was established to provide funds to eligible providers for health care-related expenses or lost revenue attributable to COVID-19.[8] HHS received a combined $178 billion in funding, of which $145.9 billion was distributed via PRF payments to providers.[9] PRF funds were distributed as direct payments to providers in a series of General and Targeted Distributions.

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

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

[5] Government Accountability Office (GAO), *COVID-19 in Nursing Homes: Most Homes Had Multiple Outbreaks and Weeks of Sustained Transmission from May 2020 through January 2021* (GAO-21-367). Accessed on Apr. 2, 2025.

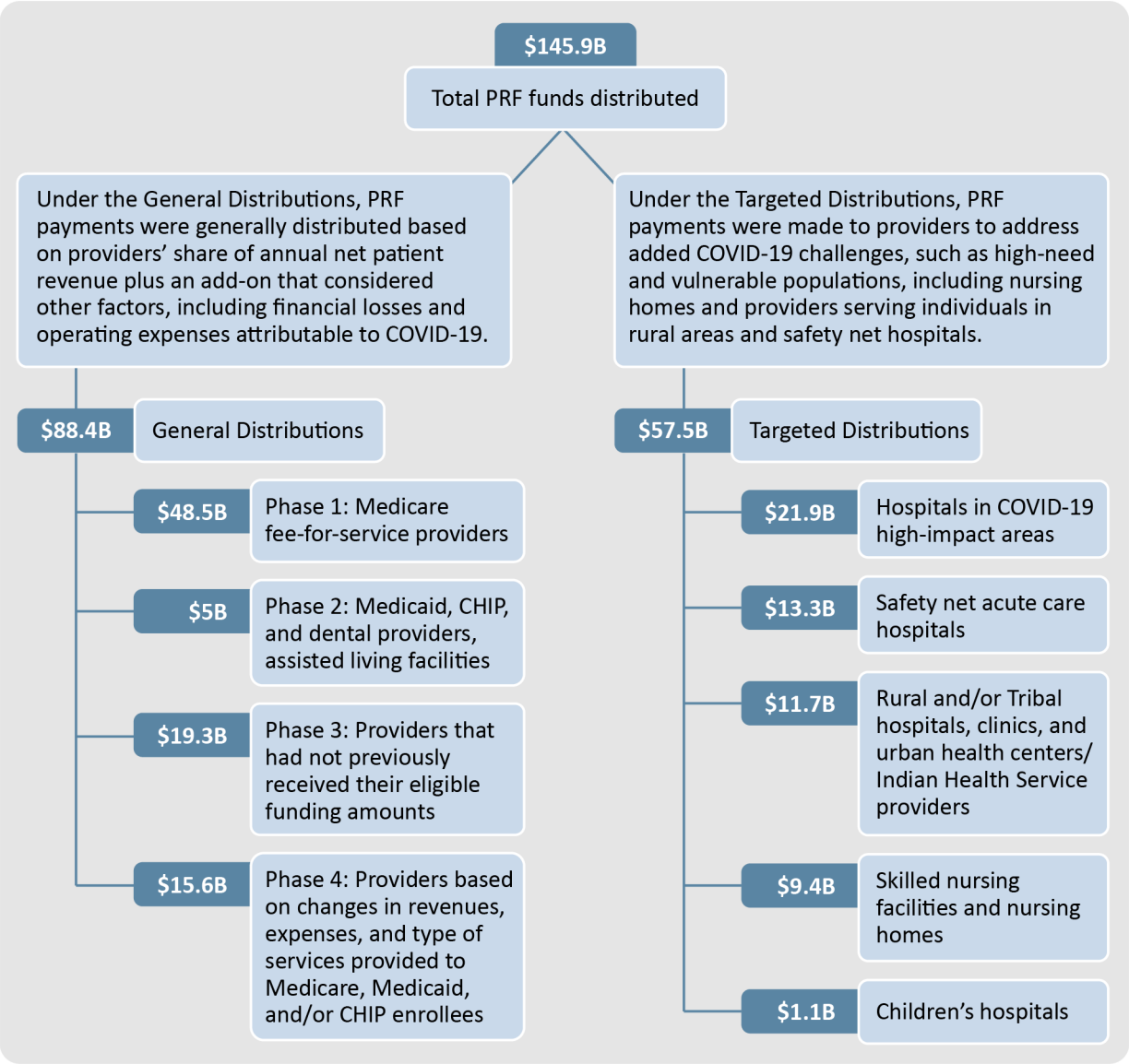
[6] GAO, *COVID-19: Federal Efforts Could Be Strengthened by Timely and Concerted Actions* (GAO-20-701). Accessed on Apr. 2, 2025.

[7] OIG, *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.

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

[9] Congress also appropriated $8.5 billion of COVID-19-related relief for rural providers enrolled in Medicare or Medicaid programs (American Rescue Plan Act of 2021, P.L. No. 117-2). This funding was administered by HRSA and had similar limitations and requirements as the PRF but was not part of the PRF.

Exhibit: Provider Relief Fund Distributions to Health Care Providers



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

HHS's and HRSA's Oversight of the Provider Relief Fund Program

The HHS Office of the Secretary was responsible for initial PRF program oversight and policy decisions. The HHS Office of the Secretary's direct responsibility for the PRF allowed HHS to meet its mission to expedite the establishment of the PRF and the distribution of funds as quickly as possible for providers' health care-related expenses or lost revenues attributable to

COVID-19. Within HHS, HRSA was responsible for providing day-to-day oversight and managed all aspects of the PRF program.[10]

HRSA provided various resources to providers on the proper use and reporting of PRF payments, including issuing a collection of evolving Frequently Asked Questions (FAQs), and other guidance on allowable expenses and lost revenues calculations.[11] HRSA also conducted technical assistance webinars on the reporting process. In addition, HRSA engaged external audit firms to conduct risk-based audits for a sample of providers to ensure that providers used PRF payments in accordance with PRF terms and conditions.

Requirements for Nursing Facilities That Received Provider Relief Fund Payments

Providers, including nursing facilities, may have been eligible to receive PRF payments from multiple distributions.[12] For example, nursing facilities may have received PRF payments through the following distributions:

- Skilled Nursing Facilities (SNFs) Targeted Distribution[13] and

- Nursing Home Infection Control (NHIC) Targeted Distribution that included: (1) direct payments to SNFs and nursing homes to build skills and enhance response to COVID-19, including improved infection controls,[14] and (2) an incentive payment structure called

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

[11] HRSA, "Provider Relief Programs: Provider Relief Fund and ARP Rural Payments Frequently Asked Questions" (PRF FAQs). Accessed on Apr. 2, 2025. HRSA, "Provider Relief Fund Distributions and American Rescue Plan Rural Distribution Post-Payment Notice of Reporting Requirements" (PRF Reporting Requirements). Accessed on Apr. 2, 2025.

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

[13] SNFs that were certified under Medicare, Medicaid, or both and had at least six certified beds were deemed eligible to receive a Targeted SNF Distribution that included a fixed distribution per facility of $50,000 plus distribution of $2,500 per bed.

the Quality Incentive Payment Program that provided more funding to nursing homes and SNFs based on certain performance measures.

Nursing facilities could have also received payments from the General and other Targeted Distributions.[15]

Throughout the report, we refer to:

- a SNF Targeted Distribution as a "SNF Distribution";
- an NHIC Targeted Distribution as an "NHIC Distribution"; and
- General and non-NHIC Targeted Distributions, including the SNF Distribution, as "non-NHIC Distributions."[16]

We refer to all General and Targeted Distributions together as "PRF payments."

Nursing facilities that received and kept PRF payments had to comply with certain provisions of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR part 75). Specifically, the nursing facilities had to comply with 45 CFR § 75.302 (Financial management and standards for financial management systems) and 45 CFR §§ 75.361 through 75.365 (Record retention and access).

As a condition of receiving and retaining PRF payments, nursing facilities were required to attest to the relevant PRF terms and conditions, including meeting eligibility criteria; filing expenditure reports; and ensuring that payments were: (1) not used to reimburse expenses or losses already reimbursed from other funding sources and (2) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities (e.g., lobbying).[17]

[14] Nursing homes and SNFs that were not revoked (i.e., the Centers for Medicare & Medicaid Services [CMS] did not revoke Medicare enrollment of a provider for reasons such as noncompliance with enrollment requirements, provider or supplier conduct, and others) had an active CMS certification, and had at least six certified beds were deemed eligible to receive a Targeted NHIC Distribution that included a fixed distribution per facility of $10,000 plus distribution of $1,450 per bed.

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

[16] The terms and conditions for the NHIC Distribution differ from those for the non-NHIC Distribution. Therefore, throughout the report we distinguish between the NHIC Distribution and the non-NHIC Distribution.

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

The terms and conditions for the non-NHIC Distribution required providers to certify that payments were: (1) used to prevent, prepare for, or respond to COVID-19 and (2) used for health care-related expenses or lost revenues (i.e., patient care revenues) attributable to COVID-19.[18]

The terms and conditions for the NHIC Distribution required providers to attest that the payments would be used for infection control expenses associated with the following items and services: (1) administering COVID-19 testing; (2) reporting COVID-19 results to local, State, and Federal governments; (3) hiring staff to provide patient care or administrative support; (4) improving infection controls; and (5) providing additional services to residents (e.g., technology that permits residents to connect with their families if the families are unable to visit in person).

Provider Relief Fund Expenditures and Lost Revenues

For reporting purposes, HRSA established periods during which providers were required to use and report on PRF payments.[19] Providers, including nursing facilities, were required to report on their use of PRF payments in broad categories (i.e., lost revenues, health care-related expenses, or general and administrative expenses). For expenses, nursing facilities were required to report their use of PRF payments for health care-related expenses (e.g., expenses for purchasing equipment such as ventilators and sanitizing supplies for infection control) and general and administrative expenses (e.g., salaries, utilities, rent), including expenses incurred prior to receipt of PRF payments (i.e., pre-award costs dated back to January 1, 2020).[20] Nursing facilities were also required to use NHIC Distribution payments for costs associated with infection control expenses. Nursing facilities were required to follow their basis of accounting (cash or accrual basis) to determine expenses and only use PRF payments for eligible expenses or lost revenues during what is known as the period of availability.[21]

For lost revenues, nursing facilities could apply their non-NHIC Distribution payments toward lost revenue amounts during a period of availability calculated using one of the following three options:

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

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

[20] HRSA, PRF Reporting Requirements.

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

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

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

3. any reasonable method of estimating revenues.[22]

Nursing facilities were not allowed to use NHIC Distribution payments to offset lost revenues.[23]

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

HOW WE CONDUCTED THIS AUDIT

Our audit covered $291 million in non-NHIC Distribution payments and related interest and $94 million in NHIC Distribution payments and related interest to a nonstatistical sample of 30 nursing facility taxpayer identification numbers (TINs) during calendar year (CY) 2020.[24] (We refer to these sample units throughout the report as "nursing facilities.")[25] The selected nursing facilities reported that they used $160 million of their PRF payments for health care-related expenses, $116 million to offset lost revenues, and $95 million for general and administrative expenses. The remaining $14 million was returned to HRSA because nursing facilities did not

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

[23] HRSA, "Nursing Home Infection Control Distribution." Accessed on Apr. 2, 2025.

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

[25] The sampling frame consisted of 12,927 nursing facilities that: (1) received and kept SNF Distribution payments, NHIC Distribution payments, or both and (2) were not covered by any HHS-OIG, HRSA, or Pandemic Response Accountability Committee (PRAC) projects. The total PRF payments (General and Targeted Distributions) to these TINs was $23.6 billion. PRF payment recipients had 90 days (or 45 days for Targeted SNF Distributions) to return a payment to HHS, otherwise the recipient was deemed to have accepted the terms and conditions. Our sample included nursing facilities that received PRF payments issued in CY 2020 and for which nursing facilities attested to the payment terms and conditions or were deemed to have accepted the terms and conditions.

use these payments.[26] Appendix E contains details on how the selected nursing facilities used PRF payments issued in CY 2020.

We selected nursing facilities that received and kept SNF Distribution payments in period 1 and NHIC Distribution payments in period 2.[27] We selected nursing facilities based on an analysis that considered the total amount of SNF and NHIC Distribution payments received and kept along with geographic location (urban and rural areas in various States).[28] We reviewed the nursing facilities' PRF payments used to offset lost patient care revenues or cover general and administrative and health care-related expenses. Specifically, for each of the selected nursing facilities that reported expenditures, we reviewed a nonstatistical sample of expenses that we selected based on materiality and expense descriptions (e.g., salaries, supplies, equipment). For the selected nursing facilities that reported lost revenues, we reviewed the nursing facilities' lost revenues calculations.[29]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology.

FINDINGS

Of the 30 selected nursing facilities, 20 used the funds for allowable general and administrative and health care-related expenditures, for infection controls expenses, and to offset lost revenues attributable to COVID-19. However, the remaining 10 nursing facilities did not comply or may not have complied with Federal requirements. Specifically, eight nursing facilities used PRF payments for unallowable expenditures or lost revenues. In addition, three nursing

[26] Nursing facilities reported these amounts on expenditure reports submitted to HRSA for reporting periods 1 and 2.

[27] To select nursing facilities for the audit, we only considered direct NHIC payments because not all nursing facilities received quality incentive payments.

[28] Our sample unit was a nursing facility that reported the use of PRF payments. Each sampled nursing facility could be a stand-alone nursing facility or part of a parent-subsidiary system that may include a parent company and various provider types (e.g., hospitals, clinics, urgent care facilities, and physician groups). The 30 selected nursing facilities each received PRF payments from $558,000 to $133 million during CY 2020 and are located in 23 States. Appendix F contains details on the sampled nursing facilities.

[29] Of the 30 selected nursing facilities, 25 nursing facilities reported both expenses and lost revenues, and 5 nursing facilities reported only expenses.

facilities may have used PRF payments for unallowable expenditures.[30] These deficiencies occurred because although nursing facilities attested to the PRF terms and conditions and HRSA provided continuously updated guidance to PRF recipients, the nursing facilities did not always maintain documentation to support reported expenditures, may have misinterpreted HRSA's guidance, made clerical errors, or did not effectively track expenses funded by PRF payments.

As a result of these deficiencies, 8 of the 30 selected nursing facilities used a total of $2,256,504 in PRF payments for unallowable expenditures and lost revenues. In addition, three nursing facilities used a total of $332,562 in PRF payments for expenditures that may not have been allowable. These funds could have been used to offset allowable lost revenues or to support other activities related to the COVID-19 public health emergency, including preventing, preparing for, and responding to COVID-19, as well as improving infection controls.

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

SOME NURSING FACILITIES USED PROVIDER RELIEF FUND PAYMENTS FOR UNALLOWABLE EXPENDITURES AND LOST REVENUES

Unallowable Costs

As a condition of receiving and retaining PRF payments, nursing facilities were required to attest to the relevant PRF terms and conditions, including meeting eligibility criteria; filing expenditure reports; and ensuring that payments were: (1) not used to reimburse expenses or losses already reimbursed from other funding sources and (2) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities (e.g., lobbying).

The terms and conditions for the non-NHIC Distribution required providers to certify that payments were: (1) used to prevent, prepare for, or respond to COVID-19 and (2) used for health care-related expenses or lost revenues (i.e., patient care revenues) attributable to COVID-19.

The terms and conditions for the NHIC Distribution required providers to attest that the payments would be used for infection control expenses associated with the following items and services: (1) administering COVID-19 testing; (2) reporting COVID-19 results to local, State, and Federal governments; (3) hiring staff to provide patient care or administrative support; (4) improving infection controls; and (5) providing additional services to residents (e.g., technology that permits residents to connect with their families if the families are unable to visit in person).

[30] Some nursing facilities had more than one deficiency. As a result, the total number of nursing facilities that used or may not have used PRF payments for unallowable or unsupported expenditures or lost revenues does not add up to 10.

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

Six sampled nursing facilities used $849,443 in PRF payments for the following unallowable expenditures:[31]

- Three nursing facilities used PRF payments to cover duplicate health care-related expenses of $29,328.

- One nursing facility used non-NHIC Distribution payments for legal expenditures totaling $386,743 due to civil and administrative proceedings against the facility. These expenditures were not attributable to COVID-19. The nursing facility stated that HRSA's regulations and guidance did not specifically address legal expenditures due to civil and administrative proceedings against the facility.

- One nursing facility used non-NHIC Distribution payments totaling $289,657 for expenditures that were reimbursed from other sources. The nursing facility explained that it failed to remove expenditures covered by other grants from its PRF expenditure tracking sheet.

- One nursing facility used non-NHIC Distribution payments for an employee's salary expense that exceeded the CY 2020 Executive Level II salary threshold by $91,076.

- One nursing facility reported PRF payments of $37,592 that exceeded actual expenses.

- One nursing facility used non-NHIC Distribution payments for landscaping expenditures of $15,047. The nursing facility explained that due to COVID-19, they did not have anyone to maintain a lot adjacent to their facility. These expenditures were not attributable to COVID-19.

Costs Not Adequately Supported

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

[31] Some nursing facilities had more than one finding. As a result, the total number of nursing facilities that used PRF payments for unallowable expenditures does not add up to six.

documentation (45 CFR §§ 75.302(b)(2) and (3)).

Two sampled nursing facilities did not maintain sufficient records that supported reported health care-related expenditures totaling $693,355. Specifically, the nursing facilities did not maintain invoices, proof of payment (e.g., bank statements or canceled checks), or both to support these expenditures.

Unallowable Use of Nursing Home Infection Control Provider Relief Fund Payments

The NHIC Distribution terms and conditions did not allow nursing facilities to use NHIC Distribution payments to offset lost revenues.

One sampled nursing facility used $517,214 in NHIC Distribution payments to offset lost revenues and reported the lost revenues as a facilities expense in its PRF report. The entity explained that this was an oversight error in the data entry during the PRF reporting process.

Inaccurate Lost Revenue Calculation

Non-NHIC Distribution payment amounts not fully expended on health care-related expenses attributable to COVID-19 may be applied to lost revenues. Lost revenues can be calculated by one of three options, including comparing budgeted patient care revenues to actual patient care revenues during CYs 2020 and 2021 (option 2).[32] Only nursing facilities that had a budget that covered the entire period of availability and was approved prior to March 27, 2020, could choose option 2 to calculate lost revenues.

One sampled nursing facility used option 2 to calculate lost revenues, but the facility did not have a CY 2021 budget approved prior to March 27, 2020, for calculating its lost revenues for CY 2021.[33] The nursing facility explained they did not use another option for calculating lost revenues due to an error. As a result, the nursing facility used $196,492 in non-NHIC Distribution payments to offset inaccurately calculated lost revenues.

SOME NURSING FACILITIES MAY HAVE USED PROVIDER RELIEF FUND PAYMENTS FOR UNALLOWABLE EXPENDITURES

As a condition of receiving non-NHIC Distribution payments, nursing facilities agreed to ensure that payments were used for purposes related to COVID-19. One of the allowable uses of non-

[32] See Appendix D for a detailed description of how providers could choose to calculate lost revenues.

[33] OIG reviewed the expenditure reports the nursing facility submitted to HRSA for reporting periods 1 and 2. The expenditure reports indicated that option 2 was selected to account for lost revenues. OIG did not attempt to determine whether any other option would be more reasonable to account for lost revenues incurred by the nursing facility during our audit period.

NHIC Distribution payments was for mortgage and rent expenses defined by HRSA as rent for a clinical setting, medical office building, and so forth.[34]

As a condition of receiving NHIC Distribution payments, nursing facilities agreed to ensure that payments were used for infection control expenses. One of the allowable uses of NHIC Distribution payments was for mortgage and rent expense defined by HRSA as a payment related to mortgage or rent for a facility specifically for infection control.[35]

The PRF recipient's records must identify the source and application of funds for federally funded activities and be supported by source documentation (45 CFR §§ 75.302(b)(2) and (3)).

Three sampled nursing facilities used PRF payments for mortgage and rent expenditures. The nursing facilities incurred the mortgage and rent expenditures before the pandemic, and these expenditures did not increase during the pandemic. Though the nursing facilities explained that they modified or used a certain percentage of the building space for COVID-19- or infection control-related needs, the nursing facilities were unable to provide documentation supporting the utilization of the building space. The nursing facilities used PRF payments to cover their entire monthly mortgage and rent expenditures. As a result, we were unable to determine whether $332,562 in PRF payments were used for the allowable mortgage and rent expenditures.

CAUSES FOR UNALLOWABLE AND POTENTIALLY UNALLOWABLE EXPENDITURES AND UNALLOWABLE LOST REVENUES

These deficiencies occurred because although nursing facilities attested to the PRF terms and conditions and HRSA provided continuously updated guidance to PRF recipients, the nursing facilities did not always maintain documentation to support reported expenditures, may have misinterpreted HRSA's guidance, made clerical errors, or did not effectively track expenses funded by PRF payments.

Further, in the context of extraordinary challenges from the COVID-19 public health emergency, HRSA's operational objective at the beginning of the public health emergency was to rapidly disburse PRF payments to support providers facing severe economic hardship. According to the nursing facilities, HRSA's guidance was frequently updated and was not always clear. Consequently, nursing facilities faced difficulties tracking allowable expenditures, reporting expenditures and lost revenues with the required level of detail, and correcting expenditure reports in the PRF Reporting Portal.

In addition to the recommendations below, key stakeholders and decisionmakers should use the information included in this report when determining lessons learned from administering

[34] HRSA, "Allowable Expenses." Accessed on Apr. 2, 2025.

[35] HRSA, "Nursing Home Infection Control Distribution." Accessed on Apr. 2, 2025.

PRF distributions during the COVID-19 public health emergency and look for additional ways to safeguard Federal funds when rapidly disbursing assistance payments to providers in response to future public health emergencies.

RECOMMENDATIONS

We recommend that the Health Resources and Services Administration:

- require the eight nursing facilities that we determined as having used PRF payments for unallowable expenditures and lost revenues totaling $2,256,504 to return the unallowable amounts to the Federal Government or ensure that the nursing facilities properly replace the unallowable expenditures and lost revenues with allowable unreimbursed lost revenues or eligible expenses, if any, and

- work with the three nursing facilities that we determined as having used PRF payments for potentially unallowable expenditures totaling $332,562 to identify and return the unallowable amounts to the Federal Government or ensure that the nursing facilities properly replace the unallowable expenditures with allowable unreimbursed lost revenues or eligible expenses, if any.

HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS

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

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We identified 12,927 nursing facilities that: (1) received and kept SNF Distribution payments, NHIC distribution payments, or both during CY 2020 and (2) were not covered by any HHS-OIG, HRSA, or PRAC projects.[36] The PRF payments to these nursing facilities totaled $23.6 billion. We selected for audit a nonstatistical sample of 30 nursing facilities that received and kept $291 million in non-NHIC Distribution payments and related interest in period 1 and $94 million in NHIC Distribution payments and related interest in period 2.[37] We selected nursing facilities based on a risk analysis that considered the total amount of SNF and NHIC Distribution payments received and kept along with geographic location (urban and rural areas in various States).[38, 39] We reviewed the selected nursing facilities' use of PRF payments received from non-NHIC and NHIC Distributions.

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

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

We conducted our audit from May 2022 through December 2024.

[36] The Coronavirus Aid, Relief, and Economic Security Act created the PRAC within the Council of the Inspectors General on Integrity and Efficiency to promote transparency and conduct and support oversight of covered funds and the COVID-19 response to: (1) prevent and detect fraud, waste, abuse, and mismanagement and (2) mitigate major risks that cut across program and agency boundaries.

[37] PRF payment recipients had 90 days (or 45 days for Targeted SNF Distributions) to return a payment to HHS; otherwise, the recipient was deemed to have accepted the terms and conditions. Our sample included nursing facilities that received both SNF and NHIC Distribution payments issued in CY 2020 for which nursing facilities attested to the payment terms and conditions or were deemed to have accepted the terms and conditions.

[38] To select nursing facilities for the audit, we only considered direct NHIC payments because not all nursing facilities received quality incentive payments.

[39] We also analyzed the attestation status during the sample selection process.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance, including the PRF terms and conditions and HRSA's FAQs related to providers' use of PRF payments;

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

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

- obtained PRF payments data for General and Targeted Distributions to nursing facilities in CY 2020;

- compiled a list of 12,927 nursing facilities that received and kept SNF Distribution payments, NHIC Distribution payments, or both in CY 2020 and were not covered by any HHS-OIG, HRSA, or PRAC projects;

- selected a nonstatistical sample of 30 nursing facilities (that received and kept SNF Distribution payments in period 1 and NHIC Distribution payments in period 2) based on the total amount of SNF and NHIC Distribution payments received and geographic locations (urban and rural areas in various States);[40, 41]

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

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

    - non-NHIC Distribution payments were used for health care-related or general and administrative expenses or were applied to offset eligible lost revenues attributable to COVID-19, and whether the amount for any lost revenues applied toward PRF payments was accurately calculated;[42]

[40] To select nursing facilities for the audit, we only considered direct NHIC payments because not all nursing facilities received quality incentive payments.

[41] We also analyzed the attestation status during the sample selection process.

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

- NHIC Distribution payments were used only for infection control expenses;

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

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

- discussed the results of our audit with HRSA officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Selected Home Health Agencies Complied With Terms and Conditions and Federal Requirements for Provider Relief Fund Payments	A-01-22-00503	11/26/2024
Seven of Thirty Hospices Reviewed Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Provider Relief Fund Payments	A-02-22-01014	11/8/2024
HRSA Made Some Potential Overpayments to Providers Under the Phase 2 General Distribution of the Provider Relief Fund Program	A-09-22-06001	3/4/2024
The Provider Relief Fund Helped Select Nursing Homes Maintain Services During the COVID 19 Pandemic, but Some Found Guidance Difficult To Use	OEI-06-22-00040	12/12/2023
HHS's Oversight of Automatic Provider Relief Fund Payments Was Generally Effective But Improvements Could Be Made	A-02-20-01025	10/30/2023
HRSA Made COVID-19 Uninsured Program Payments to Providers on Behalf of Individuals Who Had Health Insurance Coverage and for Services Unrelated to COVID-19	A-02-21-01013	7/13/2023
Targeted Provider Relief Funds Allocated to Hospitals Had Some Differences With Respect to the Ethnicity and Race of Populations Served	OEI-05-20-00580	7/12/2023
HHS's and HRSA's Controls Related to Selected Provider Relief Fund Program Requirements Could Be Improved	A-09-21-06001	9/26/2022

APPENDIX C: PROVIDER RELIEF FUND GENERAL AND TARGETED DISTRIBUTION PAYMENTS

As of October 2024, HRSA distributed $145.9 billion of the $178 billion appropriated to HHS for the PRF. Of the $145.9 billion, $88.4 billion was distributed in General Distributions and $57.5 billion was distributed in several Targeted Distributions. A portion of the remaining $32.1 billion was distributed or allocated for HRSA's program for uninsured individuals, the COVID-19 Coverage Assistance Fund, and Phase 4 General Distribution payments.[43]

General Distributions

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

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

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

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

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

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

Targeted Distributions

HRSA also distributed PRF funds to target certain types of providers in CY 2020 that had high needs due to COVID-19. These included the following:

- *COVID-19 High-Impact Area Providers:* HRSA distributed nearly $22 billion in COVID-19 high-impact area payments to hospitals that had large numbers of COVID-19 inpatient admissions.[44]

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

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

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

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

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

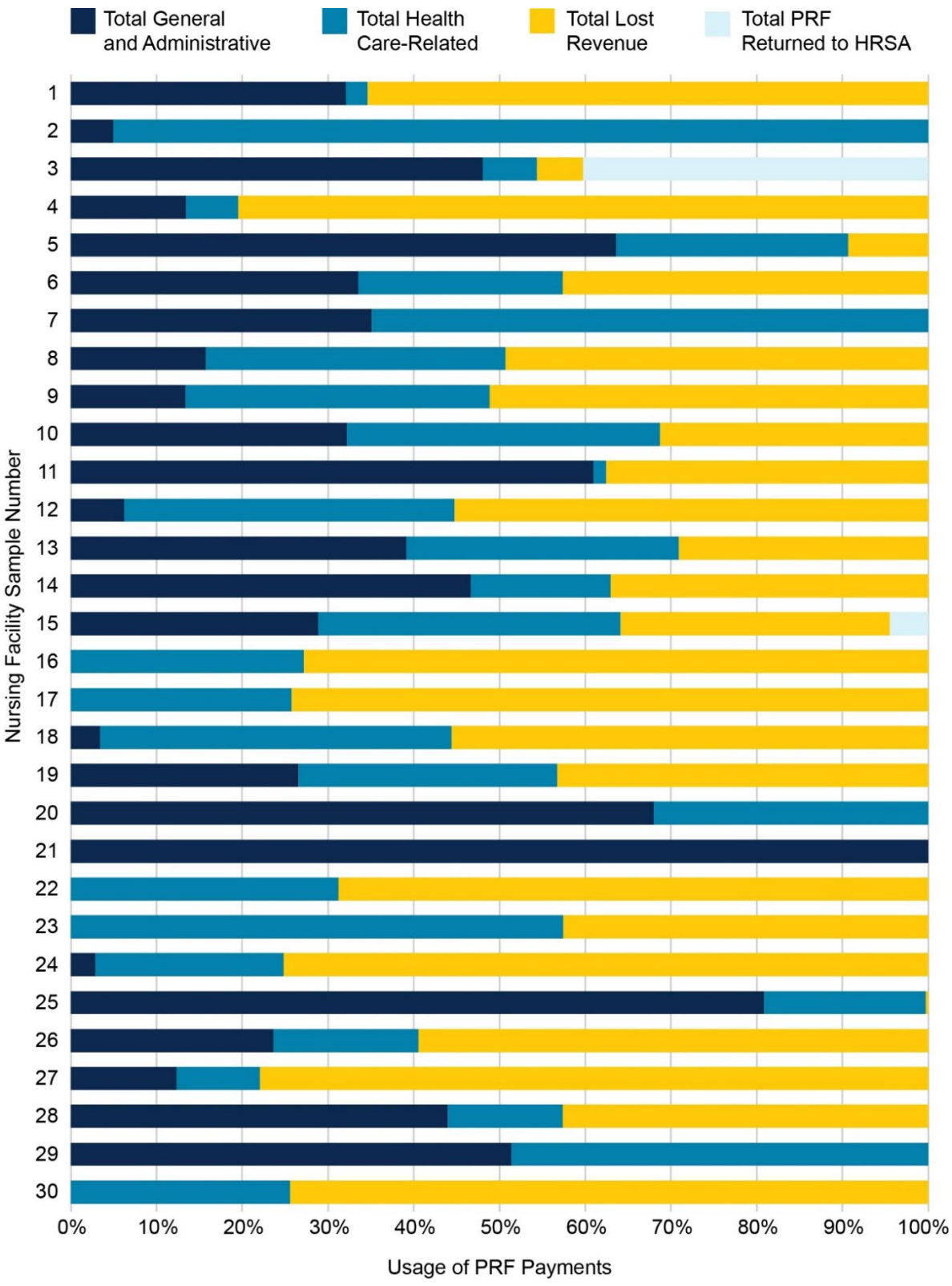
APPENDIX D: OPTIONS FOR CALCULATING LOST REVENUES

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

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

Source: HRSA, *Provider Relief Fund Lost Revenues Guide – Reporting Period 1.* Accessed on Apr. 2, 2025.

APPENDIX E: SELECTED NURSING FACILITIES' REPORTED USE OF CY 2020 PROVIDER RELIEF FUND PAYMENTS



APPENDIX F: SUMMARY OF SAMPLED NURSING FACILITIES' UNALLOWABLE OR POTENTIALLY UNALLOWABLE AMOUNTS

Sample No.	PRF Payment(s) Received[45]	Unallowable or Potentially Unallowable Amount	Reason for Unallowable or Potentially Unallowable Amount
1	$69,504,170	$37,592	Unallowable costs
2	$132,783,396	–	
3	$34,374,989	$285,420	Potentially unallowable costs
4	$42,613,522	$26,985	Potentially unallowable costs
5	$13,924,575	–	
6	$9,952,371	–	
7	$3,239,245	–	
8	$2,084,393	–	
9	$3,591,115	–	
10	$1,972,042	–	
11	$4,882,696	$477,819	Unallowable costs
12	$4,810,657	–	
13	$3,752,113	$304,393	Unsupported and unallowable costs
14	$2,972,551	–	
15	$2,398,670	–	
16	$559,429	–	
17	$590,771	–	
18	$690,204	–	
19	$557,597	$196,492	Inaccurate lost revenue calculation
20	$789,760	–	
21	$1,865,188	–	
22	$1,488,903	–	
23	$1,294,518	$702,573	Unsupported and unallowable costs
24	$1,578,316	$5,374	Unallowable costs
25	$10,148,294	$15,047	Unallowable costs
26	$5,580,694	–	
27	$5,578,613	–	
28	$10,130,776	–	
29	$9,212,758	$537,371	Unallowable use of NHIC Distribution payments and potentially unallowable costs

[45] The PRF payment included: (1) non-NHIC Distribution payments issued in period 1 and (2) NHIC Distribution payments issued in period 2. The PRF payment amounts do not include related interest.

Sample No.	PRF Payment(s) Received[45]	Unallowable or Potentially Unallowable Amount	Reason for Unallowable or Potentially Unallowable Amount
30	$1,747,335	–	
Total	**$384,669,661**	**$2,589,066**	

APPENDIX G: HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS

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

DATE: March 10, 2025

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Cynthia Baugh
Associate Administrator CYNTHIA R. BAUGH -S Digitally signed by CYNTHIA R. BAUGH -S
Date: 2025.03.10 09:58:30 -04'00'

SUBJECT: OIG Draft Report: A-05-22-00012

Attached is the Health Resources and Services Administration's response to the above subject report. If you have any questions, please contact Sandy Seaton in the Health Resources and Services Administration's Office of Federal Assistance and Acquisition Management at (301) 443-2432.

Attachments

Draft Report Titled ***"Ten of Thirty Selected Nursing Facilities Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments, A-05-22-00012"***

General Comments

The Health Resources and Services Administration (HRSA) appreciates the opportunity to comment on the Office of Inspector General's (OIG) referenced draft audit report. HRSA's responses to the OIG Draft Report recommendations are as follows.

OIG Recommendation 1

Require the eight nursing facilities that we determined as having used PRF payments for unallowable expenditures and lost revenues totaling $2,256,504 to return the unallowable amounts to the Federal Government or ensure that the nursing facilities properly replace the unallowable expenditures and lost revenues with allowable unreimbursed lost revenues or eligible expenses, if any.

HRSA Response

HRSA concurs with the OIG recommendation. HRSA will review supporting documentation and seek repayment, as appropriate. This includes seeking repayment if it is determined that:

- expenditures were not sufficiently documented;
- expenditures were not incurred to operate a facility that was used to prevent, prepare for, or respond to the coronavirus, or otherwise unallowable under HRSA's definition of allowable General and Administrative expenses; and
- the provider did not use a "reasonable method" to document lost revenues in accordance with the Consolidated Appropriations Act, 2021.

OIG Recommendation 2

Work with the three nursing facilities that we determined as having used PRF payments for potentially unallowable expenditures totaling $332,562 to identify and return the unallowable amounts to the Federal Government or ensure that the nursing facilities properly replace the unallowable expenditures with allowable unreimbursed lost revenues or eligible expenses, if any.

HRSA Response

HRSA concurs with the OIG recommendation. HRSA will review supporting documentation and will seek repayment if it is determined that expenditures were not incurred to prevent, prepare for, or respond to the coronavirus, and otherwise allowable under HRSA's definition of allowable General and Administrative expenses.

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