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

November 2024 | A-01-22-00503

Selected Home Health Agencies Complied With Terms and Conditions and Federal Requirements for Provider Relief Fund Payments

REPORT HIGHLIGHTS

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Why OIG Did This Audit

- The Provider Relief Fund (PRF), a $178 billion program, provided funds 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 administers 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 25 selected home health agencies (HHA) expended taxpayer funds in accordance with Federal and program requirements.

What OIG Found

- The selected HHAs complied with terms and conditions and Federal requirements for expending PRF funds.
- The selected HHAs reported that they used $108.7 million of their PRF payments to offset lost revenues, $58.8 million for general and administrative expenses, and $42.1 million for health care-related expenses.

What OIG Recommends

The selected HHAs complied with terms and conditions and Federal requirements for expending PRF funds. Accordingly, this report does not contain recommendations.

TABLE OF CONTENTS

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, to establish the Provider Relief Fund (PRF). The PRF provided funds to eligible hospitals and other health care providers (collectively "providers") for: (1) health care-related expenses or lost revenues (e.g., due to canceled elective services) attributable to COVID-19, (2) COVID-19 testing and treatment for uninsured individuals, and (3) the administration of vaccines.[1] These Federal laws appropriated to the PRF a combined $178 billion in funds, which were generally distributed as direct payments to providers in a series of General and Targeted Distributions.[2] As of February 2024, the Health Resources and Services Administration (HRSA) had distributed $145.9 billion of the PRF to providers.[3]

The Department of Health and Human Services (HHS) Office of the Secretary was responsible for initial PRF program oversight and policy decisions, and HRSA, within HHS, administers the PRF program.

COVID-19 created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for HHS, the Office of Inspector General (OIG) has provided oversight of HHS's COVID-19 response and recovery efforts.[4] This audit assessed selected home health agencies (HHA) compliance with terms and conditions, and Federal requirements for expending PRF payments. It is one of several 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

[1] 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 and vulnerable populations, including nursing homes 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. In response, HRSA stopped making PRF payments to providers.

[4] OIG, *HHS-OIG's Oversight of COVID-19 Response and Recovery*. As part of this plan, OIG has been conducting a series of audits of PRF payments to hospitals, home health agencies, hospices, skilled nursing facilities, rural and/or Tribal providers, dental providers, and assisted living facilities. This report is one in a series of these audits.

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 HHAs that received PRF payments complied with terms and conditions and Federal requirements for expending PRF funds.

BACKGROUND

COVID-19 National Emergency and the Provider Relief Fund

On January 30, 2020, the World Health Organization declared the COVID-19 outbreak a public health emergency of international concern, and on March 11, 2020, it characterized COVID-19 as a pandemic.[5] Then, on March 13, 2020, the President declared the COVID-19 outbreak a national emergency.[6]

As a result of the COVID-19 pandemic, many States ordered health care facilities, physicians, and other providers and professionals to delay elective or nonurgent procedures to conserve personal protective equipment and free up staff and facilities for COVID-19 patients. HHAs subsequently experienced fewer referrals for home care services and decreased revenues that threatened their financial viability. In addition, HHAs experienced longstanding staffing challenges as well as new ones resulting from the pandemic, such as maintaining adequate staffing levels. HHAs also faced numerous and widespread infection control challenges, including accessing personal protective equipment to limit exposure and spread.[7]

In response to the national emergency, the PRF was established to provide funds to eligible providers for: (1) health care-related expenses or lost revenues attributable to COVID-19, (2) COVID-19 testing and treatment for uninsured individuals, and (3) the administration of vaccines to the uninsured and underinsured.[8] The PRF program received a combined

[5] A pandemic is an epidemic that has spread over several countries or continents, usually affecting many people. An epidemic is an increase, often sudden, in the number of cases of a disease above what is normally expected in a population in a specific area.

[6] The national emergency ended on May 11, 2023.

[7] OIG Survey Results, *Home Health Agencies Used Multiple Strategies to Respond to the COVID-19 Pandemic, Although Some Challenges Persist* (OEI-01-21-00110). Issued on Oct. 18, 2022

[8] HHS, *Instructions for the Distribution for Medicaid, CHIP, and Dental Providers Via Enhanced Provider Relief Fund Payment Portal*. Accessed on Oct. 29, 2024. These instructions state that lost revenue attributable to COVID-19 means "the amount of any patient care revenue that you as a health care provider lost due to coronavirus, net of any increased revenues due to coronavirus (e.g., insurance reimbursed treatment)." This revenue may include revenue losses associated with fewer outpatient visits or canceled elective procedures or services.

$178 billion in funding from the Coronavirus Aid, Relief, and Economic Security Act; the Paycheck Protection Program and Health Care Enhancement Act; and the Consolidated Appropriations Act, 2021, of which $145.9 billion was distributed to providers for health care-related expenses or lost revenues attributable to COVID-19.[9] PRF funds were generally distributed as direct payments to providers in a series of General and Targeted Distributions. Exhibit 1 (on the next page) details the PRF distributions to health care providers. For further details on how PRF payments were distributed, see Appendix C.

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

The HHS Office of the Secretary's direct responsibility for PRF program oversight and policy decisions 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 is responsible for providing day-to-day oversight and management of all aspects of the PRF program.[10]

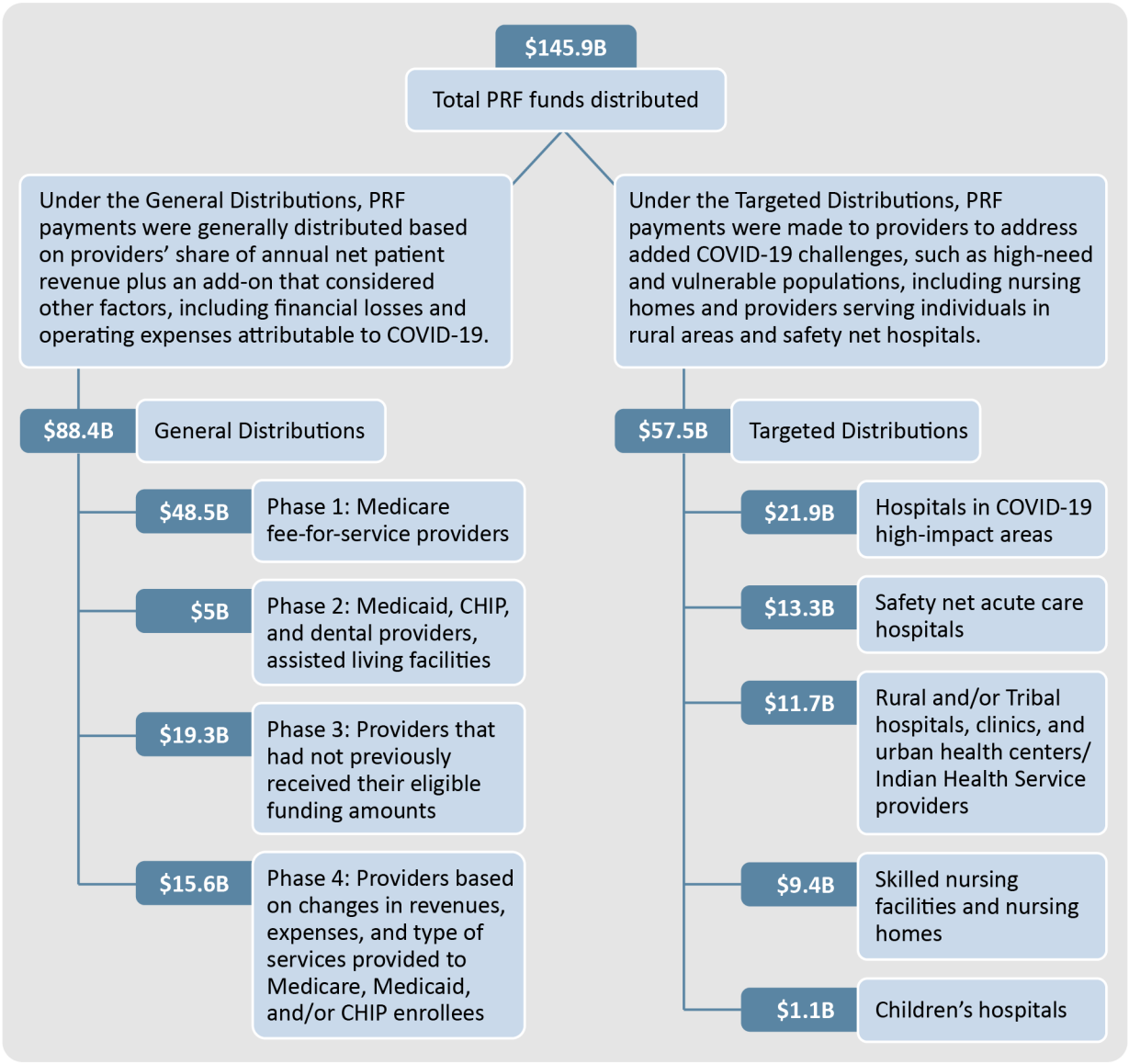
HRSA provided various resources to providers on the proper use and reporting of PRF payments, including issuing a collection of evolving Frequently Asked Questions (FAQs), and other guidance on allowable expenses and lost revenues calculations.[11] HRSA also conducted technical assistance webinars on 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.

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

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

[11] HRSA, Provider Relief: Frequently Asked Questions. Accessed on Oct. 29, 2024.

Exhibit 1: Provider Relief Fund Distributions to Health Care Providers



Note: Amounts for the Targeted Distributions in the exhibit above do not add to $57.5 billion due to rounding.

Requirements for Home Health Agencies That Received Provider Relief Fund Payments

Providers, including HHAs, may have been eligible to receive PRF payments from multiple distributions.[12, 13] HHAs that received PRF payments had to comply with certain provisions of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR part 75). Specifically, HHAs had to comply with 45 CFR § 75.302 (Financial management and standards for financial management systems) and 45 CFR §§ 75.361 through 75.365 (Record retention and access).

As a condition of receiving PRF payments, providers agreed to the PRF terms and conditions, including meeting eligibility criteria; filing expenditure reports; and ensuring that payments were: (1) used to prevent, prepare for, or respond to COVID-19; (2) used for health care-related expenses or lost revenues (i.e., patient care revenues) attributable to COVID-19;[14] (3) not used to reimburse expenses or losses already reimbursed from other funding sources; and (4) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities (e.g., lobbying).[15]

Provider Relief Fund Expenditures and Lost Revenues

HHAs were required to use PRF distributions for expenses or lost revenues attributable to COVID-19. For expenses, HHAs were required to report their use of PRF payments for COVID-19 health care-related expenses (e.g., expenses for purchasing equipment such as ventilators and sanitizing supplies for infection control) and COVID-19-related general and administrative expenses (e.g., salaries, utilities, rent), including expenses incurred prior to receipt of PRF

[12] PRF payments were distributed to providers based on providers' taxpayer identification numbers (TINs). HHAs 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 specify when providers must 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 "HHA" to refer to an HHA reporting entity. A HHA 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 HHAs). An HHA may be a stand-alone HHA, an HHA group, or a parent organization.

[13] For details on General and Targeted Distribution payments, see Appendix C. In addition to PRF payments, we note that HHAs may have received other 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.

[14] 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 non-patient care dining services, grants, bad debts, any gains or losses on investments and contractual obligations.

[15] 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.

payments (i.e., preaward costs dated back to January 1, 2020).[16] HHAs 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.[17]

For lost revenues, HHAs could apply their PRF payments toward lost revenue amounts during a period of availability calculated using one of the following three options: (1) the difference between actual net patient care revenues and 2019 actual net patient care revenues, (2) the difference between budgeted patient care revenues (approved by HHA officials prior to March 27, 2020) and actual patient care revenues, or (3) any reasonable method of estimating revenues.[18]

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

HOW WE CONDUCTED THIS AUDIT

Our audit covered $209.6 million in PRF Phase 1 General Distribution payments and related interest to a non-statistical sample of 25 HHA taxpayer identification numbers (TINs) during calendar year (CY) 2020.[19] (We refer to these sample units throughout the report as "HHAs.")[20] The selected HHAs reported that they used $108.7 million of their PRF payments to offset lost

[16] HRSA, Provider Relief Fund Distributions and American Rescue Plan Rural Distribution Post-Payment Notice of Reporting Requirements (PRF Reporting Requirements).

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

[18] 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, which was the end of the quarter in which the COVID-19 Public Health Emergency ended (HRSA Notice of PRF Reporting Requirements). Accessed on November 21, 2024.

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

[20] The sampling frame consisted of 9,578 HHAs that received and kept 1 or more PRF payments totaling approximately $13.6 billion. PRF payment recipients had 90 days to return a payment to HHS, otherwise the recipient was deemed to have accepted the terms and conditions. Our sample included HHAs that received PRF payments issued in CY 2020 and for which HHAs attested to the payment terms and conditions or were deemed to have accepted the terms and conditions.

revenues, $58.8 million for general and administrative expenses, and the remaining $42.1 million for health care-related expenses.[21] Appendix E contains details on how the selected HHAs used PRF payments issued in CY 2020.

We selected HHAs based on an analysis that considered the amount of PRF payments received, geographic location, and organizational structure (e.g., HHA groups and stand-alone HHAs).[22] We reviewed the HHAs' 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 HHAs that reported expenditures, we reviewed a non-statistical sample of expenses that we selected based on materiality and expense descriptions (e.g., salaries, supplies, equipment). For the selected HHAs that reported lost revenues, we reviewed the HHA's lost revenue calculations.[23]

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

The selected HHAs complied with terms and conditions and Federal requirements for expending PRF funds, including ensuring that 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 reimburse expenses or losses that have been reimbursed from other funding sources; and (4) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities. The HHAs used the funds for allowable general and administrative and health care-related expenditures attributable to COVID-19 and to offset lost revenues attributable to COVID-19.

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

[22] Our sample unit was a HHA that reported the use of PRF General Distribution payments. Each sampled HHA could be a stand-alone HHA or part of a parent-subsidiary system that may include a parent company and other provider types (e.g., hospice). The 25 selected HHAs each received PRF payments from $1.5 million to $99.6 million during CY 2020 and are located in 10 states. 12 of the HHAs are stand-alone HHAs and 13 are part of HHA groups.

[23] Of the 25 selected HHAs, 14 HHAs reported both expenses and lost revenues, 6 HHAs reported only expenses, and 5 HHAs reported only lost revenues.

Example: One HHA's Use of PRF Payments

For example, one of the selected HHAs received PRF payments of $1,287,322, of which it reported to HRSA that it applied $918,325 to offset lost revenues and used the remaining funds for health care-related and general and administrative expenses. Our review of the HHA's accounting records showed that lost revenues were correctly calculated based on the difference between actual net patient care revenues (i.e., difference between 2019 and 2020 actual net patient care revenues). The HHA included only eligible patient care service revenue attributable to COVID-19 in its calculation. The HHA's accounting, personnel, and other records also showed that the total reported expenses of $368,997 were used for purposes attributable to COVID-19. Specifically, the HHA used $267,221 of its PRF payments for general and administrative expenses that included personnel costs such as COVID-19 related sick pay, employee retention bonuses, and hiring bonuses. Additionally, the records showed that the HHA used $101,776 of its PRF payments for health care-related expenses that included PPE (e.g., gowns and masks).

CONCLUSION

The 25 selected HHAs complied with terms and conditions and Federal requirements for expending PRF funds. Accordingly, this report does not contain recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We identified 9,578 unique TINs related to HHA providers that received and kept Phase 1 General Distribution payments during CY 2020 totaling approximately $13.6 billion. We selected for audit a non-statistical sample of 25 HHAs that received PRF payments from General Distributions totaling $209.6 million during CY 2020.[24] We selected HHAs based on a risk analysis that considered the amount of PRF payments received, geographic location, and organizational structure (e.g, HHA groups and stand-alone HHAs). We reviewed the HHA's PRF payments used to offset lost patient care revenues and/or cover general and administrative and health care-related expenses. We reviewed the selected HHAs' use of PRF payments received from General Distributions.

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

We conducted our audit from November 2021 to November 2024.

METHODOLOGY

To accomplish our objective, we:

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

- 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;

[24] PRF payment recipients had 90 days to return a payment to HHS, otherwise the recipient was deemed to have accepted the terms and conditions. Our sample included HHAs that received PRF payments issued in CY 2020 and for which HHAs attested to the payment terms and conditions or were deemed to have accepted the terms and conditions.

- 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 Phase 1 General Distributions in 2020;

- compiled a list of 9,578 HHAs that received and kept Phase 1 General Distribution PRF payments in 2020;

- selected a nonstatistical sample of 25 HHAs that received and kept PRF payments based on the amount of PRF payments received, geographical location, and organizational structure (HHA groups and stand-alone HHAs);

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

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

    - payments used for health care-related expenses, general and administrative expenses, or applied to offset eligible lost revenues attributable to COVID-19, and that the amount for any lost revenues applied toward PRF payments was accurately calculated;[25]

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

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

- discussed the results of our audit with HRSA officials.

We shared our draft report with HRSA, and it informed us that it did not have comments other than technical comments, which we addressed as appropriate.

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

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

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
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 February 2024, HRSA distributed $145.9 billion of the $178 billion appropriated to 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 has been distributed or allocated for HRSA's program for uninsured individuals, the COVID-19 Coverage Assistance Fund, and Phase 4 General Distribution payments.[26]

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 who did not receive a Phase 1 General Distribution payment equal to 2 percent of their total patient care revenues 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 revenues 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.

[26] As of June 2023, with the passage of the Fiscal Responsibility Act of 2023, P.L. No. 118-5, Congress rescinded some 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 that had high needs due to COVID-19. These included the following:

- *COVID-19 High-Impact Area Distributions:* HRSA distributed nearly $22 billion in COVID-19 high-impact area payments to hospitals that had large numbers of COVID-19 inpatient admissions.[27]

- *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 Distributions:* 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 Provider Payments:* HRSA distributed $540 million in relief funds to the tribal hospitals, clinics, and urban health centers. These payments were based on operating expenses.

- *Skilled Nursing Facilities and Nursing Homes Payments:* 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.

[27] 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

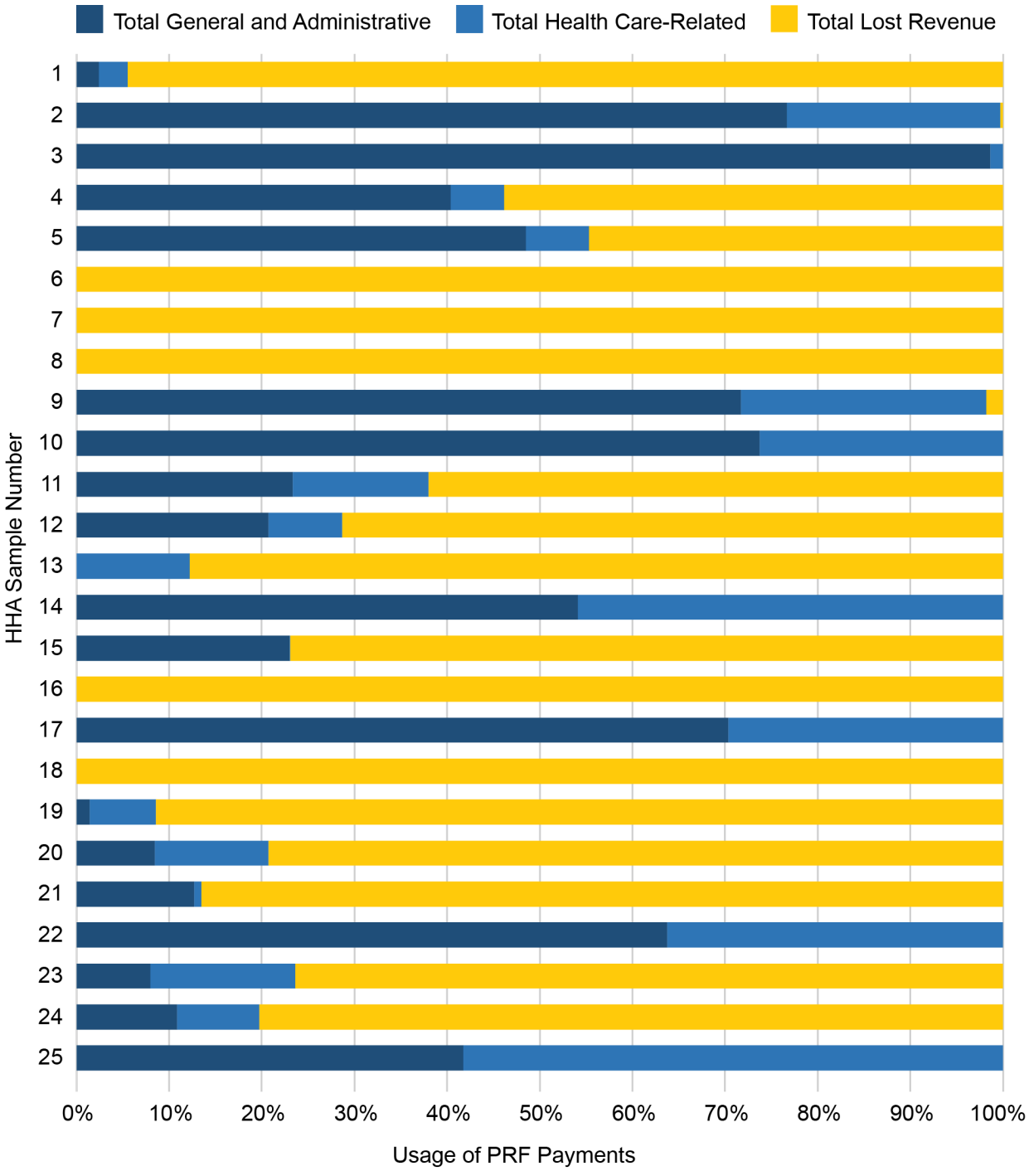
Providers, including HHAs, could use one of the following three options to calculate their lost revenues.

Table: Options for Calculating Lost Revenues

Lost Revenues Options	Option 1	Option 2	Option 3
Definition of Option	*The difference between actual patient care revenues*	*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*, August 2021. Accessed on July 26, 2024.

APPENDIX E: SELECTED HOME HEALTH AGENCIES' REPORTED USE OF CY 2020 PROVIDER RELIEF FUND PAYMENTS



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