United States Government Accountability Office

Report to Congressional Committees

September 2020

COVID-19

Federal Efforts Could Be Strengthened by Timely and Concerted Actions

GAO Highlights

Highlights of GAO-20-701, a report to congressional committees

COVID-19

Federal Efforts Could Be Strengthened by Timely and Concerted Actions

Why GAO Did This Study

As of September 10, 2020, the U.S. had over 6.3 million cumulative reported cases of COVID-19 and over 177,000 reported deaths, according to federal agencies. The country also continues to experience serious economic repercussions and turmoil.

Four relief laws, including the CARES Act, were enacted as of September 2020 to provide appropriations to address the public health and economic threats posed by COVID-19. As of July 31, 2020, the federal government had obligated a total of $1.6 trillion and expended $1.5 trillion of the COVID-19 relief funds as reported by federal agencies on USAspending.gov.

The CARES Act includes a provision for GAO to report bimonthly on its ongoing monitoring and oversight efforts related to the COVID-19 pandemic. This third report examines key actions the federal government has taken to address the COVID-19 pandemic and evolving lessons learned relevant to the nation's response to pandemics.

GAO reviewed data, documents, and guidance from federal agencies about their activities and interviewed federal and state officials, as well as industry representatives.

What GAO Recommends

GAO is making 16 new recommendations for agencies that are detailed in this Highlights and in the report.

View GAO-20-701. For more information, contact A. Nicole Clowers (202) 512-7114 or clowersa@gao.gov.

What GAO Found

In the government's ongoing response to the COVID-19 pandemic, the Congress and the administration have taken action on multiple fronts to address challenges that have contributed to catastrophic loss of life and profound economic disruption. These actions have helped direct much-needed federal assistance to support many aspects of public life, including local public health systems and private-sector businesses.

However, the nation faces continued public health risks and economic difficulties for the foreseeable future. Among other challenges, the public health system, already strained from months of responding to COVID-19 cases, will face the additional task of managing the upcoming flu season. At the same time, many of the federal, state, and local agencies responsible for responding to the ongoing public health emergency are called on to prepare for and respond to the current hurricane season. Timely and concerted federal leadership will be required in responding to these and other challenges.

GAO has identified lessons learned and issues in need of continued attention by the Congress and the administration, including the need to collect reliable data that can drive decision-making; to establish mechanisms for accountability and transparency; and to protect against ongoing cyber threats to patient information, intellectual property, public health data, and intelligence. Attention to these issues can help to make federal efforts as effective as possible.

GAO has also identified a number of opportunities to help the federal government prepare for the months ahead while improving the ongoing federal response:

Medical Supply Chain

The Department of Health and Human Services (HHS) and the Federal Emergency Management Agency (FEMA), with support from the Department of Defense (DOD), have taken numerous, significant efforts to mitigate supply shortages and expand the medical supply chain. For example, the agencies have coordinated to deliver supplies directly to nursing homes and used Defense Production Act authorities to increase the domestic production of supplies.

However, shortages of certain types of personal protective equipment and testing supplies remain due to a supply chain with limited domestic production and high global demand. The Food and Drug Administration (FDA) and FEMA have both identified shortages, and officials from seven of the eight states GAO interviewed in July and August 2020 identified previous or ongoing shortages of testing supplies, including swabs, reagents, tubes, pipettes, and transport media. Testing supply shortages have contributed to delays in turnaround times for testing results. Delays in processing test results have multiple serious consequences, including delays in isolating those who test positive and tracing their contacts in a timely manner, which can in turn exacerbate outbreaks by allowing the virus to spread undetected. In addition, states and other nonfederal entities have experienced challenges tracking supply requests made through the federal government and planning for future needs. **GAO is making the following recommendations:**

- HHS, in coordination with FEMA, should immediately document roles

and responsibilities for supply chain management functions transitioning to HHS, including continued support from other federal partners, to ensure sufficient resources exist to sustain and make the necessary progress in stabilizing the supply chain.

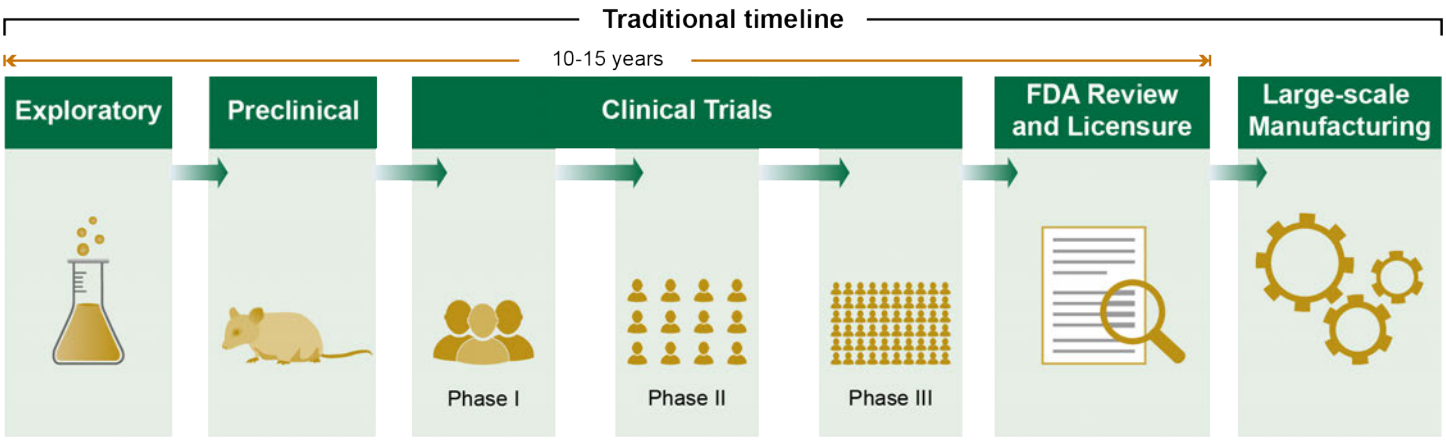
- HHS, in coordination with FEMA, should further develop and communicate to stakeholders plans outlining specific actions the federal government will take to help mitigate supply chain shortages for the remainder of the pandemic.
- HHS and FEMA—working with relevant stakeholders—should devise interim solutions, such as systems and guidance and dissemination of best practices, to help states enhance their ability to track the status of supply requests and plan for supply needs for the remainder of the COVID-19 pandemic response.

HHS and the Department of Homeland Security (DHS) objected to GAO's initial draft recommendations. GAO made revisions based on their comments. GAO maintains that implementation of its modified recommendations is both warranted and prudent. These actions could contribute to ensuring a more effective response by helping to mitigate challenges with the stability of the medical supply chain and the ability of nonfederal partners to track, plan, and budget for ongoing medical supply needs.

Vaccines and Therapeutics

Multiple federal agencies continue to support the development and manufacturing of vaccines and therapeutics to prevent and treat COVID-19. These efforts are aimed at accelerating the traditional timeline to create a vaccine (see figure).

Traditional Timeline for Development and Creation of a Vaccine



Source: GAO analysis of Food and Drug Administration (FDA) and Pharmaceutical and Manufacturers of America information. | GAO-20-701

Note: See figure 5 in the report.

As these efforts proceed, clarity on the federal government's plans for distributing and administering vaccine, as well as timely, clear, and consistent communication to stakeholders and the public about those plans, is essential. DOD is supporting HHS in developing plans for nationwide distribution and administration of a vaccine. In September 2020, HHS indicated that it will soon send a report to Congress outlining a distribution plan, but did not provide a specific date for doing so. **GAO recommends that HHS, with support from DOD, establish a time frame for documenting and sharing a national plan for distributing and administering COVID-19 vaccine, and in developing such a plan ensure that it is consistent with best practices for project planning and scheduling and outlines an approach for how efforts will be coordinated across federal agencies and nonfederal entities. DOD partially concurred with the recommendation, clarifying that it is supporting HHS in developing plans for nationwide distribution and administration of vaccine. HHS neither agreed nor disagreed with the recommendation, but noted factors that complicate the publication of a plan. GAO maintains that a time frame is necessary so all relevant stakeholders will be best positioned to begin their planning. On September 16, 2020, HHS and DOD released two documents outlining a strategy for any COVID-19 vaccine. GAO will evaluate these documents and report on them in future work**. GAO will also continue to conduct related work, including examining federal efforts to accelerate the development and manufacturing of COVID-19 vaccines and therapeutics.

COVID-19 Data

Data collected by the Centers for Disease Control and Prevention (CDC) suggest a disproportionate burden of COVID-19 cases, hospitalizations, and deaths exists among racial and ethnic minority groups, but GAO identified gaps in these data.

To help address these gaps, on July 22, 2020, CDC released a COVID-19 Response Health Equity Strategy. However, the strategy does not assess whether having the authority to require states and jurisdictions to report race and ethnicity information is necessary to ensure CDC can collect such data. CDC's strategy also does not specify how it will involve key stakeholders, such as health care providers, laboratories, and state and jurisdictional health departments. **GAO recommends that CDC (1) determine whether having the authority to require the reporting of race and ethnicity information for cases, hospitalizations, and deaths is necessary for ensuring more complete data, and if so, seek such authority from Congress; (2) involve key stakeholders to help ensure the complete and consistent collection of demographic data; and (3) take steps to help ensure its ability to comprehensively assess the long-term health outcomes of persons with COVID-19, including by race and ethnicity. HHS agreed with the recommendations.**

In addition, HHS's data on COVID-19 in nursing homes do not capture the early months of the pandemic. HHS's Centers for Medicare & Medicaid Services (CMS) began requiring nursing homes to report COVID-19 data to CDC by May 17, 2020, starting with information as of May 8, 2020, but made reporting prior to May 8, 2020 optional. By not requiring nursing homes to submit data from the first 4 months of 2020, HHS is limiting the usefulness of the data in helping to understand the effects of COVID-19 in nursing homes. **GAO recommends that HHS, in consultation with CMS and CDC, develop a strategy to capture more complete data on COVID-19 cases and deaths in nursing homes retroactively back to January 1, 2020. HHS partially agreed with this recommendation by noting the value of having complete data, but expressed concern about the burden of collecting it. GAO maintains the importance of collecting these data to inform the government's continued response and recovery, and HHS could ease the burden by incorporating data previously reported to CDC or to state or local public health offices.**

Economic Impact Payments

The Department of the Treasury's (Treasury) Internal Revenue Service (IRS) has issued economic impact payments (EIP) to all eligible individuals for whom IRS has the necessary information to do so; however, not everyone eligible was able to be initially identified. To help ensure all eligible recipients received their payments in a more timely manner, IRS took several actions to address challenges GAO reported on in June, including a policy change—reopening the Non-Filers tool registration period for federal benefit recipients and extending it through September 30—that should allow some eligible recipients to receive supplemental payments for qualifying children sooner than expected. However, Treasury and IRS lack updated information on how many eligible recipients have yet to receive these funds. The lack of such information could hinder outreach efforts and place potentially millions of individuals at risk of missing their payment. **GAO recommends that Treasury, in coordination with IRS, (1) update and refine the estimate of eligible recipients who have yet to file for an EIP to help target outreach and communications efforts and (2) make estimates of eligible recipients who have yet to file for an EIP, and other relevant information, available to outreach partners to raise awareness about how and when to file for EIP. Treasury and IRS neither agreed nor disagreed with the recommendations and described actions they are taking in concert with the recommendations to notify around 9 million individuals who may be eligible for an EIP.**

Coronavirus Relief Fund

The Coronavirus Relief Fund (CRF) is the largest program established in the four COVID-19 relief laws that provides aid to states, the District of Columbia, localities, tribal governments, and U.S. territories. Audits of entities that receive federal funds, including CRF payments, are critical to the federal government's ability to help safeguard those funds. Auditors that conduct single audits follow guidance in the Single Audit Act's Compliance Supplement, which the Office of Management and Budget (OMB) updates and issues annually in coordination with federal agencies. OMB issued the 2020 Compliance Supplement in August 2020, but the Compliance Supplement specified that OMB is still working with federal agencies to identify the needs for additional guidance for auditing new COVID-19-related programs, including the CRF payments, as well as existing programs with compliance requirement changes. According to OMB, an addendum on COVID-19-related programs, including the CRF payments, will be issued in the fall of 2020. Further delays in issuing this guidance could adversely affect auditors' ability to issue consistent and timely reports. **GAO recommends that OMB, in consultation with Treasury, issue the addendum to the 2020 Compliance Supplement as soon as possible to provide the necessary audit guidance, as many single audit efforts are underway. OMB neither agreed nor disagreed with the recommendation.**

Guidance for K-12 Schools

State and local school district officials tasked with reassessing their operating status and ensuring their school buildings are safe are generally relying on guidance and recommendations from federal, state, and local public health and education officials. However, portions of CDC's guidance on reopening K-12 schools are inconsistent, and some federal guidance appears misaligned with CDC's risk-based approach on school operating status. Based on GAO's review, Education has updated the information and CDC has begun to do so. **GAO recommends that CDC ensure that, as it makes updates to its guidance related to schools' operating status, the guidance is cogent, clear, and internally consistent. HHS agreed with the recommendation.**

Tracking Contract Obligations

Federal agencies are tracking contract actions and associated obligations in response to COVID-19 using a National Interest Action (NIA) code in the Federal Procurement Data System-Next Generation. The COVID-19 NIA code was established in March 2020 and was recently extended until March 31, 2021, while a draft of this report recommending that DHS and DOD extend the code beyond September 30, 2020, was with the agencies for comment. GAO has identified inconsistencies in establishing and closing these codes following previous emergencies, and has continued concerns with the criteria that DHS and DOD rely on to determine whether to extend or close a code and whether the code meets long-term needs. **GAO recommends that DHS and DOD make updates to the 2019 NIA Code Memorandum of Agreement so as to enhance visibility for federal agencies, the public, and Congress on contract actions and associated obligations related to disaster events, and to ensure the criteria for extending or closing the NIA code reflect government-wide needs for tracking contract actions in longer-term emergencies, such as a pandemic. DHS and DOD did not agree, but GAO maintains implementation of its recommendation is essential.**

Address Cybersecurity Weaknesses

Since March 2020, malicious cyber actors have exploited COVID-19 to target organizations that make up the health care and public health critical infrastructure sector, including government entities, such as HHS. GAO has identified numerous cybersecurity weaknesses at multiple HHS component agencies, including CMS, CDC, and FDA, over the last 6 years, such as weaknesses in key safeguards to limit, prevent, and detect inappropriate access to computer resources. Additionally, GAO's March 2019 high-risk update identified cybersecurity and safeguarding the systems supporting the nation's critical infrastructure, such as health care, as high-risk areas. As of July 2020, CMS, FDA, and CDC had made significant progress by implementing 350 (about 81 percent) of the 434 recommendations GAO issued in previous reports to address these weaknesses. **Based on the imminent cybersecurity threats, GAO recommends that HHS expedite implementation of GAO's prior recommendations regarding cybersecurity weaknesses at its component agencies. HHS agreed with the recommendation.**

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Abbreviations

ASPR	Assistant Secretary for Preparedness and Response
BARDA	Biomedical Advanced Research and Development Authority
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
COVID-NET	COVID-19-Associated Hospitalization Surveillance Network
CRF	Coronavirus Relief Fund
DHS	Department of Homeland Security
DOD	Department of Defense
DOL	Department of Labor
DOT	Department of Transportation
DPA	Defense Production Act
Education	Department of Education
EIP	economic impact payments
FAQ	frequently asked questions
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FMAP	Federal Medical Assistance Percentage
FPUC	Federal Pandemic Unemployment Compensation
GSA	General Services Administration
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IRS	Internal Revenue Service
NCHS	National Center for Health Statistics
NIA	National Interest Action
NIH	National Institutes of Health
NVSS	National Vital Statistics System
OASH	Office of the Assistant Secretary for Health
OCIO	Office of the Chief Information Officer
OMB	Office of Management and Budget
OSHA	Occupational Safety and Health Administration
PEUC	Pandemic Emergency Unemployment Compensation
PPE	personal protective equipment

PPP	Paycheck Protection Program
PUA	Pandemic Unemployment Assistance
RADx	Rapid Acceleration of Diagnostics
RRB	Railroad Retirement Board
SBA	Small Business Administration
SNAP	Supplemental Nutrition Assistance Program
SNS	Strategic National Stockpile
SSA	Social Security Administration
SSI	Supplemental Security Income
State	Department of State
TIGTA	Treasury Inspector General of Tax Administration
Treasury	Department of the Treasury
UCG	Unified Coordinating Group
UI	unemployment insurance
USAID	U.S. Agency for International Development
USTR	Office of the United States Trade Representative
VA	Department of Veterans Affairs

GAO's Mission

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Recommendations for Executive Action

Recommendations for Executive Action

We are making a total of 16 recommendations to federal agencies:

- The Secretary of Health and Human Services in coordination with the Administrator of the Federal Emergency Management Agency—who head agencies leading the COVID-19 response through the Unified Coordination Group—should immediately document roles and responsibilities for supply chain management functions transitioning to the Department of Health and Human Services, including continued support from other federal partners, to ensure sufficient resources exist to sustain and make the necessary progress in stabilizing the supply chain, and address emergent supply issues for the duration of the COVID-19 pandemic. (Recommendation 1)
- The Secretary of Health and Human Services in coordination with the Administrator of the Federal Emergency Management Agency—who head agencies leading the COVID-19 response through the Unified Coordination Group—should further develop and communicate to stakeholders plans outlining specific actions the federal government will take to help mitigate remaining medical supply gaps necessary to respond to the remainder of the pandemic, including through the use of Defense Production Act authorities. (Recommendation 2)
- The Secretary of Health and Human Services—who heads one of the agencies leading the COVID-19 response through the Unified Coordination Group—consistent with their roles and responsibilities, should work with relevant federal, state, territorial, and tribal stakeholders to devise interim solutions, such as systems and guidance and dissemination of best practices, to help states enhance their ability to track the status of supply requests and plan for supply needs for the remainder of the COVID-19 pandemic response. (Recommendation 3)
- The Administrator of the Federal Emergency Management Agency—who heads one of the agencies leading the COVID-19 response through the Unified Coordination Group—consistent with their roles and responsibilities, should work with relevant federal, state, territorial, and tribal stakeholders to devise interim solutions, such as systems and guidance and dissemination of best practices, to help states enhance their ability to track the status of supply requests and plan for supply needs for the remainder of the COVID-19 pandemic response. (Recommendation 4)
- The Secretary of Health and Human Services, with support from the Secretary of Defense, should establish a time frame for documenting and sharing a national plan for distributing and administering COVID-19 vaccine, and in developing such a plan ensure that it is consistent with best practices for project planning and scheduling and outlines an approach for how efforts will be coordinated across federal agencies and nonfederal entities. (Recommendation 5)
- As the Centers for Disease Control and Prevention (CDC) implements its COVID-19 Response Health Equity Strategy, the Director of the Centers for Disease Control and Prevention should determine whether having the authority to require states and jurisdictions to report race and ethnicity information for COVID-19 cases, hospitalizations, and deaths is necessary for ensuring more complete data, and if so, seek such authority from Congress. (Recommendation 6)

- As CDC implements its COVID-19 Response Health Equity Strategy, the Director of the Centers for Disease Control and Prevention should involve key stakeholders to help ensure the complete and consistent collection of demographic data. (Recommendation 7)
- As CDC implements its COVID-19 Response Health Equity Strategy, the Director of the Centers for Disease Control and Prevention should take steps to help ensure CDC's ability to comprehensively assess the long-term health outcomes of persons with COVID-19, including by race and ethnicity. (Recommendation 8)
- The Secretary of the Treasury, in coordination with the Commissioner of Internal Revenue, should update and refine the estimate of eligible recipients who have yet to file for an economic impact payment to help target outreach and communications efforts. (Recommendation 9)
- The Secretary of the Treasury, in coordination with the Commissioner of Internal Revenue, should make estimates of eligible recipients who have yet to file for an economic impact payment, and other relevant information, available to outreach partners to raise awareness about how and when to file for economic impact payments. (Recommendation 10)
- The Director of the Office of Management and Budget, in consultation with the Department of the Treasury, should issue the addendum to the 2020 Compliance Supplement as soon as possible to provide the necessary audit guidance. (Recommendation 11)
- The Director of the Centers for Disease Control and Prevention should ensure that, as it makes updates to its federal guidance related to reassessing schools' operating status, the guidance is cogent, clear, and internally consistent. (Recommendation 12)
- The Secretary of Homeland Security, in coordination with the Secretary of Defense, should (1) revise the criteria in the 2019 National Interest Action code memorandum of agreement to clearly identify steps they will take to obtain input from key federal agencies prior to extending or closing a National Interest Action code, (2) establish timelines for evaluating the need to extend a National Interest Action code, and (3) define what constitutes a consistent decrease in contract actions and routine contract activity to ensure the criteria for extending or closing the National Interest Action code reflect government-wide needs for tracking contract actions in longer term emergencies, such as a pandemic. (Recommendation 13)
- The Secretary of Defense, in coordination with the Secretary of Homeland Security, should (1) revise the criteria in the 2019 National Interest Action code memorandum of agreement to clearly identify steps they will take to obtain input from key federal agencies prior to extending or closing a National Interest Action code, (2) establish timelines for evaluating the need to extend a National Interest Action code, and (3) define what constitutes a consistent decrease in contract actions and routine contract activity to ensure the criteria for extending or closing the National Interest Action code reflect government-wide needs for tracking contract actions in longer term emergencies, such as a pandemic. (Recommendation 14)
- The Secretary of Health and Human Services, in consultation with the Centers for Medicare & Medicaid Services and CDC, should develop a strategy to capture more complete data on confirmed COVID-19 cases and deaths in nursing homes retroactively back to January 1, 2020, and to clarify the extent to which nursing homes have reported data before May 8, 2020. To the extent feasible, this strategy to capture more complete data should

incorporate information nursing homes previously reported to CDC or to state or local public health offices. (Recommendation 15)

- Based on the imminent cybersecurity threats, the Secretary of Health and Human Services should expedite implementation of our prior recommendations regarding cybersecurity weaknesses at its component agencies. (Recommendation 16)

Introduction

September 21, 2020

Congressional Committees

The Coronavirus Disease 2019 (COVID-19) pandemic has resulted in catastrophic loss of life and substantial damage to the global economy, stability, and security. Worldwide, there were 27,738,000 reported cases and 900,000 reported deaths due to COVID-19 as of September 10, 2020; within the United States, there were 6,344,000 cumulative reported cases and over 177,000 reported deaths.[1] The country also continues to experience serious economic repercussions and turmoil. As of August 2020, there were 13.6 million unemployed individuals, compared to nearly 5.9 million individuals at the beginning of the calendar year.[2] Due to the potential for increasing infections in the fall and winter, which would coincide with the hurricane and flu seasons, this is a pivotal time for the federal government to enhance preparations.

In response to the far-reaching public health and economic crisis, Congress and the administration have taken a series of actions. For example, in March 2020, Congress passed, and the President signed into law, the CARES Act, which provides over $2 trillion in emergency assistance and health care response for individuals, families, and businesses affected by COVID-19.[3]

The CARES Act includes a provision for us to conduct monitoring and oversight of the federal government's efforts to prepare for, respond to, and recover from the COVID-19 pandemic.[4] We are to report on, among other things, the effect of the pandemic on public health, the economy, and public and private institutions. As of September 9, 2020, we had 76 audits under way related to the pandemic examining a variety of issues, including vaccines, COVID-19 testing, the Strategic National Stockpile (SNS), use of the Defense Production Act (DPA), the Department of Veterans Affairs' (VA) response to COVID-19, child welfare and education, worker safety, and homeowner and renter protections. We continue to actively coordinate our audits with other accountability

[1]Beginning April 14, 2020, states could include probable as well as confirmed COVID-19 cases in their reports to the Centers for Disease Control and Prevention (CDC). Prior to that time, counts only included confirmed cases. According to CDC, the actual number of cases is unknown for a variety of reasons, including that people who have been infected may have not been tested or may have not sought medical care. National Center for Health Statistics (NCHS) provisional death counts include both confirmed and probable or presumed deaths. The counts reported are the total number of deaths received and coded as of the date of analysis and do not represent all deaths that occurred in that period. Provisional counts are incomplete because of the lag in time between when the death occurred and when the death certificate is completed, submitted to NCHS, and processed for reporting purposes. This delay is an average of 1–2 weeks and can range from 1–8 weeks or more, depending on the jurisdiction, age, and cause of death.

[2]Bureau of Labor Statistics, Unemployment Level (UNEMPLOY), retrieved from FRED, Federal Reserve Bank of St. Louis, accessed September 4, 2020, https://fred.stlouisfed.org/series/UNEMPLOY.

[3]Pub. L. No. 116-136, 134 Stat. 281 (2020). As of September 1, 2020, three other relief laws were also enacted in response to the COVID-19 pandemic: the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, 134 Stat. 146; Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020); and Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020). In this report, we refer to these four laws, each of which was enacted as of September 1, 2020, and provides supplemental appropriations for the COVID-19 response, as "COVID-19 relief laws," and the supplemental funding appropriated by these laws as "COVID-19 relief funds."

[4]Pub. L. No. 116-136, § 19010, 134 Stat. at 579-81.

organizations, including the Pandemic Response Accountability Committee, federal inspectors general, and state and local auditors.[5]

On August 31, 2020, we issued a report that provided a brief update on federal spending on the nation's COVID-19 response efforts and indicators for monitoring the public health system's preparedness for, response to, and recovery from COVID-19 and key areas of the economy targeted by federal efforts.[6]

This report examines

1. the key actions the federal government has taken, to date, to respond to and recover from COVID-19 and
2. evolving lessons learned relevant to the nation's response to the COVID-19 pandemic.

This report also includes 30 enclosures on a range of topics focused on the federal response to the pandemic. They are presented in appendix I.

Given the government-wide scope of this report, we undertook a variety of methodologies to complete the work, including examining a wide range of data sources and interviews with federal and state agencies and other entities. We examined federal laws, agency documents, guidance, processes, and procedures. In addition, we reviewed published reports and research papers related to our reporting objectives.

More information on our scope and methodology is in appendix II. Additionally, a list of ongoing COVID-19 related work and the status of recommendations made in the June 2020 report are in appendices III and IV, respectively.

We conducted this performance audit from May 2020 to September 2020 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

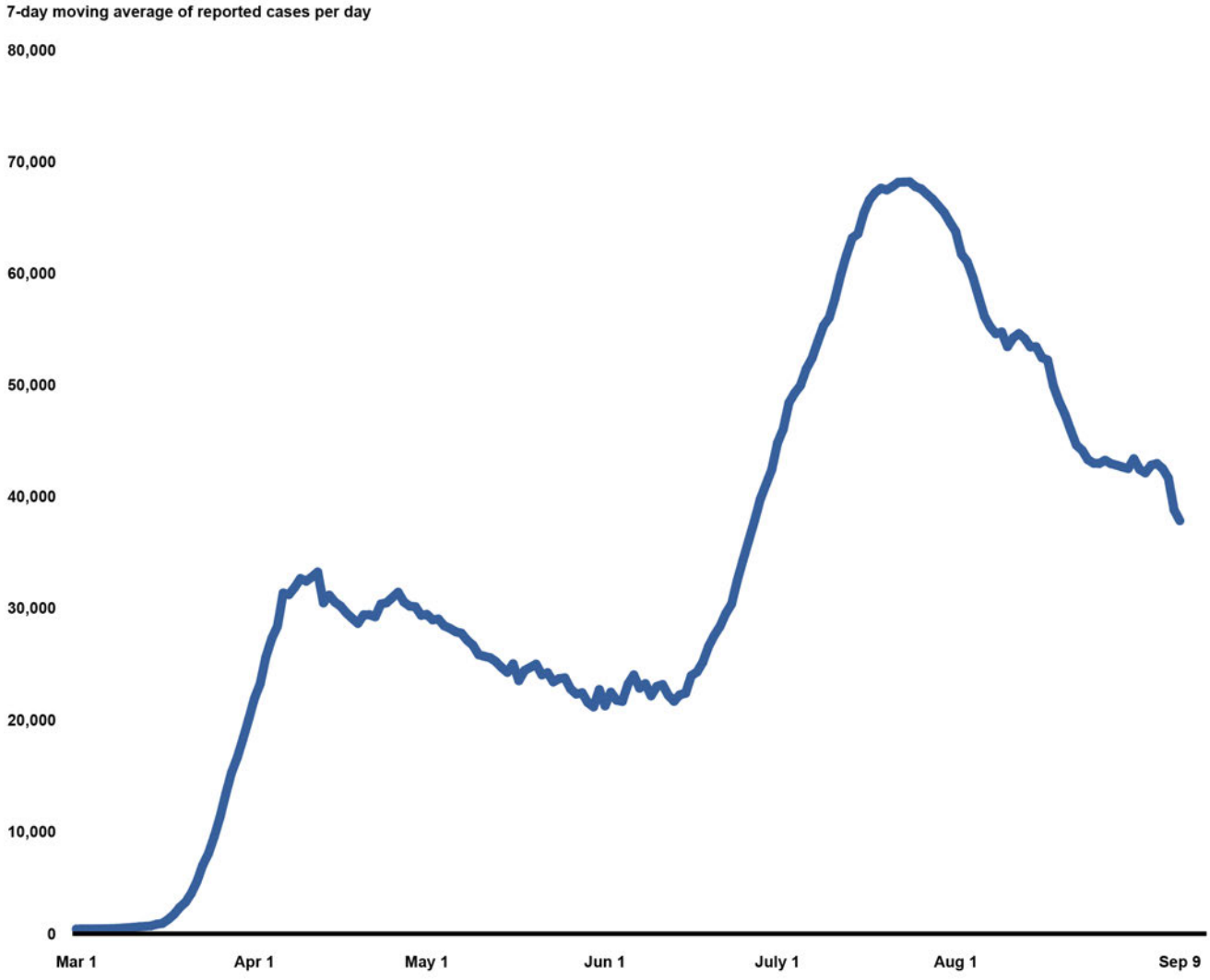
[5]The CARES Act created the Pandemic Response Accountability Committee within the Council of the Inspectors General on Integrity and Efficiency to promote transparency and conduct and support oversight of covered funds and the COVID-19 response to (1) prevent and detect fraud, waste, abuse, and mismanagement and (2) mitigate major risks that cut across program and agency boundaries.

[6]GAO, *COVID-19: Brief Update on Initial Federal Response to the Pandemic*, GAO-20-708 (Washington, D.C.: Aug. 31, 2020). Our first report was issued on June 25, 2020. See GAO, *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts*, GAO-20-625 (Washington, D.C.: June 25, 2020).

Background

After a spike of about 65,000 new cases per day in late July, on average, the United States had about 40,000 reported new COVID-19 cases per day in early September.[7] Figure 1 shows the reported U.S. COVID-19 cases per day as a 7-day moving average.

Figure 1: Reported COVID-19 Cases per Day in the United States, as of September 10, 2020



Source: GAO analysis of Centers for Disease Control and Prevention (CDC) data. | GAO-20-701

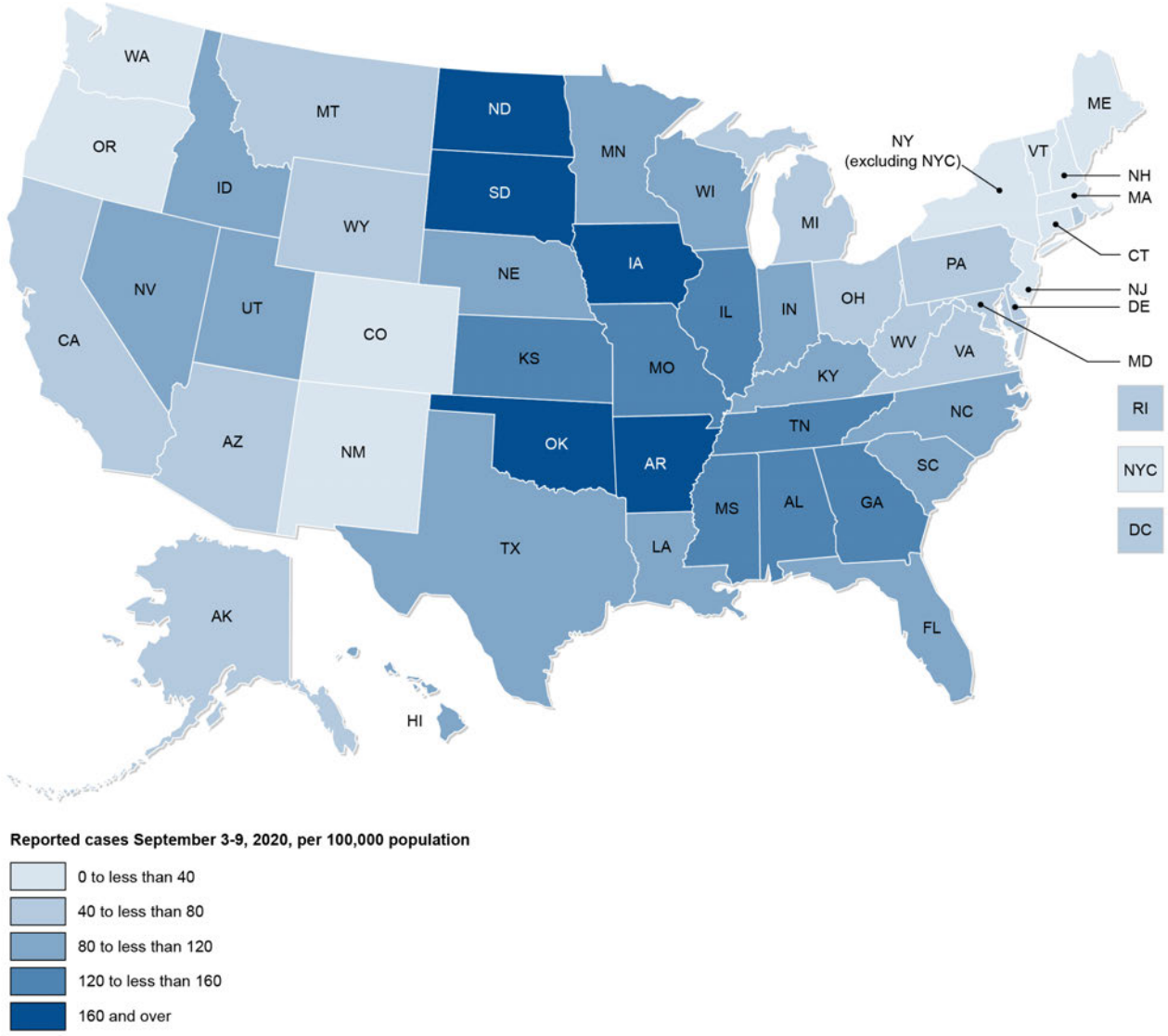
Note: Reported COVID-19 cases include confirmed and probable cases. Beginning April 14, 2020, states could include probable as well as confirmed COVID-19 cases in their reports to CDC. Prior to that time, counts only included confirmed cases. According to CDC, the actual number of cases is unknown for a variety of reasons, including that people who have been infected may

[7]CDC-reported cases include both confirmed and probable cases. CDC defines a confirmed case as meeting confirmatory laboratory evidence for COVID-19, i.e. a positive molecular test. According to CDC, a probable case is defined by one of the following: (1) meeting clinical criteria and epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19; (2) meeting presumptive laboratory evidence and either clinical criteria or epidemiologic evidence; or (3) meeting vital records criteria with no confirmatory laboratory testing performed for COVID-19.

have not been tested or may have not sought medical care. The data presented in the figure were last updated on September 10, 2020. The 7-day moving average of new cases (current day plus 6 preceding days divided by 7) was calculated to smooth variations in daily counts.

The number of reported new cases has varied geographically. For example, in early September, the states with the highest reported new cases adjusted by population were North Dakota, South Dakota, Arkansas, Iowa, and Oklahoma. Figure 2 shows reported cases per 100,000 population by state, from September 3–9, the most recent data available at the time of this analysis.

Figure 2: Reported COVID-19 Cases September 3–9, 2020, by State, per 100,000 Population



Source: GAO analysis of Centers for Disease Control and Prevention (CDC) and U.S. Census Bureau data. | GAO-20-701

Note: Reported COVID-19 cases include confirmed and probable cases. Beginning April 14, 2020, states could include probable as well as confirmed COVID-19 cases in their reports to CDC. Prior to that time, counts only included confirmed cases. According to CDC, the actual number of cases is unknown for a variety of reasons, including that people who have been infected may have not been tested or may have not sought medical care. The data presented in the figure were last updated on September 9, 2020. Rates were calculated using population estimates from U.S. Census Bureau, 2018 American Community Survey 1-Year Estimates as the number of cases per 100,000 population.

According to the Centers for Disease Control and Prevention (CDC), the fall and winter months may present additional challenges. First, colder months tend to decrease the availability of outdoor spaces and activities. Indoor spaces are more risky than outdoor spaces because there is less ventilation and it may be harder to keep people sufficiently distanced, which could increase the spread of infectious disease.

Second, according to CDC, it is likely that influenza (commonly known as flu) viruses and the virus that causes COVID-19 will both be spreading during the 2020–2021 flu season. Flu and other respiratory viruses are most common during the fall and winter. While the exact timing and duration of flu seasons can vary, flu activity often begins to increase in October. CDC estimates that influenza has resulted in approximately 9–45 million illnesses, 140,000–810,000 hospitalizations, and 12,000–61,000 deaths in the United States annually since 2010, though the severity of each flu season can vary.

Federal COVID-19 Funding and Spending

As of July 31, 2020, about $2.6 trillion had been appropriated to fund response and recovery efforts for—as well as to mitigate the public health, economic, and homeland security effects of —COVID-19 (see fig. 3).[8] As of July 31, 2020, the most recent date for which government-wide information was available, the federal government had obligated a total of $1.6 trillion and expended $1.5 trillion of the COVID-19 relief funds as reported by federal agencies on USAspending.gov.[9] The Business Loan Programs, Economic Stabilization and Assistance to Distressed Sectors programs, unemployment insurance, economic impact payments, the Public Health and Social Services Emergency Fund, and the Coronavirus Relief Fund represent $2.2 trillion, or 85 percent, of the total amounts appropriated.[10] For these six largest spending areas, agencies estimated obligations totaling $1.4 trillion and expenditures totaling $1.4 trillion as of July 31, 2020.[11]

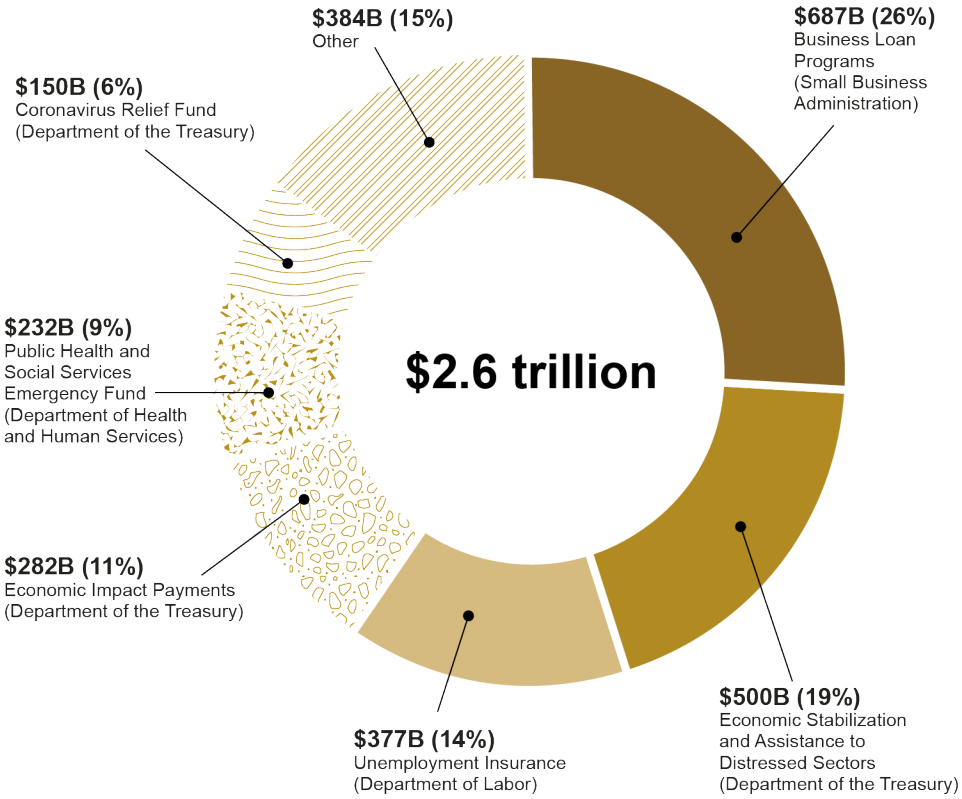
[8]An appropriation provides legal authority for federal agencies to incur obligations and make payments out of the U.S. Treasury for specified purposes.

[9]An obligation is a definite commitment that creates a legal liability of the U.S. government for the payment of goods and services ordered or received, or a legal duty on the part of the U.S. government that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the U.S. government. An expenditure is the actual spending of money, or an outlay. Expenditures include some estimates, such as estimated subsidy costs for direct loans and loan guarantees. Increased spending in Medicaid is not accounted for in the appropriations provided by the COVID-19 relief laws. USAspending.gov, accessed on September 1, 2020.

[10]SBA's Business Loan Program account includes activity for PPP and certain loan subsidies.

[11]Agencies were directed to report and attest obligations and expenditures of COVID-19 relief funds for the period ended July 31, 2020, to USAspending.gov by August 28, 2020 and certify by November 16, 2020.

Figure 3: Appropriations for COVID-19 Response from COVID-19 Relief Laws Enacted, as of July 31, 2020, by Major Spending Area



Source: GAO analysis of appropriation warrant information provided by the Department of the Treasury as of July 31, 2020. | GAO-20-701

Notes: COVID-19 relief appropriations reflect amounts appropriated under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, 134 Stat. 146; Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020); CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); and Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020). These data are based on appropriations warrant information provided by the Department of the Treasury as of July 31, 2020. These amounts could increase in the future for programs with indefinite appropriations, which are appropriations that, at the time of enactment, are for an unspecified amount. In addition, this figure does not represent transfers of funds that federal agencies may make between appropriation accounts or transfers of funds they may make to other agencies.

Major Findings

Key Federal Actions to Respond to and Recover from COVID-19

Public Health Response

In this section, we cover the Department of Health and Human Services' (HHS), the Federal Emergency Management Agency's (FEMA), and other stakeholders' public health response to the COVID-19 pandemic. HHS and FEMA are leading the COVID-19 response through the Unified Coordination Group (UCG).[12] These efforts include managing the medical supply chain; increasing testing capacity; developing, manufacturing, and distributing COVID-19 vaccines and therapeutics; and collecting data on racial and ethnic disparities as they relate to COVID-19. However, challenges remain. We are making nine recommendations to improve the federal government's public health response.[13]

According to HHS, the department had obligated about $144 billion of its more than $250 billion in COVID-19 relief funds and expended about $99 billion as of July 31, 2020. As of that date, FEMA reported that it had expended $2.5 billion for COVID-19 related assistance.

Medical Supply Chain

The federal government has continued to take steps to put supplies in the hands of those who need them. However, the availability of certain types of personal protective equipment (PPE) remains constrained and testing supply shortages persist due to a supply chain overwhelmed by the demands of the global pandemic and certain supplies not being produced domestically. In addition, states and other nonfederal entities have experienced challenges tracking supply requests made through the federal government and planning for future needs.

Federal efforts to mitigate supply chain shortages. HHS and FEMA—with support from the Department of Defense (DOD)—have taken numerous actions to mitigate supply shortages and expand the medical supply chain, chiefly through the Supply Chain Advisory Group (Advisory Group).[14] Charged by the UCG with maximizing the nationwide availability of supplies and equipment, the Advisory Group has focused on four key supply activities, according to its officials:

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[12]The UCG was established by the U.S. Government COVID-19 Response Plan—known as the PanCap Adapted, issued March 13, 2020—to coordinate the response to COVID-19. The UCG is led by officials from HHS and FEMA.

[13]Eight of these recommendations are developed in this section. The ninth recommendation—regarding collecting data on confirmed COVID-19 cases and deaths in nursing homes—is developed in the finding on evolving lessons learned.

[14]As of June 15, 2020, the Supply Chain Task Force became known as the Advisory Group, and is part of a reorganization of the original eight UCG task forces. The two groups generally have similar roles and are led by the same official, Rear Admiral John Polowcyzk, an expert in logistics planning and execution on detail from DOD's Joint Chiefs of Staff, and include officials from FEMA and HHS. According to DOD, the Supply Chain Task Force was the primary federal body coordinating and managing supply chain responsibilities. In contrast, the Advisory Group has an advisory and assistance

- *Helping preserve existing supplies.* The Advisory Group worked with CDC and the Food and Drug Administration (FDA) to provide guidance to health care providers and others on PPE decontamination and equipment efficiencies, such as techniques for using one ventilator to provide oxygen to two individuals simultaneously.[15]

- *Accelerating the delivery of supplies.* On June 30, 2020, FEMA concluded its operation of Project Air Bridge, which expedited the delivery of materials from overseas, such as masks and gloves.[16] Additionally, based on the Advisory Group's efforts to understand national demand, HHS and FEMA used DPA Title I authorities to place priority ratings on at least 18 contracts from March through May 2020 to acquire ventilators, N95 respirators, and other face coverings, with most types of items scheduled to be delivered by August 31, 2020.[17] DPA Title I authorities require the contractor (and the contractor's supply chain) to provide preferential treatment to fulfill the delivery requirements of the rated contract or order.

- *Expanding the production of supplies.* The Advisory Group and others have continued efforts to increase the domestic production of supplies. For example, as of August 15, 2020, DOD had used DPA Title III authorities and other funds to award about $627 million on 17 projects to expand domestic production of medical (including testing) supplies, such as N95 respirators, testing kits, and swabs.[18]

  These efforts to increase supply production will also help HHS accumulate stockpiles to prepare for future shortages when current demand for supplies abates. Specifically, HHS intends to build a 90-day supply of PPE in the SNS, including N95 respirators, gloves, and testing supplies, in case of an increase in COVID-19 cases.[19]

- *Gathering data to help allocate scarce supplies.* To aid in the allocation of PPE, the Advisory Group gathered supply and demand data from a variety of sources, including interagency partners and industry. For example, by obtaining and aggregating proprietary information on supply orders to, and fulfillments from, the six largest domestic medical supply distributors, officials said they received real-time information on the movement of critical medical supplies

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role, focused on transitioning responsibilities to other federal stakeholders. We refer to both as the Advisory Group in this report.

[15]According to FEMA officials, this effort transferred in March 2020 to another UCG work group, now known as the Healthcare Resilience Working Group.

[16]The Advisory Group, then the Supply Chain Task Force, led Project Air Bridge as a temporary solution to expedite the transportation of commercially distributed PPE from international manufacturers to the United States. According to FEMA officials, shipments by air were at least nine times faster than shipments by sea. FEMA officials said they would evaluate the reinstatement of an effort comparable to Project Air Bridge, if necessary. According to FEMA officials, the project concluded because private manufacturers and distributors have increased domestic production and international manufacturing capacity, and are using more maritime resources to bring in supplies.

[17]Enacted in 1950, the DPA helps ensure the availability of industrial resources to meet national defense needs. See Pub. L. No. 81-774, 64 Stat.798 (1950) (codified, as amended, at 50 U.S.C. §§ 4501 et seq.). Over time, the scope of the DPA has been expanded to include certain emergency preparedness activities and critical infrastructure protection and restoration.

[18]DPA Title III authorities enable DOD to provide financial incentives to private companies to increase production capabilities for critical security needs.

[19]For more information on HHS's effort to rebuild the SNS, including the 90-day target quantities and state efforts to stockpile supplies, see the Medical Supply Chain enclosure of this report in appendix I.

and a sense of gaps and shortfalls in supplies.[20] The Advisory Group transitioned this data collection effort to HHS, and ASPR officials told us the transition was completed September 1, 2020.

FEMA and HHS also have taken other steps to fulfill the critical supply needs of state, local, tribal, and territorial governments and health care facilities, including the following:

- *Nursing home distributions.* FEMA also coordinated the delivery directly to Medicare- and Medicaid-certified nursing homes of a 14-day supply of gloves, surgical masks, gowns, and eye protection from May through August 2020. Additionally, in July 2020, HHS announced that it would provide point-of-care testing devices and kits to all nursing homes across the country, beginning with distribution to 2,000 prioritized nursing homes.[21] According to HHS's Daily Communications Report, as of September 3, 2020, the federal government had shipped 9,894 nursing homes almost 3 million tests and 10,637 testing instruments.

- *Monthly state testing allocations.* According to HHS officials, states received monthly allocations of certain testing supplies based, in part on each state's testing plan, utilization of supplies from the prior month, epidemiological indicators, and logistical considerations. HHS officials also said that states are able to request additional testing supplies when needed, which HHS makes every effort to accommodate.
  Additionally, CDC's International Reagent Resource continues to distribute reagents—substances needed to process tests—and other resources to public health laboratories; CDC officials told us they are able to fulfill 90 percent or more of the requests they receive.[22]

- *Federal delivery deferrals.* According to Advisory Group officials, the federal government is renegotiating contracts with some of its manufacturers to defer delivery of N95 respirators to federal warehouses to help ensure supplies are available on the commercial market. Additionally, the government will work with the manufacturers to allocate those supplies to nursing homes, hospitals, and other groups that had not been previously prioritized, such as dentists' offices.

In total, as of September 1, 2020, the federal response had provided approximately 92.4 million N95 respirators, 28.1 million nonsurgical gowns, 79.7 million gloves, 228.4 million face masks, as well as other PPE to state, tribal, and territorial entities, according to federal data provided in a

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[20]Advisory Group officials told us they now collect data from nine medical supply distributors.

[21]Point-of-care testing can be defined as testing that is performed near or at the site of a patient. For more information on point-of-care testing, see GAO, *Medical Devices: Capabilities and Challenges of Technologies to Enable Rapid Diagnoses of Infectious Diseases,* GAO-17-347 (Washington, D.C.: Aug. 14, 2017).

[22]As of late July 2020, the International Reagent Resource's website stated that it may occasionally reduce or cancel orders if limited inventory, high-request volumes, or back-to-back orders exceed the International Reagent Resource's current ability, and it encouraged laboratories to limit requests to a 7- to 10-day supply in order to support equitable nationwide testing. See International Reagent Resource, "COVID-19 Diagnostic Supplies Frequently Asked Questions (FAQs)," accessed July 27, 2020, https://www.internationalreagentresource.org/QuickLinks/Covid19FAQ.aspx. HHS does not provide supplies directly to commercial laboratories, which account for about half of all COVID-19 tests performed nationwide.

COVID-19 senior leadership brief. In addition, according to HHS's Daily Communications Report dated September 10, 2020, the federal government had distributed over 95 million swabs and 76 million units of test tubes and transport media (solution for transporting viral material to keep samples viable for testing) to states, as well as point-of-care tests and kits among other items.[23]

Officials with the Advisory Group, FEMA, and the office of the Assistant Secretary for Preparedness and Response (ASPR) told us that the supply chain for many items had improved greatly since earlier in the response, and FEMA is taking additional actions to help with distribution of medical supplies now and in the future. For example, FEMA reported that supply of some types of gloves (latex as well as vinyl examination and surgical gloves) has largely caught up with demand.[24] This was echoed by officials representing seven of the eight states we spoke to in July and August 2020, who said that the situation related to PPE had improved since earlier in the response. Additionally, officials in all eight states we interviewed told us that they had or were in the process of building stockpiles of PPE—with most building at least a 30-day supply—indicating an improvement in the availability of certain PPE.

FEMA and HHS are taking additional actions to help address supply chain issues. HHS announced it has established a National Testing Implementation Forum to bring together key stakeholders from across commercial, public health, academic, and other sectors to help identify and devise solutions to address testing supply issues, among other things.[25]

Additionally, on August 17, 2020, FEMA announced it was establishing a 5-year voluntary agreement to enhance coordination, planning, and information sharing between federal departments and agencies and private sector partners around the manufacture and distribution of medical supplies for COVID-19 and future pandemics, under DPA Title VII authorities.[26] The DPA provides participants to the agreement limited protection from antitrust liability for specific actions taken in developing and executing the agreement.

Remaining medical supply chain challenges. Even with the federal efforts taken and improved availability of some supplies, there are ongoing constraints around certain types of PPE and testing supplies:

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[23]According to a COVID-19 senior leadership brief, FEMA and HHS had distributed over 1,900 Abbott ID NOW devices, and about 1.9 million Abbott ID NOW tests to state, tribal, and territorial governments, as of September 7, 2020. Abbott ID NOW tests are a type of point-of-care COVID test.

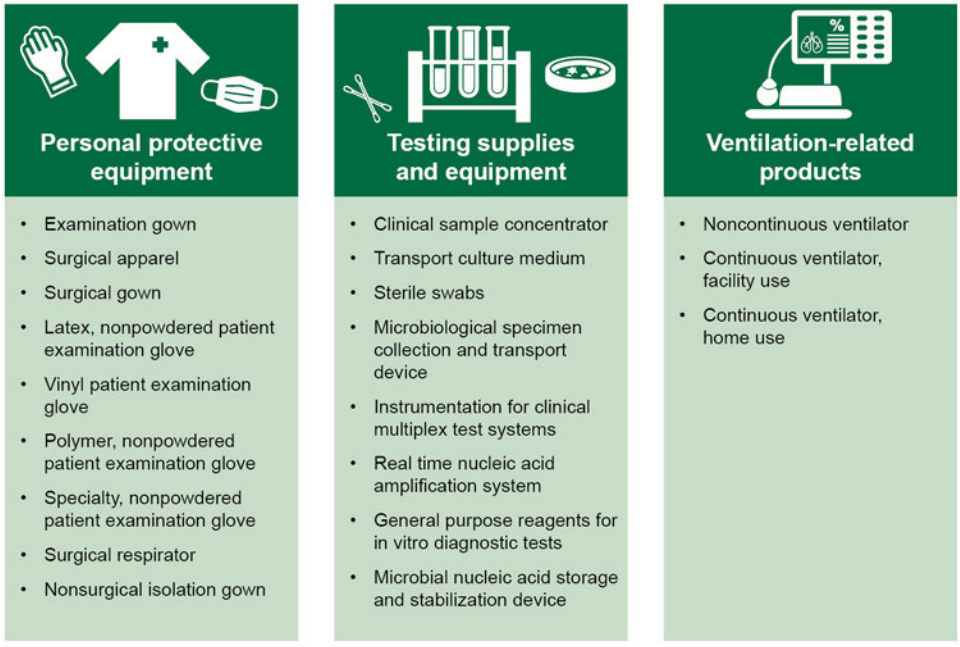
[24]See 85 Fed. Reg. 48,113, 48,116 (Aug.10, 2020).

[25]See Department of Health and Human Services, "HHS Announces National COVID-19 Testing Implementation Forum" (July 21, 2020), accessed August 20, 2020, https://www.hhs.gov/about/news/2020/07/21/hhs-announces-national-covid-19-testing-implementation-forum.html. According to the announcement, the forum is not a federal advisory committee, but it will provide an opportunity for better communication among stakeholders. The first meeting of the forum occurred on July 30, 2020 and, according to HHS, meetings will occur every two weeks.

[26]Among other things, DPA Title VII authorities authorize the President to consult with representatives of industry, business, financing, agriculture, labor, and other interests in order to provide for the making of voluntary agreements and plans of action to help provide for national defense. FEMA adopted a two-part structure for the voluntary agreement. First, the agreement allows FEMA to form a committee, which will include representatives from stakeholders involved with the distribution or manufacture of critical medical resources. Then, based on needs, the committee may form subcommittees to execute specific plans of action targeting specific medical supplies or challenges. The text of the voluntary agreement is available at 85 Fed. Reg. 50,035 (Aug. 17, 2020).

- *FDA announced a list of devices determined to be in short supply.* On August 14, 2020, FDA published a list of devices—PPE, testing supplies and equipment, and ventilation-related products—that it had determined to be in shortage during the duration of the COVID-19 pandemic (see fig. 4).[27] The Advisory Group and FEMA officials also acknowledged the constrained availability of supplies, in part due to limited U.S. manufacturing and high global demand. For example, FEMA stated that the agency had open requests from state, local, tribal, and territorial governments for more than 139 million nitrile gloves (which Advisory Group officials said were not domestically manufactured), 11 million surgical gowns, and 6 million N95 respirators, as of August 4, 2020.[28] FEMA also noted that the supply of N95 respirators for medical use is not expected to catch up to demand until January 2021. Officials within HHS's Office of the Assistant Secretary for Health (OASH), who lead federal efforts to support states in their COVID-19 testing plans, acknowledge that there are testing supply shortages. In particular, they noted shortages around some of the more efficient testing platforms requiring specialized and proprietary supplies.

Figure 4: Food and Drug Administration (FDA) List of Devices Determined to be in Shortage, as of August 2020



Source: GAO summary of FDA information. | GAO-20-701

[27]See Food and Drug Administration, *Medical Device Shortages During the COVID-19 Public Health Emergency*, (Aug. 14, 2020), accessed August 17, 2020, https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/medical-device-shortages-during-covid-19-public-health-emergency. FDA is required under section 506J(g) of the Federal Food, Drug and Cosmetics Act to maintain a publicly available, up-to-date list of the devices FDA has determined to be in shortage. Section 506J was created by the CARES Act and includes requirements for manufacturers of certain devices to notify FDA "of a permanent discontinuance in the manufacture of the device" or "an interruption in the manufacture of the device that is likely to lead to a meaningful disruption in supply of that device in the United States" during a declared public health emergency. See Pub. L. No. 116-136, § 3121, 134 Stat. at 363-66. In addition, FDA published a list of discontinued devices as reported to FDA by manufacturers. As of August 14, two infusion pumps had been reported as discontinued.

[28]See 85 Fed. Reg. 48,113, 48,116 (Aug. 10, 2020).

- *Officials from seven of eight states interviewed in July and August 2020 and stakeholder groups we interviewed also identified ongoing constraints around certain types of PPE*. For example, one state official told us that the state was unable to fulfill local entities' requests for N95 respirators and nitrile gloves, but that the state had a sufficient supply of other items, such as face shields. Additionally, two states' officials we interviewed expressed concern about the uncertain path of the virus and the impact of a fall surge on supply availability. As such, while the commercial market is currently the route for most states to obtain supplies, some state officials told us they plan to continue to request supplies from FEMA for items with more limited availability.

- *Information reported by nursing homes and medical provider associations also indicated ongoing specific constraints with PPE.* According to data that nursing homes self-reported to CDC, about 22 percent of nursing homes reported they did not have a 1-week supply of at least one or more of the following: N95 respirators, surgical masks, gloves, eye protection, or gowns, as of July 26, 2020. The American Nurses Association surveyed both members and nonmembers in late July and early August about their PPE experiences over the prior 2 weeks. Their results found that 88 percent of the over 14,000 responding nurses reported being required or encouraged to reuse single-use N95 respirators. For those who reported reusing N95 respirators, 62 percent expressed concerns about their safety as a result. Additionally, the biggest obstacle to physicians reopening their practices is "ongoing shortages of PPE, especially N95 masks and gowns," according to a June 30, 2020, American Medical Association letter to the Vice President, who leads the White House Coronavirus Task Force.[29]

- *States and associations also report pervasive testing supply shortages.* Consistent with FDA's reporting of key testing supply shortages for the duration of the pandemic, officials from seven of the eight states we interviewed in July and August 2020 identified previous or ongoing shortages of testing supplies, including swabs, reagents, tubes, pipettes, and transport media.[30]

  The Association of Public Health Laboratories reported in early August that 23 percent of public health laboratories reported they would run out of reagents or other testing supplies within a week.[31] Officials in six of the eight states we interviewed identified difficulty acquiring reagents and test kits from the commercial market, and one state official noted that challenges obtaining testing supplies have grown with the increase in testing demand across the country. Hospitals in Arkansas have had to limit their COVID-19 testing to 10 percent of full capacity due to a shortage of reagents, according to a July 2020 letter from members of the

[29]The Vice President is the Chair of the White House Coronavirus Task Force, which is responsible for coordinating a whole-of-government response to COVID-19.

[30]According to officials in five of eight states we interviewed, some of these shortages have been exacerbated by supply quality problems—including that FEMA and HHS had distributed swabs in bulk that required repackaging, test tubes that were incompatible with certain equipment, and transport media that were contaminated. According to FEMA and HHS officials, FEMA has taken steps to collect and replace some of these materials and has put a hold on the contracts associated with deficient supplies. According to HHS officials, the agency has put controls in place to monitor the quality of testing supplies states are receiving. We will continue to monitor this issue.

[31]See Association of Public Health Laboratories, "Lab Testing Capacity and Capability Survey Data Dashboard: Week of 8.10.2020," accessed August 18, 2020, https://www.aphl.org/programs/preparedness/Crisis-Management/COVID-19-Response/Pages/COVID-19-Dashboard.aspx.

Arkansas congressional delegation to the Vice President.[32] Furthermore, officials from three of eight states and two stakeholder groups that we interviewed in July and August identified plastic supplies such as pipettes as a new type of item in shortage.

In HHS's initial COVID-19 Strategic Testing Plan, submitted to Congress in May 2020, HHS did not identify specific actions it or other federal agencies would take to address certain testing supply shortages.[33] For example, the May COVID-19 Strategic Testing Plan stated that because an efficient reagent marketplace was already in place, the federal government did not intend to purchase and distribute reagents on behalf of states; however, we heard from several states that they were experiencing reagent shortages.

The subsequent COVID-19 Strategic Testing Plan, submitted to Congress in August 2020, outlined recent actions that the federal government had taken to enhance the testing supply chain, including using DPA authorities for supplies such as reagents, and that HHS would consider further use of DPA authorities moving forward.[34] However, the August COVID-19 Strategic Testing Plan did not identify actions to address pipettes and other plastic supplies that states and stakeholders have recently reported to be in short supply.

Although officials, including within OASH, acknowledged ongoing supply challenges, they provided their perspective on the issue:

- ASPR officials noted that "shortages" are subjective and depend upon several factors, including the amount and target number of days of supplies the state or hospital has determined to stockpile, or the time that it takes between requesting and receiving supplies—a perspective echoed by Advisory Group officials.

- FEMA and ASPR officials noted that state, local, tribal, and territorial governments have overestimated their needs for supplies. For example, ASPR officials noted that one state with a population of around 11 million people overestimated its need by requesting approximately 15 million N95 respirators. FEMA officials said it was difficult for states and others to assess their true resource needs, in particular, earlier in the pandemic. This exacerbated the view that shortages existed, which in turn may have led to current needs being exaggerated in the volume of open requests for supplies, according to ASPR officials.

- Some federal officials and stakeholders we spoke with noted that testing supply shortages can be fluid in nature. Many components are required to run a laboratory-based test, and many testing instruments require specialized and proprietary supplies to operate. According to some state officials, the market can experience a shortage in supply for one component that is then resolved, only to be followed by the shortage in supply of another component. For example, one state reported that early in the pandemic response, there were reported shortages of

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[32]Letter from John Boozman and Tom Cotton, U.S. Senators, and Rick Crawford, French Hill, Bruce Westerman, and Steve Womack, U.S. Representatives, to Vice President Pence, July 13, 2020.

[33]Department of Health and Human Services, *Report to Congress: COVID-19 Strategic Testing Plan* (May 24, 2020). HHS is required under the Paycheck Protection Program and Health Care Enhancement Act to update the plan every 90 days until funds provided under the act are expended. Pub. L. No. 116-139, div. B, tit. I, 134 Stat. at 626-27.

[34]Department of Health and Human Services, *Report to Congress: COVID-19 Strategic Testing Plan* (August 22, 2020). HHS did not make the August COVID-19 Strategic Testing Plan available, as of September 4, 2020.

swabs, but as those shortages resolved, shortages of other instrument-specific items, such as reagents, emerged.

Federal actions for mitigating remaining supply challenges uncertain. HHS, FEMA, and their federal partners have taken numerous actions to respond to the unprecedented need for medical supplies. Yet, as supply constraints continue, we found that HHS and FEMA have not developed plans outlining specific actions the federal government will take to help mitigate remaining medical supply gaps needed to respond to the pandemic, including through the use of DPA authorities.

FEMA and Advisory Group officials agreed a plan is an important step, and Advisory Group officials said they have begun to think about its development as federal responsibilities for supplies shift and in preparation for the potential that other agencies may need to step back and shift to other responsibilities. ASPR officials noted that they have not had an opportunity to develop a plan due to the need to focus on immediate supply needs, especially for the fall.

ASPR officials also said that they are beginning the planning process through an interagency working group, known as the Logistics, Supply Chain, and Next Generation SNS working group, to ensure that supplies are available, including through the SNS, in case of an increase in COVID-19 cases in the fall. This interagency working group provides one opportunity for developing plans outlining any specific actions the federal government will take—that could be communicated to states and other stakeholders—so that stakeholders can plan accordingly. HHS's COVID-19 Strategic Testing Plan, last updated in August and updated every 90 days, provides another opportunity for HHS to articulate plans for specific actions to mitigate remaining testing supply gaps. Plans outlining specific forward-looking actions the federal government will take could help provide certainty to stakeholders.

The March 13, 2020, U.S. Government COVID-19 Response Plan, known as the PanCap Adapted, outlines several objectives to help ensure a stabilized and resilient medical supply chain that would also be consistent with developing, and sharing with stakeholders, plans outlining specific federal actions the federal government will to take to help mitigate remaining medical supply gaps. The PanCap Adapted also notes the importance of engaging state, local, tribal, and territorial entities and nongovernmental health care organizations in achieving these objectives:

- assessing critical medical supply chain requirements and gaps,
- identifying and implementing strategies to resolve and mitigate gaps and shortfalls between production and supplies, and
- developing contingency capacity and capability to address future gaps or shortfalls.[35]

Moreover, the PanCAP Adapted calls for the development of an up-to-date, federally executable health care supply chain management strategy that includes prioritized supplies to sustain the health care infrastructure.

[35]Department of Health and Human Services, *U.S. Government COVID-19 Response Plan* (Mar. 13, 2020).

Until HHS and FEMA develop and communicate to stakeholders—such as state, local, tribal, and territorial governments—plans outlining specific actions the federal government will take to help mitigate remaining medical supply gaps, uncertainty will persist regarding whether the federal response will align with needs. Further, such plans would provide needed clarity to federal partners and nonfederal entities on priority needs and ongoing efforts to address those needs. It will be especially important to develop and communicate plans that detail 1) specific actions for increasing domestic production of medical supplies, such as circumstances under which agencies will consider use of DPA authorities, and 2) the conditions under which federal agencies would consider additional supply support. Taking such steps before the fall, when the United States will move into flu season and see a possible uptick in COVID-19 cases, both of which could further disrupt supply availability, will be important.

These plans for the ongoing pandemic can help inform a longer-term, comprehensive national supply chain strategy, which in turn could help better position all stakeholders for future pandemics or other chemical, biological, nuclear, or radiological events of this scale. We have ongoing work that could also inform the development of such a long-term national supply chain strategy, including work examining the use of the DPA to expand domestic production of critical medical supplies, federal efforts to overcome barriers to domestic drug manufacturing, and the SNS.

We will also continue to monitor actions taken in response to two recent Executive Orders focused on strengthening the domestic medical supply chain in response to challenges highlighted by COVID-19:

- In May 2020, the President signed an Executive Order authorizing the Chief Executive Officer of the International Development Finance Corporation to make loans and take other actions to expand domestic production of strategic resources to respond to the pandemic.[36]
- In August 2020, the President signed an Executive Order intended to increase domestic production of essential medicines, medical countermeasures including PPE, and their critical inputs.[37] It directs the FDA Commissioner, in consultation with the Director of the Office of Management and Budget, ASPR, the Assistant to the President for Economic Policy, and the Director of the Office of Trade and Manufacturing Policy, to create a list of these items within 90 days. It also directs federal agencies to take various steps to increase domestic production of these items.

Medical supply management responsibility shifting to HHS. Complex medical supply management responsibilities that have been shared between many agencies during the nationwide response to COVID-19 are now transitioning to HHS:

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[36]Exec. Order No. 13,922, 85 Fed. Reg. 30,583 (May 19, 2020). The first action the International Development Finance Corporation initiated under this Executive Order, in July 2020, was an agreement to provide the Eastman Kodak Company a $765 million loan to produce advance pharmaceutical ingredients, which are used in the development of pharmaceutical products. In August 2020, the International Development Finance Corporation announced that it would not proceed with the deal pending a Securities and Exchange Commission investigation into possible insider trading related to the loan.

[37]Exec. Order No. 13,944, 85 Fed. Reg. 49,929 (Aug. 14, 2020).

- Responsibility for procuring and distributing testing swabs and transport media to states transitioned from FEMA to HHS's OASH in July 2020, according to HHS officials.
- Responsibility for monitoring commercial supply availability to, for example, inform procurement decisions by analyzing data from domestic medical supply distributors transitioned from the Advisory Group to ASPR in September 2020, according to ASPR officials.
- Responsibility for other supply acquisition conducted by DOD on behalf of ASPR—including market research, contract solicitation, proposal evaluation, and contract execution—will begin to transition to ASPR in September. In preparation for this transition, DOD is currently guiding ASPR staff on these activities, according to officials from both agencies.
- Responsibility for fulfilling state, local, tribal, and territorial governments' requests for supplies and other resources will transition from FEMA to the SNS, according to HHS officials and documentation we received from ASPR.[38]

HHS has been a partner in many of the supply chain management efforts used to respond to COVID-19. Moreover, ASPR officials noted that these activities would help augment their current capabilities as the lead for the public health and medical services response.[39] However, this amount of responsibility at the scale the response necessitates may require continued support from HHS's federal partners to sustain the progress made to date for the duration of the pandemic.

For example, ASPR will take over supply acquisition responsibilities from DOD, including awarding funds for domestic production expansion projects, which DOD and ASPR officials said requires knowledge of the DPA and other applicable authorities to execute. However, only three of ASPR'S 20 contracting officers had experience using DPA authorities prior to COVID-19, according to agency officials, and hiring could be a challenge. ASPR officials acknowledged that they will need to hire acquisition staff with expertise in DPA contracting in the future, adding that staff with such expertise can be hard to locate.

ASPR officials also noted they would require new authority to enable greater supply acquisition coordination through the SNS. Specifically, ASPR does not currently have the authority to sell to, or enter into joint acquisition agreements with, states, which ASPR officials said would benefit state, local, tribal, and territorial governments.

We found that federal partners have not yet determined in what capacities or for how long they will continue to support HHS as the department takes on these additional responsibilities.

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[38]According to ASPR and FEMA officials, FEMA has been responsible for fulfilling the request or assigning it to another agency to complete, such as to ASPR's SNS. While the timing and aspects of the supply fulfillment transition are still being discussed, FEMA and ASPR officials told us that they will keep the front-end process whereby state, local, tribal, and territorial governments make requests for supplies through FEMA the same for continuity purposes.

[39]The National Response Framework is an all-hazards response structure to coordinate federal resources during emergencies and disasters. It divides the federal response into 15 emergency support functional areas that are most frequently needed during a national response. ASPR leads Emergency Support Function #8 on behalf of the Secretary of Health and Human Services.

ASPR officials said they meet weekly with other agency counterparts to discuss the logistics for transitioning responsibilities beginning in September, but have not yet developed written plans because the response necessitates a constant real-time evaluation of each agency's abilities. Our prior work has identified leading practices that can help sustain collaboration, such as developing a plan identifying roles and responsibilities for parties included in the collaborative effort.[40] Transition planning efforts are under way for many of the responsibilities mentioned, but have not yet culminated in a document that clearly defines the roles and responsibilities in the various aspects of supply chain management.

It is critically important that HHS and FEMA work with their federal partners to define roles and responsibilities for managing the medical supply chain to sustain supply chain progress. Until HHS and FEMA work with their federal partners to immediately document roles and responsibilities for supply chain management functions transitioning to HHS, they risk losing the momentum and expertise developed up to this point in the response. Additionally, without clearly defined roles and responsibilities, the federal response structure may be unable to respond to new supply chain challenges that could emerge.

State, territory, and tribal challenges managing supplies. As the federal government works to procure and distribute supplies through multiple channels to meet critical medical supply needs, its state and other nonfederal partners have experienced a variety of challenges managing supply needs—such as tracking the status and delivery of supplies from the federal government and budgeting for ongoing needs. Interviews with state and territorial officials with responsibility for managing supply needs and budgets and associations representing state, territorial, and tribal officials have identified the following challenges:

- *Knowing when or which supplies will arrive***.** Officials from the majority of 10 states we interviewed, as well as officials from one FEMA regional office and an association representing emergency managers, described challenges regarding deliveries.[41] For example, an official from one state described frustrating experiences verifying the delivery of supplies and said that manifests containing tracking information often arrived several days behind the arrival of the actual shipment. The official noted that the people delivering federal supplies did not provide estimated times of arrival and said that on multiple occasions, the delivery went to a place other than the expected delivery site, requiring state officials to respond to phone calls at 2 or 3 a.m. to help manage the resulting confusion.

  An official from another state similarly described frustrations with uncertainty about when PPE would be delivered, saying that even a number of months into the response, the state's staff cannot say with any confidence when items will arrive; rather, shipments "just show up" without advance notice.

[40]GAO, *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms*, GAO-12-1022 (Washington, D.C.: Sept. 27, 2012) and *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005).

[41]The 10 states include the eight selected states discussed throughout this section and two additional states—Kansas and Iowa—that joined an interview with the National Emergency Management Association and offered individual perspectives and experiences from their own states.

- *Tracking deliveries made directly to local points of care*. Officials from the majority of the states we interviewed, as well as officials from one FEMA regional office, reported having trouble confirming that the right entities received correct and usable supplies when supplies provided through federal programs arrive directly at local points of care, such as hospitals, laboratories, or nursing homes. For example, officials from one state described trying to track supplies delivered directly to medical facilities, and after raising the issue with FEMA and HHS representatives, received only a list of which counties received the supplies but not the specific facilities where those supplies were delivered. Another state official in a different FEMA region said that the FEMA regional office provided information stating that FEMA had shipped supplies to somewhere in the state, but the information did not specify where the supplies went or to whom they were delivered.

- *Budgeting for ongoing supply needs*. State officials described challenges determining how to best apply funding from various federal programs and make budgeting decisions for future supply needs:
    - Officials from the majority of the 10 states we interviewed expressed concerns and frustrations over uncertainty about whether and to what extent states and other recipients would be responsible for sharing the cost of supplies provided by the federal government. Officials from the majority of FEMA regional offices we interviewed also described states' confusion about reimbursement, cost share responsibility, and concerns about potential duplication of benefits. FEMA generally reimburses 75 percent of the eligible cost of medical supplies that states purchase under its Public Assistance program and received through mission assignments.[42] Conversely, supplies that states and other recipients receive directly from the SNS are covered at 100 percent and are not subject to cost sharing. To illustrate, officials from at least two states described being uncertain as to which supplies and delivery efforts were provided by FEMA programs and which were provided through another federal channel because shipments did not always contain paperwork indicating the provider, compounding confusion about whether their states would be responsible for sharing the cost for such supplies and activities.

    - State officials also reported that different timelines and guidance for FEMA's Public Assistance Program and the CRF make it difficult for nonfederal entities to optimize resources from these programs. Certain supplies are eligible under both programs. In addition, the Department of the Treasury (Treasury) has provided information describing use of the CRF to meet the nonfederal cost share for FEMA assistance. Therefore, state, territorial, and tribal officials have to make decisions about the best way to apply these funds to meet their medical supply needs. According to one state official, the different timelines and requirements for each program, particularly the requirement that payments from the CRF may only be used to cover costs incurred by

[42]See 44 C.F.R. § 206.47 (2019). This nonfederal cost share can be waived or reduced. However, to date, no such waiver or reduction has been approved. FEMA may recommend that the federal cost share be increased to 90 percent whenever a disaster is so extraordinary that actual federal obligations under the Stafford Act, excluding FEMA administrative cost, meet or exceed a certain qualifying threshold. See 44 C.F.R. § 206.47(b) (2019). If warranted by the needs of the disaster, FEMA may recommend up to 100 percent federal funding for a limited period in the initial days of the disaster irrespective of the per capita impact. 44 C.F.R. § 206.47(d) (2019).

the end of calendar year 2020, have made deciding the best way to use these funds challenging. [43] Completing Public Assistance projects typically takes time, and users can face delays during the review and approval process.

Challenges tracking supplies limit the ability of state, territorial, and tribal officials to determine if their supply requests have been met, which orders are pending, and what additional requests they may need to make. These tracking challenges, combined with uncertainty about the eventual cost share responsibility states and other nonfederal entities have, limits the information they can use to understand their overall supply picture and to budget for ongoing and future supply needs.

The PanCAP Adapted anticipates that states would request federal assistance when requirements exceeded state, local, tribal, and territorial capabilities to respond to COVID-19. In addition, it describes the responsibilities of federal agencies to ensure stabilization of the medical supply chain, including the distribution of critical medical supplies. However, for the distribution of supplies, it focuses on use of the SNS, and as we reported in June 2020, nationwide need for critical supplies to respond to COVID-19 quickly exceeded the quantity of supplies contained in the SNS.[44] When this condition became clear, the federal government and its nonfederal partners had to employ numerous additional avenues to meet supply needs.

Findings from Crimson Contagion—a 2019 national exercise that approximated some of the conditions of the COVID-19 pandemic—foreshadowed this challenge.[45] The findings noted that resource request and allocation tracking was not transparent to the range of state, local, tribal, territorial, and federal response partners because these resources are all tracked via different processes in different systems and across several agencies, which posed a challenge to developing a comprehensive common operating picture to track resource needs and supply movement.

The provision of supplies through federal programs for COVID-19 involved using systems that previously had not worked together to deliver supplies at this scale or in a situation with this level of worldwide resource scarcity, and required pursuit of numerous avenues to try to meet the needs. For example, one FEMA region reported that its states and territories sourced PPE requests through all of the following channels: (1) state and federal stockpiles, (2) existing contracts (while applying for reimbursements through FEMA's Public Assistance Program), (3) FEMA mission assignments, and (4) donations.

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[43]See 42 U.S.C. § 801(d)(3).

[44]GAO-20-625.

[45]The Crimson Contagion 2019 Functional Exercise, conducted August 13–16, 2019, exercised the nation's ability to respond to a large-scale outbreak of a novel avian influenza virus (H7N9) strain, which quickly spreads via human-to-human transmission around the world and across the continental United States with high rates of morbidity and mortality. The exercise was a multistate, whole-of-government effort focused on the response and policy issues of workforce viability, critical infrastructure protection, economic impact, social distancing, scarce resource allocation, prioritization of vaccines and other countermeasures, and medical surge operations. As we reported in June 2020, HHS officials told us they had not been able to address the Crimson Contagion findings because they were busy responding to the COVID-19 pandemic. FEMA officials similarly told us that because the draft findings and recommendations were compiled 2 months before reports of the novel coronavirus emerged, they were not able to implement solutions before the pandemic response began. Because the capabilities needed to visualize end-to-end deliveries across multiple entities are complex, it is understandable that more time will be required to devise solutions.

The scale and nature of this response, global supply shortages, and rapidly shifting ground conditions have added to the challenges faced by states, territories, and tribes—some of which are working with their own complex organizational arrangements, such as large and decentralized health care networks consisting of both public and private entities. At the same time, state officials and FEMA regional officials we interviewed have noted that federal guidance and communication to help address these issues have not always been provided consistently and effectively to state decision makers to help them to stay abreast of changing conditions and policy interpretations.

Further, standards for internal control state that management should communicate the necessary quality information externally to achieve the entity's objectives and address related risks.[46] In the case of the COVID-19 response, providing the states, territories, and tribes with clear and consistent information about critical supply needs is an indispensable part of supporting their critical role in response to nationally significant biological incidents like COVID-19. In addition, it will be important in the immediate term as the crisis continues.

Officials from the Advisory Group told us they are able to track daily transactional information from six major medical supply distributors. By tracking orders from hospitals, nursing homes, and other users to help understand the aggregate national demand; monitoring movement of materials from manufacturers to distributors; and monitoring order fulfillment, the Advisory Group is able to visualize where supplies are moving in the country.

Nevertheless, the challenges that states, territories, and tribes have faced in tracking the status and fulfillment of supplies continue to hamper their efforts to plan for and help ensure their supply needs are met. Officials from the Advisory Group acknowledged that, although the group shares what it can of the information it uses to visualize supply demand and usage nationwide, some of this information is proprietary and there are limits on sharing with nonfederal partners. At the same time, officials from the Advisory Group noted that some states have had more success tracking supplies delivered through federal and other channels, and there may be an opportunity to identify best practices that help states better monitor their overall supply operating picture.

As the nation prepares for additional COVID-19 cases this fall and winter, it is essential that agencies leading the response through the UCG take steps to address the information challenges nonfederal partners are experiencing and help ensure better capability in the coming months. The UCG has the opportunity to design interim systems and guidance and disseminate best practices to help address the challenges states, territories, and tribes face in the immediate COVID-19 response effort. Until these agencies devise such interim solutions to address challenges tracking the status of supply requests during the pandemic, states and other nonfederal entities will continue to be limited in their ability to plan for supply needs for the remainder of the COVID-19 pandemic response.

Given the complexity of the problem, the number of federal and nonfederal entities involved, and the complex and decentralized environment in which a response like this operates, building long-term capability solutions will be challenging. Establishing reliable, end-to-end logistics tracking capabilities from points of care back through the multiple distribution channels required in a

[46]GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 10, 2014). According to internal control principle 15.02, open two-way external reporting lines allow for this communication.

response of this scale is a significant undertaking and not likely to be resolved in the near term. We have ongoing and planned work on planning and building capabilities for nationally significant biological events, as well as work on the future of the SNS. We will continue to monitor long-term issues and solutions through this work.

GAO Recommendations Related to the Medical Supply Chain

- The Secretary of Health and Human Services in coordination with the Administrator of the Federal Emergency Management Agency—who head agencies leading the COVID-19 response through the Unified Coordination Group—should immediately document roles and responsibilities for supply chain management functions transitioning to the Department of Health and Human Services, including continued support from other federal partners, to ensure sufficient resources exist to sustain and make the necessary progress in stabilizing the supply chain, and address emergent supply issues for the duration of the COVID-19 pandemic. (Recommendation 1)
- The Secretary of Health and Human Services in coordination with the Administrator of the Federal Emergency Management Agency—who head agencies leading the COVID-19 response through the Unified Coordination Group—should further develop and communicate to stakeholders plans outlining specific actions the federal government will take to help mitigate remaining medical supply gaps necessary to respond to the remainder of the pandemic, including through the use of Defense Production Act authorities. (Recommendation 2)
- The Secretary of Health and Human Services —who heads one of the agencies leading the COVID-19 response through the Unified Coordination Group—consistent with their roles and responsibilities, should work with relevant federal, state, territorial, and tribal stakeholders to devise interim solutions, such as systems and guidance and dissemination of best practices, to help states enhance their ability to track the status of supply requests and plan for supply needs for the remainder of the COVID-19 pandemic response. (Recommendation 3)
- The Administrator of the Federal Emergency Management Agency—who heads one of the agencies leading the COVID-19 response through the Unified Coordination Group—consistent with their roles and responsibilities, should work with relevant federal, state, territorial, and tribal stakeholders to devise interim solutions, such as systems and guidance and dissemination of best practices, to help states enhance their ability to track the status of supply requests and plan for supply needs for the remainder of the COVID-19 pandemic response. (Recommendation 4)

Source: GAO. | GAO-20-701

Testing Capacity

Federal agencies have taken several key actions in recent months to increase testing. Diagnostic testing in the U.S. increased in July compared to June, while remaining about the same from July to August, according to testing data available on the HHS website.[47] However, testing capacity has struggled at times to keep up with increased demand, driven in part by the supply shortages described above. This has led to some delays in turnaround times for testing results. HHS and

[47]We analyzed testing data for June, July and August 2020 that we downloaded from HHS's website. According to HHS, the data represent viral COVID-19 laboratory test (polymerase chain reaction) results from laboratories in the United States, including commercial and reference laboratories, public health laboratories, hospital laboratories, and other testing locations. The data may not include results from all testing sites, such as point-of-care test sites, nor do they include COVID-19 antigen testing results, which are a specific type of viral test that can be administered at the point-of-care. According to HHS, point-of-care tests represented about 25 percent of all testing in the United States in August 2020. HHS notes on its website that the testing data reflect the majority, but not all, COVID-19 tests in the United States, and that the data are provisional and subject to change. Testing data were available for download on https://healthdata.gov/dataset/covid-19-diagnostic-laboratory-testing-pcr-testing-time-series, accessed September 4, 2020.

some researchers suggest that in light of testing constraints, tests should be prioritized for people with symptoms and other high-risk populations. Emerging testing innovations and approaches may offer increased access to testing moving forward.

Key federal actions to support testing. HHS has undertaken several key actions to expand testing levels and capacity since our June report.[48] HHS's COVID-19 Strategic Testing Plan states that the role of the federal government is to provide strategic guidance and help scale supplies, among other things, while states, territories, and tribes are responsible for formulating and implementing testing plans.[49]

- *Continued federal expenditures for testing*. The COVID-19 relief laws appropriated a total of $26.5 billion to HHS to support COVID-19 testing. HHS reported total testing-related obligations of about $14.35 billion as of July 31, 2020, and total expenditures of $1.17 billion.[50] See table 1 for HHS-reported obligations and expenditures for testing-related activities.

Table 1: HHS's Reported Obligations and Expenditures for Testing-Related COVID-19 Response Activities, as of July 31, 2020

Key Activity	Obligations ($ billions)	Expenditures ($ billions)	Percentage of obligations expended, as of July 31, 2020
Support to state, local, territorial, and tribal organizations' preparedness	$12.690	$0.867	7%
Testing for uninsured	0.163	0.161	99
Testing	1.496	0.137	9
Total	**14.349**	**1.165**	**8**

Source: GAO analysis of Department of Health and Human Services (HHS) information. | GAO-20-701

Note: the percentages represent the share of obligations for each key activity that were expended as of July 31, 2020.

We requested information from HHS to explain why expenditures represent a small share of total obligations. HHS responded that it was primarily due to the slow rate at which states have used the funds they were awarded; however, HHS's response did not address why its expenditures of amounts allocated for federal testing activities comprised 9 percent of its

[48] GAO-20-625.

[49] Department of Health and Human Services, *Report to Congress: COVID-19 Strategic Testing Plan*. HHS is required under the Paycheck Protection Program and Health Care Enhancement Act to update the plan every 90 days until funds provided under the act are expended. Pub. L. No. 116-139, div. B, tit. I, 134 Stat. at 626-27.

[50] According to CDC officials, $10.25 billion in funds provided under the Paycheck Protection Program and Health Care Enhancement Act were obligated for awards to states, territories, and local jurisdictions through CDC's Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases cooperative agreement to help them expand their testing and contact tracing capacity, among other things. An HHS official told us that recipients draw down funds in accordance with their own jurisdictional policies and practices. In addition, the Indian Health Service will provide $750 million to IHS, tribal, and urban Indian Health programs to expand testing capacity and testing-related activities.

obligations. HHS noted that the length of time it will take to spend all federal appropriations allocated for testing is highly dependent on the progression of the COVID-19 pandemic and its impact on specific U.S. geographic locations and populations.
The Paycheck Protection Program and Healthcare Enhancement Act required each state, territory, or local jurisdiction receiving funding to submit to HHS a plan for how they will meet their testing targets.[51] Officials from states we interviewed told us they intend to use these funds to support testing in various ways, such as by procuring additional testing supplies when available, creating partnerships with local private sector entities to expand testing capacity, improving mobile testing capacity, expanding the laboratory and epidemiological workforce, and investing in information technology upgrades. HHS officials told us that the funding is available to recipients for 30 months and is expected to be expended over time.

- *Enhanced support for testing supplies.* As described above, FEMA and HHS have continued to procure swabs, transport media, and point-of-care tests on behalf of states and territories. FEMA and HHS also procured point-of-care tests on behalf of certain federal agencies.[52] HHS will continue to procure these supplies through December 2020.

- *Invested in new testing technologies*. In late July, the National Institutes of Health's (NIH) Rapid Acceleration of Diagnostics (RADx) initiative awarded contracts totaling nearly $250 million to seven companies to support new testing technologies. NIH stated that these investments have the potential to increase the number, type, and availability of tests by fall 2020.[53] Four of the technologies could increase testing capacity while reducing the time to receive test results. Three of the technologies use platforms that can give rapid results in non-laboratory settings, such as work sites, nursing homes, and schools. In early September, NIH announced an additional round of awards totaling over $129 million to nine companies.[54]

- *Invested in capacity expansion for two laboratories.* On August 13, 2020, HHS announced a $6.5 million dollar investment in two commercial laboratories.[55] Specifically, the agency is providing these companies with resources, such as testing equipment and supplies, to increase testing capacity by up to an additional 4 million tests per month starting in early October.

- *Expanded support for testing sites.* HHS established public-private partnerships with a commercial laboratory company and retail pharmacy and grocery store chains to implement

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[51]Pub. L. No. 116-139, div. B, tit. I, 134 Stat. at 624. States submitted interim plans that covered May and June in late May, and plans for July through December were submitted on July 10. According to HHS, states' testing targets for May and June 2020 ranged from testing 2 percent of each state's population to nearly 15 percent each month.

[52]Some of the other agencies include the Indian Health Service, the Department of Veterans Affairs, and the Department of Energy.

[53]See National Institutes of Health, "NIH Delivering New COVID-19 Testing Technologies to Meet U.S. Demand" (July 31, 2020), accessed August 6, 2020, https://www.nih.gov/news-events/news-releases/nih-delivering-new-covid-19-testing-technologies-meet-us-demand.

[54]See National Institutes of Health, "NIH continues to boost national COVID-19 testing capacity" (Sept. 2, 2020), accessed September 4, 2020, https://www.nih.gov/news-events/news-releases/nih-continues-boost-national-covid-19-testing-capacity.

[55]See Department of Health and Human Services, "HHS Invests in Diagnostic Labs to Expand COVID-19 Testing Capacity in the United States" (Aug. 13, 2020), accessed August 18, 2020, https://www.hhs.gov/about/news/2020/08/13/hhs-invests-in-diagnostic-labs-to-expand-covid-19-testing-capacity-in-the-united-states.html.

and reimburse testing through August 2020.[56] As of mid-August, these sites had tested more than 1.6 million individuals, according to HHS documentation. In addition, HHS set up surge temporary testing sites in multiple communities to increase federal support in areas with recent spikes in new cases and hospitalizations.[57]

- *Clarified guidance and implemented enforcement mechanisms to enhance testing data.* Shortly before the August 1, 2020 testing data reporting deadline, HHS published implementation specifications with standard definitions for all of the data that laboratories are required to report to CDC through state and territorial health departments.[58] These specifications are aimed to help improve the quality of testing data CDC receives, and in turn allow the agency to more accurately monitor testing. According to CDC, 40 of the 56 states and territorial jurisdictions had completely developed the capability to relay detailed testing data to CDC as of August 24, 2020.

  To improve consistency and uniformity in the reporting of testing data, on September 2, 2020, CMS published an interim final rule that provides sanctions for laboratories that fail to report COVID-19 testing data consistent with the form and manner specified by HHS.[59] We will monitor the implementation of this guidance in our ongoing work.

Testing capacity constraints. Although HHS has undertaken efforts to increase testing across the country, laboratory testing capacity has been constrained due to shortages in supplies and equipment, as well as increased demand for tests associated with emerging hotspots in disease transmission. These constraints have led to delays in the turnaround times for testing results. Such delays have multiple serious consequences, including delays in isolating and tracing the contacts of those who test positive, which can exacerbate outbreaks by allowing the virus to spread undetected.

Two large commercial laboratories reported delays in July 2020:

- In early July, LabCorp announced on its website that its average time to deliver test results was 4 to 6 days, citing constraints in the availability of supplies and equipment.[60]

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[56]This partnership program has supported nearly 800 testing sites. After federal payments end, the program provides testing sites an option for reimbursement through private insurance, Medicare, and Medicaid. According to HHS officials, these testing sites can submit claims for reimbursement for testing services provided to the uninsured to the COVID-19 Uninsured Program, which is administered by HRSA. In some states, Medicaid is the primary payer for COVID-19 testing for uninsured individuals because state Medicaid programs have requested and received CMS approval to cover this testing.

[57]HHS provided federal support to establish temporary testing sites that each offered 5,000 no-cost tests per day for a period of 5 to 12 days.

[58]Department of Health and Human Services, *COVID-19 Lab Data Reporting Implementation Specifications*, (July 31, 2020), accessed August 3, 2020, https://www.hhs.gov/sites/default/files/hhs-guidance-implementation.pdf.

[59]85 Fed. Reg. 54,820, 54,873 (Sep. 2, 2020).

[60]LabCorp, "Media Statement: Testing Demand and Result Timeframe: July 8, 2020," accessed July 8, 2020, https://www.labcorp.com/coronavirus-disease-covid-19/labcorp-newsroom/media-statement-testing-demand-and-result-timeframe.

- Quest Diagnostics announced in late July that the average turnaround time for reporting test results had increased to 7 days or more for nonpriority populations.[61]

Both companies reported their turnaround times had decreased to 1-3 days by August 10, 2020, citing the use of new testing techniques that helped to increase their capacity.[62] Similarly, the Association of Public Health Laboratories reported that most public health laboratories were able to meet their COVID-19 testing demand in the first 2 weeks of August.[63] According to HHS documentation, 97 percent of tests run by six commercial laboratories returned results within 3 days by early September.[64] However, future surges in demand for tests could lead to further delays in testing turnaround times if laboratory supply shortages and other capacity constraints have not abated.

To help alleviate laboratory testing capacity constraints, HHS and some researchers have suggested that testing should be prioritized for certain populations. Some states have also recommended prioritizing testing for specific populations.

- In the HHS COVID-19 Strategic Testing Plan, submitted to Congress on August 22, 2020, HHS stated that communities seeing increased turnaround times for test results may choose to prioritize testing to only those who "need" a test according to CDC or state and local guidelines; however, HHS did not define who needs a test in this plan. Subsequently, on August 24, CDC revised its testing guidelines to state that asymptomatic individuals with a known exposure to COVID-19 do not necessarily need a test unless they are a vulnerable individual or their health care provider or state or local public health officials recommend a test. Further, the revised guidelines stated that asymptomatic individuals without a known exposure do not need to be tested.[65]

  Several public health organizations, including the American Medical Association, the National Association of County and City Health Officials, and others, have expressed concern over CDC's guidelines for asymptomatic people who have been exposed to COVID-19, citing the need for a rationale for the change. For example, the Association of American Medical Colleges expressed concern that the new CDC guidelines will result in less testing of asymptomatic individuals, who may go on to infect others if they carry the virus. GAO will continue to monitor this issue.

- Several states, including Alabama, California, Michigan, Minnesota, and Virginia, have issued guidelines for prioritizing testing of certain populations, such as people requiring hospitalization and health care workers. Guidelines from California, Minnesota, Michigan, and

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[61]Quest Diagnostics, "Quest Diagnostics Media Statement about COVID-19 Testing," accessed July 27, 2020, https://newsroom.questdiagnostics.com/COVIDTestingUpdates. Quest Diagnostics defines priority populations as hospital patients, pre-operative patients in acute care settings, and symptomatic health care workers.

[62]Quest Diagnostics also cited its efforts to reduce test orders for lower-risk patients.

[63]Association of Public Health Laboratories, "Lab Testing Capacity and Capability Survey Data Dashboard," accessed August 19, 2020, https://www.aphl.org/programs/preparedness/Crisis-Management/COVID-19-Response/Pages/COVID-19-Dashboard.aspx.

[64]The six laboratories, according to HHS, are LabCorp, Quest Diagnostics, BioReference Laboratories, Mayo Clinic, ARUP Laboratories, and Sonic Healthcare USA.

[65]CDC defined exposure as being within 6 feet of a person with a COVID-19 infection for at least 15 minutes.

Virginia recommend prioritizing testing for asymptomatic individuals who are close contacts of confirmed COVID-19 cases.

- In May 2020, the University of Minnesota's Center for Infectious Disease Research and Policy noted that the need for testing will likely far outpace capacity, particularly during surges, and recommended prioritizing testing based on CDC guidelines at that time.[66]

Emerging testing technologies and approaches. Recent innovations in testing technology provide the potential to alleviate capacity constraints. For example, in July 2020, FDA authorized the first two COVID-19 diagnostic tests for use with pooled samples.[67] In a pooled testing strategy, laboratories pool samples from multiple individuals in one batch to run a single test, and samples are subsequently tested individually only if the pooled batch returns a positive or inconclusive result.[68] According to LabCorp and Quest Diagnostics, two laboratory companies that have received authorizations for pooled testing, this technique can help to optimize testing capacity. The White House Coronavirus Task Force encouraged this testing approach for counties with a test positivity rate between 5 and 10 percent, stating that it could increase access to testing and reduce turnaround times for results.[69] Additionally, on August 15, 2020, FDA authorized a new laboratory-based saliva viral test that does not require specialized collection supplies or certain reagents that have been, at times, in short supply.[70]

In addition, as an alternative approach to addressing laboratory testing capacity constraints, some researchers have proposed an increased use of point-of-care antigen tests as a means to increase access to testing while reducing strain on laboratories.[71] Antigen tests can be administered and processed at care settings, such as clinics, and results are available in about 15 minutes,

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[66]Center for Infectious Disease Research and Policy, *COVID-19: The CIDRAP Viewpoint, Part 3: Smart Testing for COVID-19 Virus and Antibodies* (May 20, 2020). The report recommended prioritizing testing based on the following hierarchy: (1) those with symptoms who are critically ill and hospitalized; (2) symptomatic health care workers and first responders, symptomatic individuals in congregate living facilities, and symptomatic essential workers; (3) symptomatic individuals in the community, and (4) asymptomatic people living in congregate settings (e.g., long-term care facilities or homeless shelters).

[67]FDA authorized these two tests using an emergency use authorization. FDA may issue an emergency use authorization if the agency determines that certain medical products, such as a test, "may be effective" at diagnosing, treating, or preventing a disease, among other criteria. See 21 U.S.C. § 360bbb-3. An emergency use authorization allows tests to be made available in a much shorter time frame than typically would be necessary for approval or clearance, in part because it requires a lower level of evidence than the "effectiveness" standard that is required for FDA product approvals and clearances. To approve tests outside of an emergency, FDA determines whether there is reasonable assurance that the tests are safe and effective for their intended clinical use or that they otherwise meet the applicable statutory standard.

[68]As of September 3, 2020, FDA had authorized four pooled tests. According to FDA officials, one of the authorized pooled tests can test samples from up to 7 individuals.

[69]White House Coronavirus Task Force, *Governors Report* (July 19, 2020).

[70]Department of Health and Human Services, "Coronavirus (COVID-19) Update: FDA Issues Emergency Use Authorization to Yale School of Public Health for SalivaDirect, Which Uses a New Method of Saliva Sample Processing" (Aug. 15, 2020), accessed August 16, 2020, https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-issues-emergency-use-authorization-yale-school-public-health.

[71]Antigen viral tests are a type of diagnostic test that detects the presence of a protein that is part of SARS-CoV and SARS-CoV-2. As of September 3, 2020, FDA had granted emergency use authorizations for four antigen tests.

eliminating the risk of delayed turnaround times. Antigen tests are also less costly than other viral diagnostic tests. However, antigen tests have lower sensitivity than other viral tests, meaning they have a higher chance of producing false negatives.[72]

- Public health researchers from the Rockefeller Foundation and Harvard University have called for an increased use of antigen tests in a screening capacity, including among asymptomatic individuals, noting that this approach would be useful when re-opening certain settings, such as schools and large workplaces.
- In July and August 2020, the federal government awarded contracts to manufacturers of three antigen tests to purchase or increase production of these tests. For example, HHS awarded a contract for the delivery of 150 million Abbott BinaxNOW COVID-19 Ag Card Point of Care tests, with the intention of distributing them for testing at schools and for testing other special needs populations.[73] Also, in August 2020, 10 states joined together to conduct group purchasing of 5 million antigen tests.[74]

We have a body of ongoing work related to testing, and we will continue to monitor testing levels and federal efforts to address testing capacity constraints, among other things.

Vaccine and Therapeutics Development, Manufacturing, and Distribution

Multiple federal agencies continue to support the development, manufacturing, and distribution of vaccines and therapeutics to prevent and treat COVID-19. Through Operation Warp Speed—a partnership between DOD and HHS, including HHS's Biomedical Advanced Research and Development Authority (BARDA), CDC, and NIH—DOD is supporting HHS in developing plans for nationwide distribution and administration of any licensed or authorized COVID-19 vaccine. However, as of September 4, 2020, HHS had not documented or shared its plans, being developed with support from DOD, with relevant stakeholders or the public. Early understanding of planning efforts—such as key assumptions being made about how a vaccine will be prioritized, allocated, and administered—is essential to help ensure that coordination takes place across all levels of government and with other stakeholders and that clear and consistent messages are shared with the public on the safety and efficacy of any available vaccines. On September 16, 2020, HHS and

[72]With this in mind, FDA stated that negative results from an antigen test may need to be confirmed with a polymerase chain reaction test. According to FDA, antigen tests generally have high specificity, meaning that positive results are highly accurate.

[73]In addition, the federal government used DPA authority to contract with two other antigen test manufacturers. Specifically, through its RADx program, NIH awarded a contract to expand manufacturing capacity for Quidel antigen tests from 84 million to 220 million per year, and DOD and HHS awarded a contract to Becton, Dickinson, and Company to expand manufacturing capacity of its antigen test by 50 percent, to more than 12 million test kits per month by the end of February 2021.

[74]As of August 19, 2020, states taking part in the testing compact, in collaboration with the Rockefeller Foundation, included Arkansas, Louisiana, Maryland, Massachusetts, Michigan, North Carolina, Ohio, Rhode Island, Utah, and Virginia.

DOD released two documents outlining a strategy for any COVID-19 vaccine. GAO will evaluate these documents and report on them in future work.

Federal efforts on developing and manufacturing vaccines and therapeutics. Federal agencies have provided funding to accelerate the development and manufacturing of vaccines and therapeutics for COVID-19.[75] (See fig. 5 for an overview of the traditional timeline for development and FDA licensure of a vaccine.) Many of these activities are part of Operation Warp Speed.[76]

- HHS and DOD have announced a total of about $12.6 billion in awards to support Operation Warp Speed and to accelerate the development, manufacturing, and distribution of COVID-19 vaccines and therapeutics, as of September 1, 2020.[77] For example, HHS and DOD announced an award of a $138 million contract for the production of more than 100 million prefilled syringes by the end of 2020.

- Manufacturing capacity is being advanced for selected Operation Warp Speed vaccine candidates while they are still in development; typically, large-scale manufacturing of vaccine occurs after it is shown to be safe, pure and potent (i.e., safe and effective). According to HHS, the federal government is taking a financial risk by manufacturing certain selected vaccines before information about the vaccines' safety and efficacy is known to ensure vaccines are available as soon as possible, once such information is determined.

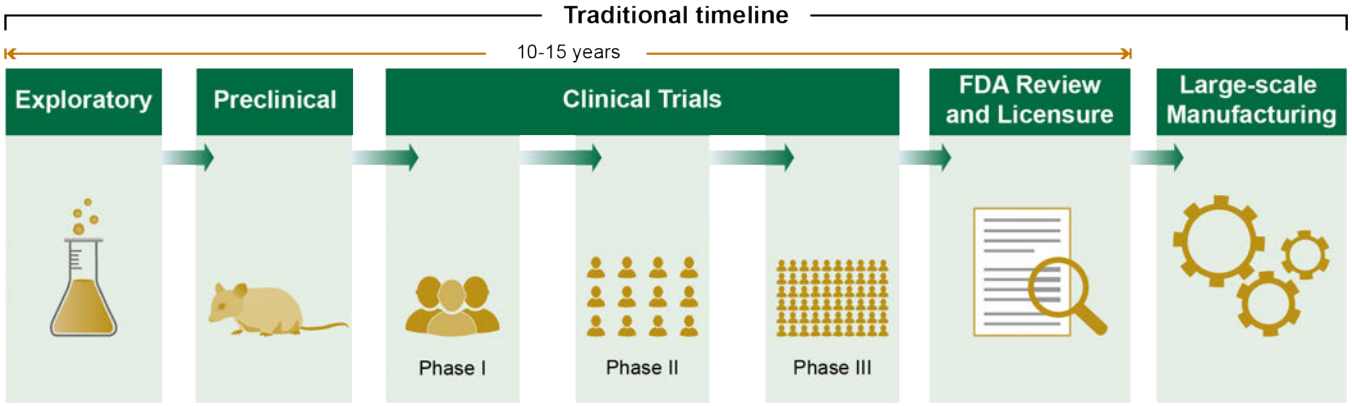
- A memorandum of understanding between DOD and HHS states that DOD will coordinate the logistics, supply chain, development, and manufacturing of vaccines and therapeutics in support of Operation Warp Speed, among other things.

[75]Our review is specific to federal efforts; there are also many nonfederal, privately funded efforts to develop vaccines and therapeutics, which are outside the scope of our review. Further, a World Health Organization document reported that as of September 3, 2020, 142 vaccine candidates were in preclinical evaluation globally, and 34 vaccine candidates were in clinical evaluation (phase 1 to phase 3 clinical trials). See World Health Organization, "Draft Landscape of COVID-19 Candidate Vaccines" (Sept. 3, 2020), accessed September 3, 2020, https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines.

[76]Secretary of Health and Human Services Alex Azar and Secretary of Defense Mark Esper oversee Operation Warp Speed, with Dr. Moncef Slaoui designated as chief advisor and General Gustave F. Perna confirmed to be chief operating officer. Department of Health and Human Services, "Fact Sheet: Explaining Operation Warp Speed" (Sept. 1, 2020), accessed September 3, 2020, https://www.hhs.gov/coronavirus/explaining-operation-warp-speed/index.html. DOD also launched an Operation Warp Speed website. See Department of Defense, *Coronavirus: Operation Warp Speed*, accessed August 18, 2020, https://www.defense.gov/Explore/Spotlight/Coronavirus/Operation-Warp-Speed/.

[77]This amount includes awards for the acquisition of medical materiel needed to administer vaccines and therapeutics, according to DOD.

Figure 5: Traditional Timeline for Development and Licensure of a Vaccine



Source: GAO analysis of Food and Drug Administration (FDA) and Pharmaceutical and Manufacturers of America information. | GAO-20-701

Note: Phase 1 clinical trials test the safety of a product with a small group of people (usually less than 100). Phase 2 clinical trials look at questions such as the maximum tolerated dose, the optimal schedule for giving the product (how many doses and at what time intervals), and whether the immune system is having the desired responses. These studies are conducted with a medium-size population of volunteers (usually a few hundred to 1,000). Phase 3 clinical trials look at things like whether the product prevents new infections or, if people become infected, if the product helps control the infections so they do not become severe. These studies involve many thousands of people, usually including participants who are at increased risk for infection.
Additionally, licensure of a vaccine requires that the establishment in which the vaccine is manufactured, processed, packed, or held meets standards designed to assure that the vaccine continues to be safe, pure, and potent (i.e., safe and effective).

Additionally, BARDA is making investments in the development of vaccines and therapeutics for COVID-19.

- As of August 18, 2020, BARDA had awarded about $10.8 billion in support of seven vaccine candidates; these awards included support for the development, manufacturing, and purchase of vaccine doses. Of these seven vaccine candidates, one was in phase 1 of clinical trials, one was in phase 1 and phase 2 of clinical trials, one was in phase 2, three were in phase 3, and the remaining vaccine candidate was not yet in clinical trials, as of September 3, 2020.[78]
- BARDA also awarded about $1 billion for nine therapeutic candidates as of August 18, 2020, and two of these candidates were in phase 1 of clinical trials, one was in phase 2 of clinical trials, and one was in phase 3 trials as of September 1, 2020. In addition, two therapeutics that received BARDA awards had been in phase 3 clinical trials but were no longer supported by BARDA.[79]

[78]Six of the seven vaccine candidates receiving awards from BARDA are part of Operation Warp Speed, according to HHS, and as such, part of the award amount reported for BARDA is also included in the Operation Warp Speed award amounts cited previously.

[79]One therapeutic candidate (sarilumab) had been in a phase 3 clinical trial, but as of July 2, 2020, the trial was stopped and was no longer receiving federal funding because it did not meet its primary and key secondary endpoints. Specifically, minor positive results from the trials were not statistically significant and there was the presence of severe adverse events, such as multi-organ dysfunction syndrome, according to the manufacturer. Another therapeutic candidate (tocilizumab) had also been in a phase 3 clinical trial, but as of July 29, 2020, the trial stopped and the therapeutic was no longer supported by BARDA. During the trial, the drug did not meet its primary

NIH has also established a COVID-19 Prevention Network that aims to enroll thousands of volunteers in large-scale phase 3 trials of vaccines and of monoclonal antibodies—laboratory-made antibodies that may be able to serve as another prevention option until a vaccine becomes available.[80] For each of the phase 3 trials, NIH is working to enroll 30,000 people and include as diverse a population as possible, including different racial and ethnic groups and a range of age groups, according to HHS.[81]

Federal efforts on distribution, including prioritizing and allocating vaccine. The federal government has taken some steps to begin determining how any licensed or authorized vaccine might be distributed, including which groups may have priority and how it might be allocated and administered. Among actions taken are the following:

- *HHS and DOD announced that McKesson Corporation will be a central distributor of COVID-19 vaccines and related supplies in support of Operation Warp Speed.* McKesson, which distributed the H1N1 vaccine during the H1N1 pandemic, will work under CDC's guidance to deliver COVID-19 vaccine to administration sites, according to HHS and DOD announcements released on August 14, 2020.

- *HHS has announced it is planning a tiered approach for vaccine distribution.* This tiered approach will build on a methodology developed as part of pandemic influenza planning and will be adjusted based on experience during the first wave of the COVID-19 response, among other things, according to an Operation Warp Speed Fact Sheet.

- *CDC and NIH have sponsored a committee of experts to develop a framework to assist policymakers in planning for the equitable allocation of COVID-19 vaccine*. This committee—convened through the National Academies of Sciences, Engineering, and Medicine and the National Academy of Medicine—held its most recent public meeting in early September 2020. On September 1, 2020, the committee released a discussion draft of a potential allocation framework for public comment.[82] The committee's final report, expected early this fall, will include a final recommended allocation framework, according to a press release announcing the draft framework. The press release also noted that the committee's final report will address related

endpoint of improved clinical status in patients with COVID-19-associated pneumonia, or its key secondary endpoint of reduced patient mortality, according to the manufacturer.

[80]Monoclonal antibodies usually only last for a few months, thus potentially requiring people to get multiple infusions or injections on a regular schedule for them to remain effective.

[81]We have reported on existing mistrust of clinical research stemming from historical events among African Americans, such as the Tuskegee Syphilis Study, and a manufacturer's efforts to address these issues to increase participation of racially and ethnically diverse populations. See GAO, *Investigational Drugs: FDA and Drug Manufacturers Have Ongoing Efforts to Facilitate Access for Some Patients*, GAO-19-630 (Washington, D.C.: Sept. 9, 2019). We have also reported on the importance of including women in clinical research; see GAO, *National Institutes of Health: Better Oversight Needed to Help Ensure Continued Progress Including Women in Research*, GAO-16-13 (Washington, D.C.: Oct. 22, 2015).

[82]National Academies of Sciences, Engineering, and Medicine 2020. *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine* (Washington, D.C.: Sept. 1, 2020), accessed September 4, 2020, https://www.nap.edu/catalog/25914/discussion-draft-of-the-preliminary-framework-for-equitable-allocation-of-covid-19-vaccine.

issues, such as vaccine hesitancy, demand, and promotion as well as risk communication and strategies for community engagement.[83]

- *CDC's Advisory Committee on Immunization Practices has established a COVID-19 vaccine work group to consider approaches for vaccine distribution*.[84] This work group intends to collect, analyze, and prepare information related to COVID-19 vaccines for presentation, discussion, deliberation, and vote by the advisory committee.[85] It is expected to make recommendations on the groups for vaccine prioritization to CDC and HHS leadership.[86] As of August 26, 2020, these recommendations had not yet been made. According to HHS, the advisory committee recognizes that vaccine prioritization will be an iterative process that will be continually refined as more information about the COVID-19 virus, vaccines, and vaccine availability becomes known.

- *CDC sent early distribution planning documents to states.* CDC sent several documents to state and local jurisdictions in late August 2020 to help them prepare for COVID-19 vaccination. These documents include (1) planning scenarios for state and local jurisdictions to use to develop operational plans for early COVID-19 vaccination when vaccine supply may be constrained, (2) planning assumptions, such as the potential timing for initial availability of a vaccine and storage and handling requirements, and (3) a checklist of early planning action items, such as identifying existing community vaccination providers.

Representatives of state, local, and territorial health officials and health care providers, including physicians, nurses, and immunization managers we interviewed, emphasized the need for the federal government to develop and share plans for the distribution and administration of COVID-19 vaccine before one becomes available. For example:

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[83]NIH and CDC requested that the committee consider the criteria that should be used to set priorities for equitable distribution among potential vaccine recipients. In its draft discussion framework, the committee identified four risk-based criteria: (1) the risk of acquiring infection because of greater exposure to the virus; (2) the risk of severe morbidity and mortality, giving higher priority to individuals at greater probability of severe disease or death from infection; (3) the risk of a negative social impact for individuals providing those functions upon which other people's lives and livelihood directly depend; and (4) risk of transmitting disease to others.

[84]The Advisory Committee on Immunization Practices is comprised of medical and public health experts who make recommendations on the use of vaccines in the civilian population of the United States. Its recommendations serve as public health guidance for safe use of vaccines and other related products.

[85]According to CDC, the COVID-19 vaccine work group has 41 members, including advisory committee voting members, liaisons, ex-officios, and consultants with expertise in epidemiology, vaccine safety, vaccinology, immunology, general medicine, geriatrics, pediatrics, obstetrics and gynecology, immunocompromised hosts, vaccine administration and delivery, public health and surveillance, ethics, health equity, communications, and emergency preparedness.

[86]The work group assumed the initial number of COVID-19 vaccine doses will be limited, which will affect which populations might be prioritized. At the July 29, 2020, public meeting, the work group proposed prioritizing essential workers, such as health care professionals, and high-risk populations, such as the elderly. At the August 26, 2020 meeting, the work group identified potential challenges with vaccine distribution and administration, such as storage and specific handling requirements for vaccine; holding mass vaccination clinics while maintaining social distancing; and reaching those in rural areas and racial and ethnic minorities.

- *Representatives said they would need time to enroll additional providers if a COVID-19 vaccine is distributed using the established immunization network* that was used during the H1N1 pandemic in 2009.[87]
- *It will be important to consider if using uniformed military personnel will improve or undermine confidence in a COVID-19 vaccine*, if DOD is expected to play a role in vaccine distribution and administration. This is particularly true in certain minority and underserved communities, where trust in the medical and political systems is strained, according to state, local, and territorial health officials.
- *Advanced planning will be needed to develop and disseminate clear public health messaging to help ensure public acceptance and uptake of the vaccine.* It will be important to address vaccine hesitancy for people concerned about the safety or effectiveness of the vaccine and to manage expectations about vaccine availability, according to representatives of state, local, and territorial health officials and immunization managers.[88]

HHS officials agreed that developing a national plan is critical. In congressional testimony on July 2, 2020, HHS officials said that critical plans needed to be developed for how a COVID-19 vaccine would be distributed and administered across the United States and that critical components include ensuring vaccine safety, effectiveness, and ultimately, vaccine confidence.[89] On September 4, 2020, HHS indicated that it would soon send a report to Congress outlining a distribution plan that takes into consideration the frameworks for vaccine distribution the department is developing, but did not provide a specific date for doing so.

In finalizing its distribution and administration plans, it will be important for HHS to define the specific roles and responsibilities for the various federal and nonfederal entities involved and include plans for public messaging to help ensure vaccine confidence. Our past work and that of others have demonstrated that proper planning—including incorporating best practices for project planning and scheduling and sharing information with stakeholders in a timely

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[87]During the H1N1 pandemic, the infrastructure of the Vaccines for Children program was used to distribute the vaccine. This is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of their families' inability to pay. The program, administered by CDC, distributes pediatric vaccines to states and health care providers. During the H1N1 pandemic, CDC used the program's central distributor to ship H1N1 vaccine; the use of this existing vaccine distribution system (enrolling additional providers to receive vaccine from the central distributor who were not part of the Vaccines for Children program) was generally cited as an effective way to distribute about 127 million of doses of H1N1 vaccine by state and local health officials.

[88]We have also previously reported that the need for clear and consistent communication to the public about vaccine availability was a lesson learned from the H1N1 pandemic. See GAO, *Influenza Pandemic: Lessons from the H1N1 Pandemic Should Be Incorporated into Future Planning,* GAO-11-632(Washington, D.C.: June 27, 2011).

[89]Francis Collins, Director, National Institutes of Health, Robert R. Redfield, Director, Centers for Disease Control and Prevention, and Gary Disbrow, Acting Director, Biomedical Advanced Research and Development Authority, *Hearing on Operation Warp Speed, vaccines, diagnostics, and therapeutics*, testimony before the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, 116th Cong., 2nd sess., July 2, 2020.

manner—will also be critical to the success of distributing and administering any licensed or authorized vaccine.[90]

By establishing a time frame for documenting and sharing a national distribution and administration plan, HHS, with support from DOD, can better ensure that all relevant stakeholders are best positioned to help plan and prepare for administering a vaccine and manage public expectations regarding a vaccine's availability, safety, and efficacy. Moreover, in developing a plan that is consistent with best practices for project planning and scheduling and outlines the approach for how efforts will be coordinated across federal agencies and nonfederal entities, HHS, with support from DOD, can help prepare for a timely, effective, and well-coordinated response involving any licensed or authorized vaccine. On September 16, 2020, HHS and DOD released two documents outlining a strategy for any COVID-19 vaccine. These documents were released after we completed our audit work and we will evaluate and report on them in future reports.

We will continue to conduct work related to vaccines and therapeutics, including examining federal efforts to accelerate the development, manufacturing, and distribution of COVID-19 vaccines and therapeutics through Operation Warp Speed. We also plan to continue work examining the federal government's plans to distribute and administer any licensed or authorized COVID-19 vaccine as well as plans for public messaging to stakeholders and the public about vaccine availability, efficacy, and safety.

GAO Recommendation Related to Vaccine Distribution

The Secretary of Health and Human Services, with support from the Secretary of Defense, should establish a time frame for documenting and sharing a national plan for distributing and administering COVID-19 vaccine, and in developing such a plan ensure that it is consistent with best practices for project planning and scheduling and outlines an approach for how efforts will be coordinated across federal agencies and nonfederal entities. (Recommendation 5)

Source: GAO. | GAO-20-701

HHS Efforts to Collect COVID-19 Data by Race and Ethnicity

HHS, particularly CDC, collects and makes publicly available data on various indicators of COVID-19 burden, including cases, hospitalizations, and deaths. CDC also collects and makes publicly available data on testing, such as the total number of positive tests out of the total number of tests reported.

[90]See *Schedule Assessment Guide: Best Practices for Project Schedules—Exposure Draft*, GAO-12-120G (Washington D.C.: May 30, 2012); GAO-11-632; and *Influenza Pandemic: HHS Needs to Continue Its Actions and Finalize Guidance for Pharmaceutical Interventions*, GAO-08-671 (Washington, D.C.: Sept. 30, 2008). In the *Schedule Assessment Guide,* we identified 10 best practices, such as the need to include all activities involved in the project's objectives and to sequence those events in a logical order. See also, Project Management Institute, *A Guide to the Project Management Body of Knowledge* (PMBOK® Guide)—Sixth Edition (2017). This guide describes that a project plan is a comprehensive document that defines the basis of all project work and describes how the project will be executed, monitored, and controlled. Additionally, *Standards for Internal Control in the Federal Government* states that, in deciding what information is required to achieve objectives, management should consider the needs of both internal and external users and that management should externally communicate necessary quality information in order to meet objectives. See GAO-14-704G.

Available data, although limited, suggest that a disproportionate burden of COVID-19 cases, hospitalizations, and deaths exists among racial and ethnic minority groups. For example, CDC found that non-Hispanic American Indian/Alaska Native persons were hospitalized with COVID-19 from March 1, 2020, to August 1, 2020, at a rate 5.2 times that of non-Hispanic White persons, and that non-Hispanic Black and Hispanic or Latino persons were hospitalized at a rate 4.7 times that of non-Hispanic White persons when adjusting for age.[91]

In addition, it is important to assess the potential long-term effects of those who have had COVID-19, including an examination of effects among different populations. Preliminary research suggests that individuals who have had COVID-19, including those who have been hospitalized, may suffer long-term health outcomes, such as heart, brain, or lung abnormalities.[92]

Gaps in data HHS collects by race and ethnicity and actions to improve data. The following describes four types of data HHS, including CDC, collects and gaps we identified in these data specific to race and ethnicity, as well as actions to improve some of these data.

- *Testing.* CDC publishes data on COVID-19 testing results on its website, such as the total number of positive tests out of the total number of tests reported. However, it does not include results by race and ethnicity, as these data are not typically collected by laboratories or sent to laboratories by providers, according to some stakeholders we interviewed.[93] We previously reported that since August 1, 2020, all laboratories have been required to report data on COVID-19 test results by race and ethnicity to CDC.[94] On July 31, 2020, HHS published guidance with standard definitions for all information that should be included in testing data, including categories to be used for race and ethnicity data.[95]

- *Cases.* CDC collects and makes available data on COVID-19 cases, including those that are probable or confirmed, from state and jurisdictional health departments. However, as of July 31, 2020, race and ethnicity data were not available for more than half—52.6 percent—of

[91]Centers for Disease Control and Prevention, *COVIDView: A Weekly Surveillance Summary of U.S. COVID-19 Activity* (Aug. 6, 2020).

[92]For example, see V. O. Puntmann et al., "Outcomes of Cardiovascular Magnetic Resonance Imaging in Patients Recently Recovered From Coronavirus Disease 2019 (COVID-19)," *JAMA Cardiology* (2020); L. Mao et al., "Neurologic Manifestations of Hospitalized Patients with Coronavirus Disease 2019 in Wuhan, China," *JAMA Neurology* (2020); and Y. Zhao et al., "Follow-up Study of the Pulmonary Function and Related Physiological Characteristics of COVID-19 Survivors Three Months after Recovery," *EClinicalMedicine* (2020).

[93]We interviewed or received written responses from stakeholders including the American Hospital Association, the American Medical Association, the Association of Public Health Laboratories, the Association of State and Territorial Health Officials, the Council of State and Territorial Epidemiologists, the COVID Tracking Project, the National Association of County and City Health Officials, and the National Independent Laboratory Association. These stakeholders were selected for a variety of reasons, including their representation of entities involved in the collection of data on indicators of COVID-19.

[94]The CARES Act included a provision requiring laboratories to submit the result of each COVID-19 test in a manner specified by the Secretary of Health and Human Services. Pub. L. No. 116-136, § 18115, 134 Stat. at 574. HHS guidance requires the reporting of test results by race and ethnicity. Department of Health and Human Services, *COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115* (June 4, 2020).

[95]Department of Health and Human Services, *COVID-19 Lab Data Reporting Implementation Specifications*.

cases with case report forms received by CDC, or 63.8 percent of total cases reported.[96] CDC officials stated that they have worked with state and local partners to improve the completeness of demographic data, including race and ethnicity, obtained through case reporting.

In addition, CDC updated its epidemiological case report form on May 15, 2020, to encourage state and jurisdictional health departments to report more detailed demographic case data, including race and ethnicity, when reporting case information.[97] CDC is also working to expand electronic case reporting through an initiative called Electronic Case Reporting Now, which the agency expects will improve the completeness of race and ethnicity data for cases.[98]

- *Hospitalizations.* CDC collects and makes available data on COVID-19 hospitalizations, including by race and ethnicity. CDC's COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) makes data available on hospitalizations by race and ethnicity. However, as of August 1, 2020, these data were limited to approximately 10 percent of the U.S. population because the data represent select counties in 14 participating states.[99] CDC also collects data on hospitalizations from states and jurisdictions that voluntarily report cases; however, according to CDC officials, these data are incomplete.

- *Deaths.* CDC collects and makes available data on COVID-19 deaths through death certificates collected in the National Center for Health Statistics' National Vital Statistics System (NVSS).[100] According to CDC, as of August 7, 2020, data on race and ethnicity were available for almost all (over 99 percent) of COVID-19 deaths reported through this system.

  CDC also collects and makes available data on deaths reported to the case surveillance system from state and jurisdictional health departments. However, CDC reported that as of July 30, 2020, several states did not provide data on race and ethnicity for deaths reported through case reporting. Race and ethnicity data were available for 83.4 percent of deaths with case report forms received by CDC, or 64.6 percent of total deaths reported through case reporting,

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[96]CDC officials noted that the number of cases with case report forms received by CDC is less than the total number of reported cases because there is generally a 2-week lag from when total cases are reported by state and jurisdictional health departments to when CDC receives the case report forms.

[97]See https://www.cdc.gov/coronavirus/2019-ncov/downloads/pui-form.pdf, accessed July 24, 2020. CDC does not require states or jurisdictions to complete case report forms, but rather encourages states and jurisdictions to voluntarily submit them along with other information they submit to CDC on case information.

[98]Electronic Case Reporting is the automated generation and transmission of case reports from electronic health records to public health agencies for review and action.

[99]COVID-NET is a surveillance system maintained by CDC that collects data on COVID-19 hospitalizations that are confirmed by laboratory testing. It includes data from hospitals in select counties in California, Colorado, Connecticut, Georgia, Iowa, Maryland, Michigan, Minnesota, New Mexico, New York, Ohio, Oregon, Tennessee, and Utah. As of August 1, 2020, approximately 6.4 percent of the data reported in COVID-NET lacked data on race and ethnicity.

[100]CDC's NVSS is maintained by its National Center for Health Statistics and is the source for official statistics on deaths in the United States. Deaths reported through this system do not distinguish between laboratory confirmed COVID-19 deaths and clinically confirmed COVID-19 deaths, including those for which COVID-19 is listed as a "presumed" or "probable" cause of death as indicated on death certificates.

as of July 31, 2020.[101] According to CDC, it is important to have complete data on deaths by race and ethnicity through case reporting because these data are generally available 2 weeks before data reported through NVSS, allowing state and jurisdictional health departments to identify trends more rapidly.

Gaps will likely persist in data by race and ethnicity. CDC expects that the steps it and HHS have taken will improve the availability of race and ethnicity information for some of the data it collects on testing and indicators of COVID-19 burden. However, gaps in data we identified will likely continue to persist for a variety of reasons, as described below.

- *Testing.* HHS's testing guidance requires laboratories to report demographic data and recommends that health care or other providers, such as public health testing providers who do not require a doctor's order, report demographic data to laboratories. However, some stakeholders we interviewed said it would be difficult for laboratories to comply with HHS's guidance on testing because providers may not collect demographic data from patients at the point of care and are unlikely to do so unless there are requirements or incentives associated with capturing these data.[102]

  To help address these difficulties, CDC officials stated that the agency has conducted outreach to provider organizations such as the American Medical Association to offer education and assistance on collecting testing data. HHS officials stated that ongoing support for health care providers will be needed to help ensure complete and consistent collection and reporting of testing data.

- *Cases.* CDC encourages state and jurisdictional health departments to report information on race and ethnicity through its case report form, but agency officials stated that CDC does not have the authority to require the reporting of this information. Further, CDC may not be receiving consistent race and ethnicity data on cases.
  HHS reported that as of June 25, 2020, 21 state health departments reported race for cases using combined categories, such as including American Indian/Alaska Native and Native Hawaiian/Pacific Islander in an "Other" category.[103] CDC noted that while its case report form includes these two racial groups as separate, state and jurisdictional health departments may report categories for race and ethnicity as "Other" within their state or jurisdictional case reporting systems. HHS stated that it is important to separate data on these two racial groups for testing and all indicators of COVID-19 burden, including cases, hospitalizations, and deaths.

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[101]CDC officials noted that the number of deaths with case report forms received by CDC is less than the total number of reported deaths through case reporting because there is generally a 2-week lag from when total deaths are reported by state and jurisdictional health departments to when CDC receives case report forms noting deaths.

[102]In addition to limitations on the collection of demographic information from point-of-care sites, such as physician's offices, we reported in June 2020 that testing data reported by CDC may not include all tests performed by laboratories at these locations. For more information, see GAO-20-625.

[103]HHS's Data Inclusion Policy uses the Office of Management and Budget's (OMB) standard categories for racial and ethnic groups specified in Office of Management and Budget, *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*, OMB Directive 15 (Oct. 30, 1997). OMB has established five minimum categories for race for federal programs to use in data collection: (1) American Indian or Alaska Native; (2) Asian; (3) Black or African American; (4) Native Hawaiian or Other Pacific Islander; and (5) White. There are two categories for ethnicity: (1) Hispanic or Latino and (2) Not Hispanic or Latino.

HHS explained that the practice of grouping race categories together into an "Other" category can disguise issues that may be unique to specific minority populations, which can further exacerbate existing disparities.

- *Hospitalizations.* CDC officials stated that the agency does not have plans to require hospitals to report race and ethnicity data for hospitalizations because it does not have the authority to do so. HHS recently released guidance that directs hospitals to provide hospital capacity and utilization data directly to HHS, rather than to CDC; however, this guidance does not include a requirement for hospitals to include race and ethnicity information in their reporting to HHS.[104] Although CDC officials stated that the agency's collection of hospitalization data, including race and ethnicity information, through COVID-NET has not been affected by this guidance, COVID-NET is limited to 14 participating states, and CDC officials noted that the agency has no immediate plans to expand it to additional states.

- *Deaths.* CDC officials stated that the agency does not have plans to require states to report race and ethnicity data for deaths reported through the case surveillance system because it does not have the authority to do so.

Electronic systems are incompatible and CDC does not have a comprehensive mechanism to assess long-term health outcomes. Gaps in race and ethnicity data may also persist due to electronic system incompatibilities, and CDC lacks a comprehensive mechanism to assess the long-term health outcomes of people who have had COVID-19.

- CDC officials noted that electronic systems that share data between providers, laboratories, and state and jurisdictional public health departments are often not compatible, resulting in difficulties in transferring complete information on race and ethnicity for testing and indicators of COVID-19 burden. For example, officials stated that information on race and ethnicity from patients' medical records may not be transferred electronically to laboratories when providers order tests. Further, the officials said that some state and jurisdictional public health departments are not able to automatically incorporate laboratory results, including any associated demographic data such as race and ethnicity, directly into their electronic surveillance systems for case reporting.

- In addition, CDC does not have a comprehensive mechanism to assess the long-term health outcomes of people who have had COVID-19, including by race and ethnicity, to identify potential long-term health effects, such as heart, brain, or lung abnormalities over many months and years. CDC stated that it is funding several studies, including a cohort study that will follow 3,900 patients with COVID-19 6 months after infection, to assess potential complications from COVID-19, including by race and ethnicity. Two additional studies will examine long-term health outcomes of persons with COVID-19 in specific groups, such as

[104]As of July 15, 2020, HHS announced that hospitals and acute/post-acute medical facilities should no longer send COVID-19 daily capacity and utilization data to CDC's National Healthcare Safety Network, a system for tracking health-care-associated infections. Rather, they are directed to report the information to HHS through one of four specified methods, such as through TeleTracking (an HHS contractor) or through their states, if approved by HHS. Data collected by HHS will be provided through the HHS Protect Public Data Hub, https://protect-public.hhs.gov/. According to CDC, this announcement does not affect hospitalization data reported through COVID-NET.

American Indian populations. However, these studies are limited to specific groups and time frames, so they are not able to identify long-term health outcomes across other population subgroups that are not included.

Some research institutions have recommended the formation of registries that identify and follow individuals who have had COVID-19 over time to better understand the long-term effects on individual and population health.[105] Further, it may be important for CDC to coordinate with other HHS agencies, such as NIH, which conducts and funds long-term public health studies. Assessing the long-term effects of COVID-19 is particularly important for groups who are disproportionately affected by COVID-19, such as racial and ethnic minority groups, to effectively direct care, inform interventions, and tailor public health messaging to these communities.

The gaps in consistency and completeness in the data collected by HHS, including CDC, that we have identified are inconsistent with the Paycheck Protection Program and Health Care Enhancement Act, which includes a provision that requires HHS to produce regular reports to Congress on COVID-19 testing, cases, hospitalizations, and deaths, disaggregated by demographic characteristics including race and ethnicity.[106] The act also specifies that these reports should include epidemiological analysis of such data, which could include an analysis of the long-term health outcomes of individuals who have had COVID-19 by race and ethnicity.

CDC equity strategy aims to reduce gaps. To help address these gaps, on July 22, 2020, CDC released a COVID-19 Response Health Equity Strategy to accelerate progress toward reducing disparities in indicators of COVID-19 burden, among other efforts to achieve health equity.[107] The strategy includes a priority to expand the evidence base by collecting and reporting complete data on COVID-19 indicators by race and ethnicity categories, among other things. It also identifies outcomes, such as ensuring that timely, complete, and representative data are available to the public and other stakeholders within 3 to 12 months to help inform how CDC addresses racial and ethnic disparities related to COVID-19.

However, CDC's equity strategy is missing critical details to help it achieve its priority of collecting complete data on testing and indicators of COVID-19 burden by race and ethnicity. In particular, the strategy does not include an assessment of whether having the authority to require states and

[105]For example, the Research Triangle Institute has recommended the formation of a broad registry of individuals who have had COVID-19 to determine the long-term effects of exposure to the disease.

[106]Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620 at 626. HHS was required to release a report no later than 21 days after enactment and then to update and resubmit the report every 30 days until the end of the public health emergency. See Centers for Disease Control and Prevention, *Report to Congress on Paycheck Protection Program and Health Care Enhancement Act Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID-19) Testing* (May 2020); *Report to Congress on Paycheck Protection Program and Health Care Enhancement Act Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID-19) Testing, Initial 30-Day Update* (June 2020); *Report to Congress on Paycheck Protection Program and Health Care Enhancement Act Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID-19) Testing, 2nd 30-Day Update* (July 2020); and *Report to Congress on Paycheck Protection Program and Health Care Enhancement Act Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID-19) Testing, 3rd 30-Day Update* (August 2020).

[107]Centers for Disease Control and Prevention, *CDC COVID-19 Response Health Equity Strategy: Accelerating Progress Towards Reducing COVID-19 Disparities and Achieving Health Equity* (July 22, 2020).

jurisdictions to report race and ethnicity information is necessary to ensure CDC can collect more complete data, and if so, whether CDC should seek such authority from Congress.

Moreover, CDC's strategy does not specify how it may involve key stakeholders who participate in the collection of information on race and ethnicity—such as health care providers, laboratories, and state and jurisdictional health departments—to obtain complete information for testing and indicators of COVID-19 burden. These key stakeholders are essential to CDC's strategy, as they are responsible for the collection of the data on race and ethnicity, and therefore their involvement is of paramount importance in ensuring the collection of complete and consistent data. Lastly, CDC's strategy does not specify how, if at all, CDC plans to assess the long-term health outcomes of individuals with COVID-19, including by race and ethnicity.

Leading practices to inform COVID-19 data collection by race and ethnicity. Our previous work has shown that strategic planning for activities below the agency-wide level is a leading practice for successful agencies, and can help agencies integrate activities, align goals, and coordinate performance management across different parts of the organization.[108] Another leading practice is to involve key stakeholders when defining desired outcomes to ensure that agency efforts and resources are targeted at the highest priorities.[109] In addition, CDC has highlighted the importance of collecting data on the recoveries of persons with COVID-19, as such information is critical to directing care, informing interventions, and tailoring public health messaging to groups that may be disproportionately affected.[110]

As CDC moves forward with its plans for implementing its COVID-19 Response Health Equity Strategy, it will be important for the agency to determine whether it is necessary to require states and jurisdictions to report race and ethnicity data, and if so, to seek authority from Congress to require the reporting of this information. In making such a determination, CDC can better ensure it is addressing gaps in critical information.

It will be equally critical for CDC to involve key stakeholders, such as health care providers, laboratories, and state and jurisdictional health departments, in implementing its equity strategy. By involving key stakeholders, the agency can help ensure that it collects complete race and ethnicity data and in a consistent manner. Moreover, by ensuring the ability to assess comprehensively data on the long-term health outcomes of persons with COVID-19, including by race and ethnicity, CDC can better ensure it is positioned to consider how groups may be disproportionately affected over time and how to address any disparate impacts. Without taking these critical steps, CDC may not be able to target most effectively its pandemic response efforts to racial and ethnic minority groups that may be disproportionately affected.

We will continue to conduct work examining HHS's, CDC's, and other component agencies' ongoing work regarding indicators of COVID-19 and disparities that exist for various populations.

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[108]For example, see GAO, *Environmental Protection: EPA Should Develop a Strategic Plan for Its New Compliance Initiative*, GAO-13-115 (Washington, D.C.: Dec. 10, 2012); *Managing for Results: Strengthening Regulatory Agencies' Performance Management Practices*, GAO/GGD-00-10 (Washington, D.C.: Oct. 28, 1999); and *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1996).

[109]GAO/GGD-96-118.

[110]Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, vol. 69, no. 30 (July 31, 2020).

GAO Recommendations Related to COVID-19 Data by Race and Ethnicity

- As the Centers for Disease Control and Prevention (CDC) implements its COVID-19 Response Health Equity Strategy, the Director of the Centers for Disease Control and Prevention should determine whether having the authority to require states and jurisdictions to report race and ethnicity information for COVID-19 cases, hospitalizations, and deaths is necessary for ensuring more complete data, and if so, seek such authority from Congress. (Recommendation 6)
- As CDC implements its COVID-19 Response Health Equity Strategy, the Director of the Centers for Disease Control and Prevention should involve key stakeholders to help ensure the complete and consistent collection of demographic data. (Recommendation 7)
- As CDC implements its COVID-19 Response Health Equity Strategy, the Director of the Centers for Disease Control and Prevention should take steps to help ensure CDC's ability to comprehensively assess the long-term health outcomes of persons with COVID-19, including by race and ethnicity. (Recommendation 8)

Source: GAO. | GAO-20-701

Table 2 provides a summary of additional information on the federal public health response presented in enclosures in appendix I, which also include descriptions of GAO's future work.

Table 2: Areas in Which the Federal Government Has Taken Action in the Public Health Response to COVID-19

Area name	Federal government's actions
Medical Supply Chain	The lack of domestic medical supplies combined with a supply chain that was overwhelmed by the demands of the global pandemic prompted numerous federal and state actions to stabilize the supply chain and increase inventories; however, there continue to be ongoing constraints around certain types of personal protective equipment (PPE) and continued testing supply shortages.
COVID-19 Testing Data	On June 4, 2020, the Department of Health and Human Services (HHS) required laboratories to begin reporting data on each COVID-19 test by August 1, 2020. Since this requirement was issued, HHS agencies have taken steps to improve testing data, but they acknowledged ongoing challenges to collecting complete and consistent data.
Vaccines and Therapeutics	Many challenges associated with efforts to develop and manufacture COVID-19 vaccines and therapeutics need to be overcome. It is also of paramount importance to have clarity on the planning for their distribution and administration, as well as timely, clear, and consistent communication to states and the public about their availability, efficacy, and safety.
Health Disparities	HHS plays a key role in collecting and making data available on indicators of COVID-19 burden, including cases, hospitalizations, and deaths. While race and ethnicity information is incomplete in these reported data, available data demonstrate racial and ethnic disparities in indicators of COVID-19 burden.
Relief for Health Care Providers	HHS continues to disburse the $175 billion appropriated for the Provider Relief Fund to financially support health care providers and finance care for COVID-19 patients and underserved populations. As of July 31, 2020, $129.7 billion had been allocated and about $92.4 billion had been disbursed to providers.
Nursing Homes	COVID-19 challenges for nursing homes remain, including challenges related to personal protective equipment, testing, and staffing shortages.
Medicaid Spending	The potential exists for two HHS agencies to issue duplicative or erroneous payments to providers, and challenges in public reporting of Medicaid COVID-19 spending continue to pose risks to transparency and oversight.
HHS COVID-19 Funding	The COVID-19 relief laws appropriated more than $250 billion to HHS to address various aspects of the public health response to COVID-19, of which about $144 billion (about 58 percent) had been obligated and about $99 billion (about 40 percent) had been expended as of July 31, 2020, according to department officials. This represents an

	increase of 43 percent and 47 percent since May 31, 2020, when reported obligations and expenditures were $101 billion and $67 billion, respectively.
Veterans Health Care	The Veterans Health Administration hired thousands of physicians and nurses to strengthen its capacity to respond to the pandemic.
Military Health	The Department of Defense's plan for potential surges in COVID-19 cases among department personnel focuses on accelerating screening and surveillance testing, and the department has identified CARES Act funding in excess of current Defense Health Program requirements, resulting in a redirection of funds.
Defense Support of Civil Authorities	The Department of Defense continues to support civil authorities by providing personnel and supplies in response to requests for assistance from other federal agencies on a fully reimbursable basis.

Source: GAO. | GAO-20-701

Assistance to Individuals

This section provides information on government assistance to individuals, including economic impact payments and unemployment insurance.

Economic Impact Payments

Data on economic impact payment recipients. Treasury and the Internal Revenue Service (IRS) have issued an EIP to all eligible individuals for whom IRS has the necessary information to do so. However, Treasury and IRS lack updated information on how many eligible recipients have yet to receive an EIP, which could hinder outreach efforts and place potentially millions of individuals at risk of missing their payment. In April 2020, Treasury estimated that 30 million individuals who do not normally file a tax return (referred to as non-filers) were eligible for an EIP.[111] At the time, Treasury estimated that the 30 million individuals included 16 million Social Security and Railroad Retirement Board (RRB) benefit recipients for whom data were available, and 14 million individuals who do not normally file a tax return or receive federal benefits and for whom no data were available.[112]

[111]Non-filers include individuals with gross income below a certain amount—including some who receive federal benefits, such as Social Security, that are not subject to tax—and who do not generally need to file a tax return.

[112]Treasury and IRS sent payments to 17.6 million Social Security and RRB benefit recipients as of July 31, 2020.

Based on IRS data, as of July 31, 2020, 5.3 million individuals had used an online IRS tool known as the Non-Filers tool to help them receive their EIP,[113] meaning there could be 8.7 million or more individuals who are eligible but have not received their EIP.

Treasury has not updated its April estimate of those who have yet to receive their EIP to account for actual numbers of filers, recipients of federal benefits who received their EIP, those who used the Non-Filers tool, or other new analyses or data. Treasury officials described the April estimate as unofficial, citing the uncertainty in the estimate, and stated they have no plans to share it with IRS's outreach partners.[114]

Internal control standards state that management should obtain relevant data from reliable sources and use that information to achieve its objectives.[115] This standard is captured in Treasury's strategic plan, which sets a goal of improving analytics to accomplish objectives.[116] Treasury officials cited two reasons for not updating the April estimates. First, the administration has not produced economic forecasts that include the effects of the pandemic. However, it is not clear why Treasury would need an updated economic forecast to estimate the number of individuals eligible for an EIP when Treasury can use 2018 and 2019 tax data and EIP payment figures to inform its estimates. Second, according to Treasury officials, updated estimates would not provide the detailed information needed for outreach. Treasury officials said that, for purposes of potential outreach, they were examining information that third parties use to notify government agencies and taxpayers about taxable payments to identify individuals with a valid Social Security number who have not received an EIP.

An updated and refined estimate of individuals who have yet to receive their EIP from Treasury or IRS could provide greater clarity about which populations may be at risk of missing out on the payment. Without an updated estimate, Treasury, IRS, other federal agencies, and IRS's outreach partners are limited in their ability to appropriately scale and target outreach and communication efforts to individuals who may be eligible for a payment. Representatives from two organizations that are conducting outreach on the payments said that an estimate of the number of individuals who still need the payment, particularly if matched with ZIP code data, could help them to focus outreach and communication resources. One IRS outreach partner also said eligible recipients who have not yet filed for the payment are outside the tax system, likely to be very low-income, and could most use the payment.

IRS's outreach partnerships. IRS publicized the EIP by partnering with other federal agencies, nonprofits, and state and local entities. For example, IRS provided its outreach partners with toolkits that contain information on filing that can be repackaged for social and traditional media campaigns. IRS also set up a website, the Economic Impact Payment Information Center,[117] which

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[113]See https://www.irs.gov/coronavirus/non-filers-enter-payment-info-here.

[114]IRS partners with nationwide and local organizations by providing outreach materials, training, and tax preparation products for taxpayer assistance and education. IRS partner organizations are meant to serve low to moderate income populations, older Americans, students, military service members, people with disabilities, and other populations. IRS refers to these organizations as outreach partners.

[115]GAO-14-704G.

[116]Department of the Treasury, *Treasury Strategic Plan for Fiscal Years 2018–2022* (Washington, D.C.: 2019).

[117]See https://www.irs.gov/coronavirus/economic-impact-payment-information-center.

includes EIP frequently asked questions (FAQs) and a tool to check eligibility and the status of payments. According to IRS officials, the website has been visited over 500 million times.

Officials from IRS outreach partners we spoke with complimented IRS on its rapid response, especially in answering their questions and pushing out helpful and timely information, when possible. They also noted some challenges. For example, several said that the EIP Information Center website was comprehensive, but that it could also be challenging to navigate, especially for an audience unfamiliar with the tax system or IRS's website. Two IRS outreach partners said they repackaged information from the IRS website into simpler language. They also said the online tool could be difficult to access and navigate, particularly on a mobile device, which may be the only device readily available to some individuals.

Data coordination. IRS used federal agency data from IRS, VA, the Social Security Administration (SSA), and RRB to identify and pay individuals eligible for an EIP but have not explored other data sources that may identify eligible recipients. Treasury has said that recipients of Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits likely contain a significant number of non-filers who have not yet received an EIP. However, Treasury and IRS do not have plans to obtain such data from either HHS or the Department of Agriculture.

According to Treasury officials, Treasury and IRS want all individuals who are eligible for an EIP to be able to claim one and are taking steps to raise awareness. However, they are also concerned about the difficulty of combining data from various agencies, which can be time-consuming, as well as potential legal restrictions that limit IRS's ability to share data. The CARES Act provided explicit authority to use data from SSA and RRB for making payments.[118] In addition, IRS worked with VA and was able to obtain data and automatically deliver payments to those benefit recipients.

We will continue to explore whether Treasury and IRS could further coordinate with other federal agencies to obtain and use data to help identify individuals eligible for an EIP before two upcoming deadlines: October 15, 2020, is the deadline to use the Non-Filers tool to file for an EIP in 2020, and December 31, 2020, is the last day IRS will issue an EIP in 2020.[119]

Disbursing payments to tax filers and non-filers. As of July 31, 2020, Treasury and IRS had disbursed 163.9 million EIPs totaling $273.5 billion.[120] Treasury and IRS had disbursed the majority of payments by May 22, as shown in figure 6. Between May 22 and July 31, Treasury disbursed nearly 410,000 payments on average each week. IRS officials reported that as of July 29, the five U.S. territories had received $4.6 billion, 91 percent of the total amount of EIPs for which they are estimated to be eligible.[121]

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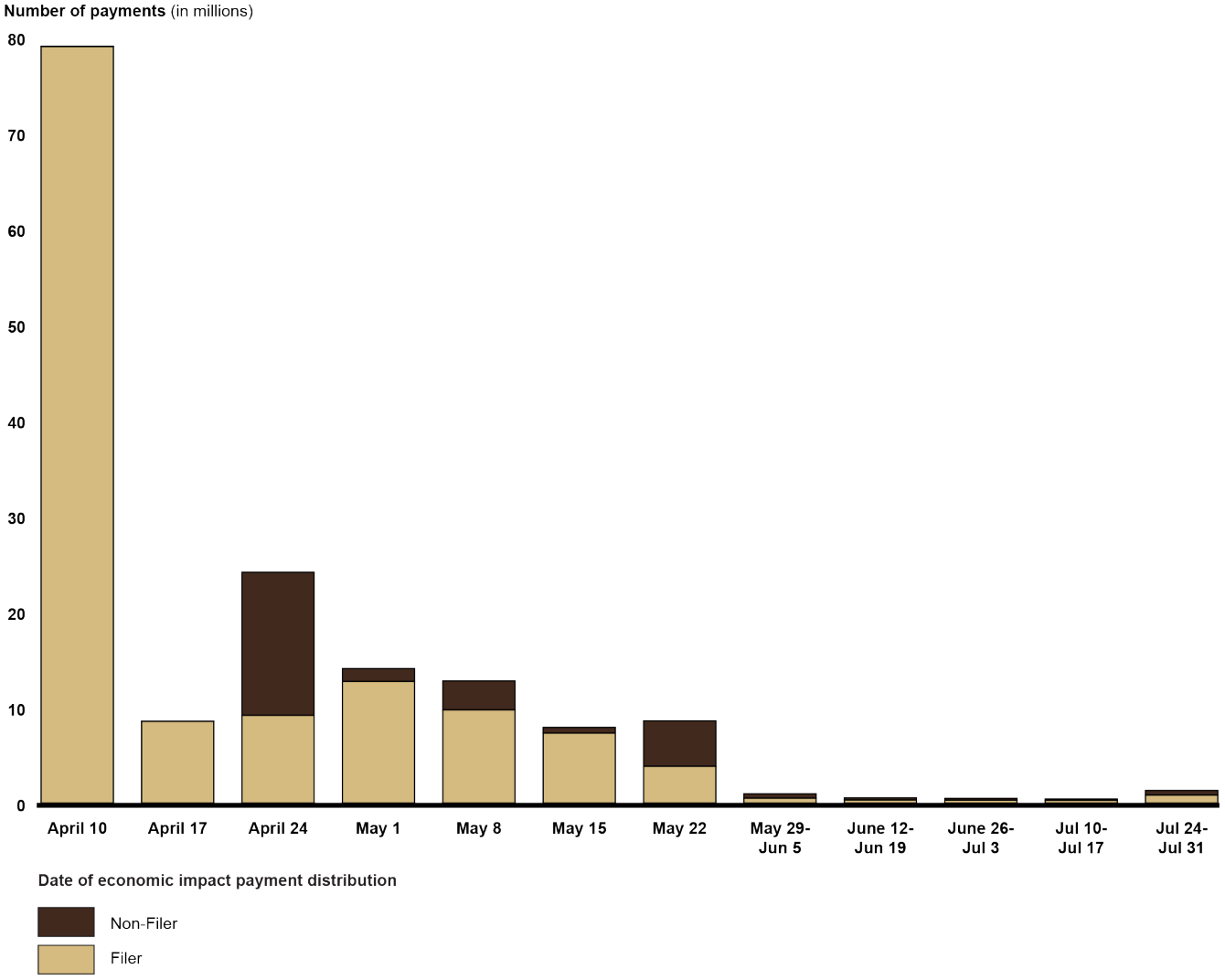
[118]Pub. L. No. 116-136, § 2201(a), 134 Stat. at 336–37, (codified at 26 U.S.C. § 6428(f)(5)(B)).

[119] The CARES Act prohibits issuance of EIPs after December 31, 2020. Pub. L. No. 116-136, § 2201(a), 134 Stat. at 336–37 (codified at 26 U.S.C. § 6428(f)(3)(A)). However, individuals are generally allowed to claim a credit when they file taxes in 2021 for tax year 2020 if they did not receive an EIP for the full amount for which they are eligible.

[120]The volume of payments is taken from the IRS Master File and does not include reversals or payments to residents of territories. The amount of payments is taken from the IRS general ledger and includes reversals and territory payments.

[121]The five U.S. territories are Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands. Residents of the territories who meet income thresholds and other CARES Act eligibility requirements are eligible for EIPs. The territories disburse payments to eligible residents based on plans they submit to Treasury. As of July 29, 2020, the total amount (U.S. dollars) paid to residents of each territory was as follows: American

Figure 6: Number of Economic Impact Payments the Department of the Treasury and Internal Revenue Service Disbursed to Tax Filers and Non-Filers, as of July 31, 2020



Source: Internal Revenue Service. | GAO-20-701

Note: Volumes reflect the latest cycle and payment type in which an economic impact payment was paid to an individual. Likewise, payments are the net of all payment attempts and reversals. Non-filers may receive more than one of the relevant government benefits, and an individual may be classified as a recipient of more than one government benefit.

According to IRS data, as of July 31, more than 26 million non-filers had received a payment, including around 21 million who received an automatic payment and more than 5.3 million non-filers who used the online tool to receive an EIP.[122]

Samoa, $30.8 million; Guam, $150.2 million; the Northern Mariana Islands, $50.9 million; Puerto Rico, $4.3 billion; and the U.S. Virgin Islands, $67.8 million.

[122]The 21 million non-filers who received automatic payments are individuals who receive government benefits and do not normally file a return. As of July 31, IRS had made 17.5 million payments to Social Security benefit recipients, 59,741 payments to RRB benefitrecipients, 2.9 million payments to Supplemental Security Income (SSI) benefit recipients, and 421,516 to VA benefit recipients. According to IRS officials, 6.8 million individuals used the online Non-Filers tool; of

Addressing payment challenges. According to analysis by the Treasury Inspector General for Tax Administration (TIGTA), IRS correctly computed the payment for at least 98 percent of EIPs issued as of May 21, 2020.[123] IRS is working to correct underpayments, and other errors, and provide guidance for how recipients can claim the correct payment amount.[124] IRS identified almost 1.1 million recipients of the almost 164 million payments made as of July 31 who received an EIP but who may be owed additional money due to a number of circumstances. For example:

- *Non-filers with qualifying children.* We reported in June 2020 that individuals who used the Non-Filers tool between April 10 and May 17 did not receive a payment that included additional money for qualifying children.[125] As of July 24, IRS identified 355,103 non-filers who received an individual payment but were still waiting to receive an additional $500 per qualifying child. On August 5, IRS stated on its EIP FAQ webpage that impacted non-filers were to receive the payment via direct deposit on August 5, and paper checks or debit cards were scheduled to be mailed August 7.

  Additionally, IRS recently announced a policy change that should allow some eligible recipients to receive supplemental payments for qualifying children sooner than expected. As we previously reported, the benefit data IRS had used to automatically send payments to non-filers did not include information on qualifying children, so those recipients were asked to use the Non-Filers tool. However, Social Security and RRB benefit recipients, who comprised nearly 14 million EIP recipients, were given only a few days' notice to add in information about qualifying children before they would no longer be able to do so. VA and SSI benefit recipients had 2 weeks to add qualifying children and totaled 2.5 million payments by the time of the deadline.
  Initially, IRS announced that those who missed the deadline would have to wait to file a tax return in 2021 to get a payment for qualifying children.[126] However, the CARES Act requires Treasury and IRS to make the payments as "rapidly as possible."[127] Waiting 9 to 12 months before an individual or family receives a complete payment during the 2020 tax filing season would not provide the immediate relief intended by the law. Therefore, in the course of our

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those, IRS certified 5.3 million to receive a payment and determined around 1.5 million were ineligible or had previously received a payment.

[123]According to Treasury, TIGTA is continuing to work with IRS to determine whether the remaining 3.1 million payments (2 percent) were computed correctly.

[124]For example, IRS's Taxpayer Advocate Service can accept cases for taxpayers whose EIP issues fall within one of five categories, including eligible individuals who : (1) used the Non-Filers tool, and claimed a qualifying child but did not receive the qualifying child portion of their payment; (2) filed an Injured Spouse Allocation (IRS Form 8379), and had his or her portion of the payment reduced for the spouse's child support obligations; (3) received an incorrect payment amount because IRS incorrectly adjusted their 2018 or 2019 return for a math error; (4) were victims of identity theft; or (5) filed a joint return with a deceased or incarcerated spouse and whose EIP payment was not issued, was returned, or was canceled.

[125]See GAO-20-625. IRS previously estimated that 450,000 non-filers did not receive their payments for qualifying children but further refined the number of affected individuals. The reduction is the result of eliminating ineligible individuals, previously paid individuals either from 2018 returns or the Social Security, RRB, SSI, and VA population prior to the filing of the 2019 non-filer returns, deceased or incarcerated individuals, or Individual Taxpayer Identification Number holders not filing jointly with a member of the armed services.

[126]Among other requirements, a qualifying child must be under age 17 at the end of the taxable year.

[127]Pub. L. No. 116-136, § 2201(a), 134 Stat. at 336 codified at 26 U.S.C. § 6428(f)(3)(A).

audit work, we asked IRS officials whether they planned to reopen the Non-Filers tool to those individuals who missed the deadline to provide EIPs for qualifying children of non-filers sooner than 2021. IRS officials said they could not reopen the tool to those who missed the deadline to add qualifying children because they would have to manually process the additional information and they lacked the resources to do so, given backlogs caused by the COVID-19 closure of IRS service centers.
On August 14, IRS changed this policy with an announcement that it would reopen the registration period. Federal beneficiaries who did not previously receive $500 per qualifying child now have until September 30, 2020, to enter information on their qualifying children and receive the supplemental $500 payments.[128] According to IRS officials, IRS figured out an automated solution that would allow IRS to add information to payments already made. Opening the registration period and extending it through September 30 allows more eligible recipients to seek the financial relief to which they are entitled and owed by law.

- *Injured spouses and domestic abuse survivors.* IRS is also taking action to issue payments to injured spouses—married taxpayers whose payments were used to cover the past-due child support of a spouse or ex-spouse. As of July 31, 2020, IRS estimated that 49,522 individuals filed an injured spouse claim and may be owed an adjustment. On August 25, IRS announced these catch-up payments will be mailed as checks to any eligible spouse the week of August 31. [129]

  There also may be some eligible EIP recipients who are domestic abuse survivors but may not have been able to claim their portion of the EIP if it was provided to an individual's bank account or address to which eligible recipients do not have access. IRS said it is considering options that may provide relief to domestic abuse survivors, including outreach to advocacy groups for victims of domestic abuse who can advise survivors of legal and other options they can pursue in such situations.

- *Widows, widowers, and spouses of deceased and incarcerated individuals.* In some cases, Treasury stopped payments to surviving spouses before they were disbursed to account for the death or incarceration of a spouse. IRS did not yet have an estimate of the number of spouses of incarcerated individuals who had their portion of the payment stopped. IRS also estimates nearly 700,000 individuals may have had their payment stopped due to being the spouse of a decedent. IRS plans to pay the eligible spouses by late summer.

Reissuing lost or destroyed EIP debit cards. Treasury and IRS also experienced some challenges related to sending "pre-paid" debit cards—cards with the set amount of EIP loaded onto them—to recipients. Treasury officials said they sent debit cards to recipients for whom the IRS had no bank account information.[130] As of July 31, 2020, 87 percent of the 3.6 million debit cards that had been

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[128]Non-filers who are not federal beneficiaries have until October 15, 2020 to use the Non-Filers tool.

[129]According to IRS, these catch-up payments will be mailed as checks to any eligible spouse who submitted Form 8379, Injured Spouse Allocation, along with their 2019 federal income tax return or, in some cases, 2018 return. These spouses do not need to take any action to get their catch-up payments. IRS will automatically issue the portion of the EIP that was applied to the other spouse's debt.

[130]Treasury estimates 1.4 to 2.5 million EIPs were mailed 1 or more days earlier than they would have been if the debit cards had not been issued.

mailed to payees had been activated. An additional 204,267 or 5.6 percent of the mailed cards had been reported as lost, stolen, or destroyed, and therefore a card was reissued. While Treasury and IRS posted several press releases at the same time the debit cards were mailed, Treasury and IRS officials also acknowledged that they could have done more to alert recipients about when to expect the cards and how to activate them.

According to Treasury officials, the plain white envelopes in which the debit cards were sent were intended to provide a degree of security by helping to prevent theft of the cards. However, some recipients may have thought that the envelope was junk mail or that the debit card was a scam. Treasury sent a follow-up letter in early July to almost 790,000 recipients of the debit cards who had yet to activate their card. According to Treasury officials, as they became aware of discarded cards, they worked with the card issuer to waive the fee for the first reissuance of any EIP card and reverse any initial reissuance fee that was charged to a recipient.

GAO Recommendations Related to Economic Impact Payments

- The Secretary of the Treasury, in coordination with the Commissioner of Internal Revenue, should update and refine the estimate of eligible recipients who have yet to file for an economic impact payment (EIP) to help target outreach and communications efforts. (Recommendation 9)
- The Secretary of the Treasury, in coordination with the Commissioner of Internal Revenue, should make estimates of eligible recipients who have yet to file for an EIP, and other relevant information, available to outreach partners to raise awareness about how and when to file for EIP. (Recommendation 10)

Source: GAO. | GAO-20-701

Unemployment Insurance

According to the Department of Labor (DOL) as of July 1, 2020, almost all states had implemented the three CARES Act UI programs, and were paying benefits under the programs.[131] DOL's data also showed that states have taken advantage of emergency administrative funding authorized under the Families First Coronavirus Response Act to assist with processing the unprecedented numbers of UI claims. According to National Association of State Workforce Agencies representatives, states have used Families First Coronavirus Response Act funding to support claims processing by, for example, hiring and training new staff, hiring contractors, contracting with call centers and consultants, and enhancing their information technology systems. The three CARES Act UI programs are as follows:

[131]By implementing the CARES Act UI programs, we mean that the states or territories had signed agreements with DOL to operate the programs and had begun paying benefits under the programs. For the purposes of these programs, the District of Columbia and various territories count as states. Although Colorado, New Hampshire and Virginia had agreements in place to operate the Pandemic Emergency Unemployment Compensation (PEUC) program, they had not yet begun paying benefits under the program as of July 1, 2020, according to DOL. Similarly, while the U.S. Virgin Islands had an agreement in place, it had not begun paying benefits under the Pandemic Unemployment Assistance (PUA) program or the PEUC program. Additionally, the CARES Act UI programs have operated concurrently with the preexisting UI program. We refer to the preexisting UI program as the regular UI program and the benefits paid under that program as regular UI benefits.

- *Pandemic Unemployment Assistance (PUA) program*. Generally authorizes up to 39 weeks of UI benefits to individuals not otherwise eligible for UI benefits, such as self-employed and certain gig economy workers, who are unable to work as a result of COVID-19, available through December 2020.[132]
- *Federal Pandemic Unemployment Compensation (FPUC) program.* Generally authorized an additional $600 benefit that augmented weekly UI benefits available under the regular UI program, as well as CARES Act UI programs, through July 2020.[133]
- *Pandemic Emergency Unemployment Compensation (PEUC) program*. Authorizes an additional 13 weeks of UI benefits to those who exhaust their regular UI benefits, available through December 2020.[134]

On August 8, 2020, the President signed a memorandum directing FEMA to provide up to $44 billion in lost wages assistance from the Disaster Relief Fund.[135] Pursuant to the presidential memorandum, upon receiving a FEMA grant, states and territories may provide eligible claimants $300 or $400 per week, which includes a $300 federal contribution.[136] As of September 9, 2020, FEMA had approved lost wages assistance grants to 48 states, the District of Columbia, and Guam.

While the number of initial claims in the regular UI program has declined overall since the beginning of April 2020, the number of UI claims receiving benefits remains persistently high, which has put pressure on states' capacity to pay for them. DOL's latest data for the week ending September 5, 2020, showed that initial claims in the regular UI program declined from a high of over 6.2 million for the week ending April 4, 2020 to 857,148.[137] Despite this overall decline in initial claims, nationwide, about 13 million regular UI claims were made for continuing unemployment during the week ending August 22, 2020.[138]

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[132]Pub. L. No. 116-136, § 2102, 134 Stat. at 313.

[133]Pub. L. No. 116-136, § 2104, 134 Stat. at 318.

[134]Pub. L. No. 116-136, § 2107, 134 Stat. at 323. In addition, the CARES Act also addressed other elements of the UI system. For example, it also authorized certain flexibilities for states in hiring additional state agency staff.

[135]The White House, *Memorandum on Authorizing the Other Needs Assistance Program for Major Disaster Declarations Related to Coronavirus Disease 2019* (Aug. 8, 2020).

[136]According to FEMA, states that provide $400 per week in lost wages assistance would contribute $100 each week in state funds, while states providing $300 per week in lost wages assistance may count existing state funding used to pay regular UI benefits to satisfy the state match.

[137]Initial claims counts presented are not seasonally adjusted, and the count for the week ending September 5, 2020 represents advance initial claims, which are preliminary and subject to revision. Due to a change in DOL methods for seasonally adjusting UI claims counts, we now report non-seasonally adjusted counts, a change from our prior reports.

[138]DOL also reported that about 14.6 million claims were made for continuing unemployment under the PUA program during the week ending August 22, 2020. Due in part to backlogs in state processing, the number of regular UI and PUA continued claims DOL reports each week includes claims from prior weeks. If an individual claims benefits for multiple weeks of unemployment during a single reporting period, each week is counted as a separate claim. Claiming benefits for multiple weeks of unemployment could be more prevalent in the PUA program because it is a new program that took

As a result of the persistently high volume of claims overall, several states have exhausted their funds to pay UI benefits, according to DOL. While the CARES Act UI programs are federally funded, regular UI is primarily funded through state and federal taxes on employers. When a state exhausts those funds, it may borrow from the federal government. From January 1, 2020, through August 31, 2020, 13 states—California, Colorado, Connecticut, Hawaii, Illinois, Kentucky, Massachusetts, Minnesota, New Jersey, New York, Ohio, Texas, and West Virginia—and the U.S. Virgin Islands took out such loans, totaling about $26 billion. According to DOL, the need for these loans was especially acute, as the pandemic had exacerbated shortfalls in states' funds that existed before the pandemic began.[139] DOL data indicate that such shortfalls were caused by many states not taking in enough funds to pay UI benefits according to the standard set in DOL regulations providing for interest-free loans to states.[140]

The expiration of the $600 additional weekly UI benefit under the FPUC program at the end of July 2020 will likely negatively affect unemployed workers—in particular, their housing and food security—and the economy. With the $600 enhancement, some UI claimants received more in total UI benefits than they would have earned in their regular wages if they were still employed, and others received less. In general, individuals receiving enhanced benefits were better positioned to spend at pre-pandemic levels without accumulating debt or using retirement savings than they would have been without the enhanced benefit.

Further, according to a recent post on the Census Bureau's website, adults in lower-income and younger households who suffered job losses during the COVID-19 pandemic reported that they have less confidence that they can pay their next month's rent or mortgage on time and that they will suffer more food insecurity.[141] With regard to nutrition assistance, generally, those who receive UI benefits may not qualify for SNAP benefits. This is because, according to the Department of Agriculture, UI is generally treated as income for purposes of SNAP eligibility, and in some cases, claimants who continue to receive regular UI benefits may be ineligible for SNAP after their enhanced benefit under the FPUC program expires.

Enhanced benefits under the FPUC program likely limited the effects of labor market disruptions on consumer spending and helped stabilize the economy, according to multiple studies.[142] For example, according to recent University of Chicago research, although consumer spending has recovered somewhat since mid-April 2020, it remains severely depressed relative to prepandemic

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time to implement and individuals are able to claim benefits retroactively. DOL also reported almost 2 million continued claims made under other unemployment programs, such as the PEUC program, for the week ending August 22, 2020.

[139]According to DOL, the U.S. Virgin Islands also had a residual loan balance that predated the pandemic, from the Great Recession.

[140]See 20 C.F.R. § 606.32 (2019).

[141]Brian Mendez-Smith and Mark Klee, "Census Bureau's New Household Pulse Survey Shows Who Is Hardest Hit During COVID-19 Pandemic" (June 19, 2020), accessed August 9, 2020, https://www.census.gov/library/stories/2020/06/low-income-and-younger-adults-hardest-hit-by-loss-of-income-during-covid-19.html.

[142]Natalie Cox et al., *Initial Impacts of the Pandemic on Consumer Behavior: Evidence from the Linked Income, Spending, and Savings Data* (Chicago, Illinois: University of Chicago Becker-Friedman Institute, July 2020). See also Diana Farrell et al., *Consumption Effects of Unemployment Insurance During the COVID-19 Pandemic* (Washington, D.C.: JP Morgan Chase Institute, July 2020) and Michael Karpman and Gregory Acs, *Unemployment Insurance and Economic Impact Payments Associated with Reduced Hardship Following CARES Act* (Washington, D.C.: Urban Institute, June 2020).

levels. The researchers explain that declines in income due to phasing out broad stimulus too quickly would result in declines in aggregate demand by low-income workers, which could pose challenges to reemployment if businesses close or scale down due to lower consumer demand.[143]

In addition to continuing to provide technical assistance and monitor states' implementation of the CARES Act UI programs, DOL has issued additional guidance on those programs and taken other actions to reinforce program integrity. For example, DOL's Occupational Safety and Health Administration has issued COVID-19 guidelines for employers on providing safe workplaces. According to DOL, however, most state laws allow claimants to refuse offers of employment for good cause—which may include, but is not limited to, the degree of risk to an individual's health and safety—and still maintain UI benefits. DOL has encouraged states to ask employers to provide information to state UI agencies when workers decline suitable work without good cause.

Following a recommendation in our June 2020 report, DOL issued guidance on August 12, 2020, addressing potential risks that certain workers being paid wages with Paycheck Protection Program (PPP) proceeds could also simultaneously be receiving UI benefits.[144] The guidance clarified that individuals working full-time and being paid through PPP are not eligible for UI, and that individuals working part-time and being paid through PPP would be subject to certain state policies, including policies on partial unemployment. Further, the guidance clarified that individuals being paid through PPP but not performing any services would similarly be subject to certain provisions of state law, and noted that an individual receiving full compensation would be ineligible for UI.

Table 3 provides a summary of additional information on federal assistance to individuals presented in enclosures in appendix I, which also include descriptions of GAO's future work.

[143]To the extent that workers quickly find reemployment after the expiration of the FPUC program, any effects on spending would not be expected. However, it may be challenging for workers to find employment. According to Bureau of Labor Statistics data, job openings in June 2020 reflect an 18 percent decline compared to June 2019.

[144]Department of Labor, *Unemployment Insurance Program Letter*, No. 14-20, Change 1 (Aug. 12, 2020).

Table 3: Areas in Which the Federal Government Has Taken Action to Assist Individuals in Response to COVID-19

Area name	Federal government's actions
Child Nutrition	Almost 400 million fewer meals for children were provided in March and April 2020 as compared with March and April 2019, and school districts and other providers reported ongoing and potential challenges to providing meals during the pandemic.
Employer Tax Relief	Some information is available about how employers are claiming refundable tax credits, but the extent of claims for the first and second quarters of 2020 will remain unknown until the relevant forms have been filed and processed; the Internal Revenue Service and the Small Business Administration are collaborating on a data-sharing agreement to ensure the applicable tax credit recipients are not also receiving loans and are in compliance with law.
Unemployment Insurance Programs	As the unemployment insurance system continues to face a high number of initial claims, the Department of Labor continues to monitor states' implementation of the CARES Act unemployment insurance programs, has issued additional guidance, and has taken steps to address program integrity.
Head Start	The Office of Head Start is awarding CARES Act funds to all grantees (based on their existing enrollment) to be used to address a variety of COVID-19 related needs, and it is finalizing plans for how it will collect detailed information on grantees' use of these funds and monitor what is spent.
Worker Safety	In the Occupational Safety and Health Administration's effort to ensure safe and healthful conditions for workers during the COVID-19 pandemic, the agency has primarily relied on guidance, and few onsite inspections have been made.
2020 Tax Filing	The COVID-19 pandemic required the Internal Revenue Service to halt certain essential filing season functions and customer service operations; thus, it now faces a large backlog of work including unprocessed tax returns—which may lead to delayed refunds to taxpayers—as well as increased refund interest payments and decreased revenue collection.

Source: GAO. | GAO-20-701

Assistance to Industry and the Economy

This section provides information on government assistance to industry and the economy, including the PPP and the housing industry.

Paycheck Protection Program

The CARES Act and the Paycheck Protection Program and Health Care Enhancement Act appropriated a total of $670 billion for PPP, including for lender fees.[145] PPP loans, which are made by lenders but guaranteed 100 percent by the Small Business Administration (SBA), are low interest (1 percent) and fully forgivable if certain conditions are met. The Paycheck Protection Program Flexibility Act of 2020 modified the program, including provisions related to loan forgiveness.[146] As modified, at least 60 percent of the loan forgiveness amount must be for payroll costs to qualify for full loan forgiveness.

As of June 30, 2020—the date PPP was originally scheduled to end—about $132 billion in loan funding remained. On July 4, 2020, PPP was extended for another 5 weeks until August 8, 2020.[147] SBA reopened the program for applications 2 days later. As of August 8, 2020, lenders had made over 5.2 million loans totaling more than $525 billion, excluding canceled loans.[148] According to SBA, canceled loans may include, but are not limited to, duplicative loans, loans not closed for any reason, and loans that were paid off.

Geographic distribution of PPP funds. As of August 8, 2020, businesses in 10 states had received $9,000 or more in PPP loans for every small business employee in that state (see fig. 7).[149]

[145]*See* Paycheck Protection and Health Care Enhancement Act, Pub. L. No. 116-139, § 101(a), 134 Stat. at 620; CARES Act, Pub. L. No. 116-136, §§ 1102(b)(1), 1107(a)(1), 134 Stat. at 293, 301. PPP was authorized under SBA's 7(a) small business lending program.

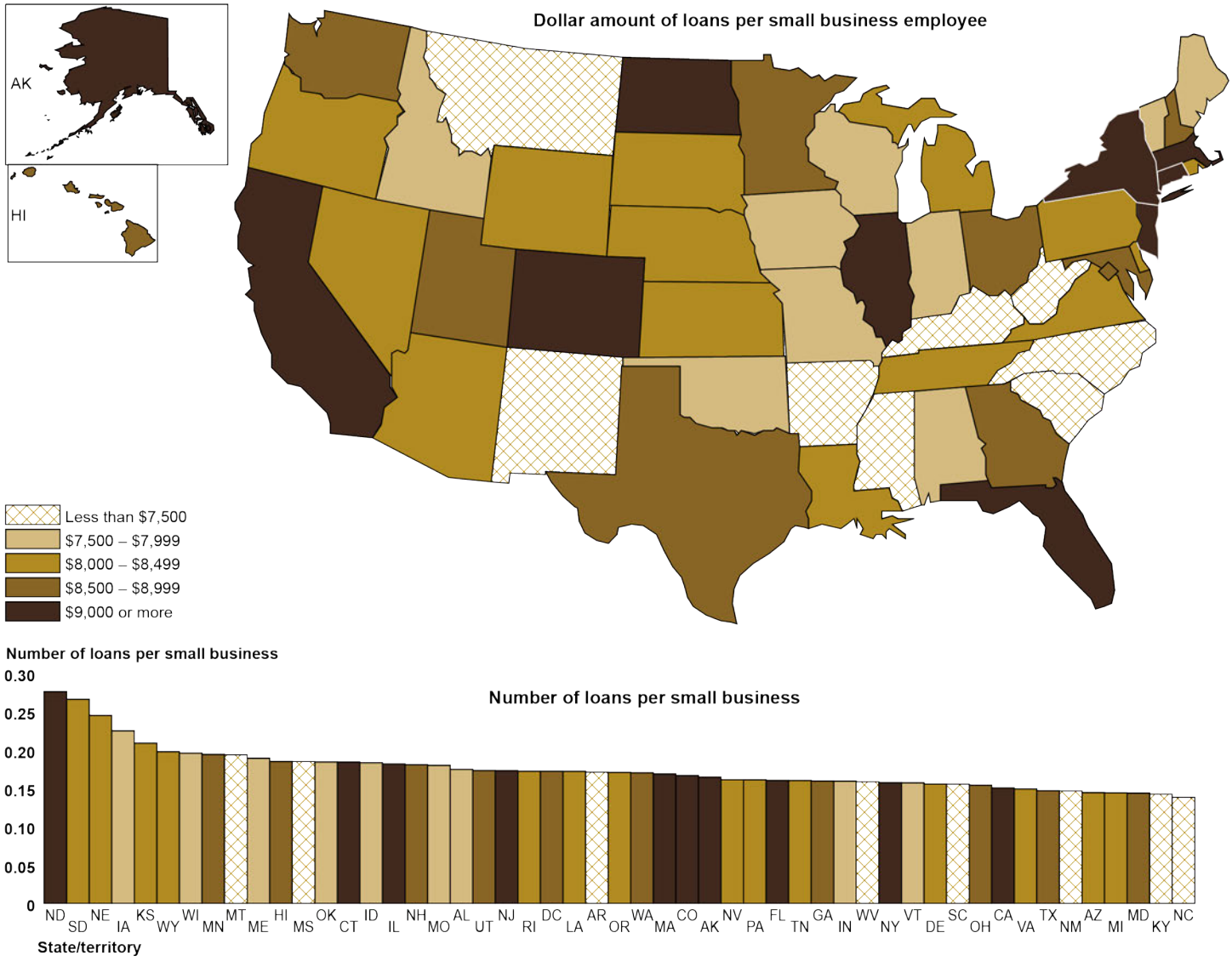
[146]See Pub. L. No. 116-142, 134 Stat. 641 (2020).

[147]See Pub. L. No. 116-147, 134 Stat. 660 (2020).

[148]As of August 8, 2020, about $134 billion in loan funding still remained.

[149]The 10 states are Alaska, California, Colorado, Connecticut, Florida, Illinois, Massachusetts, New Jersey, New York, and North Dakota.

Figure 7: Paycheck Protection Program Loans by State, as of August 8, 2020



Sources: GAO analysis of Small Business Administration data. | GAO-20-701

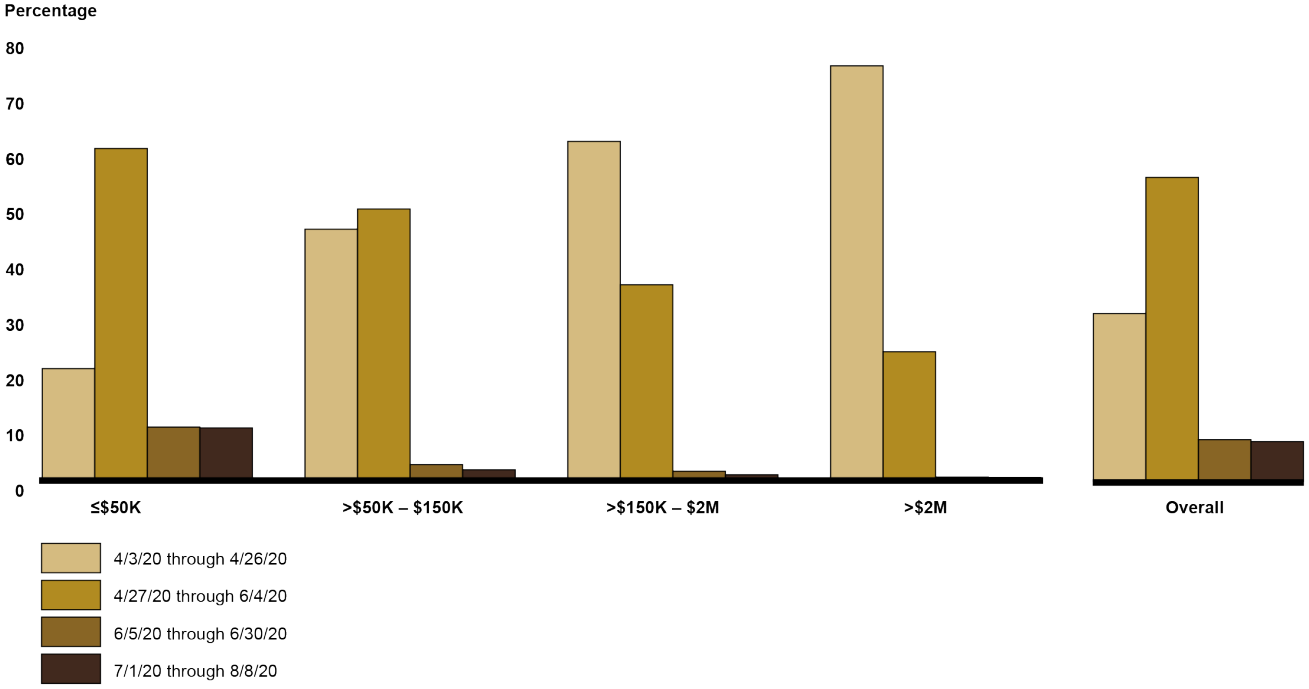
Note: Numbers of small business employees and small businesses are from the Small Business Administration's 2020 Small Business Profile, and dollar amounts and number of loans are from its Paycheck Protection Program data as of August 8, 2020. We excluded U.S. territories from the figure because the 2020 Small Business Profile used different measures for them.

PPP loan size over time. Most of the large loans (above $2 million) were made during the first phase of the program (April 3–26, 2020), and most of the smallest loans (under $50,000) were made during subsequent phases (see fig. 8). SBA has provided us loan-level data on all PPP loans approved as of August 8, 2020, including loans under $150,000.[150] According to our analysis of

[150]On July 6, 2020, SBA publicly released loan-level data for loans over $150,000, including the borrower's name and the loan amount within a range. For loans under $150,000, SBA released the loan amount within a range but did not release the borrower's name. SBA later updated these data to include loans made through the close of the program's application period (August 8, 2020).

these loan-level data, 75 percent of approved loans above $2 million were approved during the first phase of the program. As discussed in more detail later in this section, the demand for larger loans may have diminished over time due to increased scrutiny from the public, Treasury, and SBA. In contrast, 60 percent of smaller loans (less than $50,000) were approved during the second phase of the program. Of all loans approved, smaller loans (less than $50,000) comprised 46 percent during the first phase, 75 percent during the second phase, 90 percent during the third phase, and 93 percent during the fourth phase.

Figure 8: Percentage of Approved Paycheck Protection Program Loans, by Amount and Program Phase, as of August 8, 2020



Source: GAO analysis of Small Business Administration data. | GAO-20-701

Note: This analysis includes loans that were approved and subsequently canceled. Canceled loans may include, but are not limited to, duplicative loans, loans not closed for any reason, and loans that were paid off. The first phase of the program extends from April 3, 2020, when the Small Business Administration (SBA) first began accepting applications, through April 26, 2020, the day before SBA resumed accepting applications again following the second appropriation of funding (the first appropriation lapsed on April 16, 2020).
The second phase extends from April 27, 2020, when SBA resumed accepting applications, through June 4, 2020, the day before the Paycheck Protection Program Flexibility Act of 2020 was enacted (which extended the period for eligible loan forgiveness expenses from 8 weeks to up to 24 weeks). The third phase extended from June 5, 2020, through June 30, 2020, the initial loan application deadline. The fourth phase extended from July 1, 2020, through August 8, 2020, the current loan application deadline.

PPP loans by business size. The vast majority of loans to businesses that reported employees (94 percent) went to businesses with 100 or fewer employees (see table 4).

Table 4: Paycheck Protection Program Loans, by Business Size, as of August 8, 2020

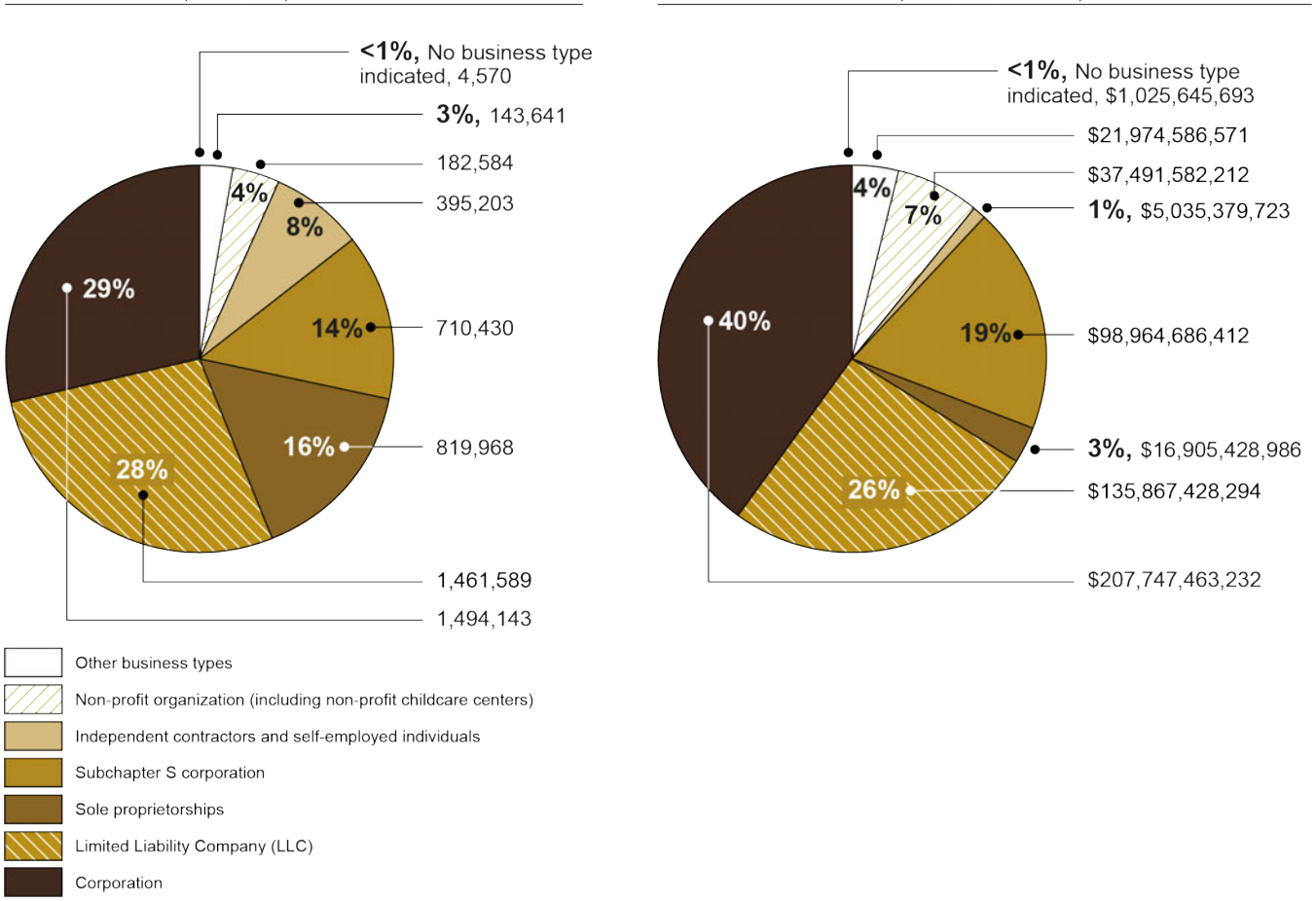
Number of employees	Number of approved loans	Dollar amount of approved loans	Percentage of approved loans	Percentage of approved amount
Not reported or zero	231,260	11,794,604,768	4.4	2.2
1	1,448,737	16,717,316,163	27.8	3.2
2–10	2,387,327	91,259,559,977	45.8	17.4
11–100	1,054,665	246,556,076,954	20.2	47.0
101–500	85,913	142,437,640,445	1.6	27.1
500+[a]	4,226	16,247,002,816	0.1	3.1
Total	**5,212,128**	**525,012,201,124**	**100.0**	**100.0**

Source: GAO analysis of Small Business Administration data. | GAO-20-701

[a]Some businesses with more than 500 employees were eligible for Paycheck Protection Program loans if they were considered small in their industries per the Small Business Administration's size standards or if they were in the accommodation and food services industry and had not more than 500 employees per physical location.

Types of businesses approved for PPP loans over time. Several types of businesses received PPP loans, but corporations and limited liability companies received the largest percentages of the approved loan amounts—40 percent and 26 percent, respectively (see fig. 9).

Figure 9: Percentage of Approved Paycheck Protection Program Loans and Approved Dollars, by Business Type, as of August 8, 2020



Source: GAO analysis of Small Business Administration data. | GAO-20-701

Note: S corporations are corporations that are taxed through their shareholders rather than through the corporation itself. The data field for "other business types" includes cooperatives, employee stock ownership plans, joint ventures, limited liability partnerships, partnerships, professional associations, and trusts.

In addition, certain types of businesses participated in the program in greater numbers at certain times. Ninety-six percent of loans to independent contractors and self-employed individuals were approved during the last three phases of the program (from April 27, 2020, through August 8, 2020). SBA did not post application guidelines for these two groups until 18 calendar days after the CARES Act was enacted (2 days before the first phase of PPP funding was exhausted).[151] Similarly, 85 percent of sole proprietorships were approved during the last three phases (from April 27, 2020, through August 8, 2020).

[151]According to SBA and Treasury officials, it took time to determine how to calculate payroll costs for independent contractors and sole proprietorships, as this was not a concept naturally applied to these types of entities. Treasury officials also stated that these types of entities had not previously been eligible for SBA programs.

Canceled PPP loans. Borrowers of loans in varying amounts canceled PPP loans.[152] As of August 8, 2020, lenders had canceled about 311,000 loans totaling about $46 billion. Following reports that publicly traded companies had received PPP loans, SBA issued guidance reminding borrowers that they should carefully review the required economic necessity certification to ensure that they qualify.[153] In subsequent rules and guidance, SBA announced that borrowers who had previously applied for a PPP loan could repay the loan in full by May 18, 2020, and would be considered to have made their economic necessity certification in "good faith." About 15 percent of all loans over $2 million were canceled (see table 5). However, the majority of loans that were canceled (about 75 percent) were less than $50,000.

[152]As noted previously, canceled loans include loans canceled for a variety of reasons. The data SBA provided did not specify the reason for loan cancelation (for example, because they were duplicates).

[153]Borrowers must certify in good faith that the"[c]urrent economic uncertainty makes this loan request necessary to support the ongoing operations of the Applicant." SBA also stated that any borrower that received a PPP loan with an original principal amount of less than $2 million would be deemed to have made the required certification concerning the necessity of the loan request in good faith.

Table 5: Canceled Paycheck Protection Program Loans, by Loan Amount, as of August 8, 2020

Amount of loan ($)	Number of canceled loans	Amount of canceled loans ($)	Percentage of approved loans canceled	Percentage of approved amount canceled
50,000 and less	232,946	3,425,420,004	6	5
50,001–150,000	38,991	3,409,857,567	4	4
150,001–2,000,000	33,296	17,113,890,518	5	6
More than 2 million	5,336	22,351,390,851	15	17
Total	**310,569**	**46,300,558,940**	**6**	**8**

Source: GAO analysis of Small Business Administration data. | GAO-20-701

Note: For purposes of this analysis, canceled loans are those in SBA's loan-level data with a status of "fully canceled."

Demographic data on PPP loans. The loan-level data that SBA provided include limited demographic data on borrowers, as SBA did not ask for demographic information on the PPP loan application. According to SBA officials, SBA does not have the legal authority to require a borrower to submit demographic data on a loan application. In a May 2020 report, the SBA Office of Inspector General noted that SBA did not request optional demographic information on the PPP loan application and suggested that the agency (1) revise the borrower application to request these optional data and (2) include optional demographic information on the loan forgiveness form.[154] SBA did not revise the borrower application to collect such information in an effort to streamline the application process, according to agency officials. Consequently, information was not reported for business owners' race for 90 percent of approved loans, gender for 79 percent of approved loans, and veteran status for 85 percent of approved loans.

To collect some demographic information, SBA has included an optional form as part of the loan forgiveness application. The form requests information such as the race, gender, and ethnicity of the borrower's principal business owner or owners. Data are not yet available to determine whether this optional form will increase the available demographic data on PPP borrowers.

Data on jobs retained with PPP loans. The system lenders were required to use to submit information on approved PPP loans to SBA included a field for the number of jobs retained, although borrowers were not asked to include this information on their loan applications.[155] Consequently, while SBA's loan-level data includes data on jobs retained with PPP loans, questions exist about the completeness and accuracy of these data. For example, for 18 percent of loans, these data were either not reported or indicated zero jobs retained, and for 1 percent of loans (about 24,000), the number of jobs retained exceeded the number of employees reported.

[154]Small Business Administration, Office of Inspector General, *Small Business Administration's Implementation of the Paycheck Protection Program Requirements*, Report No. 20-14 (Washington, D.C.: May 8, 2020). SBA includes optional demographic information—including race, gender, and veteran status—for principal business owners on its application for the standard 7(a) program.

[155]Instead, borrowers were required to include the number of employees.

Although SBA has addressed how applicants should count employees and calculate payroll for PPP in guidance and regulation, none of the guidance on its website includes instructions to help lenders calculate jobs retained.

When SBA released updated PPP loan-level data as of August 2020, the agency changed the data field previously labeled as *jobs retained* to *jobs reported*. According to SBA officials, this change properly identifies the source of the column's data since the information in it was taken from the PPP loan borrower application where applicants were asked to report their number of employees. However, the system asked lenders for both jobs retained and the number of current employees, and the two numbers sometimes differed in the data we received from SBA. The difference between what lenders were asked to report and how these data are characterized by SBA raises further questions about the quality of the jobs data.

According to SBA officials, lenders will have an opportunity to update or supplement data when they report on disbursed loans and during the loan forgiveness process.[156] SBA has added a form to its website that borrowers and lenders can use to correct any data errors. We will continue to examine the reliability of these data.

SBA's oversight plans. Although SBA has begun developing its oversight plans, including of the loan forgiveness process, it had not yet finalized or implemented them as of August 14, 2020. In our June 2020 report, we recommended that SBA develop and implement plans to identify and respond to risks in PPP to ensure program integrity, achieve program effectiveness, and address potential fraud, including in loans of $2 million or less.[157] SBA neither agreed nor disagreed with our recommendation. Because SBA had limited time to implement up-front safeguards for the PPP loan approval process and assess program risks, we reported that ongoing oversight would be crucial. We also reported that although SBA had announced efforts to implement safeguards after loan approval, the agency had provided limited information on how it would implement these safeguards.

According to SBA officials, SBA is currently working with Treasury and contractors to finalize plans for loan reviews and loan forgiveness reviews. As we previously reported, SBA and Treasury announced that SBA would review all loans of more than $2 million, and SBA said these reviews would focus on the borrower's good faith certification concerning the economic necessity of the loan request. SBA officials later clarified that the agency also would review these loans, as necessary, for compliance with general program requirements.

SBA officials told us that a contractor and SBA staff will conduct the reviews of loans over $2 million and provided the following details. The contractor will review all loans using an automated review tool and will conduct additional manual reviews of some loans based on risks detected by the automated review tool. The contractor also will review the borrower's economic necessity certification. Following the contractor's portion of the review, SBA will review all loans over $2 million with a combination of SBA contract and federal staff. In addition, a separate and

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[156]For example, in a procedural notice issued on July 23, 2020, SBA stated that lenders must confirm that the information provided by the lender to SBA when transmitting loan forgiveness decisions accurately reflects the lender's records for the PPP loan. We discuss the loan forgiveness process in more detail later in this section.

[157]GAO-20-625.

independent contractor will provide a quality assurance review on a sample of loans. As of August 14, 2020, SBA was still working with Treasury and a contractor to finalize the specific review procedures its contractors and staff would follow.

In an interim final rule posted on May 22, 2020, SBA noted that it may review any PPP loan it deems appropriate, which includes loans of less than $2 million.[158] According to SBA officials, all of the loans will undergo an automated review to flag potentially questionable loans. They stated that selected loans will undergo a manual review that may include whether a borrower was eligible for the PPP loan, calculated the loan amount correctly and used loan proceeds for the allowable uses, or was entitled to loan forgiveness in the amount claimed. On July 28, 2020, SBA officials said that the agency plans to review loans identified through specific reports of potential noncompliance or fraud and through stratified statistical sampling based on various loan characteristics. They also noted that they had begun reviews based on reports of potential noncompliance or fraud. As of August 14, 2020, SBA was working with Treasury and contractors to finalize plans to review loans of less than $2 million.

SBA officials also told us that they refer questionable loans to the SBA Office of Inspector General or the Department of Justice for further investigation. Since May 2020, the Department of Justice has publicly announced charges in over 40 fraud-related cases associated with PPP funds. The charges—filed across the United States and investigated by a range of law enforcement agencies—include making false statements and engaging in identity theft, wire and bank fraud, and money laundering.

According to GAO's Fraud Risk Framework, one of the leading practices in managing fraud risks involves the use of data analytics to detect suspicious activity, anomalies, or patterns so that managers can determine which cases of potential fraud to review in detail or identify high-risk program participants for increased oversight or review.[159] However, the usefulness of data analytics for fraud detection can be limited by the data's reliability. In conducting PPP oversight, SBA will be relying on data provided by lenders and borrowers during the loan approval and loan forgiveness processes. We and others have identified some gaps, outliers, duplicates, and anomalies in PPP loan-level data provided by lenders. Although further analysis is needed to determine whether these instances are errors that could be corrected by borrowers and lenders or whether they indicate fraud, they underscore the importance of reliable data for oversight purposes. As noted previously, SBA officials told us lenders will have an opportunity to correct loan-level data when they report on disbursed loans and during the loan forgiveness process, and borrowers can submit a form to SBA requesting a correction. It remains to be seen how much of SBA's oversight also will involve improving the quality of the data.

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[158]See 85 Fed. Reg. 33,010, 33,012 (June 1, 2020).

[159]GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 28, 2015). In its Circular A-123, OMB directed that agencies should adhere to the Fraud Risk Framework's leading practices as part of their efforts to effectively design, implement, and operate an internal control system that addresses fraud risks. Managers are responsible for determining the extent to which the leading practices in the framework are relevant to their program and for tailoring the practices, as appropriate, to align with the program's operations. Office of Management and Budget, *Management's Responsibility for Enterprise Risk Management and Internal Control*, OMB Circular A-123 (Washington, D.C.: July 15, 2016).

We maintain the importance of our prior recommendation that SBA develop and implement plans to identify and respond to risks in PPP, including risks of fraud and improper payments. As SBA finalizes the oversight plans currently under development, such plans could focus on data quality.

Loan forgiveness process. SBA posted additional guidance on the loan forgiveness process on July 23, 2020, August 4, 2020, and August 11, 2020, including on how lenders would transmit their decisions on loan forgiveness to SBA. Based on our review of SBA's rules and discussions with lender associations, uncertainty remains about some aspects of lenders' role in the process. In addition, according to SBA officials, SBA was still developing its plans for overseeing the loan forgiveness process as of August 14, 2020.

- SBA's interim final rules on loan forgiveness and a procedural notice issued on July 23, 2020, indicate that the lender is to review the borrower's application for loan forgiveness and make the decision on forgiveness.[160] However, the extent of lender review required is unclear.[161] Prior to making the decision, lenders are expected to perform a "good-faith review" in a reasonable amount of time of the borrower's calculations and supporting documents and confirm the borrower's calculations concerning amounts eligible for loan forgiveness. The interim final rules and procedural notice do not clearly define the extent of review required but one rule provides an example.[162] At the same time, the loan review procedures interim final rule and the procedural notice state that an accurate calculation of the loan forgiveness amount is the responsibility of the borrower and that lenders may rely on borrower representations.

  On August 4, 2020, SBA posted responses to frequently asked questions on loan forgiveness that answer technical questions, but do not address broader questions about lenders' role. After SBA issued additional guidance in July and August 2020, representatives of two lender associations we interviewed still had questions or concerns about the lender's role in the forgiveness process, including the level of review required and the extent to which lenders could rely on borrower certifications and calculations.

- In its July 23, 2020, procedural notice, SBA noted that it had contracted with a company to develop and make available a secure platform for lenders to submit loan forgiveness

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[160]SBA posted interim final rules on the loan forgiveness process and on loan review procedures on May 22, 2020, and revised these rules to reflect changes made by the Paycheck Protection Program Flexibility Act of 2020 in an additional interim final rule posted on June 22, 2020. See 85 Fed. Reg. 33,004 (June 1, 2020); 85 Fed. Reg. 33,010 (June 1, 2020); 85 Fed. Reg. 38,304 (June 26, 2020). In its initial interim final rule posted on April 2, 2020, SBA provided some information on loan forgiveness for both borrowers and lenders, such as the percentage that borrowers had to spend on payroll costs to be eligible for forgiveness. See 85 Fed. Reg. 20,811 (Apr. 15, 2020). In addition, SBA has provided information on loan forgiveness in responses to frequently asked questions posted on an ongoing basis and released separate PPP loan forgiveness FAQs on August 4, 2020.

[161]The lender has 60 days from receipt of a borrower's complete loan forgiveness application to review the application and make a forgiveness decision. See Pub. L. No. 116-136, § 1106(g), 134 Stat. at 301.

[162]The loan review procedures interim final rule states that minimal review of calculations based on a payroll report by a recognized third-party payroll processor would be reasonable. By contrast, if payroll costs are not documented with such recognized sources, it notes that more extensive review of calculations and data would be appropriate. 85 Fed. Reg. 33,010, 33,013 (June 1, 2020).

decisions, supporting documentation, and requests for forgiveness payments.[163] SBA launched the platform on August 10, 2020. SBA officials told us they did not expect to receive a large number of loan forgiveness decisions from lenders until early August 2020 due to the timing of the CARES Act and SBA rules.[164]

- According to SBA officials, as part of its oversight SBA will put all lender decisions granting full or partial loan forgiveness through the automated review tool provided by one of its contractors. SBA's interim final rule on loan review procedures and the July 23, 2020, procedural notice indicate that SBA reserves the right to direct a lender to deny an application or to review the lender's decision.[165] As of August 14, 2020, SBA was still developing its processes for loan reviews, which include overseeing loan forgiveness.[166]

New Renters' Relief Follows Expiration of Key CARES Act Provisions

Many credit the CARES Act with ensuring short-term housing stability during the pandemic by temporarily halting evictions for non-payment of rent and providing an additional $600 in weekly unemployment benefits. These provisions expired at the end of July, potentially leaving many millions of renters at risk of eviction.

On September 1, 2020, the CDC issued an order halting evictions of qualifying renters to prevent the further spread of COVID-19. This moratorium is in effect from September 4, 2020, through December 31, 2020 and potentially covers up to 44 million renter households.[167]

Section 4024 of the CARES Act prohibited evictions of renters living in any property with a federally backed mortgage or tenants living in rental units participating in specified federal programs for

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[163]This platform, the PPP Forgiveness Platform, also allows lenders to monitor the status of forgiveness requests and respond to any SBA inquiries or loan reviews.

[164]A lender must disburse funds for an approved loan within 10 days of making a decision, and must make a decision on loan forgiveness within 60 days of receiving a loan forgiveness application. Borrowers have either 8 or 24 weeks to incur eligible expenses for loan forgiveness.

[165]See 85 Fed. Reg. 33,010, 33,012-13 (June 1, 2020); 85 Fed. Reg. 38,304, 38,310 (June 26, 2020).

[166]SBA has 90 days from receipt of the lender's decision on loan forgiveness to remit the forgiveness amount to the lender, subject to any review of the loan, the lender's loan forgiveness decision, or the borrower's completed loan forgiveness application.

[167]Department of Health and Human Services, Centers for Disease Control and Prevention, Temporary Halt in Residential Evictions to Prevent the Further Spread of COVID-19 (Sept. 1, 2020) printed in the Federal Register at 85 Fed. Reg. 55292 (Sept. 4, 2020). This order follows an executive order signed by President Trump on August 8, 2020, which directed HHS and CDC to consider whether measures to temporarily halt tenant evictions for failure to pay rent were reasonably necessary in order to prevent the spread of COVID-19. Exec. Order No. 13,945, 85 Fed. Reg. 49,935 (Aug. 14, 2020).This estimate of covered households is the total number of rental households from the 2018 American Community Survey, the most recent estimate of the number of renter households in the U.S. The September 2020 moratorium applies to "any tenant, lessee, or resident of a residential property" who provides a declaration, under penalty of perjury, that they meet certain requirements. Among other requirements, the individual must declare they have used their best efforts to obtain all available government assistance for rent or housing, their expected income for calendar year 2020 is no more than $99,000 (or no more than $198,000 if filing a joint tax return), and they are unable to pay the full rent or make a full housing payment for certain reasons.

120 days from enactment, or through July 24, 2020, for the nonpayment of rent.[168] In total, this moratorium applied to at least 17 million renters (or about 39 percent of all renter households).[169] Depending on how many households meet the criteria the September 2020 moratorium, it could potentially cover more renter households than the Section 4024 moratorium.

In addition, the CARES Act created and funded a number of temporary UI programs, including the FPUC program, which authorized an additional $600 in weekly unemployment benefits through July 2020.[170] Many stakeholders said these enhanced benefits likely have helped unemployed households to continue paying their rent in the short term.[171] On August 8, 2020, the President signed a memorandum directing FEMA to provide up to $44 billion in lost wages assistance from the Disaster Relief Fund. Pursuant to the memorandum, upon receiving a FEMA grant, states and territories may provide eligible claimants $300 or $400 per week, which includes a $300 federal contribution.

However, available data suggest many renters continue to struggle to pay their rent during the pandemic, despite the moratoriums and enhanced unemployment benefits. According to the

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[168]Pub. L. No. 116-136, § 4024, 134 Stat. at 492. The CARES Act defines federally backed mortgages (1 to 4 units) and federally backed multifamily mortgages (5 or more units) as those purchased or securitized by the housing enterprises Fannie Mae and Freddie Mac, as well as those made, insured, guaranteed, supplemented, or assisted in any way by federal government agencies, principally the Department of Housing and Urban Development (HUD), a component of which is the Federal Housing Administration, the Department of Agriculture, a component of which is the Rural Housing Service, and VA. The enterprises are currently under the conservatorship of the Federal Housing Finance Agency. Federal programs funding rental units that were covered by section 4024 include, among others, Public Housing, the Section 8 Housing Choice Voucher program, Section 8 project-based housing, Section 202 housing for the elderly, and Section 811 housing for people with disabilities. Under the CARES Act, a tenant must be given a notice of 30 days to vacate the property, and the notice may only be issued after the expiration of the 120-day eviction moratorium. Further, section 4022 of the CARES Act placed a foreclosure and eviction moratorium on single-family properties with federally backed mortgages. Under the moratorium, owners of these properties may not be foreclosed upon and persons occupying the properties, including renters, may not be evicted in connection with the foreclosure. Pub. L. No. 116-136, § 4022 (c)(2) 134 Stat. at 491. While the eviction moratorium under section 4024 has expired, the agencies and enterprises extended their foreclosure-related eviction moratoriums under section 4022 for single-family properties until December 31, 2020.

[169]This estimate assumes that 2.8 million single-family rental units and 9.6 million multifamily rental units are financed with federally-backed mortgages and that at least 4.8 million additional households receive federal rental assistance. See Urban Institute, *The CARES Act Eviction Moratorium Covers All Federally Financed Rentals—That's One in Four U.S. Rental Units*, April 2, 2020, accessed July 11, 2020, https://www.urban.org/urban-wire/cares-act-eviction-moratorium-covers-all-federally-financed-rentals-thats-one-four-us-rental-units; GAO-20-625; and HUD, *Picture of Subsidized Households*, accessed July 13, 2020, https://www.huduser.gov/portal/datasets/assthsg.html. The estimate does not account for renter households that live in properties financed with Low-Income Housing Tax Credits and is therefore likely an underestimate of total households covered by the CARES Act eviction moratoriums. In another study, the Federal Reserve Bank of Atlanta estimated that the number of federally backed rental units ranged from an estimated 12.3 million (28.1 percent) to an estimated 20 million (45.6 percent). See Federal Reserve Bank of Atlanta, *Housing Policy Impact: Federal Eviction Protection Coverage and the Need for Better Data*, accessed September 3, 2020, https://www.frbatlanta.org/community-development/publications/partners-update/2020/covid-19-publications/200616-housing-policy-impact-federal-eviction-protection-coverage-and-the-need-for-better-data#src18.

[170]Pub. L. No. 116-136, § 2104, 134 Stat. at 318.

[171]For example, see Urban Institute, *Don't Overlook the Importance of Unemployment Benefits for Renters*, accessed July 13, 2020, https://www.urban.org/urban-wire/dont-overlook-importance-unemployment-benefits-renters; Joint Center for Housing Studies of Harvard University, *Cash Strapped during COVID-19*, accessed July 13, 2020, https://www.jchs.harvard.edu/blog/cash-strapped-during-covid-19/; and Terner Center for Housing Innovation, *Estimating COVID-19's Near-Term Impact on Renters*, accessed July 13, 2020, https://ternercenter.berkeley.edu/blog/estimating-covid-19-impact-renters.

Census Bureau's Household Pulse Survey, an estimated 46 to 51 percent of renters reported being unemployed from May–July 2020.[172] Further, a number of stakeholders have observed lower and declining rent payments since April 2020, and others have cited higher use of credit to make payments.[173] The Census Bureau's Household Pulse Survey further estimated that in July 2020, an estimated 18 percent of renters did not pay their rent during the previous month, up from an estimated 14 percent in May.[174] Over the same time frame, an estimated 27 to 33 percent of renters reported they had no or slight confidence in their ability to pay rent next month.[175] Historical data on mortgage and consumer credit delinquency rates show that a household's ability to pay its debts generally decreases in an economic downturn.[176] Some renters may also lack awareness of available rent relief options.[177]

In addition, some stakeholders have noted that despite the section 4024 moratorium, some landlords continued to file evictions and some local courts continued to process them, including evictions resulting from the non-payment of rent in circumstances that might be covered by the Section 2024 moratorium.[178] It is too soon to assess the effect of the September 2020 moratorium on eviction filings and evictions.

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[172]These estimates have a margin of error of ± 2 percentage points or less at the 95 percent confidence level. The 2020 Household Pulse Survey, an experimental data product, is an interagency federal statistical rapid response survey to measure household experiences during the COVID-19 pandemic. The survey is conducted by the Census Bureau in partnership with five other agencies from the Federal Statistical System. Response rates have ranged from 1.3–3.8 percent. The Census Bureau acknowledges that nonresponsive bias is likely to be an issue, but measures such as the demographic distribution of the survey respondents compared to benchmarks will be produced for data users to consider in their analysis.

[173]For example, the National Multifamily Housing Council estimated that full and partial rent payments to multifamily landlords from April–August 2020 lagged compared with payments from April–August 2019. In another survey, Apartment List found that for May–August, about 1 in 3 Americans did not make a full, on-time housing payment. In the first week of August 2020, an estimated 11 percent of survey respondents made a partial payment toward their monthly housing (rent or mortgage) payment; an additional 22 percent of respondents had not made any payment. Additionally, according to the Census Bureau's Household Pulse Survey, only about 60 percent of renters reported using regular income sources to meet spending needs over the last 7 days. About 20–30 percent reported using economic impact payments, credit cards or loans, money from savings or selling assets or borrowed from friends or family, or UI benefit payments, and about 5 percent used money saved from deferred or forgiven payments. These estimates have a margin of error of less than ± 2 percentage points at the 95 percent confidence level.

[174]This change was statistically significant at the 95 percent confidence level.

[175]These estimates have a margin of error of less than ± 2 percentage points at the 95 percent confidence level. Fannie Mae similarly reported that 36 percent of renters were somewhat or very concerned with their ability to pay their bills in the next month (April –July 2020), and 15 percent of renters had or planned to request lowered or delayed rent payments (± about 3 percent).See Fannie Mae, National Housing Survey: Covid-19: The Need for Consumer Outreach and Home Purchase/Financing Digitization (Washington, D.C.: August 2020)..

[176]See Board of Governors of the Federal Reserve System, *Charge-Off and Delinquency Rates on Loans and Leases at Commercial Banks*, accessible at https://www.federalreserve.gov/releases/chargeoff/delallsa.htm#fn1. Additionally, between February and May 2020, the S&P Bankcard Default Index increased by nearly 1 percentage point, from 3.41 percent to 4.40 percent, its highest level since 2012. According to the National Bureau of Economic Research, February 2020 marked the beginning of a recession.

[177]For the second quarter of 2020, Fannie Mae reported that 68 percent of renters (± about 3 percent) were unfamiliar with programs that allow renters facing financial hardship due to COVID-19 to lower or delay their rent payments. See Fannie Mae, National Housing Survey: Covid-19: The Need for Consumer Outreach and Home Purchase/Financing Digitization (Washington, D.C.: August 2020).

[178]Evictions generally are governed by state and local law. As a result, there is no comprehensive data on eviction filings and evictions. However, according to data on 17 cities collected by Eviction Lab at Princeton University, eviction filings

Moreover, while the section 4024 moratorium prevented and the September 2020 moratorium is expected to prevent eviction for many renters, they did not preclude landlords from seeking payment for accumulated rent, which some say could lead to insurmountable one-time payments for renters.[179] While landlords may be managing short-term reductions in rental payments, continued partial payment or non-payment could force some into forbearance or foreclosure.[180]

The September 2020, extension of the moratorium could help ensure renters remain housed over the duration of the pandemic, especially in states and localities without their own moratoriums.[181] However, this extension does not address longer-term issues, including how affected renters would pay their rent (including back rent and other housing expenses, such as utilities) or how

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fell sharply from previous levels beginning in March and April 2020. Cities that enacted their own eviction moratoriums during the pandemic generally saw the steepest declines; however, eviction filings tended to increase as moratoriums expired. These patterns suggest that eviction moratoriums had a limiting effect on eviction filings. Eviction Lab at Princeton University is a research organization that tracks and publishes a dataset on evictions going back to 2000 (see www.evictionlab.org). Also see Jeff Ernsthausen, Ellis Simani, and Justin Elliott, *Despite Federal Ban, Landlords Are Still Moving to Evict People During the Pandemic*, (New York, NY: ProPublica, Apr. 16, 2020), accessed July 27, 2020, https://www.propublica.org/article/despite-federal-ban-landlords-are-still-moving-to-evict-people-during-the-pandemic and National Housing Law Project, *Protecting Renter and Homeowner Rights During Our National Health Crisis*, accessed July 27, 2020, https://www.nhlp.org/campaign/protecting-renter-and-homeowner-rights-during-our-national-health-crisis-2/.

[179]The September 2020 moratorium "does not relieve any individual of any obligation to pay rent, make a housing payment, or comply with another obligation that the individual may have under a tenancy, lease, or similar contract." Further, "nothing in [the] order precludes the charging or collecting of fees, penalties, or interest as a result of the failure to pay rent of other housing payment on a timely basis, under the terms of the applicable contract." Section 4024 of the CARES Act did not relieve renters of their obligation to pay rent, but did prohibit landlords from charging fees or penalties for late rent payments.

[180]Section 4023 of the CARES Act allows forbearance on federally backed multifamily mortgages for up to 90 days, and evictions are prohibited throughout the duration of the forbearance period. During the forbearance period, landlords are prohibited from evicting tenants for nonpayment of rent. Pub. L. No. 116-136, § 4023, 134 Stat. at 491. Roughly 2 percent (1,600 loans) of the outstanding balance on multifamily loans securitized by Fannie Mae and Freddie Mac were in forbearance as of late July–early August 2020. Most Freddie Mac loans in forbearance are small balance loans that have fewer units, meaning each tenant experiencing stress will have a larger impact on small property operators, according to Freddie Mac. HUD, in Notice H 20-07, issued July 1, 2020, noted that many borrowers and lenders would negotiate additional forbearance relief beyond the 90-day period provided in the CARES Act. HUD announced it would condition, as a matter of policy, its approval of a forbearance extension on the borrower's agreement to similarly extend the Section 4023 renter protections. The Federal Housing Finance Agency announced in late June that Fannie Mae and Freddie Mac were allowing servicers to extend existing forbearance agreements with owners of multifamily properties with enterprise-backed mortgages by an additional 3 months (for a total forbearance of up to (6 months). While the properties are in the forbearance, the landlord must suspend all evictions for renters unable to pay rent.

[181]Some states and localities implemented their own eviction moratoriums; however, it was beyond the scope this report to assess those moratoriums and the extent to which they may be more comprehensive than the federal moratoriums. Notwithstanding this, according to a group of legal researchers, 18 states continue to have eviction moratoriums in place, 10 of which are scheduled to expire before December 31, 2020 (the end of the f September 2020 moratorium) and eight of which are tied to the end of the declared emergency. In addition, 27 states issued eviction moratoriums that have since expired, and six states did not issue any eviction moratoriums. This analysis includes Washington, D.C. in our analysis of states. See Emily Benfer, et. al., *COVID-19 Eviction Moratoria by State, Commonwealth, and Territory*, accessible at https://docs.google.com/spreadsheets/u/1/d/e/2PACX-1vTH8dUIbfnt3X52TrY3dEHQCAm60e5nqo0Rn1rNCf15dPGeXxM9QN9UdxUfEjxwvfTKzbCbZxJMdR7X/pubhtml. These data are widely cited by researchers, policymakers, and the media. The September 2020 moratorium does not apply to any state, local, territorial, or tribal area that has a residential eviction moratorium that "provides the same or greater level of public-health protection than the requirements" as the September 2020 moratorium.

landlords would pay their mortgages.[182] Policymakers and other stakeholders have suggested more comprehensive measures to help ensure housing and financial stability.[183] Additionally, as previously described, income support (such as enhanced UI benefits) can also help households continue to pay their rent in the short term.

Table 6 provides a summary of additional information on federal support for industry and the economy presented in enclosures in appendix I, which also include descriptions of GAO's future work.

[182] The September 2020 moratorium noted that CDC had been informed by HUD that its grantees (states, cities, communities, and nonprofits) that received Emergency Solutions Grants or Community Development Block Grant funds under the CARES Act could use these funds to provide temporary rental assistance, homelessness prevention, or other aid to individuals who were experiencing financial hardship because of the pandemic and were at risk of being evicted. Similarly, according to the moratorium, Treasury had informed CDC that the funds allocated through the CRF could be used to fund rental assistance programs to prevent eviction.

[183] For example, if enacted, the Heroes Act would provide emergency rental assistance and a federal lending facility for landlords. H.R. 6800, 116th Cong. (2020). See also Jenny Schuetz, *The Rent Is Still Due: America's Renters, COVID-19, and an Unprecedented Eviction Crisis*, testimony before the House Committee of Financial Services, Subcommittee on Housing, Community, Development, and Insurance, 116th Cong., 2nd sess., June 10, 2020; Joint Center for Housing Studies at Harvard University, *How Much Assistance Would It Take to Help Renters Affected by COVID-19?*, accessed July 7, 2020, https://www.jchs.harvard.edu/blog/how-much-assistance-would-it-take-to-help-renters-affected-by-covid-19/; National Housing Law Project, *Emergency Rental Assistance Principles and Recommendations*, (San Francisco, CA: June 9, 2020); Terner Center for Housing Innovation, *A Plan to Keep Renters Housed through the COVID-19 Recovery*, accessed July 6, 2020, https://ternercenter.berkeley.edu/blog/keeping-renters-housed-through-covid-19-recovery; Urban Institute, *Avoiding a COVID-19 Disaster for Renters and the Housing Market*, (Washington, D.C.: April 2020).

Table 6: Areas in Which the Federal Government Has Taken Action to Support Industry and the Economy in Response to COVID-19

Area name	Federal government's actions
Paycheck Protection Program	The Paycheck Protection Program closed to new applicants on August 8, 2020, and as of that date, lenders had made over 5.2 million loans totaling more than $525 billion. The Small Business Administration has started accepting loan forgiveness applications. In response to our recommendation that the Small Business Administration develop and implement plans to identify and respond to risks in the program, the agency has begun to develop oversight plans but has not yet finalized or implemented them.
Eviction Moratorium	Eviction moratoriums have helped keep renters housed, but do not address longer-term issues for renters and property owners related to unpaid rent.
Economic Injury Disaster Loan Program	After an initial backlog in processing applications, the Small Business Administration decreased its processing times for loans and advances made under the Economic Injury Disaster Loan program, but various challenges remain related to communication of program information and potential fraud.
Federal Reserve Emergency Lending Programs	Since early June 2020, seven additional emergency lending programs (or facilities) supported through CARES Act-appropriated funds became operational, resulting in a total of nine operational CARES Act facilities as of September 4, 2020. Modifications to the initial terms of the Main Street facilities serving small- and mid-size businesses continued into June and, according to Board of Governors of the Federal Reserve System officials, contributed to the facilities not becoming operational—that is, not accepting loans—until early July. The Main Street facilities serving nonprofits became operational in early September. Overall, the CARES Act facilities' transactions and purchases of assets have been relatively limited.
Financial Assistance to Aviation and Other Eligible Businesses	The Department of the Treasury continues to provide assistance out of the $78 billion available to help the nation's aviation industry and other businesses critical to national security recover from the economic effects of the COVID-19 pandemic.
Agriculture Spending	The U.S. Department of Agriculture continues to spend CARES Act funds for direct payments to agricultural producers and food purchases for redistribution to food banks, nonprofits, and other entities.
Federal Food Safety Inspections	The U.S. Department of Agriculture continues to spend CARES Act funds—more than $7.5 million spent from $33 million appropriated—to maintain staffing for federal

	inspections of meat and poultry plants as well as to provide personal protective equipment and supplies.

Source: GAO. | GAO-20-701

Assistance to States, Localities, Territories, and Tribes

This section describes the federal government's assistance to states, localities, territories, and tribes, including the CRF and guidance on physically reopening K-12 schools for in-person education.

The COVID-19 relief laws provided an estimated $335 billion in funds to agencies for assisting U.S. states, localities, territories, and tribes in their responses to the COVID-19 pandemic. As we reported in June 2020, the six programs listed in the table below account for approximately 89 percent, or $299 billion, of the total estimated federal funding to states, localities, territories, and tribes from the COVID-19 relief laws. These programs have continued to disburse funds to states, localities, territories, and tribes, totaling $176 billion as of July 31, 2020 (see table 7). This represents additional federal expenditures of $17 billion since May 31, 2020.

Table 7: Appropriations and Expenditures for Selected Federal Programs Providing COVID-19-Related Aid to States, Localities, Territories, and Tribes

Program	Appropriations ($)	Cumulative Federal Expenditures ($)		
		As of May 31, 2020	As of June 30, 2020	As of July 31, 2020
Coronavirus Relief Fund	150 billion	147 billion	149 billion	149 billion
Medicaid	52 billion[a]	7 billion	7 billion	13 billion
Federal Emergency Management Agency Disaster Relief Fund	45 billion	1 billion	2 billion[b]	3 billion[b]
Transit grants	25 billion	3 billion	6 billion	8 billion
Education Stabilization Fund	17 billion[c]	83 million	514 million	907 million
Airport grants[d]	10 billion	288 million	931 million	2 billion

Source: GAO analysis of federal laws; Congressional Budget Office data, and information and data from the Centers for Medicare & Medicaid Services and the Departments of Education, Homeland Security, Transportation, and the Treasury. | GAO-20-701

Note: The COVID-19 relief laws appropriating the amounts described in this table are the Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020) and the CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020). Some appropriation amounts include an amount available for administration expenses or for the relevant inspectors general. An expenditure is the actual spending of money, or an outlay. Numbers are rounded to the nearest million or billion.

[a]Several provisions in the Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020), authorized an increase in Medicaid funds for states and territories. The largest increase to federal Medicaid spending is based on a formula change rather than a specific appropriated amount. The Congressional Budget Office estimated that federal expenditures from this change would be approximately $50 billion.

[b]This amount represents all expenditures as of June 30 and July 31, 2020, from the Disaster Relief Fund for COVID-19. This amount includes expenditures associated with the major disaster declarations, but, according to Federal Emergency Management Agency (FEMA) officials, does not include expenditures related to the nationwide emergency or surge activity. FEMA officials also said that the agency has not obligated or expended any money appropriated to the Disaster Relief Fund by the CARES Act and, instead, has funded, and continues to fund, its obligations and expenditures related to COVID-19 relief operations from the balances of prior year appropriations to the Disaster Relief Fund. Some of the expenditures were for FEMA's Public Assistance program, which provides emergency protective assistance to state, local, territorial, and tribal governments. Expenditures for the Public Assistance program as of June 30, 2020 and July 31, 2020 were $1 billion and $2 billion, respectively.

[c]This amount is an approximation and includes funds for the Elementary and Secondary School Emergency Relief Fund; the Governor's Emergency Education Relief Fund; Education Stabilization Fund discretionary grants; formula grants to the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa (which are referred to in the law as outlying areas); and programs operated or funded by the Bureau of Indian Education. It does not include the nearly $14 billion in aid for institutions of higher education through the Education Stabilization Fund.

[d]Funds are available to eligible sponsors of airports. Nearly all of these airports are under city, state, county, or public-authority ownership.

State and local governments face increased expenditures and decreased revenues stemming from the pandemic and the resulting economic effects. In addition to updating their revenue forecasts, state and local governments have taken actions to respond to these fiscal challenges including freezing hiring, furloughing staff, restricting contracts and new spending, and freezing

discretionary spending. A number of states also tapped their reserve funds to balance budgets for fiscal year 2020.

Coronavirus Relief Fund Guidance

As shown in table 7, Treasury has disbursed nearly all of the $150 billion CRF, the largest program that provides aid to states, the District of Columbia, localities, tribal governments, and U.S. territories from the four COVID-19 relief laws.[184] Given the statutory requirement to disburse CRF payments within 30 days, Treasury made payments while Treasury, Treasury's Office of Inspector General, and OMB were still developing guidance and recipient accountability measures.[185]

Guidance. Treasury began issuing guidance on its interpretation of the eligible use of CRF payments in April 2020, at the same time it disbursed most of the CRF funds. Since that time, Treasury has continued to update its guidance on its interpretation of the eligible use of CRF payments, but has not clearly communicated that information to recipients, according to officials from associations representing state and local governments. According to Treasury officials, Treasury disseminated guidance to CRF recipients primarily by posting information on its webpage, including periodically updating an FAQ document. For example, Treasury updated its guidance document on June 30 to clarify the period in which costs must be incurred by recipients to be eligible. Treasury also updated the FAQ document on July 8 to clarify that states should transfer CRF funds to local governments that did not receive direct CRF payments, and to clarify that the costs of administering and auditing CRF funds are eligible uses.[186]

Treasury officials told us they update the FAQs to help address questions Treasury receives from CRF recipients and state and local government associations, among others. Treasury officials said they expect to continue to have an active role in policy matters related to the CRF, including providing additional guidance and responding to questions related to eligible use of funds, even after Treasury has disbursed all CRF payments. According to Treasury officials, they made efforts to participate in regular conference calls scheduled by the White House Office of Intergovernmental Affairs and calls sponsored by relevant associations when updated guidance or FAQs were released.

However, Treasury only recently began alerting individual CRF recipients when it updated the guidance and identifying the new or revised information in the guidance. For example, the Treasury CRF guidance and FAQ document both indicated the date each document was last updated, but until recently, the documents did not identify which information was new or revised. Officials from associations representing state and local governments told us that while Treasury

[184]Litigation is pending before a federal appeals court regarding whether Alaska Native regional and village corporations are eligible for CRF Tribal Set-Aside payments. *Confederated Tribes of the Chehalis Reservation v. Mnuchin*, Case No. 20-cv-5204 (D.C. Cir. July 14, 2020). Until the litigation is resolved, Treasury is subject to an injunction issued by the district court judge that bars it from disbursing CRF payments to Alaska Native regional and village corporations. *Confederated Tribes of the Chehalis Reservation v. Mnuchin*, Case No. 20-cv-01002 (D.D.C. July 7, 2020). Thus, a portion of the Tribal Set-Aside has not been disbursed.

[185]Pub. L. No. 116-136, § 5001, 134 Stat. at 502.

[186]States may transfer CRF payments to a local government, as long as the locality uses the funds for eligible expenses.

was generally accessible and responsive to questions, their members said it was challenging to continually monitor Treasury's web page for updates and search the CRF guidance documents for any changes or additions.

According to association officials, some states delayed disbursing CRF funds to subrecipients, such as local governments, because they needed additional guidance on the eligible use of CRF payments, including reporting and compliance requirements. We discussed these concerns with Treasury officials on July 30, 2020, and, when Treasury next updated its CRF FAQ document on August 10, 2020, it notified CRF recipients of the revised guidance and clearly identified which information in the guidance was new. Treasury officials told us they plan to continue these actions moving forward.

Audit requirements. The Single Audit Act establishes requirements for states, the District of Columbia, local governments, U.S. territories, Indian tribes, and nonprofit organizations that receive federal awards to undergo single audits of those awards annually (unless a specific exception applies), when their expenditures of the award meet a certain dollar threshold.[187] The audits required by the act are critical to the federal government's ability to help safeguard federal funds. Specifically, a single audit may identify deficiencies in the award recipient's compliance with applicable provisions of laws, regulations, contracts, or grant agreements and in its financial management and internal control systems. Correcting such deficiencies can help reasonably assure the effective use of federal funds and reduce the likelihood of federal improper payments.

Auditors who conduct single audits follow guidance in the Single Audit Act's Compliance Supplement, which OMB updates and issues annually in coordination with federal agencies. In a May 28, 2020, FAQ Treasury provided guidance that CRF payments are considered federal financial assistance subject to single audits. OMB's 2020 Compliance Supplement, issued in August 2020, specified that OMB is still working with federal agencies to identify the needs for additional audit guidance for new COVID-19 related programs, including the CRF, as well as existing programs with compliance requirement changes. OMB plans to publish an addendum to this Supplement in the fall of 2020. According to an official from the National Association of State Auditors, Comptrollers and Treasurers, many single audit efforts are already underway. Given that some auditors usually start their interim testing in April for June 30 year-end single audits, further delays in issuing this guidance could adversely affect auditors and the results and timing of their work, and may lead to inconsistent reporting.

GAO Recommendation Related to Coronavirus Relief Fund Audit Requirements

The Director of the Office of Management and Budget, in consultation with the Department of the Treasury, should issue the addendum to the 2020 Compliance Supplement as soon as possible to provide the necessary audit guidance, as many single audit efforts are underway. (Recommendation 11)

Source: GAO. | GAO-20-701

[187]The Single Audit Act is codified, as amended, at 31 U.S.C. §§ 7501-06, and implementing OMB guidance is reprinted in 2 C.F.R. part 200 (2020). Federal award recipients that expend $750,000 or more in federal awards in a fiscal year are required to undergo a single audit, which is an audit of an entity's financial statements and federal awards, or a program-specific audit, for the fiscal year. 31 U.S.C. § 7502; 31 C.F.R. § 200.501 (2020).

Guidance for K–12 Schools

In light of the pandemic, state and local school district officials have been tasked with reassessing their operating status and ensuring their school buildings are safe. Decisions about K-12 education are primarily a state and local issue, and these officials are the key decision makers about how and when to reopen schools for in-person learning. In doing so, state and local officials generally look to federal, state, and local public health officials and the Department of Education (Education) for guidance and information to do so in a way that helps protect America's 50 million students and 6 million teachers and staff, and slows the spread of COVID-19. On July 23, CDC announced updated guidance to help schools, school districts, and states consider how to return to in-person instruction in the fall, as well as reassess their operating status throughout the school year as local health conditions change.[188]

CDC's updated guidance includes sections for school and program administrators on preparing for a safe return and operating schools safely (including considerations for when schools should close for in-person learning). The guidance also includes sections for parents and caregivers containing decision tools and checklists designed to give families information on why the administration believes it is critical to send children safely back to school in person, how to weigh the risks and benefits of available educational options, and how to plan for the 2020–21 school year.

Education officials said that to be as helpful as possible, they also made available guidance and resources for state and local officials and education administrators. Education's website provides information on COVID-19 for schools and school personnel, including links to CDC's guidance and various federal websites with COVID-19 information. Its technical assistance center also includes links to various federal websites with COVID-19 information. However, portions of CDC's guidance on reopening K-12 schools are internally inconsistent, and some CDC, White House, and Education statements appear incongruent with a risk-based approach to determining school operating status.

Inconsistent CDC guidance. CDC's guidance on screening children and employees entering K-12 schools is internally inconsistent. For example, CDC's updated guidance, *Screening K-12 Students for Symptoms of COVID-19: Limitations and Considerations*, does not recommend that schools conduct daily symptom screening for all K-12 students, noting that since some people with COVID-19 are asymptomatic, there are limitations to such screenings. However, contradictory guidance remained accessible on CDC's website several weeks later. For example, CDC's *Considerations for K-12 Schools Readiness and Planning Tool,* still directed schools to develop a plan to conduct daily health checks (e.g., temperature screening or symptom checking) of staff and students.

Further, a CDC decision tool for physically reopening, *Schools During the Covid-19 Pandemic*, explicitly stated that schools should not physically open unless they are able to screen students

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[188]See Centers for Disease Control and Prevention, *COVID-19: Schools and Childcare Programs; Plan, Prepare, and Respond*, accessed August 6, 2020, https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/index.html. The federal government has continued to make additional updates as needed. For example, on August 18, 2020, the Department of Homeland Security's Cybersecurity and Infrastructure Security Agency added teachers, administrators, and a variety of support staff to its list of Essential Critical Infrastructure Workers.

and employees upon arrival for symptoms and history of exposure and are ready to protect children and employees at higher risk for severe illness.

CDC guidance on what to do if a student or staff member tests positive for COVID-19 is also inconsistent. In its *FAQ for School Administrators on Reopening Schools*, CDC notes that in most instances, a single case of COVID-19 in a school would not warrant closing the entire school. In contrast, in the *K-12 Schools and Childcare Programs FAQ for Administrators, Teachers, and Parents*, CDC notes that if a student or staff member is confirmed to have COVID-19, "you will likely dismiss students and most staff for 2–5 days." As we reported in June 2020, in the midst of a nationwide emergency, clear and consistent communication with health care providers and to the public—across all levels of government—is key.

In commenting on a draft of this report, CDC stated that it strives to ensure that all content is consistent and up to date. It noted that updating these documents is an iterative and ongoing process and, as a result, there can be periods of time where some documents are updated and others are not. CDC further stated that it is working to update its decision tools and re-opening guidance to align with its updated guidance, and that it has removed the decision tool, *Schools During the Covid-19 Pandemic,* from its website.

Relatedly, Education's website and technical assistance center contained incomplete summary information on CDC's mitigation strategies. Specifically, neither summary included wearing cloth masks or staying 6 feet apart when possible—strategies CDC identified as key for slowing the spread of COVID-19. We discussed this with Education, and as of August 7, the summaries on both websites had been removed. The websites still include direct links to CDC's guidance.

Certain federal guidance appears misaligned with risk-based decision-making. CDC and the Secretary of Education have both noted that school reopening plans should be tailored to the needs of local communities. Many school districts developed hybrid plans that call for students to learn remotely for part of the time, while others—including most of the nation's largest school districts—moved to remote-only learning. Yet, CDC's updated July guidance begins with a statement urging schools to reopen in person, and information encouraging schools to reopen in person is embedded throughout the guidance.

Further, the White House has urged that all schools "fully reopen" and suggested that current or future federal funds may be withheld from school districts that do not return to in-person education. The Secretary of Education also noted that the "American investment in education is a promise to students and their families. If schools aren't going to reopen and not fulfill that promise, they shouldn't get the funds. Then give [the funds] to the families to decide to go to a school that is going to meet that promise."[189] Education officials told us these comments were policy or rhetorical statements. Regardless, such statements do not appear to align with a risk-based decision-making approach, and appear incongruent with the Secretary's own statements that returning to in-person education is a state and local decision.

[189]Chris Wallace. Fox News Sunday, Fox News. https://www.foxnews.com/transcript/infectious-disease-expert-on-us-response-to-new-surge-of-coronavirus-cases-secretary-devos-on-challenge-of-reopening-americas-schools. July 12, 2020.

Although the decision to physically reopen schools is primarily a state and local issue, state and local school district officials look to the federal government for leadership and clear guidance including recommendations about how to do so safely. Unclear federal guidance and messaging risks contributing to conflict, confusion, and indecision for schools.

School facility conditions present a host of other challenges that could complicate efforts to reopen school buildings safely. For example, CDC's guidelines say to ensure ventilation systems operate properly and increase circulation of outdoor air as much as possible. However, in June 2020, based on our nationally representative survey of school districts, we estimated that 36,000 schools were in need of heating, ventilation, and air conditioning updates.[190] Safe drinking water poses another challenge for reopening schools that have been shuttered since spring 2020. CDC recommends flushing water systems after prolonged shutdown to reduce the risks of lead and legionella. However, our 2018 work on lead in school drinking water showed that an estimated 69 percent of school districts do not have flushing programs in place.[191]

Exacerbating the situation, the poorest school districts may be least able to pay for efforts to retrofit and update schools to address COVID-19-related risks. These districts educate about 1.5 million more students than wealthy districts. We also know from our past work that 80 percent of students attending the poorest schools are Black or Hispanic, and that these students already face myriad educational challenges, from less access to coursework that prepares them for college to widespread discipline disparities.

Beyond serving as safe places for tens of millions of children to learn and millions of teachers to work each day, public school facilities play an integral role in society for community members who rely on them as community centers, voting places, and emergency shelters. Returning to in-person instruction safely and securely is of paramount concern to all, and is key to sustaining economic recovery, particularly given the large numbers of parents of school-age children in the workforce.[192] As schools make their reopening plans for the fall, cogent, clear, and consistent federal guidance is critical to helping state and local officials make safe, risk-based decisions for their students, teachers, staff, and communities.

GAO Recommendation Related to Guidance for K-12 Schools

The Director of the Centers for Disease Control and Prevention should ensure that, as it makes updates to its federal guidance related to reassessing schools' operating status, the guidance is cogent, clear, and internally consistent. (Recommendation 12)

[190]GAO, *K-12 Education: School Districts Frequently Identified Multiple Building Systems Needing Updates or Replacement*, GAO-20-494 (Washington, D.C.: June 4, 2020). We calculated the number of schools that needed updates or replacement of building systems or features based on the total number of schools in the district and the percentage of schools that needed a given update or replacement. Because school districts provided this percentage as a range (e.g., 75 to 100 percent), we calculated three estimates for each system or feature: low, middle, and high. Our estimate, 36,000 schools, is the low-point, conservative estimate for schools nationwide that need updates or replacements to their heating, ventilation, and air conditioning systems and has a margin of error of 9,000 schools.

[191]GAO, *K-12 Education: Lead Testing of School Drinking Water Would Benefit from Improved Federal Guidance*, GAO-18-382 (Washington, D.C.: July 5, 2018).

[192]According to DOL's Bureau of Labor Statistics, in 2019, about 72 percent of women and over 90 percent of men with children under 18 were either working or looking for work.

Source: GAO. | GAO-20-701

Table 8 provides a summary of additional information on federal assistance to states, territories, localities, and tribes presented in enclosures in appendix I, which also include descriptions of GAO's future work.

Table 8: Areas in Which the Federal Government Has Taken Action to Assist States, Localities, Territories, and Tribes in Response to COVID-19

Area name	Federal government's actions
K-12 Education	Education Stabilization Fund spend rates remain low and federal guidance on reassessing schools' operating status should be cogent, clear, and internally consistent.
Transit Industry	The Federal Transit Administration continues to distribute CARES Act funding, with nearly all funds obligated thus far going to transit agency operating costs.
Coronavirus Relief Fund	Guidance and oversight are critical to ensure that the $150 billion in COVID-19 relief disbursed through the Coronavirus Relief Fund to states, localities, tribal governments, the District of Columbia, and U.S. territories are used appropriately.
Airport Grants	The Federal Aviation Administration continues to provide funding to help the nation's airports respond to and recover from the economic effects of the COVID-19 pandemic. As of July 31, 2020, the agency has processed grant applications for 3,213 U.S. airports, totaling about $8.7 billion.

Source: GAO. | GAO-20-701

Federal Contracting

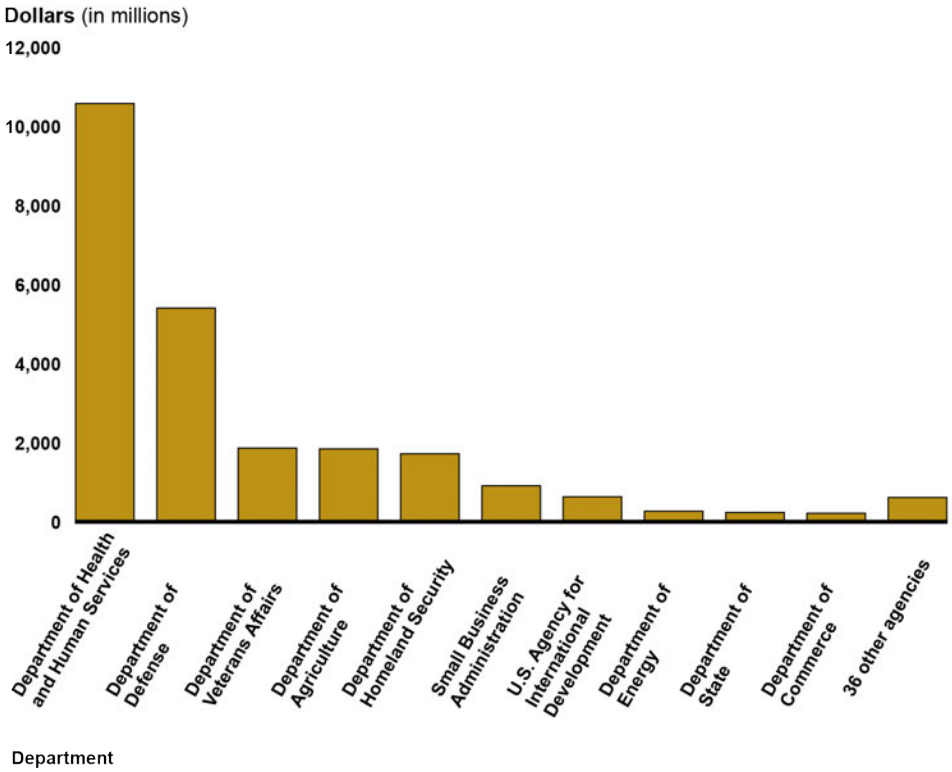
This section presents information on the federal government's contracting practices during the pandemic, including government-wide contracting obligations, tracking of contract actions, and terminated contracts.

Government-wide Contract Obligations

Government-wide contract obligations in response to the COVID-19 pandemic totaled about $24.3 billion as of July 31, 2020, with HHS continuing to account for almost half, or about 44 percent, of total obligations (see fig. 10).[193]

[193]For the purposes of this report, "contract obligations" means obligations on contracts that are subject to the Federal Acquisition Regulation and does not include, for example, grants, cooperative agreements, loans, other transactions for research, real property leases, or requisitions from federal stock.

Figure 10: Contract Obligations in Response to COVID-19 by Agency, as of July 31, 2020

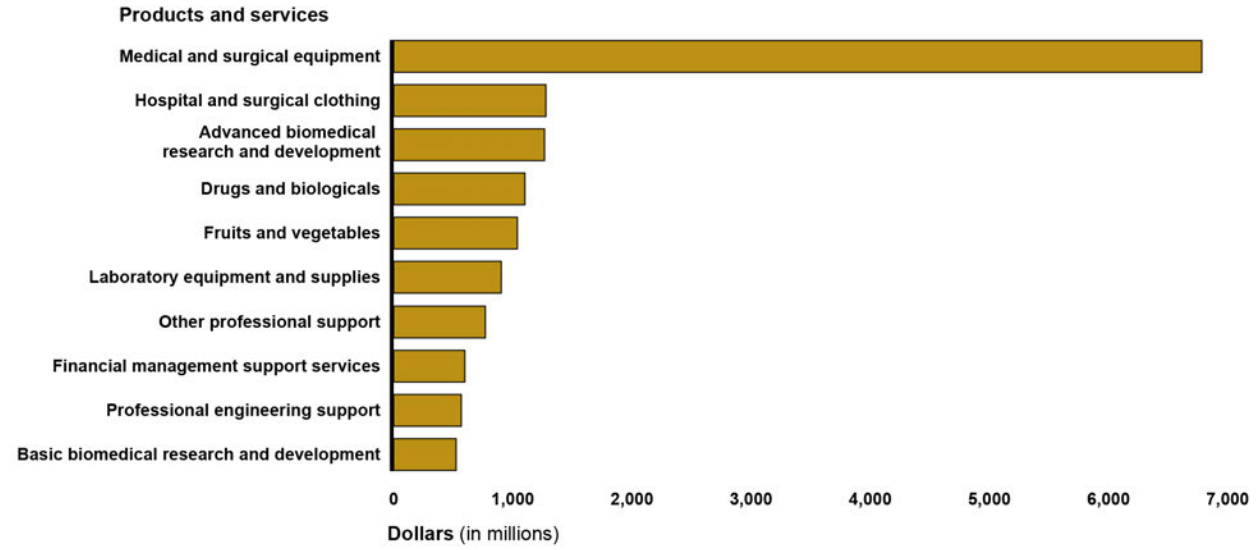


Source: GAO analysis of Federal Procurement Data System-Next Generation data. | GAO-20-701

Consistent with what we reported in June 2020, medical equipment and supplies—including ventilators and PPE—continue to be the largest area of obligations.[194] Obligations for medical equipment and supplies increased by about $1.3 billion since May 31, 2020, and accounted for about $6.8 billion, or 28 percent of total obligations. See figure 11 for additional details on the top goods and services procured.

[194] GAO-20-625.

Figure 11: Contract Obligations for Top Goods and Services Procured through Federal Contracts in Response to COVID-19, as of July 31, 2020



Source: GAO analysis of Federal Procurement Data System-Next Generation data. | GAO-20-701

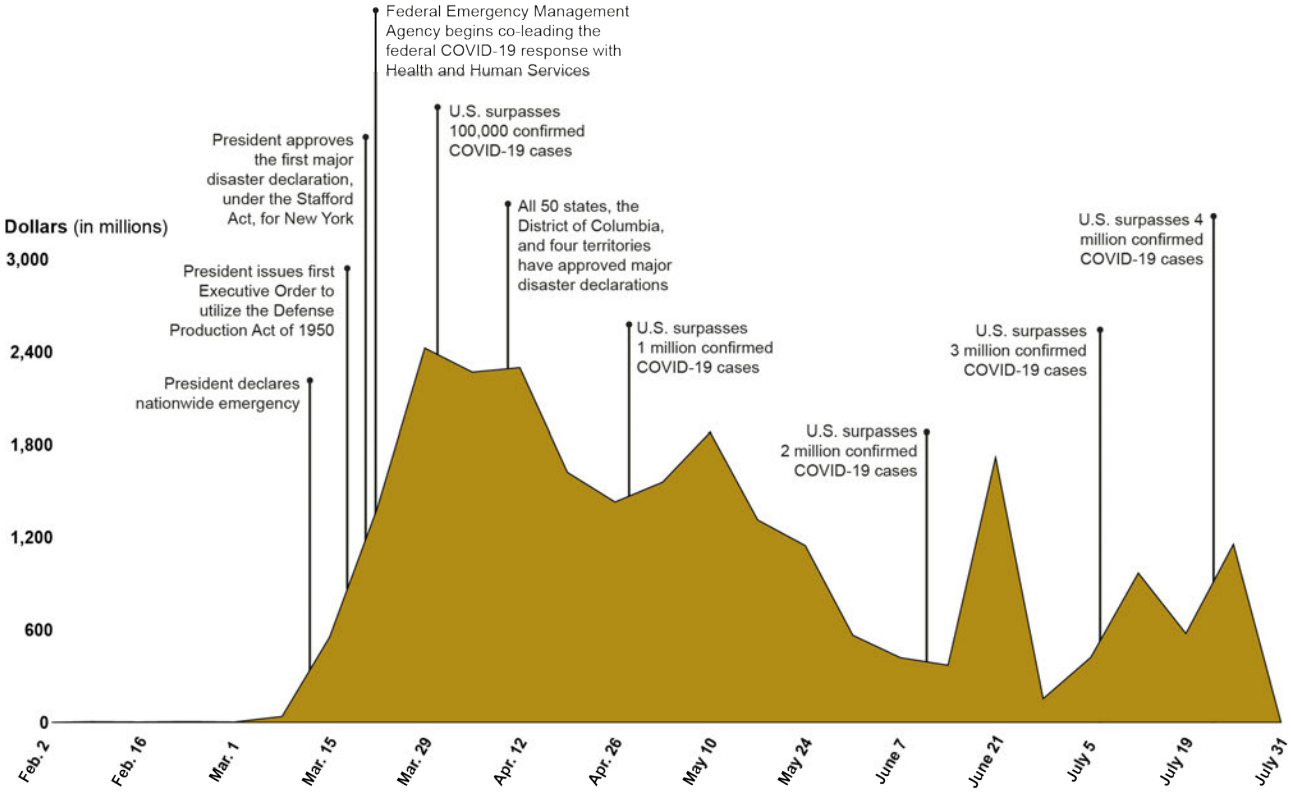
Since our June 2020 report, government-wide contract obligations have increased by about $7.4 billion—from $16.9 to $24.3 billion.[195] As shown in figure 12, federal contract obligations underwent the greatest increase from the middle to the end of March, following the President's March 13, 2020, nationwide emergency declaration.[196] As of March 15, 2020, federal agencies reported obligating about $604 million on contracts in response to COVID-19.[197] By March 29, 2020, government-wide obligations were more than $4.4 billion, an increase of more than 600 percent.

[195] GAO-20-625.

[196] See 42 U.S.C. § 5191.

[197] Obligations made by federal agencies prior to the establishment of the National Interest Action (NIA) code on March 13, 2020, were identified through the description field in the Federal Procurement Data System-Next Generation.

Figure 12: Government-wide Contract Obligations Related to COVID-19 by Week, as of July 31, 2020



Source: GAO analysis of Federal Procurement Data System-Next Generation, Executive Branch, and Centers for Disease Control and Prevention data. | GAO-20-701

As of July 31, 2020, about $12.2 billion, or 50 percent of government-wide contract obligations, were on contracts we identified as awarded noncompetitively. Agencies cited an urgent need for awarding contracts noncompetitively for about two-thirds, or $8.2 billion, of contract obligations. Awarding contracts under the unusual and compelling urgency exception to full and open competition can be necessary in certain circumstances, but our prior work has noted that promoting competition—even in a limited form—increases the potential for quality goods and services at a lower price in urgent situations.[198]

The next most cited reason for awarding contracts noncompetitively was that only one source was available to provide the goods or services; such contracts accounted for $2.2 billion, or 18 percent, of the noncompeted contract obligations.[199] Agencies competed contracts for goods

[198]GAO, *Federal Contracting: Noncompetitive Contracts Based on Urgency Need Additional Oversight,* GAO-14-304 (Washington, D.C.: Mar. 26, 2014).

[199]For the purposes of this report, obligations on contracts identified as using the unusual and compelling urgency exception and only one source include those associated with contracts subject to Federal Acquisition Regulation Part 6.302-2 and 6.302-1, as well as orders under multiple award contracts, which are subject to separate competition requirements under Federal Acquisition Regulation Part 16. Specifically, under section 16.505(b)(2), orders on multiple award contracts require contracting officers to give every awardee a fair opportunity to be considered for a delivery-order or task-order exceeding $3,500, with exceptions, including if the agency need for the supplies or services is so urgent that providing a fair opportunity would result in unacceptable delays. When using the unusual and compelling

less frequently than contracts for services—about 39 percent of obligations for goods were on competed contracts compared to 64 percent of obligations for services. For example, about $6 billion, or 89 percent of the $6.8 billion in obligations for medical and surgical equipment, were on contracts awarded noncompetitively.

Agencies have reported using a variety of contracting techniques to respond to COVID-19. For example, undefinitized contracts allow contractors to begin work before reaching a final agreement with the government on all contract terms and conditions. As of July 31, 2020, about $2.2 billion, or 9 percent of government-wide contract obligations on contracts awarded in response to COVID-19, were undefinitized contract actions. DOD reported about $1.3 billion, or about 24 percent of its COVID-19-related contract obligations, as undefinitized contract actions.

Undefinitized contract actions can allow the government to fulfill requirements that are urgent or need to be met quickly when there is insufficient time to use normal contracting vehicles. However, our prior work has noted that these types of contracts can pose risks to the government, such as when contractors lack incentives to control costs before all contract terms and conditions are defined.[200] Our work has also found that a portion of reported government-wide contract obligations have been associated with implementing a contractor paid leave provision of the CARES Act.[201]

In addition to contract obligations, some agencies have reported using other transaction agreements in response to COVID-19. For example, as of July 31, 2020, DOD reported obligating an additional $6.5 billion in prototype and production other transaction agreements, including a $2.1 billion agreement for large-scale antibody and vaccine manufacturing in response to COVID-19. Within the federal procurement data system, we found that HHS also reported obligating about $47.7 million for another transaction for clinical trials. Other transactions enable federal agencies to negotiate terms and conditions specific to a project without requiring them to comply with certain federal laws and regulations. However, our prior work has noted their use carries the risk of reduced accountability and transparency.[202] Our future work will further examine agencies' use of competition, undefinitized contract actions, and other transaction agreements.

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urgency exception to full and open competition, agencies still must request offers from as many potential sources as is practicable under the circumstances.

[200]GAO, *Defense Contracting: DOD Has Enhanced Insight into Undefinitized Contract Action Use, but Management at Local Commands Needs Improvement*, GAO-10-299 (Washington, D.C.: Jan. 28, 2010).

[201]Section 3610 of the CARES Act generally authorizes—but does not require—federal agencies to reimburse contractors for paid leave provided to their employees and subcontractors who are unable to access approved work sites due to facility closures or other restrictions, and whose duties cannot be performed remotely during the COVID-19 pandemic. See GAO, *COVID-19 Contracting: Observations on Contractor Paid Leave Reimbursement Guidance and Use*, GAO-20-662 (Washington, D.C.: Sept. 3, 2020).

[202]GAO, *Department of Homeland Security: Improvements Could Further Enhance Ability to Acquire Innovative Technologies Using Other Transaction Authority,* GAO-08-1088 (Washington, D.C.: Sept. 23, 2008) and *Defense Acquisitions: DOD Has Implemented Section 845 Recommendations but Reporting Can Be Enhanced*, GAO-03-150 (Washington, D.C.: Oct. 9, 2002).

Tracking Contract Activity

Federal agencies are tracking contract actions and associated obligations in response to COVID-19 through the use of a NIA code in the Federal Procurement Data System-Next Generation. The COVID-19 NIA code was established on March 13, 2020, to track contract actions. Since then, the code was extended to September 30, 2020, and most recently, was extended until March 31, 2021 while our draft report recommending that the Department of Homeland Security (DHS) and DOD extend the code beyond September 30, 2020, was with the agencies for comment.[203]

According to officials at DOD and DHS, they consider the criteria identified in the memorandum of agreement between DOD, DHS, and the General Services Administration (GSA) prior to making a determination of whether to close the NIA code. For example, according to the agreement, prior to closing the NIA code the agencies will consider whether government-wide contract actions show a consistent decrease in the actions awarded or if the remaining or predicted contracting activity has become routine, indicating it is no longer necessary to track contract actions.

Our prior work noted that the NIA code provides consistent tracking and government-wide visibility into contracting related to disaster events through a publicly available database, but we identified inconsistencies in establishing and closing these codes following previous disasters or emergencies. In April 2019, we recommended that GSA, in coordination with DHS and DOD, assess whether the criteria in their current NIA code agreement meet the long-term needs for high visibility events and of users, such as FEMA, other agencies, and Congress.[204] GSA and DOD concurred with our recommendation (DHS did not respond), and in August 2019 GSA, DOD, and DHS revised their agreement. However, the revised agreement did not fully address our recommendation. For example, it did not include consideration of the needs of NIA code users or the need for long-term visibility into contract actions, including awards and obligations.

We have continued concerns with the criteria DHS and DOD rely on in the memorandum of agreement to determine whether to extend or close a code, and whether the agreement meets the long-term needs for high visibility events and of users, such as other agencies and Congress. Recently, with regard to extending the NIA code for COVID-19 beyond its original expiration date of July 1, 2020, DHS and DOD notified agencies of their decision to extend the NIA code after they decided to extend it, both via email and, according to DOD officials, during an interagency meeting that included all 24 Chief Financial Officers Act agencies. However, DHS and DOD did not obtain input of key agencies before making the decision to extend the code to September 30, 2020—either in terms of the need to extend it or for how long.

For example, when we asked whether HHS, the agency obligating almost half of all government-wide contract obligations in response to COVID-19, had any contact with DHS and DOD related to extending the NIA code expiration date, HHS officials from the Office of Acquisitions told us that they were not aware of any such communications. VA officials stated that they did

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[203]DHS, DOD, and the General Services Administration have previously established a NIA code to track contract actions and associated obligations for a disease outbreak. The NIA code for Operation United Assistance-Ebola Outbreak in West Africa was open from September 15, 2014, through September 30, 2016, and reported about $569.4 million in contract actions.

[204]GAO, *2017 Disaster Contracting: Actions Needed to Improve the Use of Post-Disaster Contracts to Support Response and Recovery,* GAO-19-281 (Washington, D.C.: Apr. 24, 2019).

have communications with DHS regarding the need to extend the NIA code, and that those communications were initiated by VA. According to HHS officials, without a NIA code to track contract actions and associated obligations, they would have no way to differentiate HHS COVID-19 contract actions from other HHS actions and obligations.[205]

Federal internal control standards state that management should use quality information, and externally communicate that information to achieve its objectives.[206] This includes considering expectations of internal and external users, defining the information needed, and using quality information to make informed decisions. According to the memorandum of agreement, DHS is responsible for determining when a NIA code should end for civilian agency actions, and DOD is responsible for that determination for contingency operations.

The agreement further states that extending the NIA code is appropriate if two or more agencies have a current or anticipated need for tracking contract actions and do not have a reasonable alternate method of internally tracking them. However, the memorandum of agreement does not identify any processes or steps DHS and DOD can or should take to coordinate with the various agencies involved in emergency acquisitions to determine that need. The memorandum of agreement also does not identify how far in advance of the end date of a NIA code DHS and DOD should review contract actions to determine whether the code should be extended. Rather, the agreement states that decisions to end a NIA code can be made at any time, and that the code will, at a minimum, be reviewed at the end of each fiscal year.

Based on the current contracting environment and fluctuations in contract obligations, as shown in figure 12, it is unclear how DHS and DOD will apply some of the current criteria in the agreement for closing the NIA code—such as determining whether contract actions have shown a consistent decrease or whether predicted contracting activity has become "routine." Given the number of federal agencies involved in contracting for the response to the pandemic, establishing a process to ensure that DHS and DOD are obtaining input on the need to extend or close the NIA code from the various agencies relying on it to track contract actions and associated obligations is imperative. Equally important is identifying clear timelines for evaluating and determining whether to extend NIA code in advance of its end date. Establishing such a process and timeline will help to address the need for federal agencies, the public, and Congress to have visibility into contract actions and associated obligations related to disaster events.

GAO Recommendation Related to Tracking Contract Activity

[205]A DHS official noted that OMB Memorandum M-20-21 requires agencies to provide a funding identifier—the disaster emergency fund code—in their financial file submissions to track and report contracts that have COVID-19 funding on USAspending.gov, which is the official site to track COVID-19 funds across federal contracts, grants, and loans. According to OMB, the Federal Procurement Data System-Next Generation remains the authoritative source for procurement award data provided to USASpending.gov. OMB stated that OMB M-20-21 requires agencies to use the funding identifier to report obligations of government-wide use of CARES Act spending, and the NIA code in the Federal Procurement Data System tracks contract awards regardless of the source of the funds. As of September 4, 2020 USAspending.gov identified approximately $11.3 billion in contract awards, less than half of the contract obligations associated with NIA code contract actions in the Federal Procurement Data System-Next Generation as of July 31, 2020. Our prior work on the data reported by USAspending.gov has identified persistent data quality issues, and challenges with known data limitations not being disclosed. See GAO, *DATA Act: Quality of Data Submissions Has Improved but Further Action Is Needed to Disclose Known Data Limitations*, GAO-20-75 (Washington, D.C.: Nov. 8, 2019).

[206]GAO-14-704G.

- The Secretary of Homeland Security, in coordination with the Secretary of Defense, should (1) revise the criteria in the 2019 National Interest Action code memorandum of agreement to clearly identify steps they will take to obtain input from key federal agencies prior to extending or closing a National Interest Action code, (2) establish timelines for evaluating the need to extend a National Interest Action code, and (3) define what constitutes a consistent decrease in contract actions and routine contract activity to ensure the criteria for extending or closing the National Interest Action code reflect government-wide needs for tracking contract actions in longer term emergencies, such as a pandemic. (Recommendation 13)
- The Secretary of Defense, in coordination with the Secretary of Homeland Security, should (1) revise the criteria in the 2019 National Interest Action code memorandum of agreement to clearly identify steps they will take to obtain input from key federal agencies prior to extending or closing a National Interest Action code, (2) establish timelines for evaluating the need to extend a National Interest Action code, and (3) define what constitutes a consistent decrease in contract actions and routine contract activity to ensure the criteria for extending or closing the National Interest Action code reflect government-wide needs for tracking contract actions in longer term emergencies, such as a pandemic. (Recommendation 14)

Source: GAO. | GAO-20-701

Terminated Contracts

The federal government can partially or fully end a government contract before the contractor completes performance by terminating the contract. Depending on the circumstances, the government can terminate the contract either (1) for the convenience of the government or (2) for cause or default. For example, when the government's requirements change, rendering continued performance unnecessary, the government may choose to terminate the contract for convenience. On the other hand, when a contractor fails to perform its contractual requirements, the government may terminate the contract for cause or default.

Federal agencies reported terminating at least $229 million in contract obligations as of July 31, 2020. About three-quarters of that total ($171.3 million) was reported as terminated fully or partially for convenience, with the rest reported as terminated for cause or default. Most of the terminated contract obligations were for goods, including $97.1 million in medical equipment and supplies and $55.8 million in hospital and surgical clothing. For example, FEMA reported terminating a $53.5 million contract with Panthera Worldwide LLC for cause after the company failed to deliver 10 million N95 respirators. Both FEMA and VA also reported terminating contracts for N95 respirators with the same contractor—Federal Government Experts.[207] FEMA reported terminating a $1.9 million contract with the company for cause, while VA reported terminating a $35.4 million contract for convenience.

A variety of factors can lead the government to decide to terminate a contract. Clearly defining requirements for the type and amount of goods and services needed, based in part on market research, can help to ensure the government is contracting for what it needs. The Federal Acquisition Regulation also requires that contracts be awarded to responsible contractors, and that contracting officers take steps—such as ensuring prospective contractors have adequate financial resources and reviewing information on contractor performance and integrity—to affirm

[207]According to DHS officials, no payments were made to either Panthera Worldwide LLC or Federal Government Experts.

a contractor's responsibility.[208] Our future work will further examine the government's use of new vendors during the response to the pandemic, and agencies' contracting practices as they relate to determining whether prospective contractors are responsible.

International Response

This section presents information on the federal government's international response to the COVID-19 pandemic.

Agencies' obligations of supplemental funds and support for international response activities.[209] Two COVID-19 relief laws appropriated about $3.1 billion in supplemental funding to support the U.S. government's international response to the COVID-19 pandemic, including about $2.3 billion for diplomatic and foreign assistance programming administered by the Department of State (State) and the U.S. Agency for International Development (USAID), and at least $800 million designated for CDC's international response activities.[210] State and USAID reported obligating about $1.2 billion of their supplemental funding, as of June 26, 2020.[211] State and USAID developed a strategy to use the supplemental funds for diplomatic and foreign assistance programming, organized under four pillars (see fig. 13). CDC reported obligating about $63 million of its supplemental funding, as of July 6, 2020. CDC developed a strategy for its global disease detection and emergency response to COVID-19, which focuses on supporting priority countries, multilateral institutions, and vulnerable populations to mitigate the global impact of the pandemic.

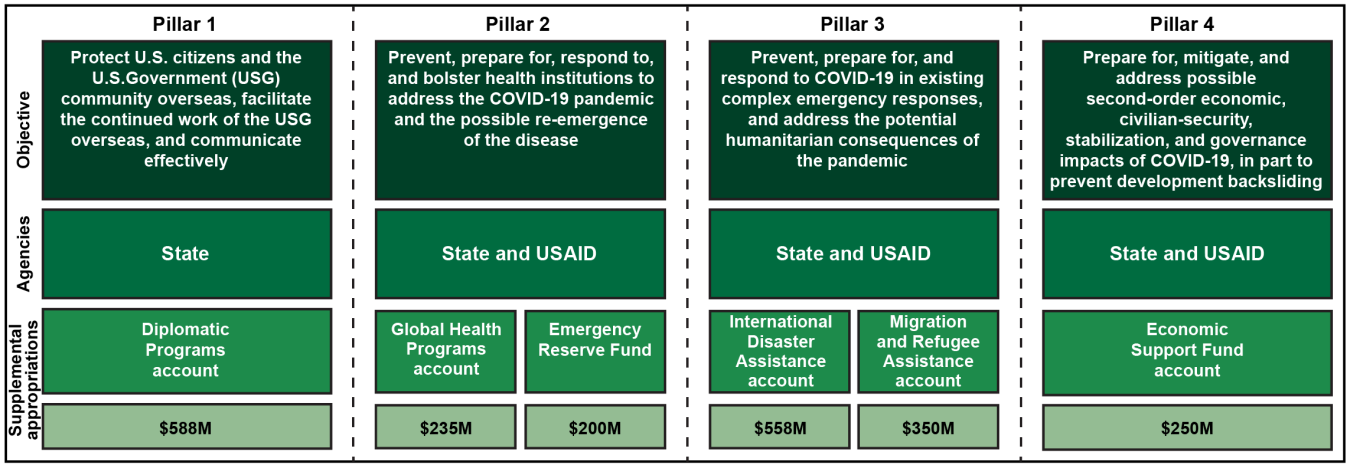
[208]Federal Acquisition Regulation 9.103 and 9.104-1.

[209]In June 2020, we reported on agencies' international COVID-19 response activities prior to receiving supplemental funds, including Department of State efforts to repatriate U.S. citizens and U.S. Agency for International Development and CDC efforts to help other countries respond to the pandemic. See GAO-20-625.

[210]This funding was provided through two COVID-19 relief laws, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, and the CARES Act, and directed to specific accounts. Pub. L. No. 116-123, tit. III and IV, 134 Stat. at 147 and 152-53; Pub. L. No. 116-136, div. B, tit. VIII and XI, 134 Stat. at 554 and 590.

[211]Our June 2020 report did not present obligations of supplemental funds related to agencies' international response activities.

Figure 13: March 2020 Department of State and U.S. Agency for International Development Strategy on the Use of Supplemental Funding to Respond to COVID-19 Abroad

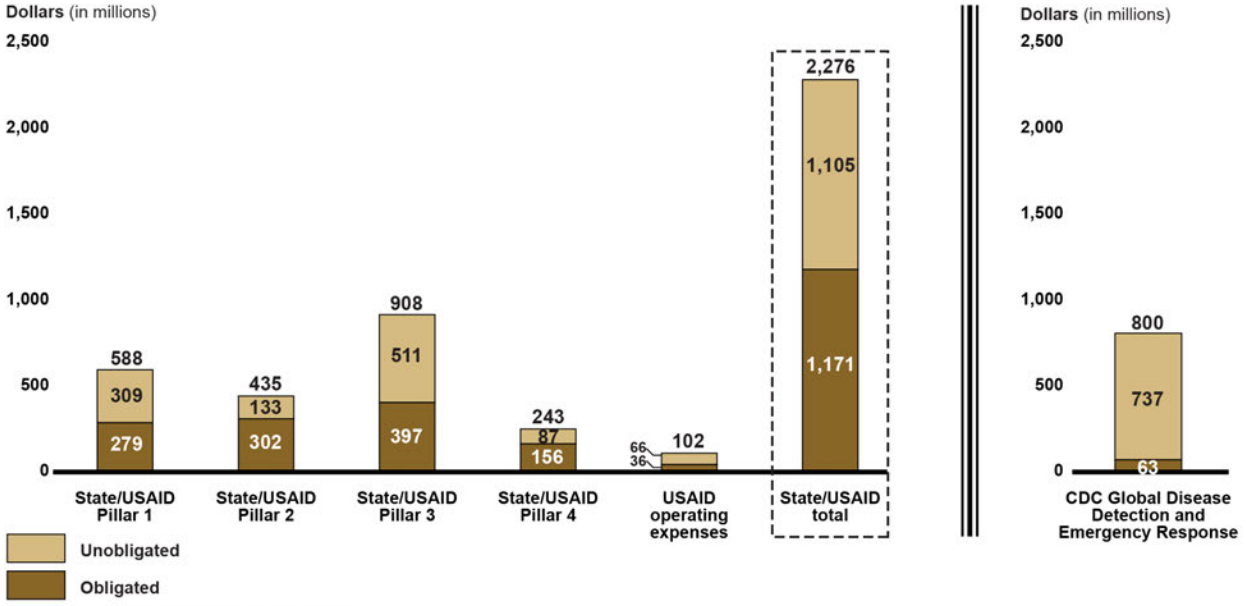


Source: Department of State (State) and U.S. Agency for International Development (USAID) Strategy for Supplemental Funding to Prevent, Prepare for, and Respond to Coronavirus Abroad. | GAO-20-701

Note: The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, appropriated $435 million (reflected in Pillar 2 in the figure) for the Global Health Programs account and directed that not less than $200 million be transferred and merged with the Emergency Reserve Fund established pursuant to section 7058(c)(1) of the Department of State, Foreign Operations, and Related Programs Appropriations Act, 2017. Pub. L. No. 116-123, tit. IV, 134 Stat. 146, 152. The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, and the CARES Act also appropriated $95 million to USAID for operating expenses and $1 million to the USAID Office of Inspector General for COVID-19-related work. Pub. L. No. 116-123, tit. IV, 134 Stat. at 152; Pub. L. No. 116-136, div. B, tit. XI, 134 Stat. 281, 590. In addition, $7 million of the $250 million appropriated for the Economic Support Fund Account in Pillar 4 was transferred to USAID for operating expenses, according to USAID officials.

Figure 14 shows State and USAID obligations, as of June 26, 2020, by strategic pillar and CDC's obligations, as of July 6, 2020, for global disease detection and emergency response.

Figure 14: Agencies' Obligations of Supplemental Appropriations for International Response to COVID-19



Numbers may not add up due to rounding.

Legend: State = Department of State; USAID = U.S. Agency for International Development, CDC = Centers for Disease Control and Prevention.

Source: Department of State, Centers for Disease Control and Prevention, and GAO analysis of supplemental appropriations for international response to COVID-19. | GAO-20-701

Note: State and USAID obligations are as of June 26, 2020. CDC obligations are as of July 6, 2020.

State and USAID. State and USAID provided details on their uses of supplemental funding, including the countries and types of activities they are supporting.

- **Pillar 1: Protecting U.S. Citizens and Maintaining U.S. Operations.** State reported obligating supplemental funding to maintain consular operations, which faced a significant decline in visa and passport fees resulting from the pandemic. State planned to use supplemental funds to, among other things, increase secure communications bandwidth, accessibility, and support for those working remotely; expand cloud and email storage capacity; and support efforts by the Bureau of Medical Services to continue effectively and safely achieving State's mission domestically and overseas by contracting for experts in areas such as infectious disease, mental health, and statistical analysis of health data. Efforts also included purchasing and distributing personal protective and testing equipment, targeted hiring, and adding capacity for medical evacuation travel and contract aviation to continue international operations in the face of reduced global commercial airline service.

- **Pillar 2: Global Health Assistance.** USAID reported obligating supplemental funding as of June 6, 2020, to provide global health assistance for at least 73 countries affected by and at risk of COVID-19; regional activities in the Caribbean, Pacific Islands, and Asia; and worldwide activities. This assistance included preventing and controlling infections in health facilities; conducting contact tracing; improving readiness to rapidly identify and treat cases; raising awareness in populations through risk communication; screening people at points of entry and exit; and purchasing commodities, including ventilators.

- **Pillar 3: Humanitarian Assistance.** USAID reported obligating supplemental International Disaster Assistance account funding as of June 6, 2020, for 11 countries, regional activities in

the Pacific Islands, and worldwide activities. This funding focuses on mitigating widespread transmission of COVID-19, addressing public health consequences, and maintaining essential health services for crisis-affected populations, particularly displaced people. Assistance efforts have included support for health interventions; water, sanitation, and hygiene services; protection services, such as psychosocial support; and risk communication activities. This funding is also supporting response logistics and the response to the secondary impacts of COVID-19, including the enormous emergency food needs, according to USAID officials. In addition, State reported that it obligated supplemental Migration and Refugee Assistance account funding as of July 10, 2020, for 56 countries and regional and worldwide activities. These obligations support assistance efforts similar to those USAID has supported with International Disaster Assistance funds, but focus on the needs of specific populations of concern, including refugees, victims of conflict, internally displaced persons, stateless persons, and vulnerable migrants.

- **Pillar 4: Economic and Development Assistance.** USAID reported that State and USAID obligated supplemental funding under Pillar 4 as of June 6, 2020, for nine countries, as well as regional and worldwide activities.[212] Examples of activities supported include providing technical assistance and access to credit for micro, small, and medium-sized enterprises; strengthening civil society; protecting and assisting vulnerable people; monitoring legal protection for journalists; and providing direct cash relief to households.

CDC. According to CDC officials, global disease detection and emergency response efforts involve several technical areas including emergency response capacity; laboratory, surveillance, and epidemiology; border health and community mitigation; infection prevention, control, and preparedness in health care facilities; and pandemic and vaccine preparedness planning. CDC also identified nearly 60 countries to which to target this assistance.

State and USAID officials identified several examples of challenges faced by implementing partners providing COVID-19-related assistance in affected countries.[213]

- **Host government COVID-19-related restrictions.** Visa restrictions, curfews, quarantines, and movement restrictions have impeded the ability of humanitarian workers to operate in some countries. For example, according to USAID officials, Nigeria's visa restrictions have created difficulty for relief workers to travel there, and Ethiopia has limited movements at land borders, except for the flow of cargo and essential goods. In Iraq, travel restrictions posed challenges delivering medical supplies to program sites.

- **Lack of key commodities.** Due to concerns around possibly diverting scarce PPE, such as surgical masks and gloves, from the domestic response to the COVID-19 pandemic in the United States, USAID officials told us that they instructed all implementing partners in early March 2020 to temporarily pause any purchases of PPE products using USAID funds. According

[212]The total of nine countries supported under Pillar 4 does not include additional countries that may have received assistance through funding allocated for regional activities.

[213]CDC officials told us on July 14, 2020, that the agency had encountered no major implementation challenges related to its global disease detection and emergency response efforts.

to USAID, this pause posed challenges for implementing partners in both protecting their own staff as well as ensuring the continuity of USAID's emergency health assistance. On June 9, 2020, USAID ended the pause by issuing interim policy guidance to allow implementing partners to procure restricted PPE materials without prior authorization in the following two situations: (1) for their staff from any source, and (2) for the protection of beneficiaries of USAID programs from PPE manufactured locally or in the same region where USAID is providing assistance as long as the PPE is not, and could not reasonably be, intended for the U.S. market.[214] Some countries may continue to face shortages of PPE, according to USAID officials. For example, USAID officials told us in early July that USAID-funded partners working in Sudan had reported that the shortage of PPE across the health sector has made it difficult for relief workers to respond safely to COVID-19.

- **Lack of qualified partners or staff.** For some countries with limited USAID presence, there are very few qualified partners to implement USAID-funded assistance. USAID partners have also faced challenges recruiting and training local staff to implement response activities. Additionally, USAID cited an example in which a program's operations in Nigeria were suspended when a quarantine was imposed following the death of a relief worker who contracted COVID-19.
- **Additional challenges for humanitarian assistance.** According to State officials, partner organizations face several challenges to providing COVID-19-related assistance to vulnerable populations that are already in the midst of a humanitarian crisis. These challenges include limited in-person implementation and monitoring; xenophobic violence directed at aid workers, refugees, migrants, and other foreigners believed to be importing the virus; closed borders; and delays in health care delivery, among many other concerns.

Table 9 provides a summary of additional information on federal actions related to the international response presented in enclosures in appendix I, which also includes descriptions of GAO's future work.

[214]According to USAID officials, the June guidance allows low- and middle-income countries to make requests for PPE from the existing joint World Health Organization–USAID stockpile.

Table 9: Areas in Which the Federal Government Has Taken Action on the International Response to COVID-19	
Area name	**Federal government's actions**
International Trade	While U.S. trade has declined overall, imports of COVID-19-related products have increased, and the U.S. government has made tariff modifications to reduce the cost of certain such products from China.
State's Repatriation Efforts	In response to the COVID-19 pandemic, the Department of State used existing authorities to transfer $260 million for efforts to evacuate and repatriate U.S. citizens.

Source: GAO. | GAO-20-701

Evolving Lessons Learned from the Ongoing COVID-19 Response Highlight Areas for Timely and Concerted Actions

This section presents new examples of previously identified lessons learned and issues in need of continued congressional oversight and action by the administration. Attention to these issues can help to make federal efforts as effective as possible.

In our June 2020 report, we identified several lessons learned from the government's response to previous emergencies, as well as the initial response to the COVID-19 pandemic.[215] These lessons included establishing clear goals and defining roles and responsibilities among those responding to a crisis, providing clear communication, collecting and analyzing data to inform future decisions, and establishing mechanisms for accountability and transparency. Through our ongoing oversight, and as described in previous sections of this report and highlighted below, we have continued to observe the need for these lessons to be heeded. We have also identified an additional evolving lesson learned: the need to guard against cyber threats as another key effort in the response to the pandemic.

Lesson: Need to Establish Clear Goals and Define Roles and Responsibilities

As we reported in June 2020, the unprecedented scale of the COVID-19 pandemic and the whole-of-government response required to address it highlight the critical importance of clearly defining the roles and responsibilities for the wide range of federal departments and other key players involved.

Our ongoing work has identified areas in which federal roles and responsibilities could be better defined and communicated. For example, while multiple federal agencies currently share medical supply management responsibilities, these responsibilities are being transitioned to HHS.

[215] GAO-20-625.

However, the precise timing and structure of some changes are undetermined. Similarly, multiple federal agencies are involved in the efforts to develop, distribute, and administer a vaccine, but the government lacks a plan that details the specific roles and responsibilities for the various federal and nonfederal entities.

As a result, officials from multiple federal, state, and local agencies expressed confusion about the federal agencies' roles in certain key efforts, like medical supply management. For example, one public health official from a large city called the federal response "incoherent, confusing, and uncoordinated." We have previously found that a lack of clarity in roles and responsibilities can lead to duplication, confusion, or gaps in preparedness.[216] We will continue to monitor this lesson in our future work.

Lesson: Provide Clear Communication

As we reported in June 2020, clear and consistent communication—among all levels of government, with health care providers, and to the public—is key during a nationwide emergency. Uncoordinated communication between the federal government and state and local jurisdictions, and with providers and the general public, can contribute to confusion and frustration.

Since our June report, we have continued to find examples of unclear and inconsistent communication. For example, as we previously noted, we found inconsistencies within CDC guidance on students entering schools and incongruent messaging from CDC, Education, and the White House on this issue. There has also been inconsistent and conflicting information from the White House and federal public health officials about the efficacy of hydroxychloroquine as a therapeutic for COVID-19 patients. Two public health experts that GAO interviewed noted that the confusing and conflicting communication from the federal government on the pandemic has hindered response and recovery efforts.

In its Crisis and Emergency Risk Communication Manual, which describes core crisis and emergency risk communication principles, CDC notes the importance of clear and consistent communication. For example, the manual states, "ensure that all communications from your organization and its partners share the same facts. Inconsistent messages increase anxiety and quickly undermine expert advice and credibility." These potential consequences could deter individuals' willingness to adopt recommended public health measures and interventions, such as vaccinations. We will continue to examine this important issue in our future work.

[216]GAO, *Transportation Security: Federal Action Needed to Help Address Security Challenges*, GAO-03-843 (Washington, D.C.: Jun. 30, 2003).

Lesson: Need to Collect and Analyze Adequate and Reliable Data to Drive Future Decisions

Nursing Home Data

HHS, through CMS, implemented a COVID-19 reporting requirement for nursing homes effective May 8, 2020.[217] Nursing homes are required to self-report data at least weekly through CDC's National Healthcare Safety Network on suspected and confirmed COVID-19 cases and deaths among residents and staff, PPE supplies, access to testing, and staff shortages, among other things. These data are then posted on a CMS website. Prior to the implementation of this new requirement, HHS had not required that nursing homes submit data to CDC on COVID-19 cases or deaths.[218]

Although CMS now requires nursing homes to report COVID-19 data, the data reported to CDC do not capture the early months of the pandemic. Reports from the early months of the pandemic indicated that nursing homes were affected disproportionately by COVID-19 due to the vulnerability of frail residents living in close proximity. CMS began requiring nursing homes to report COVID-19 data to CDC by May 17, 2020, starting with information as of May 8, 2020. CMS made reporting prior to May 8, 2020 optional.

Our review of the data shows that some nursing homes with known COVID-19 outbreaks have opted not to submit data prior to May 8, 2020. As a result, the data do not provide HHS with a complete picture of the extent of the pandemic and its effect on nursing homes. For example, the Life Care Center in Kirkland, Washington—the site of one of the first major COVID-19 outbreaks reported in a United States nursing home in February 2020—submitted data to CDC. But, with reporting prior to May 8 optional, it reported zero total confirmed resident and staff cases and zero total deaths in the CDC data from May 8 through June 21. According to a CDC review, the February 2020 outbreak at this nursing home led to 81 resident cases and 34 staff cases, as well as 23 deaths.[219] These cases may have been reported to the state or local health department, but they were not reported to CDC.

Other nursing homes that had been widely reported as having multiple COVID-19 deaths in April and May, including a New York nursing home with reports of up to 60 resident deaths, similarly did not include those deaths in the CDC data as of June 21. In contrast, other nursing homes did

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[217]85 Fed. Reg. 27,550, 27,627 (May 8, 2020) (to be codified at 42 C.F.R. § 483.80(g)). CMS is responsible for ensuring that nursing homes meet federal quality standards to participate in the Medicare and Medicaid programs.

[218]Prior to this reporting requirement, state and local health departments may have required nursing homes to report certain COVID-19 related information to them. CMS requires nursing homes to comply with these state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks. See Centers for Medicare & Medicaid Services, *State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities* (Nov. 22, 2017). However, according to CMS, a key difference between the state and local reporting and this new national reporting requirement is that reporting to state and local health departments allows the state and local departments to understand the status of their local environment, whereas this national requirement provides standardized information to assist HHS with national surveillance on the status of COVID-19 in all nursing homes.

[219]Centers for Disease Control and Prevention, "COVID-19 in a Long-Term Care Facility—King County, Washington, February 27-March 9, 2020," *Morbidity and Mortality Weekly Report*, vol. 69, no. 12 (2020).

report cases and deaths prior to May 8, but the data reported to CDC and posted to CMS's website do not clearly distinguish between nursing homes that opted to report confirmed cases and deaths prior to this time and those that did not, which further complicates tracking of pandemic trends.

CMS has stated that the information collected will be used to assist with the national surveillance of COVID-19 in nursing homes and to inform public health policies and actions. According to CDC's "Updated Guidelines for Evaluating Public Health Surveillance Systems," the acceptability and representativeness of a surveillance system relate to the quality of its data, including data completeness.[220] Without high quality, complete data, the system cannot accurately represent the health-related event under surveillance. In addition, federal internal control standards require agencies to use quality information, such as relevant data from reliable sources, to achieve agency objectives.[221]

CMS noted that nursing homes are free to report COVID-19 data to CDC going back to January 1, 2020, if they choose and that CMS will post this information. CMS notes on its website that residents and families can ask their nursing home whether this information is available or not and that they can seek information to understand why it is not available.[222] CMS also notes in its guidance that state and local health departments are able to submit the required data on behalf of nursing homes. However, the nursing homes must still report in accordance with regulation.[223]

By not requiring nursing homes to submit data from the first 4 months of 2020 and by not distinguishing in the data which homes opted to report during this time, HHS is limiting the usefulness of the data. For example, this limits HHS's and others' ability to determine how many total nursing homes were affected by COVID-19, the extent of morbidity and mortality, and whether the incidence of COVID-19 in nursing homes has changed since the early months of the pandemic. As a result, HHS components—specifically CMS and CDC—are limited in their ability to monitor trends in infection rates, identify which nursing homes have already experienced an outbreak, and oversee whether nursing homes have appropriately and effectively taken steps to prevent and mitigate the spread of COVID-19 to protect residents. Further, without data from early in the pandemic, the public and policymakers also have an incomplete picture of the toll of COVID-19 in nursing homes.

GAO Recommendation Related to Nursing Home Data

The Secretary of Health and Human Services, in consultation with the Centers for Medicare & Medicaid Services and Centers for Disease Control and Prevention, should develop a strategy to capture more complete data on confirmed COVID-19 cases and deaths in nursing homes retroactively back to January 1, 2020, and to clarify the extent to which nursing homes have reported data before May 8, 2020. To the extent feasible, this strategy to capture more complete

[220]Centers for Disease Control and Prevention, "Updated Guidelines for Evaluating Public Health Surveillance Systems," *Morbidity and Mortality Weekly Report*, vol. 50, no. RR-13 (2001).

[221]GAO-14-704G. See internal control principle 13.

[222]Centers for Medicare & Medicaid Services, *Nursing Home COVID-19 Data Release External Frequently Asked Questions*, accessed July 23, 2020, https://www.cms.gov/files/document/covid-nursing-home-data-release-external-faqs.pdf.

[223]Centers for Medicare & Medicaid Services, *Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes*, QSO-20-29-NH, (Baltimore, Md.: May 6, 2020).

data should incorporate information nursing homes previously reported to the Centers for Disease Control and Prevention or to state or local public health offices. (Recommendation 15)

Source: GAO. | GAO-20-701

Nationwide COVID-19 Data System

The COVID-19 pandemic highlights the need for federal, state, and local public health officials to access real-time information about the virus to help them effectively allocate resources and make timely, responsive decisions related to public health and safety. In our June 2020 report, we highlighted our 2017 recommendation that HHS make progress toward implementing information technology enhancements needed to establish a near real-time electronic nationwide public health situational awareness capability.[224] Since 2006, HHS has been required to establish and improve upon such a capability, in collaboration with state, local, and tribal public health officials, to enhance early detection, rapid response to, and management of potentially catastrophic infectious disease outbreaks.[225] Additionally, a public health expert we spoke to highlighted the need for a uniform and centralized system of collecting and interpreting public health data to effectively respond to the pandemic, particularly at the state and local levels.

In response to the need to quickly and securely collect and access HHS and other data for the COVID-19 pandemic, HHS launched a new data platform—HHS Protect—in April 2020. According to information from the former HHS Chief Information Officer and our review of the HHS Protect website, HHS Protect is a secure data ecosystem aimed at collecting, sharing, and analyzing near real-time COVID-19 data.[226] It is designed to provide a holistic view of the U.S. health care system to guide action for the COVID-19 response. Specifically, the former HHS Chief Information Officer said that HHS is using the platform to help identify pandemic hotspots in the United States and increase supplies to those areas most affected.

According to the former HHS Chief Information Officer, HHS Protect contains over 4 billion data elements, and HHS has sought to expand the platform's data collection and reporting. HHS Protect integrates information from more than 200 datasets from federal, state, and local government and commercial sources. These datasets include data collected by CDC, CMS, and the Health Resources and Services Administration (HRSA); commercial laboratory data on COVID-19; and

[224]See GAO-20-625 and GAO, *Public Health Information Technology: HHS Has Made Little Progress toward Implementing Enhanced Situational Awareness Network Capabilities*, GAO-17-377 (Washington, D.C.: Sept. 6, 2017).

[225]See Pandemic and All-Hazards Preparedness Act, Pub. L. No. 109-417, § 202, 120 Stat. 2831, 2847 (2006) (codified, as amended, at 42 U.S.C. § 247d-4(c)). The network is to include, for example, data and information from state, local, and tribal public health entities, including laboratories; federal health agencies; zoonotic disease monitoring systems; public and private sector health care entities; immunization information systems; and public environmental health agencies.

[226]For more information about HHS Protect, see https://protect-public.hhs.gov/pages/about, accessed July 21, 2020 and https://www.hhs.gov/about/news/2020/07/20/hhs-protect-frequently-asked-questions.html, accessed August 20, 2020. On August 28, 2020, the HHS Chief Information Officer, with whom we spoke, resigned from his position. See HHS press release, "HHS Deputy Secretary Hargan Statement on Appointment of Acting CIO," accessed on September 2, 2020, https://www.hhs.gov/about/news/2020/08/28/hhs-deputy-secretary-hargan-statement-on-appointment-of-acting-cio.html.

data on ventilators, hospitalizations, and nursing homes, among other data.[227] According to the former HHS Chief Information Officer, HHS Protect obtains information from all 50 states and territories from about 2,100 direct data streams, and his office has worked with states and territories to improve the reporting of their information to the platform. For example, officials from the HHS Office of the Chief Information Officer (OCIO) worked with one state to identify and correct a discrepancy in the state's data on HHS Protect by reviewing logs of when the state's health department uploaded its data to the platform. In addition to these datasets, HHS Protect has mapping technology to view data by ZIP code and supervised machine learning capability to aid with modeling for the pandemic response.

During a demonstration of HHS Protect, we observed COVID-19 testing, case, and hospitalization data by selected states and counties, which are customized based on a user's access to certain data sets. For example, HHS OCIO officials told us that users from a specific state are granted access to nonpublic data from that state in HHS Protect. During the demonstration, we also observed several visual analysis tools, including dashboards, graphs, and a link chart. Users are also able to generate reports and queries and save them to their profile on the platform, according to OCIO officials.

To obtain more hospital data for HHS Protect, HHS revised its guidance for hospitals to report COVID-19 capacity and utilization data directly to HHS through TeleTracking, or states may submit these data on behalf of hospitals to HHS as of July 15, 2020. According to the former HHS Chief Information Officer, the number of hospitals reporting data has increased since this change.[228] He said that as of July 24, 2020, HHS Protect receives data from between 4,200 and 5,800 hospitals daily. Additionally, the HHS OCIO created a new public dashboard, the HHS Protect Public Data Hub, to provide daily hospital utilization data to replace CDC's National Healthcare Safety Network dashboard, which had previously published these data.[229] According to the former HHS Chief Information Officer, the HHS Protect Public Data Hub provides more information from a larger number of hospitals than the National Healthcare Safety Network dashboard. According to data published on July 30, 2020, about 92 percent of hospitals nationally reported at least one data element within the past 7 days on the HHS Protect Public Data Hub.[230]

The transition of COVID-19 hospital data to HHS Protect prompted some public health and state government organizations to raise questions about the reporting process and accessibility of the data. For example, the American Public Health Association, in a letter signed by over 100 public

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[227]According to the former HHS Chief Information Officer, HHS Protect does not store any personally identifiable information or personal health information.

[228]According to the former HHS Chief Information Officer, HHS Protect is seeking to obtain data from all 6,200 hospitals considered acute care facilities by the White House Coronavirus Task Force.

[229]The COVID-19 Hospital Reporting Dashboard on the HHS Protect Public Data Hub website provides hospital capacity and utilization data submitted directly to Teletracking and HHS Protect, as well as historical data from the National Healthcare Safety Network. The HHS Protect Public Data Hub displays the percentage of hospitals reporting one or more elements into HHS Protect for the most recent collection date (during the last 7 days). See the Department of Health and Human Services, "Percentage of Hospitals Reporting by State," HHS Protect Public Data Hub, accessed July 31, 2020, https://protect-public.hhs.gov/pages/covid19-module.

[230]The percentage of hospitals reporting varied by state, from about 68 to 100 percent. However, the percentage of hospitals that are reporting the proportion of intensive care unit beds available on a daily basis is unclear.

health and medical organizations, recommended that the new hospital reporting requirements be reversed to maintain the integrity of COVID-19 data, keep public health data accessible to the public, and better ensure the availability of hospital data for state and local responses to the pandemic.

Others have also expressed concern about the transition of data collection to HHS Protect. The National Governors Association requested a 30-day delay in the implementation of these new requirements so that hospitals would have time to learn the new system, and recommended that HHS make the hospitalization data publicly available.[231] A health expert affiliated with Johns Hopkins University School of Medicine that we spoke with also expressed concerns about the effectiveness and transparency of HHS Protect and the availability of the data being reported under the system to the public. However, according to information from the CDC Director and former HHS Chief Information Officer, the transition of hospital data to HHS Protect is intended to help streamline and enhance data collection and reduce data duplication.

As part of their concerns, the American Public Health Association and public health experts we spoke with noted the key role and expertise that CDC has in collecting and analyzing public health data to inform the nation's response to the pandemic. Specifically, in its letter, the American Public Health Association expressed concern that placing the collection of medical data, including hospital data, outside of CDC would put the quality and integrity of the data at risk, and could undermine the pandemic response. On July 31, 2020, the CDC Director testified at a congressional hearing that he was not involved in the decision to report COVID-19 hospital data through HHS Protect, and that he learned about the decision only after it had been made. HHS OCIO officials told us that they work with CDC to help validate hospital data in HHS Protect, and that they considered CDC an "equal partner" in the development of HHS Protect.

Since the launch of HHS Protect in April 2020, HHS has worked to expand access to the platform to a variety of federal, state, local, and commercial entities, according to the former HHS Chief Information Officer. Initially, HHS focused on granting access to partners who provided data to HHS Protect. It did not bring on all users at the outset because of costs associated with scaling up the help desk capabilities of the OCIO and uncertainty about the volume and quality of data available on the platform.

The former HHS Chief Information Officer said that, as HHS Protect added new datasets over time, HHS broadened its outreach to states, congressional staff, ASPR and FEMA regional and state contacts, and professional associations, such as hospital associations, in an effort to expand access to the platform.[232] To gain access to HHS Protect, individuals must be sponsored and approved by a federal or state entity. Once access is authorized, users are able to view all publicly available datasets in HHS Protect, but must request and be granted access to non-publicly

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[231]See press release from National Governors Association, "Governors Call on the Administration to Delay Changes to Hospital Reporting Requirements" (July 16, 2020), accessed on July 28, 2020, https://www.nga.org/news/press-releases/governors-call-on-the-administration-to-delay-changes-to-hospital-reporting-requirements/.

[232]According to an HHS press statement on July 15, 2020, HHS Protect had 1,200 users. Subsequently, on August 11, 2020, OCIO officials estimated that there were a few thousand users in HHS Protect, including about 700 users sponsored by states and about 200 sponsored by CDC. Separately, the HHS Chief Information Officer stated that new users are added to the platform daily.

available datasets by the data owner. During the HHS Protect demonstration, we observed a data catalog that users may view to identify and request access to non-publicly available data.

As HHS further develops the HHS Protect platform, it will be important to consider prior challenges the agency has faced in developing and implementing information technology systems and data-sharing networks among federal, state, and local public health entities. For example, since 2003, we have described challenges related to sharing data among public health entities, including the lack of an overall strategy to guide the establishment of interoperability among related systems.[233] We also described state and local public health officials' concerns regarding the cost and effort associated with providing data to federal entities to be integrated and shared on a nationwide basis, and whether those integrated data enhanced public health officials' ability to prepare for and respond to emergencies. In 2017, we identified weaknesses in HHS's planning efforts to establish an electronic nationwide public health situational awareness network.

Given the role that HHS Protect is playing in public health surveillance for the ongoing pandemic, we plan to evaluate HHS's implementation of the platform, including the quality and reliability of the data and the extent to which the data are made available and are transparent. As HHS further develops HHS Protect, we also plan to review CDC's role in its development and the collection of data in the platform.

Lesson: Establish Transparency and Accountability Mechanisms

COVID-19 Testing Payments

HHS has an important oversight role to ensure that federal COVID-19 funds distributed by its agencies do not result in duplicate payments for health care services. Two HHS agencies—HRSA and CMS—pay for COVID-19 testing for uninsured individuals. Initial spending on testing for these two programs is just beginning, and continued monitoring and oversight will be critical to ensure that payments do not duplicate each other and that providers are paid appropriately based on the individuals they serve.

HRSA administers a $2 billion program for COVID-19 testing for the uninsured. CMS has the authority to approve state Medicaid programs' requests to pay providers for COVID-19 testing of uninsured individuals, with the federal government responsible for 100 percent of the payment costs. The Congressional Budget Office estimates that the Medicaid payments for testing uninsured individuals will total approximately $2 billion in 2020 and 2021.

As of July 30, 2020, HRSA had paid $137 million for COVID-19 testing of uninsured individuals. Of this $137 million, about $29 million was paid to providers in the 16 states and one of the three

[233]For additional information, see GAO-17-377.

U.S. territories where CMS has approved Medicaid payments for the same purpose. While state reporting of Medicaid payments is incomplete—for example, one state reported $51 in payments as of July 31, 2020—it is unclear if the controls in place can effectively ensure that payments by HRSA and states' Medicaid programs do not duplicate each other.

Providers' understanding of the new—and optional—Medicaid benefit as a source of coverage for the uninsured is an important control to ensure correct billing for their services and prevent potential duplicate or erroneous payments. While CMS has issued guidance to states, and HRSA has provided guidance and communication to providers, the new coverage may be less known and understood by providers, in part because of inconsistent communication across the states.

Our review of the 16 states implementing this optional Medicaid benefit for testing of the uninsured found some examples of inconsistent information and in one case inaccurate communication to providers on states' websites. For example:

- Two states offer clear and accurate instructions that providers should bill the state Medicaid program first and that HRSA is the payer of last resort.
- One state provides opposite, and inaccurate guidance, directing providers to bill HRSA until HRSA's funds are exhausted, at which point providers can bill Medicaid. The state's website also provides a link for providers to access the HRSA payment website.
- Some other state websites we reviewed had more limited information on Medicaid's optional coverage or HRSA's provider payment program and how providers should bill the programs.

Providers submitting claims to HRSA are required to attest that they have confirmed that the individuals they tested are uninsured and have no other source of health insurance coverage through an individual or employer-sponsored plan, a federal health care program, or the Federal Employees Health Benefits. HRSA's program administrator implemented a prospective payment control on June 1, 2020 to check for insurance coverage for individuals on COVID-19 testing claims submitted to HRSA for payment. Further, HRSA officials reported that its program administrator is developing additional payment controls. On September 9, 2020, HRSA reported that retrospective payment controls began on August 31, 2020 that will recoup any improper payments identified, and additional prospective payment controls to help identify and deny claims for those with coverage under Medicaid's new COVID-19 testing benefit will begin by the end of September 2020.

Given the amount of funds paid to date, the controls are relatively untested; thus we continue to have concerns about the potential for duplicate payments and will review developments regarding CMS's and HRSA's programs.

Lesson: Need to Guard against Cyber Threats

COVID-19 has highlighted the need for the government's continued attention to cyber threats that pose a serious challenge to national security, economic well-being, and public health and safety. Since March 2020, malicious cyber actors have exploited COVID-19 to target organizations that make up the health care and public health critical infrastructure sector, including government entities, such as HHS, and nongovernmental health care organizations.

For example, the former HHS Chief Information Officer stated that the department has been the target of sophisticated daily cyberattacks for the last several months. Recent alerts issued by DHS's Cybersecurity and Infrastructure Security Agency and other government entities have also described significant attacks on numerous other health care organizations, such as pharmacies, academic institutions, and medical research organizations. The malicious actors were targeting patient information, intellectual property, public health data, and intelligence.

Safeguarding federal information systems and those supporting our nation's critical infrastructure, such as health care, has been a longstanding GAO concern.[234] We first designated cybersecurity as a government-wide high-risk area in 1997, and expanded the area to include safeguarding the systems supporting our nation's critical infrastructure in 2003.[235] Our March 2019 high-risk update continued to identify these areas as high-risk.[236]

Over the last 6 years, we have identified numerous cybersecurity weaknesses at multiple HHS component agencies, including CMS, FDA, and CDC.[237] These agencies rely extensively on information systems to collect, process, and maintain highly sensitive information used to deliver services to citizens, including approving drugs for market, providing health insurance benefits, monitoring pandemics and disease outbreaks, and conducting medical research. We identified weaknesses in key safeguards to limit, prevent, and detect inappropriate access to computer resources and maintain secure configurations of software and hardware. Our related reports included 434 technical and information security program recommendations to address these weaknesses at HHS component agencies.

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[234]Presidential Policy Directive 21 on critical infrastructure security and resilience identifies health care as one of the 16 critical infrastructure sectors. The other sectors are chemical; commercial facilities; communications; critical manufacturing; dams; defense industrial base; emergency services; energy; financial services; food and agriculture; government facilities; information technology; nuclear reactors, materials, and waste; transportation systems; and water and wastewater systems.

[235]GAO, *High-Risk Series: An Overview*, GAO#HR#97-1 (Washington, D.C.: February 1997), *High-Risk Series: Information Management and Technology*, GAO#HR#97-9(Washington, D.C.: February 1997), and *High-Risk Series: An Update,* GAO-03-119 (Washington, D.C.: Jan. 2003).

[236]GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, GAO-19-157SP (Washington, D.C.: Mar. 6, 2019).

[237]See GAO, *Information Security: Significant Progress Made, but CDC Needs to Take Further Action to Resolve Control Deficiencies and Improve Its Program*, GAO-19-70 (Washington, D.C.: Dec. 20, 2018); *Information Security: FDA Needs to Rectify Control Weaknesses That Place Industry and Public Health Data at Risk*, GAO-16-513 (Washington, D.C.: Aug. 30, 2016); *Healthcare.gov: Actions Needed to Enhance Information Security and Privacy Controls*, GAO-16-265 (Washington, D.C.: Mar. 23, 2016); and *Healthcare.gov: Actions Needed to Address Weaknesses in Information Security and Privacy Controls*, GAO-14-730 (Washington, D.C.: Sept. 17, 2014).

As of July 2020, CMS, FDA, and CDC had made significant progress in resolving many of the security deficiencies by implementing 350 (about 81 percent) of the 434 recommendations.[238] However, we are currently evaluating the effectiveness of information security controls at NIH and have identified numerous similar technical and information security program deficiencies. These weaknesses continue to place sensitive health care information at an increased risk of compromise from cyber-based attacks.

As the lead federal agency for coordinating security and resilience activities in the health care sector, HHS has taken steps to strengthen cybersecurity, but additional action is needed. In February 2018, we reported that although HHS had taken steps to encourage use of the National Institute of Standards and Technology cybersecurity framework within the health care sector, HHS had not developed a method to determine the level and type of framework adoption within the sector.[239] Additionally, in February 2020, we reported that HHS had not collected or reported improvements resulting from the cybersecurity framework's use.[240] We made recommendations to address these issues—specifically, in February 2018 we recommended that HHS measure the level and type of framework adoption, and in February 2020 we recommended that HHS collect and report on sector-wide improvements. While HHS agreed with the recommendations, as of July 2020, it had not implemented them.[241]

We will continue to review HHS's efforts to address its cybersecurity responsibilities, including as they relate to its COVID-19 response efforts.

GAO Recommendation Related to Department of Health and Human Services Cyber Threats

Based on the imminent cybersecurity threats, the Secretary of Health and Human Services should expedite implementation of our prior recommendations regarding cybersecurity weaknesses at its component agencies. (Recommendation 16)

Source: GAO. | GAO-20-701

[238]For two of the recommendations to FDA, the agency issued a waiver for one and accepted the risk for the other; as a result, the recommendations were not implemented.

[239]GAO, *Critical Infrastructure Protection: Additional Actions Are Essential for Assessing Cybersecurity Framework Adoption,* GAO-18-211 (Washington, D.C.: Feb. 15, 2018). The National Institute of Standards and Technology developed the Framework for Improving Critical Infrastructure Cybersecurity (cybersecurity framework) to provide a set of industry standards and best practices to help the owners and operators of critical infrastructure with managing cybersecurity risks. The National Institute of Standards and Technology released the first iteration of the draft on February 12, 2014, and released an update to the framework on April 16, 2018. National Institute of Standards and Technology, *Framework for Improving Critical Infrastructure Cybersecurity*, version 1.1 (Gaithersburg, Md.: Apr. 16, 2018).

[240]GAO, *Critical Infrastructure Protection: Additional Actions Needed to Identify Framework Adoption and Resulting Improvements,* GAO-20-299 (Washington, D.C.: Feb. 25, 2020).

[241]We identified the recommendation for HHS to develop a method to determine the level and type of cybersecurity framework adoption in the health care sector as a priority recommendation. Priority recommendations are those that GAO believes warrant priority attention from heads of key departments or agencies to significantly improve government operations.

Continued Congressional Attention Needed in Several Areas

In our June 2020 report, we recommended that Congress take action in three areas to improve the federal government's response and recovery; to date, these recommendations have not been implemented.[242] We again call attention to these important issues.

Aviation preparedness. In our June 2020 report, we urged Congress to take legislative action to require the Secretary of Transportation to work with relevant agencies and stakeholders, such as HHS, DHS, members of the aviation and public health sectors, and international organizations, to develop a national aviation-preparedness plan to limit the spread of communicable disease threats and minimize travel and trade impacts. We originally made this recommendation to the Department of Transportation (DOT) in December 2015.[243] As of August 2020, no aviation-preparedness plan had been developed.

Although DOT supports the inclusion of aviation in a comprehensive pandemic preparedness plan, it maintains that other federal agencies should lead such planning efforts. DOT has reiterated that because HHS and DHS are responsible for communicable disease response and preparedness planning, respectively, these departments should lead any efforts to address planning for communicable disease outbreaks, including for transportation.[244]

However, in May 2020, DHS stated that it had reviewed its existing national, sector, and modal plans for pandemic preparedness and response activities and determined that it is not best situated to develop a national aviation preparedness plan. It noted that DOT, along with HHS and DHS, would be the appropriate lead. In June 2020, HHS stated that it is not in a position to develop a national aviation preparedness plan because it does not have primary jurisdiction over the entire aviation sector or the relevant transportation expertise. Also, the National Response Framework—a guide to how the nation responds to all types of disasters and emergencies—identifies DOT as the lead federal agency for coordinating the management of transportation systems and infrastructure during domestic threats or in response to actual or potential incidents.[245]

Several recent developments indicate progress to respond to this recommendation. For example, in May 2020, the House of Representatives passed H.R. 6800, referred to as the HEROES Act, which

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[242]GAO-20-625.

[243]GAO, *Air Travel and Communicable Disease: Comprehensive Federal Plan Needed for U.S. Aviation System's Preparedness*, GAO-16-127 (Washington, D.C.: Dec. 16, 2015).

[244]DOT has pointed to Presidential Policy Directive/PPD-8 as part of its rationale for why other federal agencies should lead an aviation preparedness plan to respond to communicable disease threats. This directive, published in March 2011, calls for the establishment of a risk-informed National Preparedness Goal to define the capabilities needed to prepare for the nation's greatest risks and a National Preparedness System, consisting of an integrated set of guidance, programs, and processes that will enable the nation to meet the goal. The directive states that the Secretary of Homeland Security is responsible for coordinating the domestic all-hazards preparedness efforts of all executive departments and agencies, but that it is not intended to alter or impede the ability of executive departments or agencies to perform their responsibilities under law and other presidential guidance.

[245]The National Response Framework includes Emergency Support Functions that describe federal coordinating structures that group resources and capabilities into functional areas most frequently needed in a national response. DOT is the coordinator and primary agency for Emergency Support Function #1–Transportation.

would require DOT, in coordination with HHS, DHS, and other appropriate federal departments and agencies, to develop a national aviation preparedness plan. The legislation directs that the plan incorporate all elements referenced in the recommendation from our December 2015 report. The plan would also be required to provide for an adaptable and scalable framework to help align individual airport and airline plans, as well as to improve coordination among appropriate federal, state, and local governments.

In addition, in August 2020, the Senate Committee on Commerce, Science, and Transportation favorably reported S. 3681, Ensuring Health Safety in the Skies Act of 2020. This bill would require HHS, DHS, and DOT to form a joint task force on air travel during and after the COVID-19 public health emergency, and it includes a provision for the task force to develop operating procedures to manage future anticipated public health crises affecting air travel. The task force would be focused on COVID-19 and the immediate aftermath of the pandemic, not future communicable disease threats.

In early July 2020, DOT, HHS, and DHS issued guidance to airports and airlines for implementing measures to mitigate the public health risks associated with COVID-19.[246] Among other things, the document establishes the principles for implementing public health measures in the aviation sector and identifies risk mitigation measures that should be applied for the entire passenger journey in the air transportation system, such as social distancing and contact tracing. While this guidance is a positive step, DOT has not taken action to develop an aviation preparedness plan for future communicable disease threats that incorporates all of the elements referenced in our 2015 report, such as protocols for responding to the threat and coordination among stakeholders. Without such a plan, the United States will not be as prepared to minimize and quickly respond to future communicable disease events.

Full access to death data. In our June 2020 report, we urged Congress to amend the Social Security Act to explicitly allow SSA to share its full death data with Treasury for data matching to prevent payments to ineligible individuals.

In June 2020, the Senate passed S.4104, referred to as the Stopping Improper Payments to Deceased People Act. If enacted, the bill would allow SSA to share these data with Treasury's Bureau of the Fiscal Service to help prevent paying improper payments to deceased individuals.

Fiscal assistance through Medicaid. In our June 2020 report, we urged Congress to Assistance Percentage (FMAP) formula for any future changes to the FMAP—the statutory formula according to which the federal government matches states' spending for Medicaid services—during the current or any future economic downturn. Our past work has found that during economic downturns—when Medicaid enrollment can rise and state economies weaken—the FMAP formula, which is based on each state's per capita income, does not reflect current state economic conditions. In addition, past efforts to provide states with temporary increases in the FMAP were not as timely or responsive as they could have been. No congressional action has been taken to date.

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[246]Departments of Transportation, Homeland Security, and Health and Human Services, *Runway to Recovery: The United States Framework for Airlines and Airports to Mitigate the Public Health Risks of Coronavirus* (Washington, D.C.: July 2020).

Conclusions

In their ongoing response to the COVID-19 pandemic, federal agencies have continued to take action on multiple fronts to address unprecedented challenges that have contributed to catastrophic loss of life and profound economic disruption. These actions have helped direct much-needed federal assistance to support many aspects of public life, including local public health systems and private-sector businesses. Attention to the lessons we have identified—including the need for adequate and reliable data to drive decision-making, transparency and accountability mechanisms, and protection against cyber threats, among other things—can help to make these efforts as effective as possible.

Even amidst ongoing federal efforts, the nation faces continued public health risks and economic difficulties for the foreseeable future. The public health system, already strained from months of responding to COVID-19 cases, will face the additional task of managing the upcoming flu season. At the same time, many of the federal, state, and local agencies responsible for responding to the ongoing public health emergency will also be called on to prepare for and respond to the current hurricane season. This will occur as Americans spend more time indoors as the weather turns colder in most parts of the country—creating the potential for an increase in the spread of COVID-19. These are foreseeable, near-term risks, and preparing for them must be an urgent priority for the federal government.

Our recommendations identify a number of opportunities to help the federal government prepare for the months ahead while improving the ongoing federal response. Specifically, they aim to help federal agencies to prepare for, respond to, and recover from the challenges that lie ahead and to manage federal funds efficiently and responsibly. Timely and concerted federal leadership will be a critical component of an effective, agile response, and government leaders must be ready to move quickly to address both known challenges and unexpected events. We will continue to provide ongoing oversight of the federal response to COVID-19 and to identify opportunities for improvement.

Agency Comments and Our Evaluation

We shared a draft of this report with multiple agencies for review and comment.[247] Agency comments specific to the enclosures in appendix I are included in each enclosure. In addition, agencies provided the following comments:

Department of Defense. In its comments, reproduced in appendix V, DOD partially agreed with our recommendation to establish a time frame for documenting and sharing a national plan for distributing and administering a COVID-19 vaccine, and did not agree with our recommendation to revise the criteria in its 2019 National Interest Action (NIA) code memorandum of agreement between itself, DHS, and GSA. Specifically:

- DOD partially concurred with our recommendation to establish a time frame for documenting and sharing a national plan for distributing and administering COVID-19 vaccine. In commenting on the draft report, DOD clarified that it is supporting HHS in developing plans for nationwide distribution and administration of vaccine to counter COVID-19. We revised the recommendation to reflect DOD's supporting role in developing these plans.

- DOD stated that it disagreed with the recommendation to revise the criteria in its 2019 NIA code memorandum of agreement. DOD indicated that revising the agreement to address the second and third part of the recommendation would limit the government's flexibilities.

  We maintain that adding some clarity and specificity to the criteria is important, as it would better ensure consistent application of the criteria over time, as well as enhance visibility for agencies, Congress, and the public regarding decisions to extend or close the NIA code. For example, establishing time frames for evaluating the need to extend a NIA code will help ensure interested parties have sufficient notice as to whether a code will be extended, thus allowing sufficient time to for these entities to provide input regarding the need to extend the code.
  Furthermore, we believe additional specificity could be added to the criteria without being unduly restrictive. For example, providing clarification in the memorandum of agreement as to what is considered "routine" could better ensure consistent application of criteria over time, increase transparency regarding when a code is close to closing, and yet still allow for professional judgment to be applied. Such clarification could perhaps be based on historical analysis of different types of similar events (e.g., hurricanes, public health emergencies, or contingency operations).

- Regarding the first part of the recommendation on obtaining input from other federal agencies, DOD noted that the memorandum of agreement already includes a description of the communication methods used with other federal agencies. However, as we note in our report, the agreement does not identify any processes or steps DHS and DOD could or should take to coordinate with the various agencies involved in emergency acquisitions to determine

[247]We shared a draft of this report with the Departments of Defense, Education, Labor, Housing and Urban Development, Health and Human Services, Veterans Affairs, Homeland Security, State, Agriculture, Transportation, and the Treasury. We also shared a draft with the Federal Reserve, Small Business Administration, Consumer Financial Protection Bureau, Federal Housing Finance Agency, U.S. Agency for International Development, Office of the United States Trade Representative, Office of Management and Budget, and Internal Revenue Service.

that they will consider requests from agencies for extensions based on the criteria in the agreement and their discretion. Given the stated intent of the NIA code in the agreement for federal agencies to identify contracts awarded in response to high visibility disasters, emergencies, and contingency operations with significant multi-agency federal procurement impact, proactively obtaining input from other agencies involved in the response is necessary to ensure the successful tracking of government-wide procurements for these high-visibility events.

- Finally, DOD stated that it and DHS are committed to annually reviewing the memorandum of agreement for necessary updates, including communication with other federal agencies over NIA codes. We encourage DOD, DHS, and GSA—the third signatory to the agreement responsible for managing the code in the Federal Procurement Data System-Next Generation—to use this annual review to implement this recommendation so as to better ensure consistent application of the criteria and increased transparency regarding the process for extending and closing NIA codes.

- In the draft product we provided DOD and DHS for comment, we included an additional recommendation for DHS and DOD to extend the NIA code beyond September 30, 2020. In its comments, DHS and DOD concurred with this recommendation and extended the NIA code until March 31, 2021, while the report was with the agencies for comment. Because DOD and DHS's actions addressed our draft recommendation, we have withdrawn that recommendation from our final report.

DOD also provided technical comments that we incorporated as appropriate.

Department of Education. In its comments, reproduced in appendix VI, Education stated that it continues to be proud of the department's accomplishments in meeting the timeline set forth under the CARES Act and in awarding funds efficiently to states. Education noted that the agency worked in consultation and collaboration with CDC on school reopening resources, has updated Education's COVID-19 web page, and is always working to improve it. Education provided technical comments, which we incorporated as appropriate.

Department of Health and Human Services. In its comments, reproduced in appendix VII, HHS highlighted actions it has taken with respect to the medical supply chain, vaccine manufacturing, collection of data on race and ethnicity, and its guidance for schools. HHS stated that it agreed with five of our 10 recommendations. HHS's comments on the remaining five recommendations are summarized below:

- HHS did not agree with the three recommendations in the draft report related to the medical supply chain. First, HHS did not concur with the recommendation related to developing roles and responsibilities for the supply management functions that are transitioning to HHS. In response to our second recommendation, HHS commented that it is in the process of producing documented responsibilities. However, HHS did not address any of the issues in our report regarding the transition of responsibilities. As such, we stand behind the evidence presented and this recommendation.

For our other two recommendations regarding the medical supply chain, HHS commented that our report prioritizes "anonymous anecdotes" to develop our recommendations and objected that we did not disclose to HHS the names and titles of the officials with whom we spoke. Our findings are based on evidence from numerous sources and are an evaluation of the sum of the evidence to identify themes and challenges that reoccurred frequently. These include August 2020 federal reports on medical supply availability, interviews with federal officials, and interviews with senior state officials in multiple departments who were in appropriate positions to discuss state actions, supply availability, and the federal response. Consistent with generally accepted government auditing standards, we sought out officials with direct knowledge of the issues we studied and further confirmed that knowledge during the course of the interview. Specifically, we interviewed senior officials from departments of health and emergency preparedness from eight select states. Consistent with GAO practices, we selected the states we interviewed using robust methodological standards. We described the selection criteria and disclosed the eight selected states in the report's objectives, scope, and methodology section, as well as the two states that provided additional evidence during a call with a national association (a total of 10 states for the findings about state, territorial, and tribal supply issues).

As noted in the report, generally we reported those issues that arose in a majority of state interviews. These same concerns also arose in a number of the interviews we conducted with national associations and with FEMA regional offices. These were not isolated, singular opinions expressed by state officials removed from the response. HHS also stated that without knowing the title or name of the individuals who described challenges with the federal distribution of medical supplies, it cannot take corrective actions. We disagree. Our recommendations are not that HHS should individually follow up with each of the officials we interviewed to adjudicate individual issues that have already occurred. The intent of the recommendations is that HHS and FEMA, as leads for this pandemic response, seek to better understand the problems we identified and devise solutions to help ensure the federal government can mitigate remaining medical supply gaps, and assist states, tribes, and territories in serving their citizens effectively.

In addition, in response to a draft of the second recommendation, which directed the department to further develop and communicate a comprehensive supply management plan in coordination with FEMA, HHS emphasized the work that had been done to manage the medical supply chain and increase supply availability. We agree that HHS, FEMA, and their federal partners have taken numerous actions to respond to the unprecedented need for medical supplies and our report describes many of these efforts. However, we found that certain supply constraints continue without plans outlining the specific actions the federal government will take to address them. We also report on differing perspectives about the extent of the medical supply gaps that remain. Further, HHS stated that our draft recommendation suggested that the federal government should federalize all supply procurement and distribution. This is not the intent of the recommendation. Rather, we believe that HHS, in coordination with FEMA, should further develop and communicate to stakeholders any plans outlining specific actions the federal government will take to address remaining medical supply gaps. This is an important step to help ensure federal response efforts align with demand. Further, it would provide needed clarity to federal partners and nonfederal entities on priority needs and ongoing efforts to address those needs. We maintain our recommendation is warranted and have modified it to clarify our intent.

For our recommendations that HHS and FEMA work with relevant federal, state, territorial, and tribal stakeholders to devise interim solutions to the supply challenges they face for the remainder of the response—visibility, tracking, and budgeting—HHS also described efforts that it already undertakes, with the implication that these are sufficient to address any challenges described in the narrative supporting this recommendation. We commend HHS for these actions, and at the same time, note that nonfederal officials continued to report the kind of challenges we described irrespective of these efforts. We note that perhaps these venues are one good starting point to conduct the kind of outreach and listening sessions necessary to begin to help states, tribes, and territories address the challenges they are still facing, particularly as conditions may worsen as we move into fall and winter months.

- While HHS officials neither agreed nor disagreed with our recommendation to establish a time frame for documenting and sharing a national plan for distributing and administering COVID-19 vaccine, in its comments, HHS noted that several factors complicate the publication of a firm vaccine distribution timeline and affect the administration and distribution of a vaccine. Such factors include the number of doses that may need to be administered and vaccine storage requirements; these factors depend on which vaccine candidate or candidates are identified and on clinical trial results. HHS further commented that it will soon send a report to Congress outlining a distribution plan that takes into consideration these issues as well as the frameworks HHS is developing with input from CDC's Advisory Committee on Immunization Practices and the National Academies of Sciences, Engineering, and Medicine. We agree these are critical steps, along with the planning documents CDC sent to state and local jurisdictions, and we are encouraged that HHS intends to outline a distribution plan soon. Yet we continue to believe the Secretary of Health and Human Services, with support from the Secretary of Defense, should establish a specific time frame for documenting and sharing its national plan. This will allow all relevant stakeholders to be best positioned to also begin planning for administering a vaccine, and will help ensure a well-coordinated response involving any licensed or authorized vaccine.

- HHS partially agreed with our recommendation that HHS, in consultation with CMS and CDC, develop a strategy to capture more complete data on confirmed COVID-19 cases and deaths in nursing homes back to January 1, 2020, and to clarify the extent to which nursing homes have reported data before May 8, 2020. Specifically, HHS agreed that collecting more complete data would be useful for determining the total number of nursing homes affected, the extent of morbidity and mortality, and changes in incidence over time. Further, HHS noted that having complete data would be useful in the review of policies and practices put in place during the pandemic.

  However, HHS said, because retroactively collecting the data "may be overly burdensome on health care providers," it does not believe devoting substantial agency or health care provider resources during the pandemic "would be prudent." We maintain the importance of developing a strategy to collect data from this critical time period of early COVID-19 spread in nursing homes and maintain that the agency could begin by incorporating data previously reported to CDC or to state or local public health offices, which would ease the burden on nursing homes.

HHS also provided technical comments that we incorporated as appropriate.

Department of Homeland Security: In its comments, reproduced in appendix VIII, DHS did not concur with the recommendations in the draft report related to the medical supply chain. DHS echoed many of the same concerns as HHS including the claim that we prioritize anonymous anecdotes in developing our recommendations. As we stated in our response to HHS, our findings are based on evidence from numerous sources and are an evaluation of the sum of the evidence to identify only themes and challenges that reoccurred frequently. These include August 2020 federal reports on medical supply availability, interviews with federal officials, and interviews with senior state officials in multiple departments who were in appropriate positions to discuss state actions, supply availability, and the federal response.

Importantly, we had multiple discussions about these recommendations with FEMA officials and provided several opportunities for them to provide feedback and discuss concerns. For example, while the draft was being reviewed by DHS, we met with FEMA headquarters officials to discuss, and ultimately revise, the language of the first two recommendations to better characterize FEMA's supporting role. At the time of those discussions, FEMA indicated it concurred with these first two recommendations given the modifications. Additionally, we discussed the third recommendation in detail with FEMA headquarters officials with direct knowledge of the agency's response functions. Those officials described that requests for and distribution of medical supplies were handled through multiple systems across agencies. These officials also said they were aware of good practices being used by states that would be valuable to share with their nonfederal partners and indicated they agreed with the recommendation.

Regarding our first supply chain recommendation related to developing roles and responsibilities for the supply management functions that are transitioning to HHS, DHS commented that DHS, FEMA, and HHS have articulated roles and responsibilities and that FEMA continues to collaborate on plans regarding supply chain management and stabilization through working groups and lines of effort. However, given the amount of responsibility, increase in needed expertise, and continued support that HHS will need moving forward, we believe that written plans documenting roles and responsibilities are critical for this transition. As such, we continue to believe this recommendation is important.

DHS also did not concur with the second supply chain recommendation in our draft report that it coordinate with HHS to develop and communicate a comprehensive supply management plan. DHS noted that FEMA has been successful in identifying supply gaps and taking swift action to ensure those needs are met, and we commend the department for these actions taken. Similar to HHS, DHS questioned the intent of our recommendation. As we stated in our response to HHS, the intent of the recommendation is not to federalize all supply procurement and distribution but to further develop and communicate to stakeholders any plans outlining specific actions to address remaining medical supply gaps. We maintain our recommendation is warranted and have modified it to clarify our intent.

For our recommendations that HHS and FEMA work with relevant federal, state, territorial, and tribal stakeholders to devise interim solutions to the supply challenges they face for the remainder of the response—visibility, tracking, and budgeting—DHS described FEMA's close coordination with nonfederal partners and efforts to provide guidance to assist with navigating the pandemic response. DHS commented that FEMA's role in providing assistance through the Stafford Act authorities is "nothing new" for FEMA's nonfederal partners who recurrently interact with FEMA on

disaster response and said it issued supplemental guidance to help those less familiar with this process.

However, DHS also stated that the unprecedented challenges caused by the pandemic led HHS and FEMA and their partners to execute an unprecedentedly comprehensive effort to obtain medical supplies necessary to respond to the pandemic. We commend DHS for its outreach and guidance that it provides to nonfederal partners, yet also recognize that a response as vast and complex as this pandemic response may also reveal challenges as well as successes. We stand by our recommendations that HHS and FEMA continue to engage their nonfederal partners to identify best practices within the states and disseminate guidance that addresses continued challenges.

Further, in its comments, DHS did not agree with the recommendation to revise the criteria in its 2019 NIA code memorandum of agreement, noting that it cannot establish timelines for evaluating the need to extend a NIA code or establish criteria for opening or closing a code without agreement from the other signatory agencies—DOD and GSA. DHS stated its Office of the Chief Procurement Officer will, however, discuss revisions with DOD and GSA that would clarify the process, criteria, and timelines for establishing, extending, or closing the NIA code, including communication with other agencies. We maintain that adding some clarity and specificity to the criteria is important, as it would better ensure consistent application of the criteria over time, as well as enhance visibility for agencies, the Congress, and the public regarding decisions to extend or close the NIA code. We encourage DHS, DOD, and GSA to use this annual review to implement this recommendation so as to better ensure consistent application of the criteria and increased transparency regarding the process for extending and closing NIA codes.

DHS also stated in its response that NIA codes are not meant to track "long term" actions. However, historically, NIA codes can and have been used to track contract actions long term. For example, contingency operations in Iraq and Syria and to counter terrorism through Operation Freedom's Sentinel have had open NIA codes since 2014 and 2015; Hurricane Sandy had an open NIA code from 2012 to 2017; and the Gulf Oil Spill had an open NIA code from 2010 through 2013.

DHS also stated in its response that the appropriate mechanism for tracking expenditure funds used to respond to and recover from national emergencies and disasters is USASpending.gov. However, the tracking of appropriated funds is different from tracking contract actions and their associated obligations using the NIA code. Specifically, while efforts have been made to track and report COVID-19 relief funds on USAspending.gov (including funding related to contracts as well as, for example, grants and loans) based on a disaster emergency fund code, this code is used to track obligations associated with COVID-19 appropriations, such as CARES Act funding, whereas the NIA code tracks contracts for COVID-19 regardless of the source of funds. According to USASpending.gov, not all contract awards coded with the NIA code are tied to COVID-19 supplemental appropriations—meaning they may not be included in what is reported on USASpending.gov.

According to OMB, as the implementation of the disaster emergency fund code proceeds, OMB will continue to monitor the two sets of data to assess overlap. Furthermore, efforts to track COVID-19 spending through the code on USASpending.gov are relatively new, with agencies having just certified their obligations from April, May, and June 2020 as of August 14, 2020. As a result,

these efforts do not currently provide a complete picture of contracts awarded in response to COVID-19 and coded with the NIA code that are not funded through COVID-19 appropriations. As we note in our report, as of September 4, 2020, USASpending.gov identified $11.3 billion in contract obligations, less than half of the amount we identified as associated with COVID-19 contract actions based on the NIA code as of July 31, 2020. As a result, the NIA code remains an important and necessary tool for tracking procurement data, including associated obligations, in the Federal Procurement Data System-Next Generation.

In the draft report we provided DHS and DOD for comment, we included an additional recommendation for DHS and DOD to extend the NIA code beyond September 30, 2020. In its comments, DHS and DOD concurred with this recommendation and extended the NIA code until March 31, 2021, while the report was with the agencies for comment. Because DHS and DOD's actions addressed our draft recommendation, we have withdrawn that recommendation from our final report.

DHS also provided technical comments, which we incorporated as appropriate.

Department of Housing and Urban Development. In its comments, reproduced in appendix IX, HUD noted its efforts to inform renters, landlords, and other stakeholders of the CARES Act protections available to them, for example through a consumer call center and website developed jointly with the Consumer Financial Protection Bureau and the Federal Housing Finance Agency.

Department of the Treasury. In its comments, reproduced in appendix X, Treasury described the role it has played implementing the CARES Act, including EIP, Federal Reserve lending facilities, assistance to the aviation industry, the CRF, and PPP.

Treasury neither agreed nor disagreed with our recommendations. The letter states that Treasury supports the goal of our recommendations and describes actions it intends to take in coordination with IRS in concert with our recommendations to target outreach to individuals who may be eligible for an EIP.

Specifically, Treasury stated that it is working with IRS to examine tax information returns from 2018 and 2019 to identify potentially eligible recipients who have not yet received an EIP. The letter states that Treasury and IRS plan to send a notice to around 9 million individuals identified through this process on how to claim an EIP. Treasury and IRS also plan to continue to coordinate with EIP outreach partners including Volunteer Income Tax Assistance, Tax Counseling for the Elderly, Low Income Taxpayer Clinics, and other community organizations.

We acknowledge Treasury and IRS's commitment to reaching as many EIP eligible recipients as possible and their efforts to use available data to do so. However, we continue to emphasize the need for Treasury and IRS to update and refine the estimate of eligible recipients who have yet to receive an EIP. We believe that an updated estimate will help Treasury, IRS, and Congress better understand the magnitude of the eligible population that has not received an EIP. This information can also inform and support outreach efforts.

Gaps in information return data also could impede Treasury and IRS's ability to identify some eligible recipients. For example, we reported in May 2020 that IRS may be missing

many individuals working in the platform economy due to reporting threshold rules.[248] We recommended that IRS work with Treasury to amend the rules, but IRS stated that it could not agree to do that due to higher priority guidance projects.

The lack of an estimate of eligible recipients who have not received an EIP limits Treasury and IRS's, as well as their outreach partners', ability to appropriately scale and target outreach and communication efforts to reach potentially eligible individuals.

Treasury also provided technical comments, which we incorporated as appropriate.

Department of Veterans Affairs. In its comments, reproduced in appendix XI, VA stated that it has continued to provide care for veterans with COVID-19. Among the topics covered, VA noted its efforts to increase staffing.

Internal Revenue Service. In its comments, reproduced in appendix XII, IRS highlighted the role it played to issue more than 160 million EIPs. IRS deferred to Treasury to respond to our two recommendations. Although IRS neither agreed nor disagreed with the recommendations, the response states that IRS will continue to work to identify recipients who are eligible for EIPs and encourage them to use the Non-Filers tool before the October 15 filing deadline. Further, IRS will continue to prioritize and dedicate resources to ensuring eligible recipients receive their full payments. IRS also provided technical comments, which we incorporated as appropriate.

Office of the United States Trade Representative (USTR). USTR provided comments, reproduced in appendix XIII, cautioning about overestimating the amount of trade for COVID-19-related products due to data limitations. We clarified that we present the values of imports in categories containing such products as an indicator of import trends. USTR also supplied technical comments, which we incorporated as appropriate.

Small Business Administration. SBA provided technical comments that we incorporated as appropriate. Some of these comments were more than technical in nature, as summarized below:

- SBA stated it is not accurate to suggest that SBA is not responding to our June 2020 recommendation that SBA develop and implement plans to identify and respond to risks in PPP to ensure program integrity, achieve program effectiveness, and address potential fraud, including in loans of $2 million or less. In particular, SBA noted that it has briefed us on its efforts in multiple interviews and has committed to continuing to update us as the plans are finalized.

  In the report, we acknowledge that SBA has begun developing its oversight plans. For example, we noted that according to SBA officials, SBA is currently working with Treasury and contractors to finalize plans for loan reviews and loan forgiveness reviews. However, we cannot consider the recommendation implemented until SBA provides documentation outlining the review procedures and showing that reviews have been completed.

[248]GAO, *Taxpayer Compliance: More Income Reporting Needed for Taxpayers Working Through Online Platforms*, GAO-20-366, (Washington, D.C: May 28, 2020).

- SBA also said that our statement that there are questions about the completeness and accuracy of the PPP data on jobs retained was inconsistent with our statement in the scope and methodology that we determined that the PPP data we used were sufficiently reliable. We assessed the reliability of each data variable we used individually. In the scope and methodology, we stated that we found the data sufficiently reliable to describe the geographic distribution of PPP funds, changes in PPP loan size over time, PPP loans by business size and type, and the extent of canceled loans. We did not report data on jobs retained because borrowers were not asked to include this information on their loan applications, none of the guidance on SBA's website includes instructions to help lenders calculate jobs retained, and these data were either not reported or indicated zero jobs retained for 18 percent of loans.

U.S. Agency for International Development. In its comments, reproduced in appendix XIV, USAID highlighted its efforts to respond to COVID-19 abroad, including additional total obligations of supplemental funding, as of August 24, 2020. USAID also provided technical comments, which we incorporated as appropriate.

Technical comments. In addition to those listed above, the following agencies also provided technical comments, which we incorporated as appropriate: Departments of Agriculture, Labor, and State; Federal Housing Finance Agency (including Fannie Mae and Freddie Mac); and the Office of Management and Budget.

We are sending copies of this report to the appropriate congressional committees, the Director of the Office of Management and Budget, White House Coronavirus Task Force, and other relevant agencies. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-5500 or dodarog@gao.gov. Questions can also be directed to Kate Siggerud, Chief Operating Officer, at (202) 512-5600, A. Nicole Clowers, Managing Director, Health Care, at (202) 512-7114 or clowersa@gao.gov or Orice Williams Brown, Managing Director, Congressional Relations, at (202) 512-4400 or williamso@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report.

Gene L. Dodaro

Comptroller General of the United States

Congressional Addressees

The Honorable Richard C. Shelby
Chairman
The Honorable Patrick J. Leahy
Vice Chairman
Committee on Appropriations
United States Senate

The Honorable Lamar Alexander
Chairman
The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Ron Johnson
Chairman
The Honorable Gary C. Peters
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Nita M. Lowey
Chairwoman
The Honorable Kay Granger
Ranking Member
Committee on Appropriations
House of Representatives

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Greg Walden
Republican Leader
Committee on Energy and Commerce
House of Representatives

The Honorable Bennie Thompson
Chairman
The Honorable Mike D. Rogers
Ranking Member
Committee on Homeland Security
House of Representatives

The Honorable Carolyn B. Maloney
Chairwoman
The Honorable James R. Comer
Ranking Member
Committee on Oversight and Reform

House of Representatives

Appendixes

Appendix I: Report Enclosures

Relief for Health Care Providers

The Department of Health and Human Services continues to disburse the $175 billion appropriated for the Provider Relief Fund to financially support health care providers and finance care for COVID-19 patients and underserved populations. As of July 31, 2020, $129.7 billion had been allocated and about $92.4 billion had been disbursed to providers.

Entities involved: Department of Health and Human Services, including its Health Resources and Services Administration

Key Considerations and Future GAO Work

As the Department of Health and Human Services (HHS) works to get funds to eligible providers, it will continue to be important that robust internal controls are in place to help ensure funds are appropriately disbursed and used, notwithstanding the imperative of a quick federal response to the COVID-19 crisis. For example, it is important that funds not be provided to ineligible providers, such as hospitals that have closed. We plan to conduct additional work to examine HHS's efforts to provide assistance to providers.

Background

The scale of the nationwide COVID-19 pandemic requires a "whole-of-government" approach to respond, including engaging multiple federal agencies to support the public health and medical response. HHS is designated as the lead agency for responding to a public health emergency, including a pandemic.[249] The COVID-19 pandemic has severely strained health care resources in some areas and reduced revenue that hospitals and other health care providers generate from the provision of non-urgent health services.

To respond to these crises, $175 billion was appropriated to reimburse eligible providers for health care-related expenses or lost revenues attributable to COVID-19, known as the Provider Relief Fund. Specifically, the CARES Act appropriated $100 billion and the Paycheck Protection Program and Health Care Enhancement Act appropriated an additional $75 billion for the fund.[250] The Health Resources and Services Administration (HRSA), within HHS, administers payments from the Provider Relief Fund.

[249]Given the nationwide response required to address the COVID-19 pandemic, HHS has been designated as the lead federal agency for the public health and medical portion of the response, while the Department of Homeland Security's Federal Emergency Management Agency has been designated as the lead agency for coordinating the overall federal response.

[250]Pub. L. No. 116-136, div. B, tit. VIII, 134 Stat. 281, 563 (2020); Pub. L. No. 116-139, div. B, tit. I, 134 Stat. 620, 622 (2020).

Overview of Key Issues

Provider Relief Fund. As of July 31, 2020, HHS had allocated about $129.7 billion from the Provider Relief Fund, with $45.3 billion not yet allocated. Of the total allocated, about $92 billion has been disbursed and about $38 billion is yet to be disbursed. HHS allocated about $50 billion for general relief for health care providers and $70.1 billion for seven targeted areas.[251] Additionally, HHS told us that it allocated $10 billion for the treatment of uninsured COVID-19 patients.[252] See table below for a summary of Provider Relief Fund allocations and disbursements.

[251]The $70.1 billion was calculated by adding the allocations of the seven targeted areas: rural health care facilities, high-impact hospitals, skilled nursing facilities, Indian health care providers, safety net hospitals, Medicaid and CHIP providers, and dental providers.

[252]The Families First Coronavirus Response Act and the Paycheck Protection Program and Health Care Enhancement Act each appropriated $1 billion to reimburse providers for conducting COVID-19 testing for the uninsured, separate from the Provider Relief Fund.

Summary of the Provider Relief Fund ($175 billion) Allocations and Disbursements, as of July 31, 2020

Description	Allocation ($ billions)	Dates and amounts of initial disbursement ($ billions)	Disbursement ($ billions)
General relief to health care providers[a]	49.5	April 10, 2020: 30 April 24, 2020: 20	41.7
Rural health care facilities[b]	11.3	May 6, 2020	11.2
High-impact hospitals[c]	22.0	May 7, 2020: 12 week of July 20, 2020: 10	20.2
Uninsured treatment[d]	10.0	May 15, 2020	0.379
Skilled nursing facilities[e]	5.0	May 22, 2020	4.8
Indian health care providers[f]	0.5	May 29, 2020	0.489
Safety net hospitals[g]	13.3	June 12, 2020	13.1
Medicaid and Children's Health Insurance Program (CHIP) providers[h]	15.0	July 3, 2020	0.505
Dental providers[i]	3.0	July 28, 2020	0.008
Administration	0.128	N/A	0.008
Unallocated funds	45.3	N/A	
Total	**175.0**		**92.4**

Source: Summary of Department of Health and Human Services (HHS) funding data. | GAO-20-701

[a]HHS allocated about $50 billion from the Provider Relief Fund for general disbursement to facilities and providers that participate in Medicare fee-for-service based proportionally on eligible providers' share of 2019 net patient revenue from the Medicare fee-for-service program. For both the $30 billion and $20 billion disbursements, providers must have had active Medicare billing privileges and have treated patients after January 31, 2020, among other terms and conditions.

[b]HHS initially allocated $10 billion to rural hospitals, including rural acute care general hospitals and Critical Access Hospitals, Rural Health Clinics, and Community Health Centers located in rural areas. On July 10, 2020, HHS announced an additional allocation of about $1 billion for specialty rural hospitals, urban hospitals with certain rural Medicare designations, and hospitals in small metropolitan areas.

[c]HHS initially allocated $12 billion for hospitals with high COVID-19 admissions, with $2 billion of these payments going to hospitals based on their Medicare Disproportionate Share funding. On July 17, 2020, HHS announced an additional allocation of $10 billion to hospitals based on the number of COVID-19 inpatient admissions.

[d]HHS told us that it allocated $10 billion for providers who submit claims for reimbursement for care or treatment related to positive diagnoses of COVID-19 provided to individuals who do not have any health care coverage at the time the services were provided. The Office of Management and Budget (OMB) told us on September 3, 2020, that the amount of this allocation is not final.

[e]HHS allocated about $5 billion to eligible skilled nursing facilities (SNF). Eligible SNFs for this disbursement are those that are certified with six or more certified beds.

[f]HHS allocated $500 million for the Indian Health Service, including tribal hospitals, clinics, and urban health centers.

[g]HHS initially allocated $10 billion for safety net hospitals that serve a disproportionate number of Medicaid patients or provide large amounts of uncompensated care, and operate on thin margins. On July 10, 2020, HHS allocated an additional $3 billion for certain safety net hospitals, expanding the criteria for payment qualifications to meet a revised profitability threshold.

[h]HHS allocated $15 billion for providers who did not receive funds from the $50 billion general relief disbursement, billed the Medicaid/CHIP programs or Medicaid managed care plans for health care-related services from January 1, 2018, to December 31, 2019, and provided patient care after January 31, 2020.

[i]HHS told us that it allocated $3 billion for dental providers. OMB told us on September 3, 2020, that the amount of this allocation is not final.

Summary of fund disbursements. As of July 31, 2020, $92.4 billion from the $129.7 billion allocated had been disbursed to providers. The amount disbursed is less than the amount allocated because some of the disbursements are in progress and providers have declined about $3.3 billion so far from previous disbursements; those funds are available for subsequent allocations. Over the past 3 months, funds started being allocated to areas particularly impacted by the COVID-19 outbreak.

Funds from the first general relief disbursement. HHS quickly disbursed the initial $30 billion from the general relief allocation based proportionally on eligible providers' share of 2019 net patient revenue from the Medicare fee-for-service program, and those disbursements began on April 10, 2020, and are now complete.[253] Disbursements to individual providers ranged from less than $1 to about $139.7 million.

Among other things, providers who wished to keep these funds were required to attest to receipt of the funds and to agree to the program terms and conditions within 90 days of receipt. HHS regarded any provider not returning a payment within 90 days of receipt as accepting its terms and conditions. Recipients will be required to submit documents to substantiate that funds were used for increased health care-related expenses or lost revenue attributable to COVID-19 and were not otherwise reimbursed. HRSA officials told us that guidance concerning the required documentation will be issued shortly and that providers will need to submit the documents in early 2021.

According to our analysis of information provided by HRSA, as of July 15, 2020, there were 322,854 recipients of the initial disbursement of $30 billion and 312,614 recipients kept payments totaling about $28.9 billion. Among providers keeping the funds, 223,516 (72 percent) attested to their eligibility, while the other 28 percent did not respond to the attestation request. About 10,240 recipients returned payments totaling about $1.3 billion to HRSA.[254]

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[253]One-third of Medicare beneficiaries receive care from Medicare Advantage plans, not fee-for-service Medicare. These plans receive a set, capitated amount to finance care for each beneficiary. Any payments that providers received from Medicare Advantage plans were not considered in the calculations for this disbursement from the Provider Relief Fund. These providers may be eligible for future disbursements.

[254]There is a small proportion of providers who kept and then rejected the funds (0.61 percent). Additionally, of the 70,904 providers who received payments from the second general relief disbursement of $20 billion, 990 providers (about 1.4 percent) returned a total of about $1.8 billion of the funding disbursed as of July 15, 2020. As of August 3, 2020, of the 395 high-impact hospitals that received payments from the high-impact hospital fund, 11 providers (about 2.8 percent) returned a total of about $191.7 million from the initial disbursement of $10 billion.

Our preliminary analysis found four closed hospitals that initially received funds from the first general relief disbursement. These four hospitals received a total of $558,000. However, the funds to the closed hospitals we identified were declined or returned and no funding remained with them. HRSA officials stated that they have program integrity strategies to help with recovering funds from closed hospitals. HRSA officials also told us that they had frequent communication in advance with providers to help ensure the eligibility of fund recipients.

GAO Methodology and Agency Comments

To conduct our work, we examined publicly released HHS documents and obtained information from HRSA. To determine if allocated funds went to any closed hospitals, we compared a dataset of hospitals receiving funds provided by HRSA to federal and academic datasets of closed hospitals. Our review of the data sources we used provides reasonable assurance of the data's reliability. We provided HHS and the Office of Management and Budget (OMB) with a draft of this enclosure. OMB provided technical comments on this enclosure, which we incorporated as appropriate. HHS did not provide comments on this enclosure.

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Nursing Homes

COVID-19 challenges for our nation's nursing homes remain, including challenges related to personal protective equipment, testing, and staffing shortages.

Entities involved: Centers for Disease Control and Prevention and Centers for Medicare & Medicaid Services, both within the Department of Health and Human Services.

Key Considerations and Future GAO Work

COVID-19 is a continuing, pressing concern for our nation's nursing homes. New data, which could be improved, indicate nursing home residents have been disproportionately affected by COVID-19.

To address gaps in the new reporting requirements on COVID-19 cases and deaths in nursing homes, we recommend that the Secretary of Health and Human Services—in consultation with the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC)—develop a strategy to capture more complete data on confirmed COVID-19 cases and deaths in nursing homes retroactively to January 1, 2020.

Since June 2020, we have identified concerns related to personal protective equipment (PPE), testing, and staffing shortages in nursing homes that we will continue to examine in future reports. We also have ongoing work on oversight of infection prevention and control and emergency preparedness in nursing homes.

Background

The health and safety of the 1.4 million elderly or disabled residents in the nation's more than 15,000 Medicare and Medicaid certified nursing homes—who are often in frail health and living in close proximity to one another—has been a particular concern during the COVID-19 pandemic.[255] CMS, an agency within the Department of Health and Human Services (HHS), is responsible for ensuring that nursing homes meet federal quality standards to participate in the Medicare and Medicaid programs. To monitor compliance with these standards, CMS enters into agreements with state survey agencies in each state government to conduct (1) recurring comprehensive standard surveys and (2) as-needed investigations. In response to the pandemic, HHS, primarily through CMS and CDC, has taken a range of actions to address infection prevention and control in nursing homes, on which we reported in our June 2020 report, including providing guidance and technical assistance to nursing homes to improve infection control practices, shifting to targeted infection control surveys of nursing homes, and modifying reporting requirements for nursing homes. In addition, in June 2020, CMS announced the establishment of the 25-

[255]COVID-19 has affected vulnerable populations in other settings beyond nursing homes, including assisted living facilities. However, as the federal role in oversight of nursing homes is more significant than in other settings such as assisted living facilities, the federal response has been more focused on nursing homes.

member Coronavirus Commission on Safety and Quality in Nursing Homes, which was tasked with conducting a comprehensive assessment of the response to the COVID-19 pandemic in nursing homes and deliver a report to CMS in early fall 2020.[256]

Congress specifically appropriated $100 million in the CARES Act for this oversight program, and it directed the agency to prioritize the use of funds for nursing home facilities in localities with community transmission of COVID-19.[257] According to CMS, of this amount, the agency plans to provide state survey agencies approximately $81 million through September 30, 2023. In addition, HHS announced in May that it would contribute $4.9 billion from the CARES Act to assist nursing homes with responding to COVID-19 and announced in July that it would provide an additional $5 billion.

Overview of Key Issues

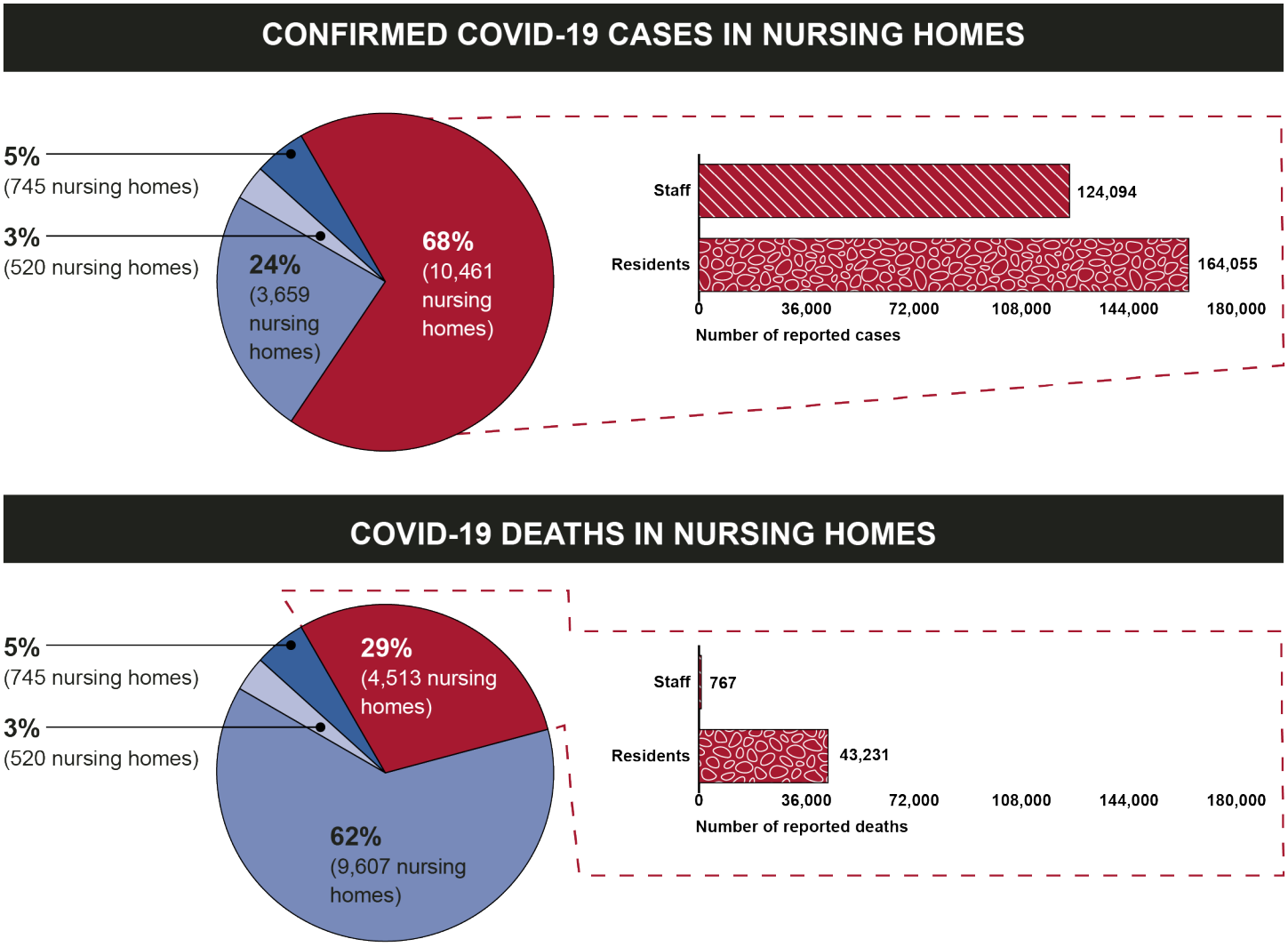
Initial results of self-reported COVID-19 cases and deaths. Since May 2020, CMS has required nursing homes to self-report COVID-19 data on the number of suspected and confirmed cases and deaths to CDC.[258] Specifically, as of July 26, 2020, 68 percent of all nursing homes had reported to CDC at least one confirmed resident or staff case, and 29 percent had reported at least one resident or staff COVID-19 death. (See figure).

[256]While CMS has indicated it plans to publicly release the assessment, as of September 4, it has not been released.

[257]Pub. L. No. 116-136, div. B, tit. VIII, 134 Stat. 281, 557 (2020).

[258]Beginning in May 2020, CMS implemented a new reporting requirement for nursing homes to report suspected and confirmed COVID-19 cases and deaths directly to CDC on an ongoing basis. As of July 26, approximately 95 percent of nursing homes had reported the required data to CDC. In addition, some nursing homes opted to report cases back to January 1, 2020, but it is unclear how many homes chose to do so.

Nursing Home Staff and Resident Confirmed COVID-19 Cases and Deaths, as Reported to CDC, May 8, 2020 through July 26, 2020



Source: GAO analysis of CDC data. | GAO-20-701

Note: Totals may not add to 100 due to rounding. In comparison, according to CDC, there were about 4.2 million total COVID-19 cases and 145,982 total deaths across the United States, as of July 26, 2020. It is likely that both the nursing home and total U.S. cases and deaths are underreported. Approximately 95 percent of nursing homes had reported the required data from May 8 through July 26, 2020, to CDC. In addition, some nursing homes opted to report cases back to January 1, 2020, but it is unclear how many homes chose to do so.

These data reveal nursing home residents have accounted for at least one-quarter of all reported U.S. COVID-19 deaths—an estimate that is likely underreported, as CMS does not require nursing

homes to report data prior to May 8, 2020.[259] As a result, the data do not provide HHS with a complete picture of the extent of the pandemic and its effect on nursing homes. For example, the Life Care Center in Kirkland, Washington—the site of one of the first major COVID-19 outbreaks reported in a U.S. nursing home in February 2020—submitted data to CDC, but, with reporting prior to May 8 optional, reported zero total confirmed resident and staff cases and zero total deaths in the CDC data from May 8 through June 21. According to a CDC review, the February 2020 outbreak at this nursing home led to 81 resident cases and 34 staff cases, as well as 23 deaths.[260] These cases may have been reported to the state or local health department, but they were not reported to CDC.

Status of required targeted infection control surveys. Since March 2020, state survey agencies have been conducting targeted infection control surveys and high priority complaint investigations in nursing homes rather than traditional comprehensive standard surveys and lower priority complaint investigations.[261] States had until July 31, 2020, to complete the targeted infection surveys in all nursing homes or be subject to a corrective action plan and then they had an additional 30 days to complete their surveys to avoid a reduction of their CARES Act supplemental funding.[262] According to CMS, as of July 31, 2020, 15,158 nursing homes (98.5 percent) nationwide had received a targeted infection survey or high priority complaint investigation. Twenty-four state survey agencies had not completed targeted infection surveys in all nursing homes in their state by July 31. Most of these state survey agencies had surveyed 90 percent or more of the nursing homes in their states. Two states—Maryland and Alaska—had surveyed 80 percent or fewer. According to CMS officials, state survey agencies conducting high priority complaint investigations of nursing homes integrated the targeted infection control survey into their evaluation of a home.

Results from targeted infection control surveys. We found that about 3 percent of the nursing homes (342 out of 10,183 homes) receiving targeted infection control surveys or high priority complaint investigations from March 4 through June 28, 2020 had infection control deficiencies.[263]

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[259]In comparison, according to CDC, there were about 4.2 million total COVID-19 cases and 145,982 total deaths across the United States, as of July 26, 2020. It is likely that both the nursing home and total U.S. cases and deaths are underreported.

[260]Centers for Disease Control and Prevention, "COVID-19 in a Long-Term Care Facility—King County, Washington, February 27-March 9, 2020," *Morbidity and Mortality Weekly Report*, vol. 69, no. 12 (2020).

[261]On June 1, CMS issued survey re-prioritization guidance as part of its nursing home reopening strategy. Specifically, once a state enters phase 3—a threshold based on factors including case status in the community and the nursing home, as well as access to testing, PPE, and adequate staffing—state survey agencies were authorized to expand beyond conducting targeted infection control surveys and high priority complaint investigations to include lower priority complaint investigations. Centers for Medicare & Medicaid Services, "COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control Deficiencies, and Quality Improvement Activities in Nursing Homes," QSO-20-31-ALL, (Baltimore, Md.: June 1, 2020).On August 17, CMS revised this guidance to authorize traditional comprehensive standard surveys and lower priority complaint investigations as soon as state survey agencies have the resources, such as staff and PPE. Centers for Medicare & Medicaid Services, "Enforcement Cases Held During the Prioritization Period and Revised Survey Prioritization," QSO-20-35-ALL, (Baltimore, Md.: Aug. 17, 2020).

[262]Centers for Medicare & Medicaid Services, "COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes," QSO-20-31-All, (Baltimore, Md.: June 1, 2020).

[263]At the time of our review, CMS had posted data on the completion status for targeted infection surveys and high priority complaint investigations by state through July 31, 2020. However, the results of these surveys and complaint investigations were only available through June 28, 2020.

This is substantially lower than the trends in infection control deficiencies cited in nursing homes in the years prior to the COVID-19 pandemic. Specifically, our May 2020 report found that approximately 40 percent of surveyed nursing homes had infection control deficiencies in each year from 2013 through 2019.[264] According to CMS officials, there are differences between the administration and structure of the targeted infection control survey and the comprehensive standard survey that may contribute to this trend. For example, according to CMS, a standard survey is usually conducted over 3 to 5 days with a larger team of surveyors, allowing for more time for surveyors to potentially observe deficient practices. In contrast, according to CMS, the targeted infection control survey is a quick spot-check on compliance to ensure the nursing homes have the correct processes and procedures in place, with limited ability for the surveyors to observe and document deficient practices. About 93 percent of the infection control deficiencies from the targeted infection control surveys were classified by surveyors as not severe, meaning the surveyor determined that residents were not harmed. Examples of the infection control deficiencies cited included lack of or incorrect use of PPE, challenges related to identifying and isolating residents diagnosed with COVID-19, and staffing shortages.

PPE challenges. In March 2020, CDC released guidance recommending that nursing home staff wear surgical masks at all times in the home and, when caring for a resident with known or suspected COVID-19, staff should wear an N95 or higher level respirator, eye protection, gloves, and a gown.[265] However, CMS noted that it was aware of a scarcity of PPE in certain areas of the country.[266] From May through August 4, 2020, the Federal Emergency Management Agency (FEMA) coordinated a two-shipment initiative to send a 14-day supply of PPE to all Medicare- and Medicaid-certified nursing homes. In a hearing before the Health Subcommittee of the House Ways and Means Committee on June 25, 2020, an expert witness said that there had been reports from some nursing homes that the PPE received from FEMA was unusable. Further, the witness stated that nursing homes are continuing to face a shortage of PPE, leading them to reuse supplies between residents.[267] FEMA officials acknowledged some issues with the initial round of supplies sent to nursing homes and said that adjustments were made in subsequent rounds.

Concerns about the quality of the FEMA supplies and shortages of supplies were echoed by representatives of national associations representing nursing homes, residents, and their families. According to data nursing homes self-reported to CDC, as of July 26, 2020, about 22 percent of nursing homes reported they did not have a one-week supply of at least one or more of the following: N95 respirators, surgical masks, gloves, eye protection, or gowns.[268] Of these, N95

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[264]See GAO, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic.* GAO-20-576R. Washington, D.C.: May 20, 2020.

[265]Centers for Disease Control and Prevention, "Preparing for COVID-19 in Nursing Homes & Long-Term Care Facilities," March 21, 2020, last updated June 25, 2020, accessed from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

[266]CMS directed state survey agencies not to cite nursing homes for not having certain supplies if they are having difficulty obtaining these supplies for reasons outside of their control. Centers for Medicare & Medicaid Services, "Prioritization of Survey Activities," QSO-20-20-All, (Baltimore, Md.: March 23, 2020).

[267]Examining the COVID-19 Nursing Home Crisis: Hearing Before the Health Subcomm. of the H. Ways and Means Comm., 116th Cong. 2020 (Statement of David Grabowski, Professor, Harvard Medical School).

[268]As of July 26, 2020, about 8 percent of nursing homes reported they had no remaining supplies of at least one or more of the following: N95 respirators, surgical masks, gloves, eye protection, or gowns.

respirators were the most needed, with 17 percent of nursing homes reporting they did not have a one-week supply according to data self-reported to CDC as of July 26, 2020, followed by surgical gowns (12 percent of nursing homes). On August 25, HHS announced the release of 1.5 million N95 respirators from the Strategic National Stockpile for distribution to more than 3,000 nursing homes across the United States.

Testing challenges. As part of its May 2020 reopening guidance for nursing homes, CMS recommended that (1) all staff be regularly screened for symptoms and tested weekly, and (2) all residents be regularly screened and tested if a symptomatic resident is identified or a staff member is diagnosed with COVID-19.[269] Testing plans should also include an arrangement with laboratories to process these tests quickly. There have been reports of nursing homes having difficulty meeting HHS testing recommendations due to challenges obtaining testing supplies and delays receiving results in a timely manner. Because of this, homes have struggled to identify infected residents and staff and isolate them from one another. This is particularly true of identifying asymptomatic carriers of the disease, who may show no symptoms; therefore, screening for symptoms alone without the use of a diagnostic test would fail to identify them.

On July 14, 2020, HHS announced plans to distribute antigen diagnostic tests and associated point-of-care testing instruments to nursing homes in COVID-19 hotspots across the country to help identify and prevent the spread of COVID-19 through rapid, on-site testing.[270] After the initial distribution of these antigen diagnostic tests and instruments, nursing homes are responsible for procuring additional tests directly from the manufacturer. CMS notes that, while positive results from an antigen test confirm the presence of a SARS-CoV-2 infection, negative results from these antigen tests should be treated as presumptive, do not rule out SARS-CoV-2, and these negative results should not be used as the sole basis for treatment or patient management decisions, including infection control decisions.[271] In addition, CMS recommends that negative results should be confirmed with an alternate form of testing, such as a molecular diagnostic viral test.[272] According to HHS, as of September 3, 2020, 9,894 nursing homes had received 2,952,850 tests and 10,637 testing instruments.

On August 25, 2020, HHS, through CMS, released an interim final rule revising its regulations to require that nursing homes test all staff and residents for COVID-19 as part of their requirements for the Medicare and Medicaid programs.[273] CMS later released guidance on these testing requirements, noting that nursing homes should prioritize testing staff and residents with symptoms of COVID-19 first, followed by performing testing of all staff and residents in the case

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[269]Centers for Medicare & Medicaid Services, "Nursing Home Reopening Recommendations for State and Local Officials," QSO-20-30-NH, (Baltimore, Md.: May 18, 2020). Also see Centers for Disease Control and Prevention, "Testing Guidelines for Nursing Homes," June 25, 2020, update accessed July 27, 2020 https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

[270]The antigen viral test detects the presence of a protein that is part of SARS-CoV-2, the virus that causes COVID-19, and SARS-CoV.

[271]CMS, *Frequently Asked Questions: COVID-19 Testing at Skilled Nursing Facilities/Nursing Homes,* https://www.cms.gov/files/document/covid-faqs-snf-testing.pdf, accessed August 7, 2020.

[272]A molecular diagnostic viral test detects the presence of genetic material from SARS-CoV-2.

[273]Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; 85 Fed. Reg. 54820 (Sep. 2, 2020) (to be codified at 42 C.F.R. § 483.30(h)).

of an outbreak. The CMS guidance also requires routine staff testing based on the degree of community spread, ranging from testing staff once a month in counties with low community spread to twice a week in counties with high community spread.[274] CMS does not require residents to be routinely tested—including asymptomatic residents; however, the nursing home must test residents if they display symptoms or in the event of a COVID-19 outbreak in the nursing home.[275]

Staffing challenges. Research has established that higher nurse staffing levels are typically linked with higher quality nursing home care. However, staffing shortages in nursing homes have become exacerbated by the spread of COVID-19. For example, a nursing home cited for deficiencies in its targeted infection control survey had 24 staff who became sick and were unable to work. These concerns were echoed by representatives of national associations representing nursing homes, residents, and their families, noting that nursing homes are struggling to find enough staff to replace those who are out sick or do not have child care. According to representatives from a national association, some nursing homes are using alternative staffing models, such as hiring temporary employees to work as nurse aides and care for residents.[276] According to data nursing homes self-reported to CDC, as of July 26, 2020, 18 percent of nursing homes reported a shortage of aides, about 16 percent reported a shortage of nursing staff, 9 percent reported a shortage of other staff, and 2 percent reported a shortage of clinical staff.

GAO Methodology and Agency Comments

To conduct this work, we reviewed CMS and CDC data, agency guidance, and other relevant information on HHS's response to the COVID-19 pandemic. We also spoke to CMS and CDC officials, as well as representatives from national organizations representing nursing homes, residents, and their families, and researchers with experience in nursing home infection control. In addition, we analyzed CMS data on targeted infection control surveys and complaint investigations conducted in nursing homes, which included data from March 4, 2020, through June 28, 2020, and CDC data on COVID-19 reported by nursing homes for the week ending July 26, 2020.[277] We

[274]Low community spread is defined as a county positivity rate in the past week of less than 5 percent, medium community spread is defined as a county positivity rate in the past week of 5 to 10 percent, and high community spread is defined as a county positivity rate in the past week of greater than 10 percent. In areas of medium and high community spread, the frequency of testing presumes availability of point-of-care testing on-site at the nursing home or where off-site testing turnaround time is less than 48 hours.

[275]In the event of an outbreak, all staff and residents must be tested. CMS notes that routine testing of asymptomatic residents is not recommended unless prompted by a change in circumstances, such as identification of a COVID-19 case in the facility. In addition, nursing homes may consider testing residents who leave the facility frequently, such as for dialysis or chemotherapy.

[276]In March 2020, CMS waived the requirement that a nursing home not employ anyone for more than 4 months unless they meet certain training and certification requirements to address potential staffing shortages in nursing homes due to the COVID-19 pandemic.

[277]The CMS targeted infection control and complaint surveys were accessed on August 10, 2020, from https://www.cms.gov/files/zip/nursing-home-infection-control-surveys.zip. The CDC data on COVID-19 in nursing homes were accessed on August 10, 2020, for the week ending July 26, 2020, from https://data.cms.gov/Covid19-nursing-home-data.

analyzed the CDC data as they were reported by nursing homes to CDC. We did not otherwise independently verify the accuracy of the information with these nursing homes. We assessed the reliability of the datasets used in our analyses by checking for missing values and obvious errors and reviewing relevant CMS and CDC documents. We determined the data were sufficiently reliable for the purposes of our reporting objective.

We provided HHS and the Office of Management and Budget (OMB) with a draft of this enclosure. HHS provided technical comments, which we incorporated as appropriate. OMB did not have comments on this enclosure.

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Related GAO Products

Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic. GAO-20-576R. Washington, D.C.: May 20, 2020. [278]

For the data on COVID-19 in nursing homes, we analyzed and reported data that had been determined by CDC to pass quality assurance checks.

[278]This report is our most recent analysis of CMS nursing home infection prevention and control deficiency data, part of a broader GAO body of work examining oversight of nursing homes including ongoing work examining HHS actions to address COVID-19. For brief summaries of some GAO reports more generally on the health and welfare of the elderly in nursing homes and other settings since 2015, including any recommendations, see *Nursing Homes: Better Oversight Needed to Protect Residents from Abuse*, GAO-20-259T, (Washington, D.C.: Nov. 14, 2019).

Medical Supply Chain

The lack of domestic medical supplies combined with a supply chain that was overwhelmed by the demands of the global pandemic prompted numerous federal and state actions to stabilize the supply chain and increase inventories; however, there continue to be ongoing constraints around certain types of personal protective equipment and continued testing supply shortages.

Entities involved: Department of Defense; Department of Health and Human Services including its Office of the Assistant Secretary for Preparedness and Response; Federal Emergency Management Agency

Key Considerations and Future GAO Work

In response to the unprecedented national crisis caused by COVID-19, numerous federal actions were taken to improve the availability of critical medical supplies needed to protect the health and well-being of Americans. These actions included expediting critical medical supplies from overseas, enhancing visibility over the commercial medical supply chain, leveraging interagency acquisition partnerships, and using authorities, such as the Defense Production Act (DPA), to increase domestic supply production.[279]

Nevertheless, supply of some types of personal protective equipment (PPE) remain constrained and shortages of testing supplies, including substances needed to process COVID-19 tests—known as reagents—persist. Although the federal government continues to provide PPE and testing supplies to state, local, tribal, and territorial governments, as well as to health care facilities, we found that the Department of Health and Human Services (HHS) and Federal Emergency Management Agency (FEMA) have not developed and communicated plans to address remaining medical supply gaps, including through the use of DPA authorities. As such, we are recommending that HHS, in coordination with FEMA, further develop and communicate to stakeholders plans outlining specific actions the federal government will take to help mitigate remaining medical supply gaps necessary to respond to the remainder of the pandemic, including through the use of Defense Production Act authorities.

We also found that many medical supply management responsibilities that have been shared between multiple agencies are now transitioning to HHS. Although HHS has been a partner in many of these efforts, this level of responsibility may require continued support from HHS's federal partners to sustain the progress made to date for the duration of the pandemic. Transition planning efforts are underway, but have not yet culminated in a written plan. As such, we are recommending that HHS and FEMA immediately document roles and responsibilities for supply chain management functions transitioning to HHS, including continued support from other federal partners.

[279] Enacted in 1950, the DPA helps ensure the availability of industrial resources to meet national defense needs. See Pub. L. No. 81-774, 64 Stat. 798 (1950) (codified, as amended, at 50 U.S.C. §§ 4501 et seq.). Over time, the scope of the DPA has been expanded to include certain emergency preparedness activities and critical infrastructure protection and restoration.

We reported in June 2020 about concerns related to the distribution, acquisition, and adequacy of supplies during the COVID-19 response, including from the Strategic National Stockpile (SNS), as well as the use of the DPA for the purpose of increasing the availability of medical supplies. We are conducting a comprehensive body of work on the SNS, including efforts to modernize it, in response to the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 and the CARES Act.[280]

We also have ongoing work related to federal agencies' use of DPA authorities as a tool to obtain needed medical supplies and expand domestic production of these items. Additionally, we are examining overseas manufacturing of critical pharmaceutical products purchased by federal agencies and the extent to which federal efforts exist to overcome barriers to domestic drug manufacturing. Finally, we will continue to conduct work examining HHS and its agencies' ongoing roles with regard to COVID testing.

Background

The nationwide need for critical supplies to respond to COVID-19 quickly exceeded the quantity contained in the SNS, which is managed by the Office of the Assistant Secretary for Preparedness and Response (ASPR), within HHS. To help address the shortages of supplies and manage the multiple dimensions of the supply chain, FEMA and the Department of Defense (DOD) established the Supply Chain Advisory Group (Advisory Group) and Joint Acquisition Task Force (JATF), respectively.[281] Both were created days after FEMA assumed responsibility for the federal response on March 19, 2020.

- The Advisory Group was tasked with maximizing the nationwide availability of PPE, ventilators, and other material. In response, Advisory Group officials said they focused on four key supply activities: helping preserve existing supplies; accelerating the delivery of supplies; expanding the availability of supplies; and gathering data to help allocate scarce supplies.
- The JATF was established to support the acquisition needs of federal agencies in their public health response activities and provide access to DOD's acquisition capabilities, tools, and skill sets. For example, the JATF provided acquisition specialists that conducted market research for specific PPE, such as N95 respirators, and provided recommendations to HHS on acquisition strategies.

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[280]Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019, Pub. L. No. 116-22, § 403(a)(5), 133 Stat. 905, 946-47; CARES Act, Pub. L. No. 116-136, § 19010, 134 Stat. 281, 579-81 (2020).

[281] As of June 15, 2020, the Supply Chain Task Force became the Supply Chain Advisory Group. We refer to both as the Advisory Group. Both are part of FEMA's National Response Coordinating Center, which is the hub for coordinating actions and resources across federal agencies, and are led by Rear Admiral John Polowcyzk, an expert in logistics planning and execution, on detail from DOD's Joint Chiefs of Staff. According to DOD, the Supply Chain Task Force was the primary federal body coordinating and managing supply chain responsibilities. In contrast, the Advisory Group has an advisory and assistance role, focused on transitioning responsibilities to other federal stakeholders. The JATF was part of DOD's COVID-19 response and was available to support other agencies, such as FEMA and HHS, as needed.

The four relief laws enacted to assist the COVID-19 response as of September 1, 2020, appropriated funding for HHS activities that could include, but were not limited to, the SNS.[282] As of July 31, 2020, HHS reported it obligated almost $8.4 billion of the $10.7 billion it planned to use for the SNS to purchase PPE and ventilators for immediate use as well as to replenish SNS inventory, among other purposes, and had expended $1.8 billion.[283]

Overview of Key Issues

In the face of shortages of critical supplies, health care systems in some U.S. communities were put under severe strain and required assistance from the federal government to stabilize the medical supply chain. Several federal actions were implemented to immediately attempt to re-supply the U.S. health care system with needed PPE and critical supplies.

As the response has progressed, the key federal agencies involved—FEMA, HHS, and DOD—have begun to focus on intermediate goals, such as increasing domestic manufacturing capacity and rebuilding the SNS to better position the U.S. to respond to continuing COVID-19 outbreaks and future emergencies. In addition to federal efforts to stabilize the supply chain, states also have been building their own stockpiles of critical supplies; however, concerns regarding certain supply shortages remain.

Responding to immediate needs. In March 2020, the Advisory Group established a public-private partnership with the commercial medical supply sector to address the nation's immediate need for critical supplies, according to an Advisory Group official. As we reported in June 2020, one of the Advisory Group's first efforts was to expedite critical supplies from overseas manufacturers to the United States through Project Air Bridge in collaboration with six large U.S medical supply distributors. This program continued through June 2020 and, according to FEMA, will be restarted if needed. In June 2020, the head of the Advisory Group testified that the prioritization scheme for supplies was public hospitals, Department of Veterans Affairs' facilities, private hospitals, and nursing homes.

In addition, as of August 15, 2020, HHS and FEMA used DPA Title I authorities to place priority ratings on at least 18 contracts from March through May 2020 to acquire ventilators, N95 respirators, and other face coverings. Most types of items were scheduled to be delivered by August 31, 2020. DPA Title I authorities require the contractor (and the contractor's supply chain) to provide preferential treatment to fulfill the delivery requirements of the rated contract or order.

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[282]As of September 1, 2020 the four relief laws enacted to assist the response to COVID-19 were the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, 134 Stat. 146; Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020); CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); and Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020).

[283]In June 2020, based on information from HHS, we reported that the department planned to use $16.7 billion to purchase PPE and ventilators for immediate use as well as to replenish SNS inventory, and to purchase supplies to expand testing for COVID-19, among other purposes. However, in August 2020, HHS revised that information, reporting that $10.7 billion would be used for the SNS. ASPR officials told us in August 2020 that $6 billion was reallocated for Operation Warp Speed and that they were unable to spend $1 billion of the initial $16.7 billion.

As of September 1, 2020, the federal response had provided approximately 92.4 million N95 respirators, 28.1 million non-surgical gowns, 79.7 million gloves, 228.4 million face masks, as well as other PPE to state, tribal, and territorial entities according to federal data provided in a COVID-19 senior leadership brief. In addition, according to HHS's Daily Communications Report dated September 10, 2020, the federal government had distributed over 95 million swabs and 76 million units of test tubes and transport media (solution for transporting viral material to keep samples viable for testing) to states.

Expanding domestic supply. DOD officials testified in June 2020 that understanding the demand for PPE and critical supplies is a critical component for adding domestic manufacturing capacity as demand projections provide an incentive for manufacturers to begin or ramp up production.[284] The head of the Advisory Group testified in June 2020 that he was working to aggregate overall demand by gathering information from a variety of sources, including interagency partners and states.

Advisory Group and JATF officials testified in June 2020 that the United States would soon be producing certain supplies domestically at quantities sufficient to meet demand. For example, according to a JATF official, in 2021, the United States would produce in excess of one billion N95 respirators a year. However, the head of the Advisory Group testified that other supplies—such as nitrile gloves—will take longer to produce domestically due to a limited U.S. manufacturing base.

The Advisory Group and others have continued efforts to increase the domestic production of supplies. For example, as of August 15, 2020, DOD has used DPA Title III authorities and other funds to award about $627 million on 17 projects to expand domestic production of medical (including testing) supplies, such as N95 respirators, testing kits, and swabs.[285]

Rebuilding federal and state stockpiles. Overall responsibility for rebuilding the SNS belongs to ASPR. In a May 2020 information request to solicit industry feedback on restructuring the SNS, HHS asked for information on managing inventory, maintaining adequate reserves, and enhancing domestic manufacturing, among other things.[286]

Interagency work plans from June 2020 also note that HHS will be developing a comprehensive SNS strategy as well as working to replenish the SNS. ASPR officials told us that by September 2020 they will have preliminary recommendations for modernizing the SNS, to include defining the optimal strategy related to pandemic preparedness and response. ASPR officials have also commented that they intend to build a 90-day supply of N95 respirators, gloves, ventilators and other equipment in the SNS.

ASPR officials told us in late July 2020 that they deferred delivery of supplies to the SNS to ensure they were commercially available. As a result, the SNS has only recently begun accumulating some

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[284]The responsibility for understanding the demand for PPE and critical supplies currently resides with the Advisory Group, but is being transitioned to HHS, according to Advisory Group officials.

[285]DPA Title III authorities enable DOD to provide financial incentives to private companies to increase production capabilities for critical security needs.

[286]U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, *Request for Information – Strategic National Stockpile* (Washington: D.C. May 15, 2020).

supplies. The speed at which ASPR will be able to build a 90-day supply of PPE will depend on demand, such as whether there is another surge in COVID-19 cases.

Although ASPR officials said that the delivery of supplies to the SNS will soon increase, they noted that they are trying to reach the 90-day supply levels without exacerbating a constrained supply chain. As of July 30, 2020, the SNS was still in the process of replenishing its inventory, according to ASPR officials. See table below for a comparison of SNS inventory against planned inventory levels.[287]

[287] The SNS will also stockpile certain testing supplies including nasal swabs (54 million), sample tubes (36 million), transfer media (36 million), pipettes (36 million) and pipette tips (36 million), according to HHS's COVID-19 Strategic Testing Plan. The COVID-19 Strategic Testing Plan notes that the planned inventory amounts are estimated based on the assumption that 12 million tests would be completed per month for testing supplies.

Strategic National Stockpile Inventory of Certain Supplies		
Supply	**Planned 90-day inventory**	**Inventory on hand as of July 15, 2020**
Personal protective equipment		
Gloves	4.5 billion	1 million
N95 respirators	300 million	38 million
Surgical or procedural masks	400 million	8 million
Gowns or coveralls	265 million	1.2 million
Eye protection or face shields	18 million	1.2 million

Source: Department of Health and Human Services (HHS). | GAO-20-701

Note: Planned 90-day inventory of personal protective equipment (PPE) are from HHS officials. Assistant Secretary for Preparedness and Response officials told us they based the PPE inventory targets on peak usage rates of PPE since the start of the COVID-19 response.

In addition to federal efforts to stabilize the supply chain, states have also been building their own stockpiles of critical supplies. The head of the Advisory Group told us in August 2020 that most states have at least a 60 day supply of PPE in their state health warehouses. Officials in all eight states we spoke with noted plans for a state stockpile of supplies; however, these stockpiles were in various stages of completion (see table below).

Officials in two states noted that they have to balance the effort of building a stockpile against other factors, such as the immediate need for supplies across the state or the ability to find sufficient warehouse space to store that quantity of supplies. Additionally, several states noted that building state stockpiles is complicated by not knowing what they can expect from the SNS in the future. One state official noted that there needs to be a realistic conversation with the SNS about what is expected of states, especially if the SNS is stockpiling huge quantities of inventory.

Selected State Inventories of Personal Protective Equipment		
State	**Approximate Inventory Target**	**Progress**
State A	Planned but target not determined	#
State B	30-day or less	#
State C	30-day	◒
State D	30 to 90 day	#
State E	90-day	#
State F	90-day	#
State G	90-day	#
State H	180-day	#

Legend:
State officials noted an existing stockpile that was at target for planned inventory amounts for most personal protective equipment (PPE).
◒ State officials noted an existing stockpile that still needed several items of PPE to get to the target planned inventory amounts.
State officials are planning a stockpile but are facing challenges with implementation such as acquiring PPE, finding space, or providing PPE to communities.

Source: State officials as of July and August 2020. | GAO-20-701

States, providers, and other stakeholder groups have identified ongoing constraints around certain types of PPE.

- Seven of eight state officials we interviewed in July and August 2020 noted that the situation related to PPE had improved since earlier in the response, but they noted continuing challenges in obtaining some types of PPE. For example, officials from one of the eight states we interviewed told us they are unable to fulfill local entities' requests for N95 respirators and nitrile gloves, but have sufficient supply of other items, such as face shields. Another state noted that they have a good inventory of most PPE but continue to wait on commercial orders for gloves, which they expect to start receiving soon. Additionally, two states' officials expressed concern about the uncertain path of the virus and the impact of a fall surge on supply availability.

- Although FEMA coordinated the delivery to nursing homes of a 14-day supply of gloves, surgical masks, gowns, and eye protection from May through July 2020, some nursing homes reported low inventories of supplies in July 2020. Specifically, according to data nursing homes self-reported to the Centers for Disease Control and Prevention (CDC), as of July 26, 2020, about 22 percent of nursing homes did not have a one-week supply of at least one or more of the following: N95 respirators, surgical masks, gloves, eye protection, or gowns.

- The American Nurses Association surveyed both members and non-members in late July and early August about their PPE experiences over the prior two weeks. Their results found that 88 percent of the over 14,000 responding nurses reported being required or encouraged to

reuse single-use N95 respirators. For those who reported reusing N95 respirators, 62 percent expressed concerns about their safety as a result.

- Additionally, the biggest obstacle to physicians reopening their practices is "ongoing shortages of PPE, especially N95 respirators and gowns," according to a June 30, 2020, American Medical Association letter to the Vice President.

Testing supply shortages persist, according to state officials we interviewed. Officials at seven of eight states we spoke with in July and August 2020 identified ongoing shortages of testing supplies. For example, officials in one state noted that while they are currently well positioned to meet the demand for PPE, testing supplies continue to be in short supply, noting particular challenges in obtaining reagents.

Officials in several states identified difficulty with acquiring reagents or test kits from the commercial market, and one state noted that challenges in obtaining testing supplies have grown with the increase in testing demand across the country. In a July 13, 2020, letter to the Vice President, who leads the White House Coronavirus Task Force, members of the Arkansas Congressional delegation said hospitals in their state have had to limit their COVID-19 testing to 10 percent of full capacity due to a shortage of reagents.. Additionally, officials from the Association of Public Health Laboratories we interviewed noted that their members generally do not have enough supplies on hand—such as transport media—to absorb rapid surges in testing demands.

Federal officials acknowledged certain, ongoing supply challenges, but also provided their own perspectives on the issue. For example, ASPR officials noted that "shortages" are subjective and depend upon numerous factors, including the amount and target number of days of supplies a state or hospital has determined to stockpile. Additionally, FEMA and ASPR officials noted that state, local, tribal, and territorial governments have overestimated their needs for supplies, which may lead to the impression that the federal government is not being responsive to open requests. FEMA officials noted that resource requests are an ongoing discussion to determine what is really needed and what can be supplied.

HHS and FEMA continue to announce activities that may help alleviate supply chain challenges faced by state, local, tribal, and territorial governments, as well as to health care facilities—such as renegotiating federal PPE contracts so that supplies would be available commercially or for direct shipment of point-of-care testing devices and kits to nursing homes. However, until HHS and FEMA develop and communicate to stakeholders plans outlining specific actions the federal government will take to help mitigate remaining medical supply gaps, uncertainty will persist regarding whether the federal response will align with needs. It will be especially important to develop and communicate plans before the fall, when the United States will move into flu season and a possible uptick in COVID-19 cases, both of which could further disrupt supply availability. Additionally, it is critically important that HHS and FEMA work with their federal partners to define roles and responsibilities for managing the medical supply chain to sustain supply chain progress. Until HHS and FEMA work with their federal partners to immediately document roles and responsibilities for supply chain management functions transitioning to HHS, they risk losing the momentum and expertise developed up to this point in the response. Additionally, without clearly defined roles and responsibilities, the federal response structure may be unable to respond to new supply chain challenges that could emerge.

GAO Methodology and Agency Comments

To understand the federal efforts to stabilize the medical supply chain, we reviewed information contained in interagency senior leadership briefs as well as both the oral and written congressional testimony of key federal officials. The information in this enclosure highlights examples of distribution and acquisition actions that these entities took; it is not an exhaustive list.

We also analyzed data on nursing home PPE levels from CDC data on COVID-19 reported by nursing homes for the week ending July 26, 2020. We did not otherwise independently verify the accuracy of the information with these individual nursing homes. We assessed the reliability of the datasets used in our analyses by checking for missing values and obvious errors and reviewing relevant CDC documents. We determined the data were sufficiently reliable for the purposes of our reporting objective.

We also selected eight states—California, Colorado, Idaho, Massachusetts, Nebraska, New Jersey, New Mexico, and South Carolina—to interview in July and August 2020 based on a variety of criteria including a range of COVID-19 case counts per capita, regional diversity, and participation in Crimson Contagion, a recent large-scale influenza exercise, among other things. In each of these states, we spoke with, or received written responses from, senior officials in the departments of health, emergency management, or both. In addition, we obtained written responses and interviewed officials from HHS, FEMA, DOD, and the Advisory Group—due to their significant role in federal supply acquisition and distribution efforts—about agency actions to increase supply, including contracting decisions, and how they made distribution decisions.

We provided HHS, Department of Homeland Security (DHS), DOD, and the Office of Management and Budget (OMB) with a draft of this enclosure. There were no comments on the enclosure. HHS and DHS provided general comments which are summarized in the Agency Comments and Our Evaluation section of this report.

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COVID-19 Testing Data

On June 4, 2020, the Department of Health and Human Services required laboratories to begin reporting data on each COVID-19 test by August 1, 2020. Since this requirement was issued, the department's agencies have taken steps to improve testing data, but they acknowledged ongoing challenges to collecting complete and consistent data.

Entities involved: Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, Food and Drug Administration, Office of the Assistant Secretary for Health, and National Institutes of Health, all within the Department of Health and Human Services.

Key Considerations and Future GAO Work

Department of Health and Human Services (HHS) agencies have taken steps to improve COVID-19 testing data that laboratories are required to report, but laboratories have faced challenges meeting the deadline to report these data. On June 4, 2020, HHS published guidance that required laboratories to begin reporting detailed testing data to the Centers for Disease Control and Prevention (CDC) through state or local health departments by August 1, 2020. However, not all states had fully developed the capability to report these data to CDC as of August 24, 2020, and CDC officials acknowledged that not all laboratories were able to fully develop information systems to report testing data by the deadline to begin reporting.

CDC reported that as of August 24, 2020, 40 of 56 states and territories had fully developed the capability to relay these detailed testing data to CDC. HHS's Office of the Assistant Secretary for Health (OASH) confirmed that laboratories and other stakeholders—such as health care providers who order tests—required additional guidance and technical assistance to help ensure complete and consistent testing data are collected and reported. HHS and CDC have taken some steps to address certain challenges identified by stakeholders by publishing implementation specifications and conducting outreach. As we reported in June 2020, the absence of complete and consistent COVID-19 testing data has made it more difficult to track the infection rate, mitigate the effect of infections, and inform decisions on reopening communities.

We will continue to conduct work examining HHS and its agencies' ongoing roles with regard to testing data. This will include an examination of activities and challenges to collect complete and consistent testing data. In addition, we are recommending actions CDC should take to help ensure the complete and consistent collection of data on race and ethnicity under its COVID-19 Response Health Equity Strategy, which addresses testing and other data.

Background

COVID-19 testing can detect the presence of the virus that causes COVID-19 (known as viral tests) or antibodies produced in the bodies of patients who have had COVID-19, even if they did not show symptoms (known as antibody tests). Federal guidelines recommend that communities

use testing data, particularly the total number of viral tests performed for COVID-19 and the percentage of viral tests with positive results, to make decisions about reopening communities. The CDC—the official federal source for reporting testing data—has received testing data provided by state and jurisdictional health departments, which, in turn, received these data from laboratories.

The CARES Act included a provision requiring laboratories to submit the result of each COVID-19 test to the Secretary of Health and Human Services in a manner specified by the Secretary.[288] As previously reported, HHS issued guidance, pursuant this authority, on June 4, 2020, requiring laboratories performing COVID-19 tests to submit detailed testing data that go beyond what HHS had previously requested. The laboratories must include data on the specific type of test used and patient demographics, such as race and ethnicity.

Overview of Key Issues

Since HHS published its June 4, 2020, guidance requiring laboratories to report COVID-19 testing data, HHS agencies have taken steps to address challenges that we have identified to help ensure these data are complete and consistent. HHS directed laboratories to report testing data through existing channels to state and jurisdictional health departments, which provide these data to CDC. CDC has worked with these health departments to obtain data on each individual test that is reported by laboratories, including information about the patient, type of test, and test result.

As of August 24, 2020, 40 of 56 state and territorial jurisdictions—which account for approximately 75 percent of testing nationwide—have developed the capability to report this detailed information for individual tests to CDC, and the remaining 16 jurisdictions had begun working with CDC to do so, according to CDC. These 16 jurisdictions include both small and large states, states located across geographic regions, and states with large populations of racial or ethnic groups that have been disproportionately affected by COVID-19, such as California and Oklahoma.[289] Obtaining this detailed information on each test from states and territories can help CDC differentiate viral and antibody testing data, which we previously identified as an inconsistency in CDC's reporting of testing data.[290] It also can help CDC determine the extent to which laboratories include all required information in the testing data they report.

Laboratory stakeholders identified additional challenges to reporting complete and consistent COVID-19 testing data. CDC officials acknowledged that not all laboratories were able to fully develop information systems to report testing data by the August 1, 2020, deadline, but HHS agencies have taken steps to address certain challenges. Laboratory and health care provider

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[288]Pub. L. No. 116-136, § 18115, 134 Stat. at 574.

[289]The 16 jurisdictions that had not fully developed the capability to report detailed testing data to CDC as of August 24, 2020, included California, Delaware, District of Columbia, Maine, Mississippi, Missouri, North Dakota, Northern Marianas, Ohio, Oklahoma, Puerto Rico, Rhode Island, Tennessee, Virgin Islands, Washington, and Wyoming.

[290]As of August 21, 2020, CDC's COVID Data Tracker website excluded antibody tests from its testing data.

associations we contacted identified the following key challenges that laboratories faced in meeting the August 1, 2020, deadline for compliance.

- **Adopting standard definitions of testing data.** Laboratory stakeholders sought to clarify with HHS the standard definitions for testing data to help ensure laboratories collected and reported consistent testing data. CDC has collaborated with stakeholders to publish standard definitions for newly requested information, such as codes that identify the specific COVID-19 tests that have been authorized. On July 14, 2020, CDC and OASH acknowledged that additional guidance to clarify standard definitions for required testing data will be needed and provided evidence of CDC's and the Food and Drug Administration's (FDA) work with stakeholders to develop and implement this guidance. On July 31, 2020 – one day before the August 1, 2020, deadline for laboratories to begin reporting testing data – HHS published implementation specifications with standard definitions for all the information that should be included in testing data. [291]

- **Modifying information systems to collect and report testing data as required.** According to one laboratory association we spoke with, some laboratories have made changes to their information system's infrastructure to meet the requirement to provide testing data. However, others struggled to meet the requirement's August 1, 2020, deadline. Laboratories may exchange testing data with numerous health care providers and state public health agencies, which can require multiple updates to multiple data systems to meet the new requirements. For example, a laboratory association we contacted explained that one laboratory performs tests for more than 200 separate clinics, and each clinic orders tests through a unique electronic health records system.
  Some laboratories have developed the technical capability to report testing data electronically, including the 50 state public health laboratories, according to a laboratory association we spoke with. However, laboratory associations told us that some laboratories are new to reporting public health data and may make additional changes to information systems after the August 1, 2020, deadline to fully comply with reporting requirements, according to laboratory associations.

- **Obtaining required testing data from health care providers who order tests.** In addition to laboratories, health care providers play key roles in collecting and reporting complete and consistent testing data. Health care providers collect testing samples from patients and collect data that accompany the testing orders they send to laboratories, such as patients' race, ethnicity, age, and zip code. However, if health care providers do not obtain this information, the information will remain missing from testing data unless it can be obtained through additional communication with these providers or from other sources, such as state or regional health information exchanges.
  Laboratory associations we contacted emphasized the importance of educating health care providers to collect required data from patients when collecting testing samples in order to comply with reporting requirements. However, representatives from provider groups told us that updating electronic health records to capture the newly requested data when ordering COVID-19 tests will be challenging because these data systems require significant effort to

[291] Department of Health and Human Services, *COVID-19 Lab Data Reporting Implementation Specifications*, (July 31, 2020), accessed Aug. 17, 2020 at https://www.hhs.gov/sites/default/files/hhs-guidance-implementation.pdf.

update. CDC has conducted outreach to provider organizations such as the American Medical Association to offer education and assistance on collecting testing data, and OASH confirmed on July 14, 2020, that ongoing support for health care providers will be needed to help ensure complete and consistent collection and reporting of testing data.

To improve consistency and uniformity in the reporting of testing data, on September 2, 2020, the Centers for Medicare & Medicaid Services (CMS) published an interim final rule that provides sanctions for laboratories that fail to report COVID-19 testing data consistent with the form and manner specified by HHS. In the preamble to this rulemaking, CMS acknowledged that it did not know the complete universe of laboratories conducting COVID-19 tests. However, the rule required accrediting organizations and states that evaluate laboratories to notify CMS within 10 days after identifying a laboratory that fails to report COVID-19 test results as required, and this may help to identify laboratories that have conducted COVID-19 tests but not reported results. Further, the interim final rule imposes sanctions on laboratories that fail to comply, which may include civil monetary penalties.[292]

Looking forward, HHS agencies have identified challenges collecting testing data that may arise as testing technology evolves, and they reported steps to address these challenges. Specifically, the CARES Act requirement for laboratories to submit data would not apply to any tests entirely performed in non-laboratory settings such as at home, according to OASH, because laboratories would not be involved. The FDA has not authorized any of these non-laboratory COVID-19 tests as of September 1, 2020, but the National Institutes of Health (NIH) and FDA are working to facilitate the development and authorization this technology.[293] FDA has asked developers of non-laboratory tests to indicate in their applications for emergency use authorization whether test results will be shared with CDC. The NIH's Rapid Acceleration of Diagnostics Tech initiative, which aims to accelerate the availability of tests in non-laboratory settings and other tests, is evaluating options to transmit data from these tests to HHS, according to OASH.

GAO Methodology and Agency Comments

To conduct this work, we obtained information from CDC, FDA, and OASH officials on steps taken to collect and improve the quality of testing data since we last reported in June 2020, and we reviewed HHS agency guidance related to states' and laboratories' submission of testing data. Further, we interviewed or obtained written responses from laboratory and health care provider associations whose members have a primary responsibility for collecting testing data to obtain their perspectives on agency actions and challenges with regard to testing. These groups included the American Clinical Laboratory Association, Association of Public Health Laboratories, National Independent Laboratory Association, American Medical Association, American College of

[292]See 85 Fed. Reg. 54,820, 54,826, 54,873 (Sep. 2, 2020) (preamble, II.C.; codified in pertinent part at 42 C.F.R. §§493.41, .555(c)(6), .1100(a), .1804(c)(1), .1834(d)(2)(iii)).

[293]In contrast to tests performed entirely in non-laboratory settings, FDA has authorized the collection of samples at home to be sent to laboratories for COVID-19 testing. Laboratories are required to report data for these tests.

Emergency Physicians, and the American Hospital Association. We selected these groups because they represent specialty and non-specialty front-line health care workers, and commercial, clinical, and public health laboratories that, collectively, have performed tens of millions of COVID-19 tests. We provided HHS and the Office of Management and Budget (OMB) with a draft of this enclosure. HHS provided technical comments on this enclosure, which we incorporated as appropriate. HHS also provided general comments, which are summarized in the Agency Comments and Our Evaluation section of this report. OMB did not provide comments on this enclosure.

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Vaccines and Therapeutics

Many challenges associated with efforts to develop and manufacture COVID-19 vaccines and therapeutics need to be overcome. It is also of paramount importance to have clarity on planning for their distribution and administration, as well as timely, clear, and consistent communication to states and the public about their availability, efficacy, and safety.

Entities involved: Department of Defense; Department of Health and Human Services, including its Biomedical Advanced Research and Development Authority, Centers for Disease Control and Prevention, Food and Drug Administration, and National Institutes of Health; and the Department of Veterans Affairs

Key Considerations and Future GAO Work

Since June 2020, we have identified the critical importance of planning for the development, distribution, and administration of COVID-19 vaccine(s), as well as timely, clear, and consistent communication to states and local health officials, stakeholders, and the public about vaccine availability, efficacy, and safety. This includes identifying and defining the roles and responsibilities of federal agencies (including the Department of Health and Human Services (HHS) and the Department of Defense (DOD)); private sector industry (such as distributors); state and local public health officials; and health care providers (such as pharmacists).

The federal government has taken some steps to begin determining how vaccine—when available—may be distributed, including which groups may have priority and how it might be allocated and administered. For example, the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices has convened a COVID-19 work group and is expected to make recommendations on groups for vaccine prioritization to CDC and HHS leadership. Through Operation Warp Speed—a partnership between DOD and HHS, including HHS's Biomedical Advanced Research and Development Authority (BARDA), CDC and the National Institutes of Health (NIH)—DOD is supporting HHS in developing plans for nationwide distribution and administration of any licensed or authorized vaccine. However, as of September 4, 2020, HHS had not documented or shared its distribution and administration plans, being developed with support from DOD, with relevant stakeholders or the public.

To facilitate distribution and administration of any licensed or authorized COVID-19 vaccine, we recommend the Secretary of Health and Human Services, with support from the Secretary of Defense, establish a time frame for documenting and sharing a national plan for distributing and administering COVID-19 vaccine. We recommend they ensure that such a plan is consistent with best practices for project planning and scheduling and outlines an approach for how efforts will be coordinated across federal agencies and nonfederal entities. On September 16, 2020, HHS and DOD released two documents outlining a strategy for any COVID-19 vaccine. GAO will evaluate these documents and report on them in future work.

Representatives of state, local, and territorial health officials, immunization managers, and health care providers we interviewed emphasized the need for the federal government to develop and share plans for the distribution and administration of vaccine before one becomes available, so

they have sufficient lead-time to prepare to vaccinate their communities. They noted advanced planning will be needed to develop and disseminate clear public health messaging to help ensure public acceptance and uptake of the vaccine. It will be important to address vaccine hesitancy for people concerned about the safety or effectiveness of the vaccine and to manage expectations about vaccine availability, according to representatives of state, local, and territorial health officials, and immunization managers. These representatives and we have previously noted that experience with the 2009 H1N1 pandemic taught that announcements about when vaccine might be available need to include careful phrasing to manage public expectations and take into account likely delays or changes in expected availability.

We will continue to conduct work related to vaccines and therapeutics, including examining federal efforts to accelerate the development, manufacturing, and distribution of COVID-19 vaccine(s) and therapeutics through Operation Warp Speed. We also plan to continue work examining the federal government's plans for the distribution and administration of any licensed or authorized vaccine and for public messaging to states and the public about vaccine availability, efficacy, and safety.

Background

Vaccination is critical for reducing infection rates and severity of disease and mortality due to COVID-19, but as of September 2020, there are no COVID-19 vaccines licensed by the Food and Drug Administration (FDA), and developing a vaccine takes time. Therapeutics to treat COVID-19 are also essential, particularly until a vaccine becomes available; however, no drug has been proven to be safe and effective and approved by FDA for treating COVID-19 at this time. As of August 2020, two therapeutics to treat COVID-19—the investigational drug, remdesivir, and COVID-19 convalescent plasma—had been granted emergency use authorization by FDA to treat hospitalized patients.[294]

The time frame for developing and distributing an effective vaccine or therapeutics is uncertain. State and local health officials, health care providers, and vaccine experts have predicted that wide-scale distribution of a vaccine may be months after a vaccine becomes available, and initial distribution may be limited (e.g., to health care providers or first responders) until sufficient doses

[294]Plasma is the liquid portion of blood that contains antibodies. According to FDA, patients with COVID-19 may improve faster if they receive plasma from those who have recovered from COVID-19, because the plasma may have the ability to fight the virus that causes COVID-19Under an emergency use authorization, FDA may allow therapeutics and vaccines to be used to respond to a declared emergency such as COVID-19 without formal FDA approval, as long as certain conditions are met and the scientific evidence suggests the known and potential benefits outweigh the known and potential risks. FDA also granted emergency use authorization for hydroxychloroquine sulfate and chloroquine phosphate for treatment of certain hospitalized patients in March 2020, However, FDA announced that it was revoking the emergency use authorization for these two therapeutics on June 15, 2020, because the agency determined they were unlikely to be effective treatments for COVID-19 and that the known and potential benefits of these products do not outweigh their known and potential risks, which include serious cardiac adverse events. To inform clinicians how to care for patients with COVID-19, the National Institutes of Health website includes COVID-19 Treatment Guidelines; these guidelines include recommendations for remdesivir and other treatments. The COVID-19 Treatment Guidelines panel stated that based on the available evidence, it determined there are insufficient data to recommend either for or against the use of convalescent plasma for the treatment of COVID-19, as of September 1, 2020.

are manufactured. In addition, a vaccine or vaccines may be initially made available under an emergency use authorization.

As part of a broader strategy to accelerate the development, manufacturing, and distribution of COVID-19 vaccines and therapeutics, among other things, Operation Warp Speed aims to deliver up to 300 million doses of a safe and effective COVID-19 vaccine in early 2021. Operation Warp Speed also engages with private firms and other federal agencies, such as the Department of Veterans Affairs (VA).

The CARES Act and the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, appropriated funding for HHS activities to support the development of vaccines and therapeutics for COVID-19. This included appropriations to FDA, NIH, and the Public Health and Social Services Emergency Fund (PHSSEF).[295] For example, the CARES Act appropriated about $27 billion to the PHSSEF for activities that include, but are not limited to, developing countermeasures and vaccines and purchasing vaccines and therapeutics; of this amount, not less than $3.5 billion is provided to BARDA for manufacturing, producing, and purchasing vaccines and therapeutics, among other things.[296]

Overview of Key Issues

Numerous federal agencies are facilitating the development of multiple candidates for vaccines and therapeutics to prevent and treat COVID-19. As of August 5, 2020, there were at least 26 federally funded clinical trials related to COVID-19 vaccines and therapeutics at various stages, according to NIH's ClinicalTrials.gov.[297] Of these, at least three were trials of vaccine candidates and at least 23 were trials related to therapeutics, including convalescent plasma and remdesivir.

As of July 31, 2020, HHS reported it had obligated about $12.995 billion and expended about $100 million for vaccines, and it obligated about $2.065 billion and expended about $71 million for therapeutics.

We reported examples of federal agencies' activities related to vaccines and therapeutics in our June 2020 report. Additional activities include the following:

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[295]See CARES Act, Pub. L. No. 116-136, div. B., tits. I, VIII, 134 Stat. at 509, 555-56, 560-61; Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, div. A., tits. I, III, 134 Stat. at 146, 148, 149-50, The Public Health and Social Services Emergency Fund (PHSSEF) is an account through which funding is provided to certain HHS offices, such as the Office of the Assistant Secretary for Preparedness and Response.

[296]CARES Act, Pub. L. No. 116-136, div. B, tit. VIII, 134 Stat. at 560-61.

[297]According to NIH, ClinicalTrials.gov provides the best source for up-to-date information on clinical trials and studies related to COVID-19 in the United States, as the website is updated regularly, and the number of clinical trials related to COVID-19 is increasing. The website was created to establish a registry of clinical trials information for both federally and privately funded trials conducted under investigational new drug applications to test the effectiveness of experimental drugs for serious or life-threatening diseases or conditions.

- **Operation Warp Speed** announced awards totaling about $12.6 billion to accelerate the development, manufacturing, and distribution of COVID-19 vaccines and therapeutics, as of September 1, 2020.[298] For example, in June 2020, it announced adding about $628 million to an existing contract to secure domestic manufacturing capacity for potential COVID-19 vaccines and therapeutics, including capabilities to fill vaccine vials and finish packaging vaccine.

- **BARDA** awarded about $10.8 billion for seven vaccine candidates and about $1 billion for nine awards for therapeutic development, as of August 18, 2020. According to HHS, six of the seven vaccine candidates are part of Operation Warp Speed, and as such, part of these award funds are included in the Operation Warp Speed amounts above.

- **CDC's** Advisory Committee on Immunization Practices established a COVID-19 Vaccine Work Group to collect, analyze, and prepare information related to COVID-19 vaccines for presentation, discussion, deliberation, and vote by the advisory committee. CDC provides technical and administrative support and contributes to the evidence that informs the advisory committee's recommendations, including for use of future COVID-19 vaccines.

- **FDA** issued guidance for industry on the development and licensure of vaccines to prevent COVID-19 in June 2020. According to the agency, FDA would expect that a COVID-19 vaccine would be at least 50 percent more effective than placebo in preventing COVID-19 or SARS-CoV-2 infection among the clinical trial participants. FDA's guidance also encourages the enrollment of populations most affected by COVID-19 in clinical trials, specifically racial and ethnic minorities.
  Under its Coronavirus Treatment Acceleration Program, FDA reported it had reviewed more than 270 trials of potential therapies for COVID-19 and that another 570 or more development programs for therapeutic agents were in the planning stages as of July 31, 2020. FDA also issued guidance for industry on developing drugs and biological products for the treatment or prevention of COVID-19, as well as on the administration and study of one investigational treatment being explored for COVID-19—convalescent plasma collected from individuals who have recovered from COVID-19.

- **NIH's** National Institute of Allergy and Infectious Diseases established a new clinical trials network that aims to enroll thousands of volunteers in large-scale clinical trials to test a variety of investigational vaccines and monoclonal antibodies intended to protect people from COVID-19. [299] The NIH Director testified that each of the vaccine trials will aim to enroll 30,000 participants, half of whom will get the vaccine, half of whom will get a placebo. [300]

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[298]The amount reported by Operation Warp Speed includes the acquisition of medical material, such as glass vials needed to administer vaccines and therapeutics, according to DOD. See Department of Health and Human Services, "Fact Sheet: Explaining Operation Warp Speed" (Sept 1, 2020), accessed September 3, 2020, https://www.hhs.gov/coronavirus/explaining-operation-warp-speed/index.html.

[299]Monoclonal antibodies are laboratory-made antibodies that may be able to serve as another prevention option until a vaccine becomes available. They usually only last for a few months, thus potentially requiring people to get multiple infusions or injections on a regular schedule for them to remain effective. Currently, drugs approved or developed for other purposes, as well as other investigational therapeutic agents, are being studied for the treatment of COVID-19.

[300]See Francis Collins, Director, National Institutes of Health, Robert R. Redfield, Director, Centers for Disease Control and Prevention, and Gary Disbrow, Acting Director, Biomedical Advanced Research and Development

According to NIH, the first phase 3 clinical trial that the clinical trial network was expected to conduct involves testing the investigational vaccine developed by scientists from NIH's National Institute of Allergy and Infectious Diseases and their collaborators at the biotechnology company, Moderna, Inc. [301] According to NIH, this phase 3 trial began on July 27, 2020. In addition, NIH, along with CDC, requested a committee of experts develop a framework to assist policymakers in planning for allocation of COVID-19 vaccine. [302]

- **DOD** is actively participating in Operation Warp Speed and collaborating with HHS to make awards. DOD is also conducting research on candidates for vaccines and therapeutics. For example, DOD is working to adapt DNA technology to rapidly manufacture and deliver a vaccine for use by DOD personnel. According to DOD, the new DNA vaccine approach offers vaccine stability and ease of large-scale production. In addition, DOD is supporting a study on the investigational drug remdesivir.
- **VA** is partnering with Operation Warp Speed and others as part of nationally coordinated efforts for new vaccines and therapies. According to VA, those efforts were in the early stages and officials hoped to start the first clinical trial in late July.

GAO Methodology and Agency Comments

To conduct this work, we reviewed the most recent HHS and DOD information available on vaccine and therapeutic development, manufacturing, and distribution efforts as of August and September 2020, including clinical trial information from NIH's clinical trial website, ClinicalTrials.gov (accessed Aug. 5, 2020), and vaccine and therapeutic development and manufacturing awards under Operation Warp Speed from HHS and from BARDA's medicalcountermeasures.gov website (accessed Aug. 18, 2020). We also reviewed VA information on its activities related to vaccines and therapeutics.

Authority, Hearing on Operation Warp Speed, Vaccines, Diagnostics, and Therapeutics, testimony before the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, 116th Cong., 2nd sess., July 2, 2020. In August 2020, NIH stated that not all clinical trials will have a 1:1 ratio of vaccine to placebo; some clinical trials are designed for a 2:1 ratio of vaccine to placebo.

[301]Phase 3 clinical trials look at things like whether the product prevents new infections or, if people become infected, if the product helps control the infections so it does not become severe disease. These studies involve many thousands of people, usually including participants who are at increased risk for infection.

[302]NIH and CDC requested that the National Academy of Medicine and the National Academies of Sciences, Engineering, and Medicine form a committee to consider the criteria that should be used to set priorities for equitable distribution among potential vaccine recipients. On September 1, 2020, the committee released a discussion draft of a potential allocation framework for public comment. National Academies of Sciences, Engineering, and Medicine 2020. *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine* (Washington, D.C.: Sept. 1, 2020), accessed September 4, 2020, https://www.nap.edu/catalog/25914/discussion-draft-of-the-preliminary-framework-for-equitable-allocation-of-covid-19-vaccine. The committee's final report, expected in early fall 2020, will include a final recommended allocation framework, and will address other issues, such as vaccine hesitancy, demand, and promotion as well as risk communication and strategies for community engagement, according to a press release announcing the draft framework.

We also reviewed relevant federal laws and agency and agency-related documents (e.g., FDA guidance for clinical trials, presentation materials by CDC's Advisory Committee on Immunization Practices' workgroup, documents related to NIH's new clinical trial network, HHS's and DOD's Operation Warp Speed Fact Sheets), and interviewed HHS and DOD officials. In addition, we reviewed documents and interviewed officials representing associations of state, local, and territorial health officials and immunization managers. We also reviewed information from manufacturers that had received federal funding to develop therapeutics. The information in this enclosure highlights examples of the types of development and manufacturing activities conducted or supported by these agencies, it is not an exhaustive list.

We provided a draft of this report to HHS, DOD, VA, and the Office of Management and Budget (OMB) for review and comment. HHS and DOD provided general comments, which are summarized in the Agency Comments and Our Evaluation section of this report. In addition, HHS, DOD, and VA provided technical comments on this enclosure, which we incorporated as appropriate. OMB did not provide comments on this enclosure.

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Related GAO Products

Investigational Drugs: FDA and Drug Manufacturers Have Ongoing Efforts to Facilitate Access for Some Patients. GAO-19-630. Washington, D.C.: September 9, 2019.

National Institutes of Health: Better Oversight Needed to Help Ensure Continued Progress Including Women in Research. GAO-16-13. Washington, D.C.: October 22, 2015.

Influenza Pandemic: Lessons from the H1N1 Pandemic Should Be Incorporated into Future Planning. GAO-11-632. Washington, D.C.: June 27, 2011.

Influenza Pandemic: HHS Needs to Continue Its Actions and Finalize Guidance for Pharmaceutical Interventions, GAO-08-671. Washington, D.C.: September 30, 2008.

Medicaid Spending

The potential exists for two Department of Health and Human Services agencies to issue duplicative or erroneous payments to providers, and challenges in public reporting of Medicaid COVID-19 spending continue to pose risks to transparency and oversight.

Entities involved: Centers for Medicare & Medicaid Services and the Health Resources and Services Administration, within the Department of Health and Human Services; and the Office of Management and Budget.

Key Considerations and Future GAO Work

We found the potential for duplicate or erroneous payments for COVID-19 testing of uninsured individuals by the Health Resources and Services Administration (HRSA) and the Centers for Medicare & Medicaid Services (CMS). Despite controls implemented by HRSA and CMS, we continue to have concerns about the potential for duplicate payments and will continue to monitor these issues going forward.

In our June 2020 report, we highlighted concerns that CMS's separate reporting of COVID-19 Medicaid spending, rather than reporting on USAspending.gov, might diminish the usefulness of this information for Congress and the public. We also highlighted concerns about the potential effects of state flexibilities to respond to COVID-19, including improper Medicaid payments and the complexity of calculating the various Medicaid matching rates. We continue to have these concerns and will monitor and report our findings on these issues going forward.

Background

Medicaid is one of the nation's largest sources of funding for health care services for low-income and medically needy individuals, covering an estimated 76 million people and spending approximately $667 billion in fiscal year 2019. States and territories administer their Medicaid programs within broad federal rules and according to state plans approved by CMS, which oversees Medicaid at the federal level. The federal government matches states' spending for Medicaid services according to a statutory formula known as the Federal Medical Assistance Percentage (FMAP).[303]

The Families First Coronavirus Response Act (FFCRA) provides a temporary increase in the FMAP for all qualifying states and territories.[304] FFCRA also created an option for states to provide

[303]The FMAP is calculated based on each state's per capita income relative to national per capita income. For the District of Columbia and U.S. territories, the FMAP is set by statute regardless of their per capita incomes. Additionally, federal law specifies a maximum amount, or allotment, for federal contributions to Medicaid spending in U.S. territories, in contrast to the states and the District of Columbia, for which federal Medicaid spending is open-ended.

[304] Pub. L. No. 116-127, § 6008, 134 Stat. 178, 208-09 (2020) ("FFCRA").

Medicaid coverage of COVID-19 diagnostic testing and related services to uninsured individuals.[305] The FFCRA and the Paycheck Protection Program and Health Care Enhancement Act each appropriated $1 billion to reimburse providers for conducting COVID-19 testing of uninsured individuals.[306] HRSA is responsible for administering these funds and paying providers that submit claims for COVID-19 testing.

Overview of Key Issues

Potential duplicate or erroneous payments for COVID-19 testing. HRSA administers a $2 billion program to pay for COVID-19 testing of uninsured individuals. In addition, CMS has approved 16 states and three territories to make Medicaid payments to providers for COVID-19 testing of uninsured individuals, with the federal government responsible for 100 percent of the cost. The Congressional Budget Office estimates that the Medicaid payments for testing of uninsured individuals will total approximately $2 billion in 2020 and 2021.

As of July 30, 2020, HRSA has paid $137.2 million for COVID-19 testing of uninsured individuals, with a total of $28.9 million in payments made to providers in the 16 states and one of three territories approved to use 100 percent federal Medicaid funds to pay for testing of uninsured individuals. While state reporting of Medicaid payments for COVID-19 testing is incomplete—a total of $51 in Medicaid payments for COVID-19 testing for uninsured individuals have been reported as of July 31, 2020—CMS officials expect payments to increase in the future.

Providers' understanding of the new and optional Medicaid benefit as a source of coverage for testing the uninsured is an important control to ensure correct billing for their services and prevent potential duplicate or erroneous payments. Both CMS and HRSA have taken some steps to provide guidance and communicate this new benefit to states and providers.

- CMS provided guidance to states regarding when Medicaid should be billed first for COVID-19 testing. States choosing to use the optional benefit for testing the uninsured have communicated with providers regarding billing. Our review of the 16 state websites, however, found some examples of inconsistent information and in one case inaccurate communication to providers. For more information, refer to the Medicaid COVID-19 testing for uninsured individuals section of the body of this report.
- HRSA requires providers submitting claims to attest that they have confirmed individuals are uninsured, and HRSA's program administrator implemented a prospective payment control on June 1, 2020 to check for insurance coverage for individuals on COVID-19 testing claims submitted to HRSA for payment. Further, HRSA officials reported that its program administrator is developing additional payment controls. On September 9, 2020, HRSA reported that retrospective payment controls that will recoup any identified improper payments began on August 31, 2020. HRSA expects that additional prospective payment

[305]FFCRA, § 6004(a)(3), 134 Stat. at , 205-06.

[306] FFCRA, div. A, tit. V, 134 Stat. at 182; Pub. L. No. 116-139, div. B., tit. I, 134 Stat. 620, 626 (2020).

controls to help identify and deny claims for those with coverage under Medicaid's new COVID-19 testing benefit will begin by the end of September 2020.

We continue to have concerns about the potential for duplicate or erroneous payments and plan to monitor the results of these prospective and retrospective payment controls to assess their effectiveness.

Public reporting of COVID-19 Medicaid spending. The CARES Act requires each agency administering COVID-19 funds to report monthly to the Office of Management and Budget (OMB) and others on the use of those funds. OMB guidance generally directs agencies to meet this requirement through public reporting to USAspending.gov.[307] Agencies reporting their COVID-19 relief spending in USAspending.gov were required to report their June 2020 spending by July 30, 2020, and will report monthly thereafter.

According to CMS officials, CMS reported spending for June 2020 to USASpending.gov for all Medicaid spending and will report all Medicaid spending monthly, but cannot separately report the COVID-19 components of Medicaid payments through USAspending.gov. According to CMS officials, CMS plans to report each state's federal COVID-19 Medicaid expenditures to OMB, and publish the data on Medicaid.gov, rather than USAspending.gov, and on a quarterly basis, rather than monthly. In accordance with regular Medicaid expenditure reporting practices, states and territories report quarterly their Medicaid expenditures to CMS, and this reporting includes identifying some expenses related to the COVID-19 relief laws. According to CMS, each quarter's data will be finalized 6 months after the end of each quarter, and once it is finalized, CMS expects to publish it within 30 days. For example, CMS plans to publish federal COVID-19 Medicaid expenditure data for the quarter ending June 30, 2020, by January 30, 2021. In our June 2020 report, we raised concerns that separate reporting might diminish the usefulness of this information for Congress and the public. We continue to have these concerns and will monitor and report our findings on this issue.

Oversight of state Medicaid flexibilities. In our June 2020 report, we raised concerns about the potential effects of state flexibilities, including improper Medicaid payments, the complexity of calculating the various Medicaid matching rates, and risk of incorrect payments caused by numerous sources of federal funds flowing to the same or similar entities. CMS issued guidance to states in June 2020, regarding several Medicaid program changes made in response to the COVID-19 pandemic, including guidance on reporting expenditures eligible for an increased matching rate, data states should collect and report on claims for COVID-19 testing for the uninsured, and provider attestation requirements for providers receiving retainer payments. We continue to have concerns about those issues and will continue to monitor and report on our findings going forward.

Medicaid spending. As of July 31, 2020, COVID-19-related federal Medicaid expenditures totaled approximately $13 billion, or 7 percent of total federal spending on Medicaid services for this

[307]OMB memorandum M-20-21 notes that some provisions may be excluded from this requirement, and in these instances, agencies should work with their OMB representative to identify an alternative reporting approach to provide transparency on how the funds are spent.

time period.[308] According to CMS officials, 16 states and three territories have elected and were approved to implement 100 percent coverage of COVID-19 diagnostic testing and related services to uninsured individuals under their Medicaid plans. As of July 31, 2020, very few expenditures have been reported for this testing.[309]

[308]The most recent available payment information is for the second quarter of fiscal year 2020 (January 1, 2020, through March 31, 2020) and the third quarter of fiscal year 2020 (April 1, 2020 through June 30, 2020). States can report payments and adjustments to payments up to 2 years after a quarter ends.

[309]The state of Utah reported $51 for COVID testing of uninsured individuals as of July 31, 2020.

Federal Medicaid COVID-19 and Total Expenditures, by State and Territory, as of July 31, 2020		
State or territory	COVID-19-related federal Medicaid expenditures from the 6.2 percentage point increased FMAP	Total federal Medicaid services expenditures in 2020
	Dollars in millions	
Alabama	198	2,526
Alaska[a]	17	377
Arizona	303	5,957
Arkansas	156	2,758
California	1,626	33,217
Colorado	236	2,943
Connecticut[ab]	102	1,267
Delaware[a]	90	1,229
District of Columbia[a]	41	611
Florida	877	9,384
Georgia	351	4,203
Hawaii	54	810
Idaho	69	1,017
Illinois[a]	336	4,275
Indiana	387	5,923
Iowa	138	1,963
Kansas	122	1,284
Kentucky	248	5,048
Louisiana	283	5,030
Maine[ab]	45	571
Maryland[a]	139	1,871
Massachusetts[ab]	241	2,877

Michigan[a]	280	5,152
Minnesota[ab]	206	2,236
Mississippi[a]	126	1,712
Missouri	319	3,890
Montana[ab]	15	323
Nebraska	71	738
Nevada	42	714
New Hampshire	62	783
New Jersey[a]	406	5,306
New Mexico	137	2,731
New York	1,806	22,915
North Carolina[ab]	180	2,111
North Dakota	33	420
Ohio[a]	610	9,053
Oklahoma	147	1,829
Oregon[a]	4	2,653
Pennsylvania[ab]	400	4,609
Rhode Island	31	450
South Carolina	213	2,631
South Dakota	28	324
Tennessee	311	3,577
Texas	1,337	15,129
Utah[c]	77	1,217
Vermont	45	552
Virginia	0	3

Washington[ab]	9	1,787
West Virginia[ab]	51	865
Wisconsin[a]	301	2,355
Wyoming[a]	17	181
States total[d]	**13,320**	**191,389**
American Samoa	1	21
Guam	2	66
Northern Mariana Islands	2	25
Puerto Rico	45	1,143
Virgin Islands[ab]	1	17
Territories total[d]	**51**	**1,272**

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-20-701.

Note: Federal Medicaid payments were available for the second and third quarters of fiscal year 2020—January 1, 2020, through June 30, 2020—and do not include expenses for program administration.

[a]Twenty-one states and one territory reported uncertified third quarter expenditures. Certified state expenditures have been reviewed by states and are certified as being Medicaid allowable expenditures. Both certified and uncertified state expenditures are preliminary, as they are subject to further review and are likely to be updated as states continue to report their expenditures and receive federal matching funds. States can report payments and adjustments to payments up to 2 years after a quarter ends.

[b]Nine states and one territory had not yet reported any third quarter expenditures as of July 31, 2020.

[c]Utah was the only state that reported expenditures for COVID-19 testing for the uninsured, and total reported expenditures were $51.

[d]Totals may not sum exactly due to rounding.

GAO Methodology and Agency Comments

To conduct this work, we reviewed federal laws, CMS and HRSA data, CMS Medicaid guidance, HRSA guidance, Congressional Budget Office spending estimates, OMB guidance, and our prior work related to Medicaid. We discussed HRSA's efforts to prevent duplicate or erroneous payments with HRSA officials. We also discussed CMS's guidance to states and its Medicaid expenditure reporting system with CMS officials and conducted data reliability checks on state-reported expenditure data.

We provided a draft of this report to HHS and OMB for review and comment. We received technical comments from both, which were incorporated as appropriate. HHS also provided

general comments which are summarized in the Agency Comments and Our Evaluation section of this report.

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Related GAO Products

Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures. GAO-18-564. Washington, D.C.: August 6, 2018.

Veterans Health Care

The Veterans Health Administration hired thousands of physicians and nurses to strengthen its capacity to respond to the pandemic.

Entities involved: Department of Veterans Affairs, including its Veterans Health Administration

Key Considerations and Future GAO Work

We have previously reported shortcomings in staffing capacities and human capital management at the Department of Veterans Affairs (VA) and highlighted these concerns in our June 2020 report. As COVID-19 cases have risen over the summer, and as VA begins to implement its phased reopening, we continue to monitor the extent to which the Veterans Health Administration (VHA) has the capacity to both respond to the evolving medical needs of veterans and to carry out its "Fourth Mission," its statutory obligation to support the civilian public health response during times of national public health emergency.

VA began expanding services in May 2020 as part of its phased reopening plan and as of July 2, 2020, has reinstated in-person services at more than 100 medical facilities. As of August 2020, VA reports sufficient staffing at most facilities, but continued monitoring will be important in light of VA's multiple missions as the pandemic continues and potentially worsens.

Ensuring well-qualified providers is critical, particularly given VA's efforts to onboard thousands of physicians and nurses in response to the pandemic. We previously reported concerns regarding VA medical centers' reviews and responses to issues raised about and actions taken against its privileged providers—those approved to independently perform specific services.[310] For example, in November 2017, we recommended that VHA require its medical centers to document reviews of providers, develop timeliness requirements for conducting those reviews, and report providers to state licensing boards when there are serious concerns about their clinical practice and other relevant organizations in a timely manner. VA agreed with these recommendations and, as of July 2020, told us they are in the process revising their policies for these recommendations.

Our work examining VA's response to the COVID-19 pandemic is ongoing. We plan to examine or have work already underway for future reports on a number of issues, including VA's prioritization of access to care during COVID-19; VA's "Fourth Mission" to support the civilian public health response to COVID-19; VA's use and oversight of the supplemental funds for COVID-19 response; infectious disease prevention in VA's long-term care programs; and VA's management and expenditure of COVID-19 emergency funds to procure necessary, time-critical medical supplies, such as personal protective equipment (PPE).

[310]Privileges are the specific set of clinical services that a provider is approved to perform independently at a medical facility, based on the provider's professional performance, judgement, clinical competence, and skill.

Background

VA administers one of the largest health care systems in the United States and is charged, through VHA, with providing health care services to the nation's eligible veterans and beneficiaries. VHA employs more than 320,000 employees, including 26,779 physicians and 75,475 registered nurses, and provides health care to more than 9 million veterans through VA medical centers, community-based outpatient clinics, and community living centers.[311]

VA received approximately $20 billion in supplemental funding to support its efforts to address COVID-19.[312] VHA plans to use these supplemental funds, along with existing funds, to deliver care for veterans in response to COVID-19, including hiring of additional employees.

According to VA documents, as of August 28, 2020, VHA reported:

- 44,305 cumulative veteran cases of COVID-19, including 3,013 active cases, 38,684 convalescent cases, and 2,608 deaths;[313] and
- 1,495 self-reported employee cases of COVID-19, 49 employee deaths, and 1,757 staff that were unable to work due to COVID-19.[314]

Overview of Key Issues

In response to COVID-19, VHA officials told us they used various strategies to hire and onboard staff quickly. In addition, VHA continues to reinstate in-person services at its medical facilities, although VHA officials told us some facilities in localities with recent COVID-19 surges have temporarily paused reinstating or reduced in-person services.

Staffing. VHA officials stated the agency has hired new staff, redistributed staff across the system, and maximized competencies of current staff during the COVID-19 pandemic. According to VHA, as of July 7, 2020, the majority of its facilities reported no significant problems with staffing needed to provide both COVID-19 and non-COVID-19 care in its facilities.

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[311]A community living center is a VA-owned and -operated nursing home.

[312]Families First Coronavirus Response Act, Pub. L. No. 116-127, div. A, tit. VI, 134 Stat. 178, 183 (2020) ($60M) and the CARES Act, Pub. L. No. 116-136, div. B, tit. X, 134 Stat. 281, 583 (2020) ($19.6B). Funds appropriated to VA under the Families First Coronavirus Response Act are available until September 30, 2022. Funds appropriated for VA programs under the CARES Act are available until September 30, 2021, except those for the VA Office of the Inspector General (OIG). CARES Act funds for the VA OIG are available until September 30, 2022.

[313]VA defines convalescent cases as those patients tested or treated at a VA facility for known or probable COVID-19 who are either post-hospital discharge or 14 days after their last positive test, whichever comes later.

[314]According to VA documentation, some veteran employees are also included in the deceased veterans' data. VA reported it has tested or treated 4,587 employee cases of COVID-19.

VHA officials stated it has recruited both permanent employees and short-term (up to 120 day) temporary appointments. Officials also stated that VHA's overall turnover rate was 1.7 percent and it netted 5,522 additional staff from April 1, 2020 to June 30, 2020.[315]

In June 2020, we reported that VHA officials told us they used various strategies to recruit and retain employees in response to COVID-19, such as using special hiring authorities for temporary, non-competitive appointments. In response to the pandemic, VHA officials said they have also

- accelerated onboarding processes, reducing the time it takes to hire new staff from 94 days before the COVID-19 pandemic to an average of 10 to 12 days during the COVID-19 hiring surge, with some hires taking only 3 days. VHA has done this by using temporary and expedited credentialing processes, which can be completed faster than the standard credentialing process (1 day for temporary credentialing and 3 days for expedited credentialing, instead of 30 days). VHA told us full credentialing is still required subsequently to the temporary credentialing process and any provider with a history of licensure actions or significant malpractice history is not eligible for it.[316] The expedited credentialing and privileging process waives the required contacts and verifications, which are completed at a later date. Given our past findings about the timeliness and documentation of VHA's reviews of provider quality, it is critical that VHA complete the full credentialing and privileging processes in a timely manner.
- restructured its onboarding processes for new employees, allowing them to begin work more quickly. For example, VHA told us they implemented a VHA-wide mandatory training moratorium to defer non-COVID related training by 120 days for VHA clinicians and staff.

GAO Methodology and Agency Comments

To conduct this work, we reviewed VHA documents, federal laws, and VHA written responses to GAO questions. We provided VA and the Office of Management and Budget (OMB) with a draft of this enclosure. VA provided general comments which are summarized in the Agency Comments and Our Evaluation section of this report. In its comments, VA stated that it has continued to provide care for veterans with COVID-19 and noted its efforts to increase staffing. VA did not have technical comments on this enclosure. OMB provided comments on the report and other enclosures, but did not have technical comments on this enclosure.

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[315]VA officials stated VHA onboarded 23,823 staff between March 29 and June 29, 2020—including 4,719 nurses and 833 physicians. VHA officials stated these staff included a combination of new external hires and internal hires from promotion, conversion, and reassignment of current VHA employees.

[316]The full credentialing process involves primary source verification by VA staff and a VA facility committee review.

Related GAO Products

Veterans Health Administration: Steps Taken to Improve Physician Staffing, Recruitment, and Retention, but Challenges Remain, GAO-18-623T (Washington, D.C.: June 21, 2018)

VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns, GAO-18-63 (Washington, D.C.: November 15, 2017)

Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies, GAO-18-124. (Washington, D.C.: October 19, 2017).

Military Health

The Department of Defense's plan for potential surges in COVID-19 cases among department personnel focuses on accelerating screening and surveillance testing, and the department has identified CARES Act funding in excess of current Defense Health Program requirements, resulting in a redirection of funds.

Entities involved: Defense Health Agency, within the Department of Defense

Key Considerations and Future GAO Work

We plan to continue to monitor the Department of Defense's (DOD) testing efforts, spend plan, and budget execution as part of the response to and recovery from the COVID-19 pandemic.

Background

In 2019, DOD operated 475 military Medical Treatment Facilities (MTF) to deliver care to the approximately 9.6 million individuals eligible for DOD health care services, including active-duty and retired servicemembers and their dependents.[317] Since 2017, DOD has been reforming the military health system, including consolidating the administration of the MTFs under the Defense Health Agency (DHA). DOD paused the consolidation in April 2020 to prioritize its response to COVID-19. In July 2020, the DHA announced that the pause on its consolidation efforts will continue until leaders determine the appropriate time to resume such activities. DOD received $3.8 billion for the Defense Health Program, to prevent, prepare for, and respond to coronavirus, domestically or internationally.[318] DOD's CARES Act spend plan fully funds the most immediate, critical COVID-19 response requirements in accordance with the department's mission priorities and, more specifically, its top two priorities: (1) protecting military and civilian personnel and their families and (2) safeguarding national security capabilities.[319]

[317]DOD, through the Defense Health Program, provides worldwide medical services to active-duty and other eligible beneficiaries, including costs associated with the delivery of TRICARE benefits.

[318]Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, div. B, title III, 134 Stat. 281, 518 (March 27, 2020). The Families First Coronavirus Response Act, Pub. L. No. 116-127, title II, 134 Stat. 178, 181 (March 18, 2020) also appropriated $82 million to the Defense Health Program. Under the CARES Act, DOD received a total of $10.5 billion which, in addition to the $3.8 billion enacted for the Defense Health Program, included appropriations for the National Guard, the defense working capital funds, and the Office of the Inspector General, among other things. We discuss the funding provided to the National Guard for personnel and operations and maintenance in the enclosure on DOD Support to Civil Authorities.

[319]Under Secretary of Defense (Comptroller), *Department of Defense Spend Plan for Funding Received in the – Coronavirus Aid, Relief, and Economic Security "CARES" Act (P.L. 116-136)* (May 2020) (submitted to the Pandemic Response Accountability Committee May 29, 2020).

Overview of Key Issues

As of September 9, 2020, DOD reported 58,058 cumulative, confirmed cases of COVID-19 including servicemembers, dependents, civilians, and contractors, an increase of 487 percent since June 1, 2020. According to DOD officials, the department is focused on accelerating screening and surveillance testing of its personnel, among other things. Concurrently, DOD has allocated CARES Act amounts appropriated for Defense Health Program activities to specific initiatives, including expanding intensive care unit bed capacity at MTFs, which are no longer needed. As a result, DOD has reprogrammed the funds for other DHA purposes or transferred funds to other DOD accounts for other COVID-19 costs.[320]

Testing. DOD is currently conducting three types of COVID-19 testing: screening, surveillance, and diagnostic. In June 2020, DOD accelerated both its screening testing and surveillance testing for select groups of asymptomatic servicemembers, in addition to its ongoing diagnostic testing of servicemembers with symptoms of (or exposure to) COVID-19. The goal of testing is to break the chain of disease transmission to reduce risk to the force and to the department's missions.[321]

Based on the availability of tests, DOD conducts screening testing in a tiered priority structure prior to servicemembers' deployment or the start of training.[322] DOD also plans to conduct surveillance testing on select populations, such as health care personnel, who are at increased risk for infection and transmission. Testing will occur every 14 days on 10 percent of its health care personnel, 10 percent of selected servicemembers living in congregate settings—such as ships, and eventually 1 percent of all other servicemembers, as resources permit.

Each military service is responsible for identifying its testing requirements—that is, the number of servicemembers that health care personnel and commanders deem appropriate for screening testing, and the number of servicemembers that military public health officials designate for surveillance testing. According to DOD officials, this testing approach will help position DOD for a possible second wave of COVID-19 later in 2020. However, in the event of a second wave of COVID-19 cases, DOD officials explained that an increase in demand for testing supplies would constrain the department's capacity to continue surveillance testing.

According to DOD, the department is currently meeting its initial testing projections of 50,000 to 65,000 tests per week in Tier 0 through Tier 4. Officials further stated that, as DOD's testing

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[320]Section 13001 of the CARES Act provides DOD with the authority to transfer amounts appropriated to the department by the Act to other applicable DOD appropriations for expenses incurred in preventing, preparing for, or responding to COVID-19, including expenses incurred in support of other federal departments and agencies, and state, local and Indian tribal governments.

[321]DOD described its latest strategy and guidance for surveillance and screening testing in a June 11, 2020, memorandum from the Undersecretary of Defense (Personnel and Readiness) entitled *Force Health Protection Guidance (Supplement 11) – Department of Defense Guidance for Coronavirus Disease 2019 Surveillance and Screening with Testing*.

[322]On April 22, 2020, DOD announced a tiered approach to diagnostic testing, prioritizing diagnostic testing for personnel in the following order: (1) Tier 1, personnel responsible for critical national defense capabilities; (2) Tier 2, engaged fielded forces around the world; (3) Tier 3, forward-deployed and redeploying forces; and (4) Tier 4, remaining DOD personnel.

strategy has matured, additional requirements have been added, and DOD's new projections anticipate testing at 75,000 to 110,000 per week as DOD expands diagnostic, screening, and surveillance testing (dependent upon testing supply availability). According to DOD officials, from February 24, 2020, through July 31, 2020, the department tested 270,150 out of approximately 1.3 million active-duty servicemembers for COVID-19. During that time period, DOD conducted a total of 381,278 tests, which includes servicemembers tested more than once.

CARES Act Spending Plan. DOD's Defense Health Program received $3.8 billion to prevent, prepare for, and respond to COVID-19, domestically or internationally as shown in the table below.[323] As reported on USAspending.gov, as of July 31, 2020, the Defense Health Program had obligated approximately $974.2 million and expended approximately $157.6 million.[324]

[323]The Defense Health Program provides worldwide medical services to active-duty forces and other eligible beneficiaries, including costs associated with the delivery of the TRICARE benefits.

[324]USAspending.gov, accessed on September 10, 2020. As noted above, in addition to the $3.8 billion enacted for the Defense Health Program in the CARES Act, the Families First Coronavirus Response Act, Pub. L. No. 116-127, title II, 134 Stat. 178, 181 (March 18, 2020), also appropriated $82 million to the Defense Health Program and is included as part of these obligations and expenditures.

Defense Health Program CARES Act COVID-19 Appropriations		
Cost Category	**Description/Types of Requirements**	**Amount ($ millions)**
Medical care	Increased health care for eligible military members, dependents, and retirees Procurement of medical equipment	1,407.0
Diagnostics and medical research	Development of vaccines and anti-virals 24/7 laboratory operations Procurement of diagnostic tests and research	1,351.9
Medical countermeasures	Procurement of vaccines and anti-virals Public health surveillance Medical personal protective equipment	570.0
Cleaning contracts and non-medical supplies and equipment	Increased cleaning contracts and biohazard mitigation	15.0
Military health system direct care capacity	Restoration/modification of military treatment facilities to support increased screening and treatment packages	150.0
DOD operations	Increased operations and deployment schedules Costs to support social distancing, quarantine requirements, etc.	60.2
Transfer or reprogramming	Funds redirected to other COVID-19 response costs	252.0
Total		**3,806.1**

Source: GAO analysis of Department of Defense "CARES Act" Spend Plans and guidance. I GAO-20-701.

Congress provided DOD with specific transfer authority in section 13001 of the CARES Act. Section 13001 authorizes the transfer of funds appropriated to specific DOD accounts to other applicable DOD appropriation accounts for expenses incurred in support of preventing, preparing for, or responding to COVID-19, including expenses incurred in support of other Federal Departments and agencies, and state, local, and Indian tribal governments.

DOD's May 2020 spend plan identified $252 million of the $3.8 billion appropriated for the Defense Health Program as available for reprogramming or transfer to fund other COVID-19 response efforts, such as COVID-19 vaccine development and other COVID-19 research

and development efforts.[325] These funds were made available primarily due to reduced requirements for expansion of medical facilities, including MTF bed expansion and procurement of expeditionary hospital packages. Specifically, $113 million was transferred from the Defense Health Program appropriation account to the Research, Development, Test and Evaluation, Defense-Wide appropriation account to identify approved drugs that might be effective for COVID-19 treatment, and test methods for diagnosing COVID-19, among other things. The spend plan also identified an additional $139 million of CARES Act funding transferred to various appropriation accounts for other DOD COVID-19 priorities.

According to officials, DOD continues to monitor its spending and plan for adjustments. For example, DOD officials stated they are evaluating options for transferring or reprogramming funds initially designated to purchase a vaccine, since it is unlikely a vaccine will be available for purchase prior to the end of fiscal year 2020 when the CARES Act funding expires. Army officials also stated they are considering reprogramming funds for deployable medical capabilities that need additional equipment, such as ventilators.

GAO Methodology and Agency Comments

To conduct this work, we reviewed DOD guidance and documentation and the most recent DOD data available as of July 31, 2020. We also interviewed DOD officials knowledgeable about COVID-19 response efforts and reviewed publicly available DOD media reports, statements, and documents**.** We provided a draft of this enclosure to DOD and the Office of Management and Budget (OMB) for review and comment. DOD provided technical comments on this enclosure, which we incorporated as appropriate. DOD also provided general comments which are summarized in the Agency Comments and Our Evaluation section of this report. OMB did not provide comments on this enclosure.

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[325]This includes COVID-19 research and development efforts undertaken by the Defense Advanced Research Projects Agency.

Defense Support of Civil Authorities

The Department of Defense continues to support civil authorities by providing personnel and supplies in response to requests for assistance from other federal agencies on a fully reimbursable basis.

Entities involved: Department of Defense, including its active duty, reserve, and National Guard forces, the U.S. Army Corps of Engineers, and the Defense Logistics Agency

Key Considerations and Future GAO Work

We continue to examine the support the Department of Defense (DOD) provides to civil authorities as part of the response to and recovery from the COVID-19 pandemic and coordination among the federal agencies supporting the pandemic response.

Background

While DOD's primary mission is to defend the nation, the department is often asked to play a prominent role supporting civil authorities and must be prepared to provide a rapid response when called upon during disasters and declared emergencies (natural or man-made). DOD provides such support through its Defense Support of Civil Authorities mission and is authorized to do so when requested by another federal agency and approved by the Secretary of Defense or when directed by the President.[326]

DOD received approximately $1.5 billion for National Guard personnel and operations expenses incurred in responding to COVID-19 through the CARES Act to prevent, prepare for, and respond to coronavirus, domestically or internationally.[327] Section 13001 of the CARES Act also provided DOD with the authority to transfer amounts appropriated to the department by the Act to other applicable DOD appropriations for expenses incurred in preventing, preparing for, or responding to COVID-19, including in support of other federal departments and agencies, and state, local, and tribal governments.[328]

[326]Requesting agencies could include, for example, the Federal Emergency Management Agency (FEMA), Health and Human Services (HHS), or the U.S. Department of Agriculture. DOD provides such support through federal military forces, DOD civilians, DOD contract personnel, or DOD component assets, to include the National Guard and the U.S. Army Corps of Engineers.

[327]Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, div. B, title III, 134 Stat. 281, 518 and 520 (March 27, 2020). As we previously noted, DOD received about $10.5 billion under the Act which, in addition to the National Guard activities, included appropriations for the Defense Health Program, the defense working capital funds, and the Office of the Inspector General, among other things. We discuss the funding provided to the Defense Health Program for military health care in the separate Military Health enclosure.

[328]Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, div. B, title III, § 13001, 134 Stat. 281, 521 (March 27, 2020).

However, in a memorandum dated April 1, 2020, the acting Undersecretary of Defense (Comptroller) clarified that transfers under section 13001 may be made only to meet the department's requirements, stating that DOD does not receive appropriations for, and has no authority to provide National Guard support to, federal agencies, states, local, territorial or tribal governments on a non-reimbursable basis. Therefore, the transfer authority provided under section 13001 does not authorize DOD to use its appropriations to support other entities.[329]

Overview of Key Issues

DOD support efforts. According to DOD officials, the department's response to the COVID-19 pandemic has evolved since the spring as more information has become known. DOD officials stated that the department will continue to support civil authorities by fulfilling validated mission assignments from Federal Emergency Management Agency (FEMA) to supplement states' capabilities, for example, if state medical personnel become sick. According to officials, the department took specific measures in the spring—such as halting training activities and delaying accessions of new recruits—to help safeguard the department's readiness and mission. These measures made available certain resources, such as medical personnel, to provide support to the civil response.

However, DOD officials also stated that the department recently resumed some temporarily paused activities, such as training and accessions, which reduced its medical capacity that could be used in support of civil authorities because that capacity was needed for the department's internal safety and mitigation plans. For example, the Navy increased medical capacity on its ships at sea following an outbreak of COVID-19 on the U.S.S. Roosevelt that sickened approximately 1,000 sailors.

DOD officials also stated that COVID-19 hotspots have more recently shifted to locations such as Texas and Florida that have higher concentrations of DOD personnel, dependents, and retirees. As a result, the department is seeing increases in the number of cases among its own population and must ensure it maintains the capacity to treat its beneficiaries, while also providing support to civil authorities.

According to DOD officials, as of July 31, 2020, DOD had responded to over 200 FEMA mission assignments and other requests for assistance. Further, as of July 31, 2020, approximately 770 medical personnel were providing support to two states—California and Texas. Approximately 25,000 National Guard members also remained on orders to support the response to COVID-19.[330]

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[329]Undersecretary of Defense (Comptroller), *Availability of National Guard Funding under the "Coronavirus Aid, Relief, and Economic Security Act" ("CARES" Act)* (April 1, 2020).

[330]According to DOD officials, approximately 3,570 medical personnel provided support at the peak of the COVID-19 response in late April 2020. In June 2020, we reported that more than 57,200 military personnel, including more than 41,000 National Guard personnel in Title 32 status, had provided support in response to the COVID-19 pandemic. According to DOD officials, as of July 2020, the department had identified approximately 500 additional personnel that could be made available to provide support to the COVID-19 response.

At the request of the Secretary of Defense, pursuant to 32 U.S.C. 502(f), governors have utilized Guard members to fulfill validated FEMA mission assignments on a fully reimbursable basis to support COVID-19 testing, infection control, and food distribution efforts, among other things.[331] DOD officials stated that COVID-19 contact tracing and mapping has emerged as a newer role for Guard members.[332] Other examples of civil support provided by June 2020:

- Tennessee National Guard members assisted with COVID-19 testing of residents in long-term care facilities and correctional facilities, as well as state employees.
- Georgia National Guard members conducted infection control in 2,311 facilities, including nursing homes, and trained non-DOD personnel in infection control.
- National Guard members in Georgia, Kansas, North Carolina, Ohio, and Washington, among others, supported food distribution efforts. For example, Washington Guard members delivered 1.7 million meals and 23.8 million pounds of food.
- Missouri National Guard members processed and transported decedents.

CARES Act funding for DOD support of civil authorities. Of the approximately $1.5 billion DOD received from the CARES Act for National Guard personnel and operations expenses incurred in responding to COVID-19, $746.6 million was for the Army National Guard Personnel and $482.1 million was for the Air National Guard Personnel. In addition, the Army and Air National Guards received $262.5 million for their operations and maintenance activities associated with the COVID-19 response. In a series of Presidential memoranda sent to the Secretaries of Defense and Homeland Security during March, April, May, and June, FEMA was directed to fund 100 percent of emergency assistance associated with COVID-19 response activities undertaken by state National Guards.[333] As reported on USAspending.gov, as of July 31, 2020 the National Guard had obligated more than $98.2 million and expended more than $36.1 million.[334]

DOD's May 2020 CARES Act spend plan details the department's review and prioritization process, and the resulting plan for utilizing the supplemental funding.[335] As detailed in the spend plan and shown in the table below, the department identified $777.7 million of the amount appropriated

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[331]Title 32 of the United States Code governs the National Guard. National Guard members may be placed in a duty status pursuant to section 502(f)(2)(A) to support operations or missions undertaken by the member's unit at the request of the President or the Secretary of Defense.

[332]In July 2020, the Chief of the National Guard Bureau was reported stating that approximately 120,000 National Guard members had responded to various natural disasters, global military operations, and civil disturbances, in addition to the COVID-19 pandemic that year. The Chief also stated that the National Guard's operations tempo would likely not slow with COVID-19 cases on the rise in some states and no reduction in worldwide operational commitments.

[333]The 100 percent federal cost share for the states' and territories' use of National Guard forces was available for orders of any length authorizing duty through August 21, 2020.

[334]USAspending.gov, accessed on September 2, 2020.

[335]According to the spend plan, DOD's COVID-19 mission priorities are: (1) protecting military and civilian personnel and their families; (2) safeguarding national security capabilities; and (3) supporting the President's whole-of-nation response to the pandemic, with a focus on the first two priorities Under Secretary of Defense (Comptroller), *Department of Defense Spend Plan for Funding Received in the – Coronavirus Aid, Relief, and Economic Security* "*CARES*" *Act (P.L. 116-136)* (May 2020) (submitted to the Pandemic Response Accountability Committee May 29, 2020).

to the Army and Air National Guards' Personnel account, and $141.7 million of the amount appropriated to the Army and Air National Guards' Operations and Maintenance account to be transferred among various other appropriations.[336]

[336]According to officials, the Army National Guard plans to identify an additional $114 million and the Air National Guard plans to identify an additional $131 million for transfer in a forthcoming update to their spend plans.

National Guard CARES Act Appropriations and Transfers			
Appropriation	**Enacted ($ thousands)**	**Funds available for transfer ($ thousands)**	**Total ($ thousands)**
National Guard Personnel, Army	746,591	(506,912)	239,679
National Guard Personnel, Air Force	482,125	(270,739)	211,386
Total	1,228,716	(777,651)	451,065[a]
Operations and Maintenance, Army National Guard	186,696	(107,533)	79,163
Operations and Maintenance, Air National Guard	75,754	(34,200)	41,554
Total	**262,450**	**(141,733)**	**120,717**

Source: GAO analysis of Department of Defense "CARES Act" Spend Plan. I GAO-20-701.

[a]According to officials, the Army National Guard plans to identify an additional $114 million and the Air National Guard plans to identify an additional $131 million from the personnel accounts to return for reprogramming in forthcoming updates to their spend plans.

According to National Guard officials, because National Guard support to the states for COVID-19 response is being reimbursed by FEMA, amounts appropriated in the CARES Act for similar activities are not needed and cannot be fully obligated before the end of the fiscal year on September 30, 2020, when the amounts will expire.[337] Consequently, the National Guard has identified amounts as available for transfer to other DOD accounts for COVID-19-related priority activities.

For example, of the $1.2 billion appropriated to National Guard personnel accounts, $506.9 million is available for transfer from the Army National Guard personnel account and $270.7 million is available from the Air National Guard personnel account. According to Army and Air National Guard officials, the remaining $451 million will be used for National Guard personnel to conduct additional screenings and tests for COVID-19 at National Guard locations and buildings, and for additional manpower to receive and issue PPE from a central warehouse for National Guard personnel who are not providing reimbursable support to FEMA.

[337]Amounts appropriated to the National Guard are not available to support state-level response activities in the absence of a reimbursable agreement between a federal agency and the National Guard, as in the case of FEMA, or between the National Guard and a particular state.

GAO Methodology and Agency Comments

To conduct this work, we reviewed documentation and the most recent data available from DOD through July 31, 2020, and interviewed DOD officials. We provided a draft of this enclosure to DOD and the Office of Management and Budget (OMB) for review and comment. DOD provided technical comments on this enclosure, which we incorporated as appropriate. DOD also provided general comments which are summarized in the Agency Comments and Our Evaluation section of this report. OMB did not have comments on this enclosure.

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HHS COVID-19 Funding

The COVID-19 relief laws appropriated more than $250 billion to the Department of Health and Human Services to address various aspects of the public health response to COVID-19, of which about $144 billion (about 58 percent) had been obligated and about $99 billion (about 40 percent) had been expended as of July 31, 2020, according to department officials. This represents an increase of 43 percent and 48 percent since May 31, 2020, when obligations and expenditures were $101 billion and $67 billion, respectively.

Entities involved: Department of Health and Human Services

Key Considerations and Future GAO Work

As part of our monitoring and oversight responsibilities in the CARES Act, we are conducting work examining the Department of Health and Human Services's (HHS) use of appropriations contained in four relief laws enacted to help fund the COVID-19 response. Specifically, we will be examining the status of obligations and expenditures of these funds; the activities funded, including how those activities were determined; and efforts to monitor funding use and any related challenges.

Background

HHS received approximately $250.6 billion in supplemental appropriations from four relief laws enacted to assist the response to COVID-19.[338] The following table provides HHS appropriations by COVID-19 relief law.

[338]Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, 134 Stat. 146 (2020); Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020); CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020).

Supplemental Appropriations to HHS for COVID-19 Response

Legislation	Appropriations ($ millions)
Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. No. 116-123)	6,497.0
Families First Coronavirus Response Act (Pub. L. No. 116-127)	1,314.0
CARES Act (Pub. L. No. 116-136)	142,833.4
Paycheck Protection Program and Health Care Enhancement Act (Pub. L. No. 116-139)	100,000.0
Total	**$250,644.4**

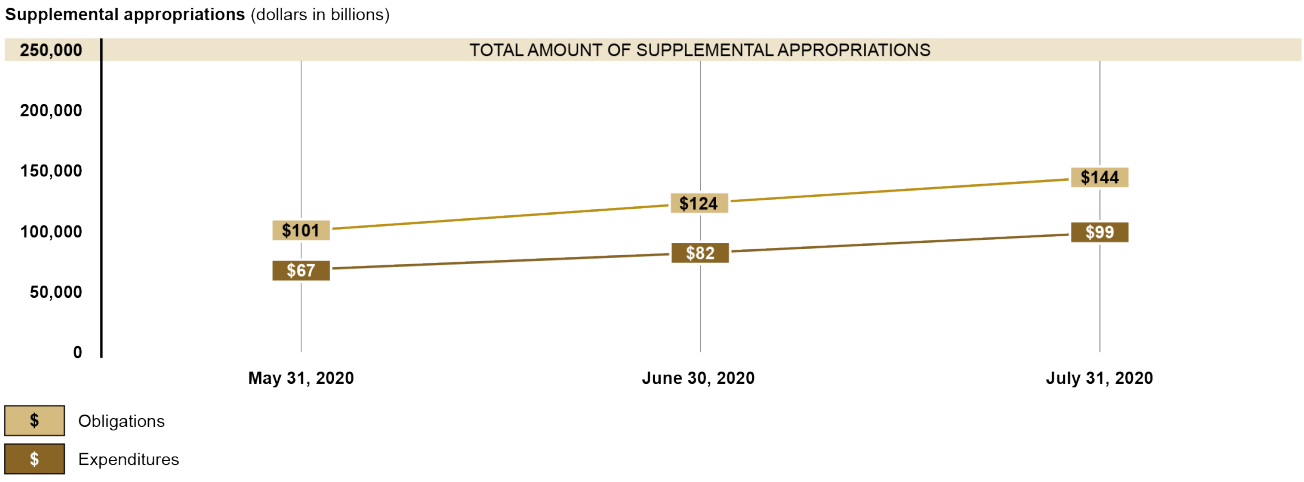
Source: Department of Health and Human Services (HHS) data and GAO analysis of appropriation warrant information provided by the Department of the Treasury. | GAO-20-701

Note: HHS reported that of its total COVID-19 supplemental appropriations, the agency transferred $289 million to the Department of Homeland Security, and $300 million in appropriations are not available until future actions by HHS.

Overview of Key Issues

Of the $250.6 billion appropriated, HHS reported that it had obligated about $144 billion and expended about $99 billion, as of July 31, 2020—an increase of 43 percent and 48 percent respectively since May 31, 2020.

Supplemental Appropriations to HHS for COVID-19 Response and HHS's Reported Obligations and Expenditures, by Law, as of July 31, 2020



Source: Department of Health and Human Services (HHS) data. | GAO-20-701

HHS reported appropriations, obligations, and expenditures by agency. As of July 31, 2020, the Indian Health Service and Public Health and Social Services Emergency Fund (of which the Provider Relief Fund is the largest line item) had expended the largest portion of their supplemental appropriations (54 and 42 percent respectively). The Centers for Medicare & Medicaid Services, Food and Drug Administration, and the National Institutes of Health had each expended less than 5 percent of their supplemental appropriations. The following table provides HHS's reported appropriations, obligations, and expenditures by HHS agency.

Department of Health and Human Services (HHS) Reported Appropriations, Obligations, and Expenditures for COVID-19 Response, by Agency, as of July 31, 2020

Agency or key fund	Appropriations ($ millions)	Obligations ($ millions)	Expenditures ($ millions)
Administration for Children and Families	6,274.0	6,072.1	1,208.7
Administration for Community Living	1,205.0	1,205.0	317.8
Agency for Toxic Substances and Disease Registry	12.5	2.2	1.1
Centers for Disease Control and Prevention	6,500.0	2,770.2	459.6
Centers for Medicare & Medicaid Services[a]	200.0	37.7	3.5
Food and Drug Administration	141.0	25.3	3.4
Health Resources and Services Administration	1,320.0	1,318.2	374.4
Indian Health Service	1,096.0	663.9	592.2
National Institutes of Health	1,781.4	521.7	52.4
Public Health and Social Services Emergency Fund (PHSSEF)[b]	231,689.5	131,244.7	96,132.8
Office of the Assistant Secretary for Preparedness and Response[c]	*12,501.9*	*9,810.4*	*2,557.0*
Biomedical Advanced Research and Development Authority[c]	*17,497.0*	*14,997.7*	*177.0*
Provider Relief Fund[c]	*175,000.0*	*92,687.2*	*92,398.4*
Testing for uninsured [c]	*2,000.0*	*162.9*	*161.2*
Other PHSSEF[c]	*24,690.6*	*13,586.5*	*839.2*
Substance Abuse and Mental Health Services Administration	425.0	423.4	4.1
Total	**$250,644.4**	**$144,284.1**	**$99,150.0**

Source: Department of Health and Human Service (HHS) data. | GAO-20-701

Note: The COVID-19 relief laws included provisions for HHS to transfer appropriated funds to various HHS agencies. HHS also reported that of its total COVID-19 appropriation, the agency transferred $289 million to the Department of Homeland Security, and $300 million in appropriations are not available until future actions by HHS.

[a]These amounts do not reflect Medicaid and Medicare expenditures. As of July 31 2020, COVID-19 related federal Medicaid expenditures totaled approximately $13 billion, or 7 percent, of total spending on Medicaid services for this time period. In addition, the Congressional Budget Office estimated that some provisions of the CARES Act will increase Medicare payments to providers by $8 billion in 2020 and 2021.

[b]The Public Health and Social Services Emergency Fund (PHSSEF) is an account though which funding is provided to certain HHS offices, such as the Office of the Assistant Secretary for Preparedness and Response. Amounts have been appropriated to this fund for the COVID-19 response to support certain HHS agencies and response activities. PHSSEF appropriations transferred to other HHS agencies or key funds not specifically listed are included under "Other PHSSEF." For example, the Health Resources and Services Administration received $975 million in transfers from the PHSSEF, and this is represented in the table in "Other PHSSEF."

[c]The italicized amounts are subtotals of the PHSSEF and are not added in the total since they are included in the PHSSEF amount. Italicized amounts listed under the PHSSEF appropriations column are HHS allocations based on a combination of appropriations made in the relief laws, and approved allotment decisions made by HHS in coordination with OMB. The Provider Relief Fund reimburses eligible health care providers for health care related expenses or lost revenues that are attributable to COVID-19. The CARES Act and Paycheck Protection Program and Health Care Enhancement Act appropriated $175 billion for provider relief. In addition, the Families First Coronavirus Response Act and the Paycheck Protection Program and Health Care Enhancement Act designated up to $2 billion to reimburse providers for COVID-19 testing for uninsured individuals. Provider Relief Fund expenditures may also be referred to as disbursements.

HHS reported allocations, obligations and expenditures for a variety of COVID-19 response activities, including activities to support testing, the development of vaccines or therapeutics, and the acquisition of critical supplies. As of July 31, 2020, 53 percent of funds allocated to the Provider Relief Fund had been expended, compared with less than 5 percent of the funding each for telehealth, testing, vaccines, drug and therapeutics, and disease detection. The following table provides HHS's reported allocations, obligations, and expenditures by selected key response activity.

Department of Health and Human Services (HHS) Reported Allocations, Obligations, and Expenditures for COVID-19 Response, by Selected Key Response Activity, as of July 31, 2020

Key activity	Total HHS allocations ($ in millions)	Total HHS obligations ($ in millions)	Total HHS expenditures ($ in millions)
Health centers[a]	2,020.0	2,017.9	494.4
Head Start	750.0	654.3	25.1
Provider Relief Fund[b]	175,000.0	92,687.2	92,398.4
Testing for uninsured	2,000.0	162.9	161.2
Support to state, local, territorial, and tribal organizations for preparedness	13,990.1	12,689.7	867.0
Strategic National Stockpile	10,710.0	8,380.6	1,839.8
Telehealth	159.5	37.3	0.6
Testing	2,821.1	1,496.4	136.9
Vaccines	14,022.3	12,955.3	99.5
Drugs and therapeutics	2,536.4	2,064.7	70.5
Global disease detection and emergency response	800.0	90.8	9.6
Other response activities[c]	25,835.1	11,047.2	3,047.1
Total	**$250,644.4**	**$144,284.1**	**$99,150.0**

Source: Department of Health and Human Service (HHS) data. | GAO-20-701

Note: HHS reported allocations, obligations, and expenditures for these activities based on the primary programmatic recipient organization of the funds, although some activities apply to multiple categories. For example, certain funds in the "support to state, local, territorial, and tribal organizations for preparedness" category were provided for testing but are not reflected in the "testing" category. According to HHS officials, the allocations reported for the key activities above are based on amounts appropriated for these activities in the relief laws and approved allotment decisions made by HHS in coordination with the Office of Management and Budget.

[a]Health centers provide a comprehensive set of primary and preventative health care services to individuals regardless of their ability to pay. Approximately $17 million of this funding is for Health Center Program look-alikes, which are centers that do not receive Health Center Program funding but meet program requirements.

[b]The Provider Relief Fund reimburses eligible health care providers for health care related expenses or lost revenues that are attributable to COVID-19. The CARES Act and Paycheck Protection Program and Health Care Enhancement Act appropriated $175 billion for provider relief. In addition, the Families First Coronavirus Response Act and the Paycheck Protection Program and Health Care Enhancement Act designated up to $2 billion to reimburse providers for COVID-19 testing for uninsured individuals. Provider Relief Fund expenditures may also be referred to as disbursements.

[c]According to HHS officials, other response activities includes Centers for Disease Control and Prevention wide activities and program support, healthcare preparedness and response activities, Biomedical Advanced Research and Development Authority diagnostics development, and various activities conducted by the National Institutes of Health.

GAO Methodology and Agency Comments

We requested, and HHS provided, data on appropriations, obligations, and expenditures by HHS agency and by key response activity, as of July 31, 2020. We also obtained and analyzed appropriation warrant information provided by the Department of the Treasury as of May 31, 2020. To assess the reliability of the data reported by HHS, we compared them with the federal spending database, USAspending.gov, as well as HHS's spending database, taggs.hhs.gov, and HHS's documentation on spending, and we determined that the data were sufficiently reliable for the purposes of our reporting objective.[339] We also reviewed the four relief laws enacted to assist the response to COVID-19. We provided HHS and the Office of Management and Budget (OMB) with a draft of this enclosure. HHS did not provide comments on this enclosure. OMB provided technical comments, which we incorporated as appropriate.

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[339]We searched HHS's Tracking Accountability in Government Grants System website and USAspending.gov—a publicly available website developed and operated by the Department of the Treasury that includes detailed data on federal spending, including obligations, across the federal government. See https://taggs.hhs.gov/coronavirus (accessed July 31, 2020) and https://USAspending.gov (accessed August 1, 2020). We did not independently validate the data provided by HHS.

Health Disparities

The Department of Health and Human Services plays a key role in collecting and making data available on indicators of COVID-19 burden, including cases, hospitalizations, and deaths. While race and ethnicity information is incomplete in these reported data, available data demonstrate racial and ethnic disparities in indicators of COVID-19 burden.

Entities involved: Department of Health and Human Services, including the Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, Indian Health Service, and Office of Minority Health

Key Considerations and Future GAO Work

The Department of Health and Human Services (HHS), including the Centers for Disease Control and Prevention (CDC), collects and makes some data available on indicators of COVID-19 burden by race and ethnicity, but gaps exist in these data. For example:

- Race and ethnicity information was missing for more than half (52.6 percent) of cases with case report forms received by CDC, or 63.8 percent of total cases reported as of July 31, 2020.[340]
- CDC's hospitalization data are limited to select counties in 14 states, and race and ethnicity information are not complete in the reported data.
- Several states do not include race and ethnicity in their reporting of deaths to CDC through case reporting as of July 30, 2020, according to CDC. Race and ethnicity data were missing for 16.6 percent of deaths with case report forms received by CDC, or 35.4 percent of total deaths reported through case reporting, as of July 31, 2020.[341]

To help address these gaps, on July 22, 2020, CDC released a COVID-19 Response Health Equity Strategy to accelerate progress towards reducing disparities in indicators of COVID-19 burden, among other efforts to achieve health equity.[342] However, CDC's strategy does not include an assessment of whether having the authority to require states and jurisdictions to report

[340]CDC officials noted that the number of cases with case report forms received by CDC is less than the total number of reported cases because there is generally a 2-week lag from when total cases are reported by state and jurisdictional health departments to when CDC receives the case report forms. Total cases reported by CDC include those that are both probable and confirmed. A probable case (1) meets clinical criteria and epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19, (2) meets presumptive laboratory evidence (i.e., antibody or antigen test) and either clinical criteria or epidemiologic evidence, or (3) meets vital records criteria with no confirmatory laboratory testing performed for COVID-19.

[341]CDC officials noted that the number of deaths with case report forms received by CDC is less than the total number of reported deaths through case reporting because there is generally a 2-week lag from when total deaths are reported by state and jurisdictional health departments to when CDC receives case report forms noting deaths.

[342]Centers for Disease Control and Prevention, *CDC COVID-19 Response Health Equity Strategy: Accelerating Progress Towards Reducing COVID-19 Disparities and Achieving Health Equity* (July 2020).

race and ethnicity data for cases, hospitalizations, and deaths is necessary to ensure CDC can collect more complete data, and if so, whether CDC should seek such authority from Congress. Moreover, CDC's strategy does not specify how it will involve key stakeholders who participate in the collection of information on race and ethnicity—such as health care providers, laboratories, and state and jurisdictional health departments—to obtain complete information for indicators of COVID-19 burden. CDC's strategy also does not specify how, if at all, CDC plans to assess the long-term health outcomes of individuals with COVID-19, including by race and ethnicity.

Without including these elements within its strategy, the agency risks continuing to collect incomplete and inconsistent information, and may not be able to effectively target its pandemic response efforts to racial and ethnic minority groups that may be disproportionately affected. As CDC implements its COVID-19 Response Health Equity Strategy, we recommend in this report that the Director of CDC 1) determine whether having the authority to require states and jurisdictions to report race and ethnicity information for COVID-19 cases, hospitalizations, and deaths is necessary for ensuring more complete data, and if so, seek such authority from Congress; 2) involve key stakeholders to help ensure the complete and consistent collection of demographic data; and 3) take steps to help ensure its ability to comprehensively assess the long-term health outcomes of persons with COVID-19, including by race and ethnicity.

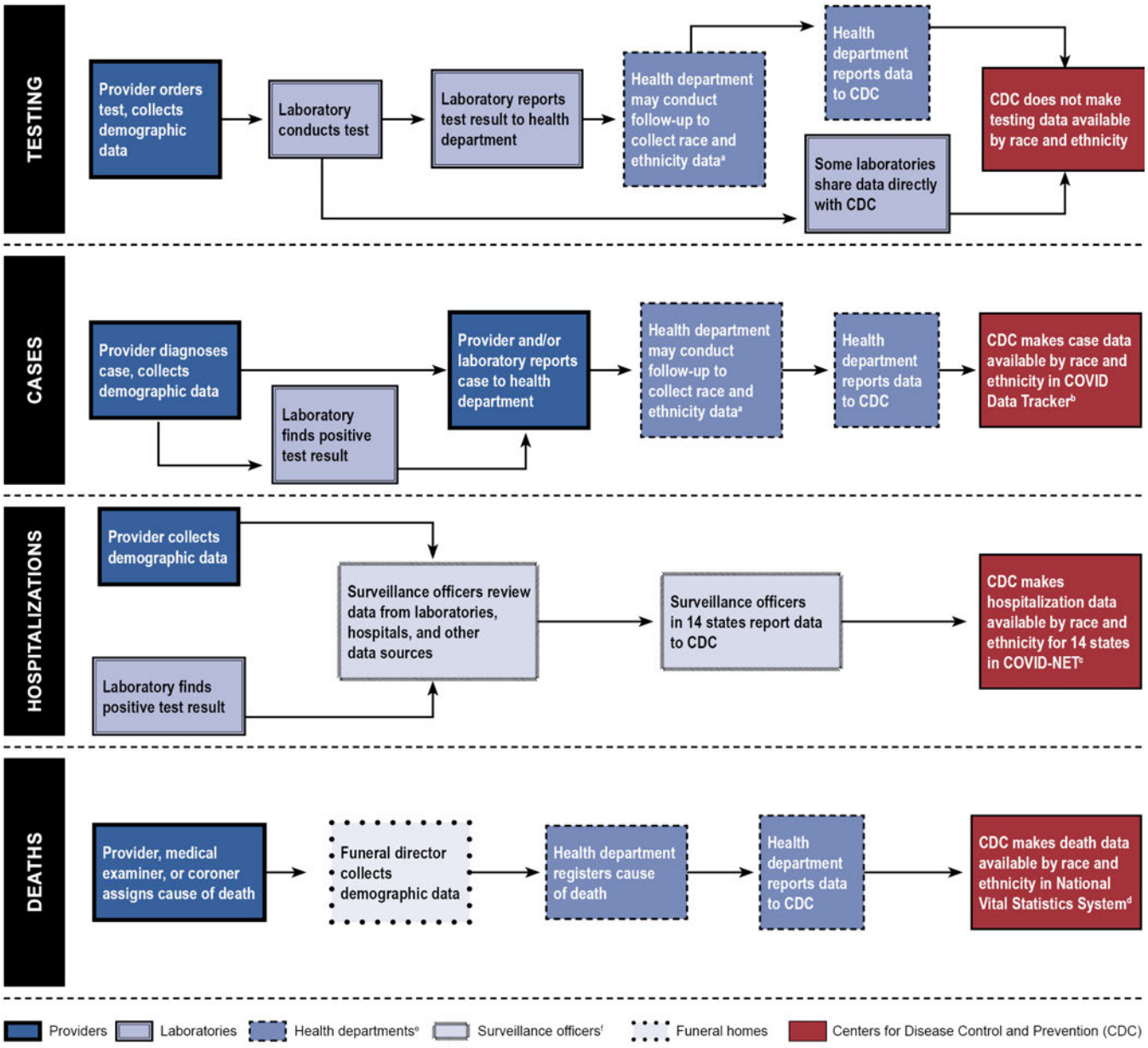
We will continue to conduct work examining HHS, CDC, and other component agencies' ongoing work regarding indicators of COVID-19 and disparities that exist for various populations.

Background

HHS and its agencies, including CDC, collect and make data available on various indicators of COVID-19, including testing, cases, hospitalizations, and deaths (see figure).[343] These data are collected from a variety of sources, such as health care providers, laboratories, funeral homes, and state and jurisdictional health departments.

[343]For more information on how CDC collects and shares data on COVID-19, see GAO, *COVID-19 Data Quality and Considerations for Modeling and Analysis*, GAO-20-635SP (Washington, D.C.; July 30, 2020).

Centers for Disease Control and Prevention (CDC)'s General Process for Collecting and Making Available Race and Ethnicity Data on Indicators of COVID-19



Source: GAO analysis of CDC documents and interviews with CDC officials. | GAO-20-701

[a]Health departments may conduct follow-up with patients, laboratories, providers, and obtain additional information from electronic health information systems to collect missing race and ethnicity data. Providers and laboratories may also conduct follow-up to collect these data.

[b]CDC's COVID Data Tracker provides maps, charts, and data on COVID-19 (see https://www.cdc.gov/covid-data-tracker/index.html#demographics, accessed July 31, 2020).

[c]CDC's COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) is a surveillance system maintained by CDC that makes data available on COVID-19 hospitalizations that are confirmed by laboratories (see https://gis.cdc.gov/grasp/COVIDNet/COVID19_5.html, accessed August 7, 2020). Data are collected from select counties in 14 participating states. On July 13, 2020, HHS released guidance that requires hospitals to provide hospitalization data directly to HHS, rather than CDC; however, this

guidance does not include a requirement for hospitals to include race and ethnicity information in their reporting to HHS and it does not affect data collected through COVID-NET.

[d]CDC's National Center for Health Statistics (NCHS) maintains the National Vital Statistics System, which is the source of official statistics on deaths in the United States (see https://www.cdc.gov/nchs/nvss/vsrr/covid19/health_disparities.htm, accessed August 6, 2020). CDC also collects data on deaths through case reporting, which is not depicted in this graphic.

[e]For purposes of this figure, "health department" includes both state and local health departments. Generally, data are first reported at the local level (i.e., county health departments) and then at the state level (i.e., state health departments). According to CDC, in some states or jurisdictions, officials who register cause of death and report this data to CDC may not be located within the health department.

[f]COVID-NET data are collected by surveillance officers who are trained to obtain data in a standardized and uniform way.

Data collected and made available by CDC on indicators of COVID-19 by race and ethnicity is important for assessing potential disparities in these groups. CDC has reported that long-standing systemic health and social inequities have put persons in racial and ethnic minority groups at increased risk of acquiring and suffering worse outcomes from COVID-19. According to CDC, history shows that severe illness and death rates tend to be higher for racial and ethnic minority groups during public health emergencies. Race and ethnicity data on indicators of COVID-19 burden can help decision-makers understand the spread and severity of COVID-19 in different populations.

Overview of Key Issues

Though limited, available data from CDC and others demonstrate disparities in COVID-19 indicators by race and ethnicity, with racial and ethnic minorities bearing a disproportionate burden of COVID-19 cases, hospitalizations, and deaths.[344]

- **Cases.** CDC race and ethnicity data on COVID-19 cases, while incomplete, demonstrate that racial and ethnic minority groups have been disproportionately affected. Among cases with known race and ethnicity reported to CDC as of July 31, 2020, 32 percent of cases were for persons who were Hispanic or Latino (compared to 18 percent of the U.S. population), 20 percent were non-Hispanic Black (compared to 13 percent of the U.S. population), and 1.3 percent were non-Hispanic American Indian/Alaska Native (compared to 0.7 percent of the U.S. population).[345] Though race and ethnicity data were missing for 53 percent of cases, these

[344]While CDC does not publicly report data on COVID-19 test results by race and ethnicity, federally supported Community Based Testing Sites provide incomplete data on race and ethnicity. These data reflect higher positivity rates among racial and ethnic minorities. According to HHS, as of July 13, 2020, these testing sites reported that 5.0 percent of White persons tested positive, compared to 20.9 percent of Hispanic or Latino persons, 8.3 percent of Native Hawaiian or other Pacific Islander persons, 8.3 percent of Asian persons, 7.1 percent of Black persons, 5.3 percent of American Indian/Alaska Native persons, and 7.2 percent of persons reporting an "Other" race. However, according to HHS, race and ethnicity data was missing for 46 percent and 58 percent, respectively, of tests conducted at these sites. The number of positive tests is not equal to the number of cases, as one person may be tested more than once, and a probable case may not have confirmatory laboratory testing performed.

[345]Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, Vol. 69, No. 24 (June 19, 2020). We compared CDC data in this report with data from the CDC COVID Data Tracker, accessed July 31, 2020, https://www.cdc.gov/covid-data-tracker/#demographics.

findings suggest that persons in these groups experience a disproportionately high burden of COVID-19 cases.[346]

Additionally, a Centers for Medicare & Medicaid Services (CMS) preliminary analysis of Medicare fee-for-service claims data and Medicare Advantage encounter data for services from January 1 through June 20, 2020, received by July 17, 2020, found racial and ethnic disparities in COVID-19 case rates, with case rates highest for Black beneficiaries (1,658 cases per 100,000), Hispanic or Latino beneficiaries (1,230 cases per 100,000), and American Indian/Alaska Native beneficiaries (1,125 cases per 100,000) and lowest among White beneficiaries (712 cases per 100,000).[347]

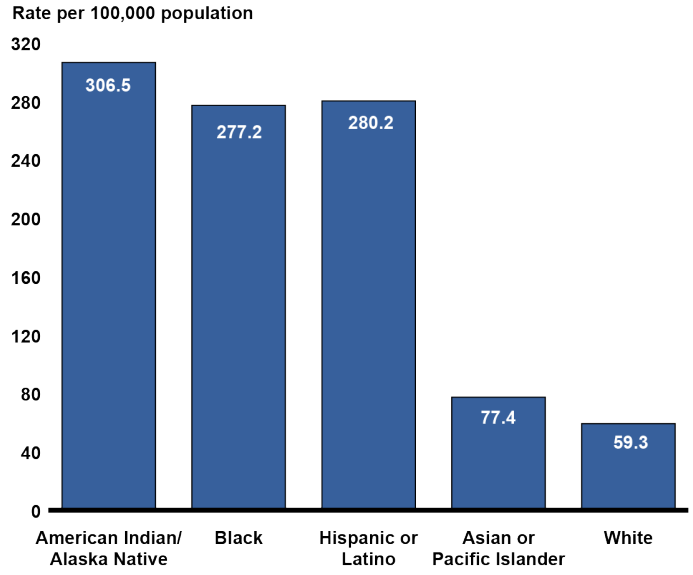
- **Hospitalizations.** CDC data indicate that racial and ethnic minority groups are disproportionately hospitalized with COVID-19 in select counties in 14 states included in CDC's COVID-19-Associated Hospitalization Surveillance Network (COVID-NET). [348] According to CDC's analysis of data from COVID-NET hospitalizations between March 1, 2020, and August 1, 2020, non-Hispanic American Indian/Alaska Native persons were hospitalized with COVID-19 at a rate 5.2 times that of non-Hispanic White persons, and non-Hispanic Black and Hispanic or Latino persons were hospitalized at a rate 4.7 times that of non-Hispanic White persons when adjusting for age (see figure).

[346]Additional disparities may be observed at the state or jurisdictional level. CDC reported that as of August 10, 2020, counties with large non-Hispanic Black, Hispanic, non-Hispanic American Indian/Alaska Native, non-Hispanic Asian, or Native Hawaiian or other Pacific Islander populations were more likely to have a recent high burden of COVID-19 cases.

[347]Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Preliminary Medicare COVID-19 Data Snapshot* (July 28, 2020).

[348]COVID-NET is a surveillance system maintained by CDC that collects data on COVID-19 hospitalizations that are confirmed by laboratory testing. It includes data from select counties in California, Colorado, Connecticut, Georgia, Iowa, Maryland, Michigan, Minnesota, New Mexico, New York, Ohio, Oregon, Tennessee, and Utah, representing approximately 10 percent of the U.S. population. As of August 1, 2020, approximately 6.4 percent of the data reported in COVID-NET lacked data on race and ethnicity.

COVID-19 Hospitalization Rates from Select Counties in 14 States, Adjusted for Age, by Race and Ethnicity, March 1, 2020 through August 1, 2020



Source: Centers for Disease Control and Prevention (CDC). | GAO-20-701

Note: White, Black, American Indian/Alaska Native and Asian or Pacific Islander persons were non-Hispanic. Hispanic or Latino persons might be of any race. Hospitalization data are from Centers for Disease Control and Prevention's Coronavirus Disease 2019 (COVID-19)-Associated Hospitalization Surveillance Network (COVID-NET), which provides data from select counties in 14 states, representing 10 percent of the U.S. population. Age-adjusted rates, which hold constant the age distributions between different population groups, allow researchers to focus analyses on other demographics, such as race and ethnicity, without being concerned about differences that are due to different age distributions of the racial and ethnic groups. These rates are particularly important to consider for indicators of COVID-19 because persons in older age groups are more likely to experience hospitalizations and deaths.

Additionally, CMS found racial and ethnic disparities in COVID-19 hospitalization rates among Medicare beneficiaries, with hospitalization rates highest for Black beneficiaries (670 hospitalizations per 100,000), American Indian/Alaska Native beneficiaries (505 hospitalizations per 100,000), and Hispanic or Latino beneficiaries (401 hospitalizations per 100,000) and lowest among White beneficiaries (175 hospitalizations per 100,000) as of June 20, 2020.[349]

- **Deaths.** A CDC analysis of National Center for Health Statistics (NCHS) death certificate data indicated a disproportionate number of deaths among non-Hispanic Black persons, who represent approximately one in four COVID-19 deaths in the United States. [350] As of August 12, 2020, NCHS data show that non-Hispanic Black persons died of COVID-19 at a rate 2 times higher than non-Hispanic White persons (see figure). [351]

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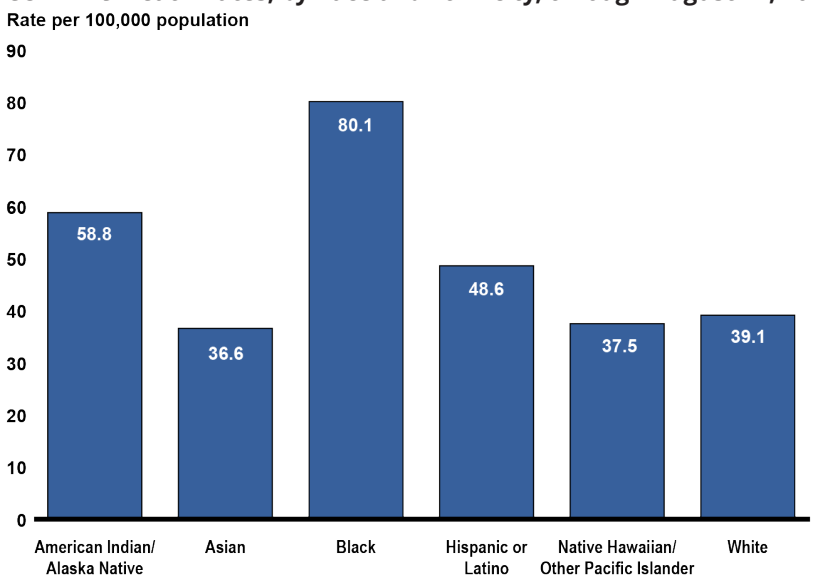
[349]Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Preliminary Medicare COVID-19 Data Snapshot* (July 28, 2020).

[350]The National Center for Health Statistics' (NCHS) National Vital Statistics System is the source of official statistics on deaths in the United States.

[351]Department of Health and Human Services, Centers for Disease Control and Prevention, *Report to Congress on Paycheck Protection Program and Health Care Enhancement Act Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID-19) Testing, 3rd 30-Day Update* (August 2020). Disparities by race and ethnicity can also be observed at the state or jurisdictional level. GAO analyzed CDC's NCHS death certificate data in states with more than 100 deaths and 10 or more deaths for the race or ethnicity group, and found that non-Hispanic Black persons had an elevated

COVID-19 Death Rates, by Race and Ethnicity, through August 12, 2020



Source: Centers for Disease Control and Prevention (CDC) analysis of National Center for Health Statistics (NCHS) death certificate data. | GAO-20-701

Note: Data are from Department of Health and Human Services, Centers for Disease Control and Prevention, *Report to Congress on Paycheck Protection Program and Health Care Enhancement Act Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID-19) Testing, 3rd 30-Day Update* (August 2020). White, Black, American Indian/Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander persons were non-Hispanic. Hispanic or Latino persons might be of any race. Death rates include deaths reported by the 50 states and the District of Columbia, and are reported by CDC/NCHS from its National Vital Statistics System (NVSS), which is the source of official statistics on deaths in the United States. CDC noted that death certificate data are provisional, and may not include all deaths through August 12, 2020. CDC stated that 99 percent of deaths in NVSS have race and ethnicity information.

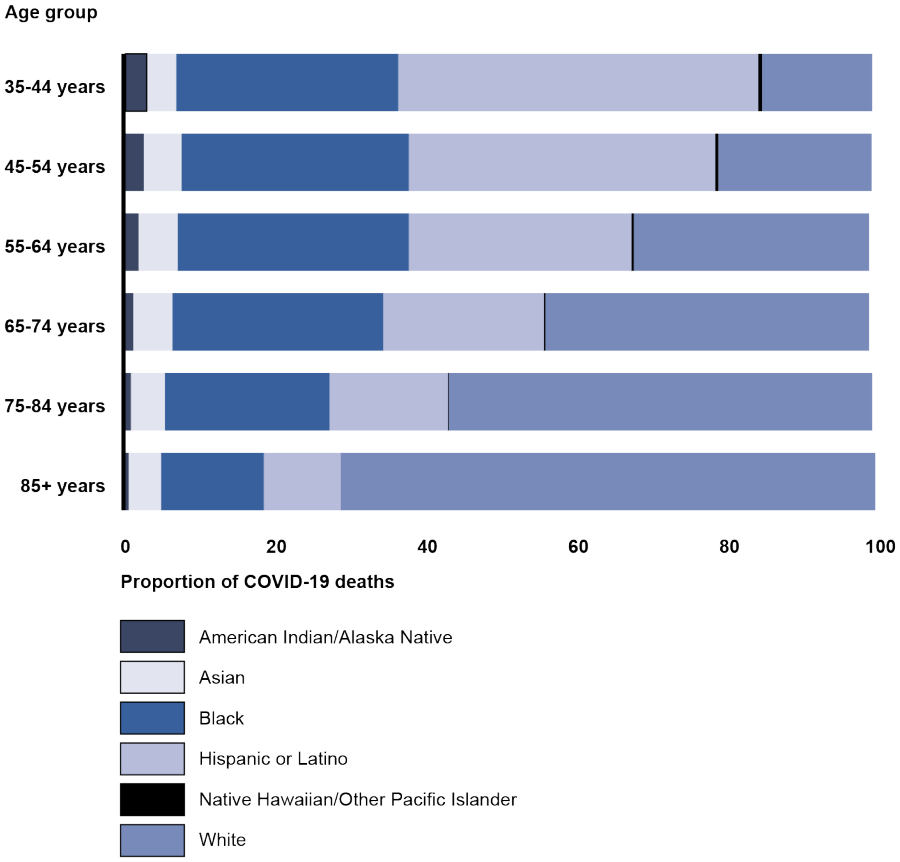
Additional disparities may be observed within age groups. In particular, racial and ethnic minority populations comprise a larger proportion of COVID-19 deaths at younger ages (see figure).[352] CDC also reported that as of August 12, 2020, non-Hispanic Black persons older than age 75 had the highest death rate (824.7 per 100,000), followed by Hispanic or Latino persons older than age 75 (656.0 per 100,000) and non-Hispanic American Indian/Alaskan Native persons older than age 75 (428.3 per 100,000).[353] In addition, we found that non-Hispanic Black and Hispanic or Latino persons accounted for the largest proportion of COVID-19 deaths in younger age groups, such as age 35-44 and 45-54 (see figure).

share of deaths in 20 of 38 states, Hispanic persons had an elevated share in 34 of 43 states, and non-Hispanic American Indian/Alaskan Native persons had an elevated share in 12 of 22 states. We defined an elevated share of deaths as having a relative difference of 30 percent or more, accounting for the geographic location of the deaths and the age distribution of the population groups.

[352]The age distribution of the population and of COVID-19 deaths may vary between race and Hispanic origin groups.

[353]Department of Health and Human Services, Centers for Disease Control and Prevention. *Report to Congress on Paycheck Protection Program and Health Care Enhancement Act Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID-19) Testing, 3rd 30-Day Update* (August 2020).

Distribution of COVID-19 Deaths, by Race and Ethnicity and Age Group, through August 5, 2020



Source: GAO analysis of Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics (NCHS) data. | GAO-20-701

Note: White, Black, American Indian/Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander persons were non-Hispanic. Hispanic or Latino persons might be of any race. Deaths data includes deaths reported by the 50 states and the District of Columbia, and is from the National Center for Health Statistics' (NCHS) National Vital Statistics System (NVSS), which is the source of official statistics on deaths in the United States. NCHS noted that death certificate data are provisional, and may not include all deaths through August 5, 2020. NVSS also provides data on individuals younger than age 35 and on individuals of more than one race and of unknown race, which were not included in this figure.

HHS's Office of Minority Health, CDC, the Indian Health Service (IHS), and researchers noted various social and health-related factors that may contribute to disparities by race and ethnicity in COVID-19 disease burden, including the following:[354]

- higher rates of employment in essential industries, such as service, health care, and agriculture;
- limited or no paid sick leave or ability to work from home;
- lower earnings, lower educational attainment, and higher rates of joblessness;

[354]For example, see M. L. Wang, et al., "Addressing inequalities in COVID-19 morbidity and mortality: research and policy recommendations," *Translational Behavioral Med*icine. (2020) and Selden T. M. and Berdahl T. A., "COVID-19 and racial/ethnic disparities in health risk, employment, and household composition," *Health Affairs 39, No. 9.* (2020).

- higher rates of uninsurance and other barriers to accessing care, such as mistrust of the health care system, language barriers, and cost of missing work;
- higher population density and overcrowded, multigenerational, or multi-family homes;
- greater reliance on public transportation;
- overrepresentation in jails, prisons, homeless shelters, and detention centers;
- limited plumbing and access to clean water;
- higher rates of underlying health conditions, such as chronic lung disease, asthma, and obesity; and
- experiences of racism, stigma, and systemic inequities.

According to HHS and CDC, these factors may make it more difficult for persons in racial and ethnic minority groups to quarantine, practice social distancing, and follow sanitation guidelines. They may also contribute to greater prevalence of, or increase the risk of worse health outcomes from, COVID-19.

As we previously noted, gaps exist in the data HHS collects on race and ethnicity for COVID-19 testing, cases, hospitalizations, and deaths. While CDC has developed a strategy to help address these gaps, this strategy does not include several elements that are critical to the collection of complete and consistent data, such as involving key stakeholders. Without including these elements, the agency risks continuing to collect incomplete and inconsistent information, and may not be able to effectively target its pandemic response efforts to racial and ethnic minority groups that may be disproportionately affected.

GAO's Methodology and Agency Comments

To conduct this work, we reviewed the most recent agency data on indicators of COVID-19 reported by CDC and CMS as of August 5, 2020; reviewed federal laws, agency guidance and documentation; and interviewed or obtained written responses from HHS officials, including those from its Office of Minority Health, CDC, and IHS. We also conducted interviews and reviewed written responses provided by organizations that represent entities involved in the collection of data on indicators of COVID-19, referred to as stakeholders, to obtain their perspectives on agency actions and challenges.[355] We provided HHS, the Office of Management and Budget (OMB),

[355]We interviewed or received written responses from stakeholders including the American Hospital Association, the American Medical Association, the Association of Public Health Laboratories, the Association of State and Territorial Health Officials, the Council of State and Territorial Epidemiologists, the COVID Tracking Project, the National Association of County and City Health Officials, and the National Independent Laboratory Association. These stakeholders were selected for a variety of reasons including their representation of entities involved in the collection of data on indicators of COVID-19.

CDC, and CMS with a draft of this enclosure. HHS and CMS provided technical comments on this enclosure, which we incorporated as appropriate. HHS provided general comments which are summarized in the Agency Comments and Our Evaluation section of this report.

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Related GAO Product

COVID-19 Data Quality and Considerations for Modeling and Analysis. GAO-20-635SP. Washington, D.C.; July 30, 2020.

Child Nutrition

Almost 400 million fewer meals for children were provided in March and April 2020 than in March and April 2019, and school districts and other providers reported ongoing and potential challenges to providing meals during the pandemic.

Entities involved: Food and Nutrition Service within the Department of Agriculture.

Key Considerations and Future GAO Work

We will continue to monitor challenges faced by school districts and other entities in providing meals to children during the pandemic, as well as the Food and Nutrition Service's use of CARES Act funding and its efforts to provide flexibilities to states and school districts to support these efforts. In addition, we plan to examine the rollout of the newly established Pandemic EBT program—which provides additional benefits to households with children who would have received free or reduced-price school meals if not for school closures due to COVID-19—including program costs, participation, and challenges providing benefits to households.

Background

Child nutrition programs administered by the Department of Agriculture's (USDA) Food and Nutrition Service (FNS) provide cash reimbursements for meals and snacks provided to eligible children in schools, or at other locations when schools are closed.[356] In fiscal year 2019, the National School Lunch Program (NSLP), the School Breakfast Program (SBP), Summer Food Service Program (SFSP), and other child nutrition programs received $23.1 billion in federal funds. The largest program, NSLP, had an average daily participation of almost 30 million students in 2019, with over 94,000 participating schools. Eligibility and target populations vary across programs; however, in general, the largest subsidies are provided for free or reduced-price meals and snacks served to children from low-income households.[357]

The CARES Act provided $8.8 billion in supplemental funds to support child nutrition programs during the COVID-19 pandemic, and as of July 31, 2020, FNS had obligated most of these funds ($7 billion) for reimbursement of meals, and disbursed $4.1 billion to states and other providers. Meal reimbursement costs include the provision of free meals to more children, under waivers described below, as well as weekend meal service, according to FNS.

[356]Free and reduced-price meals are served to eligible children, while children who are not eligible for free or reduced-price meals may purchase full-price meals. Providers receive federal cash reimbursements for each meal they serve depending on the fee category (free, reduced-price, and full-price).

[357]For the 2019-20 school year, a family of four generally had to have an income below $33,475 or $47,638 in order to be eligible for free or reduced-price meals, respectively. Child Nutrition Programs: Income Eligibility Guidelines, 84 Fed. Reg. 10,295 (Mar. 20, 2019).

FNS was also apportioned $9.7 billion for a new program, Pandemic EBT (Electronic Benefits Transfer), for fiscal year 2020, and, as of July 31, 2020, had disbursed an estimated $5 billion to states for this program.[358] Authorized under the Families First Coronavirus Response Act, this program provides additional benefits to households with children who would have received free or reduced-price school meals if not for school closures due to COVID-19. Eligible households receive benefits on an EBT card, similar to how benefits are provided for the Supplemental Nutrition Assistance Program (SNAP). The law authorized benefits to be provided through September 30, 2020. All states and the District of Columbia have been approved to operate a Pandemic EBT program, and states estimated that this program would serve 29 million children, according to FNS.

Overview of Key Issues

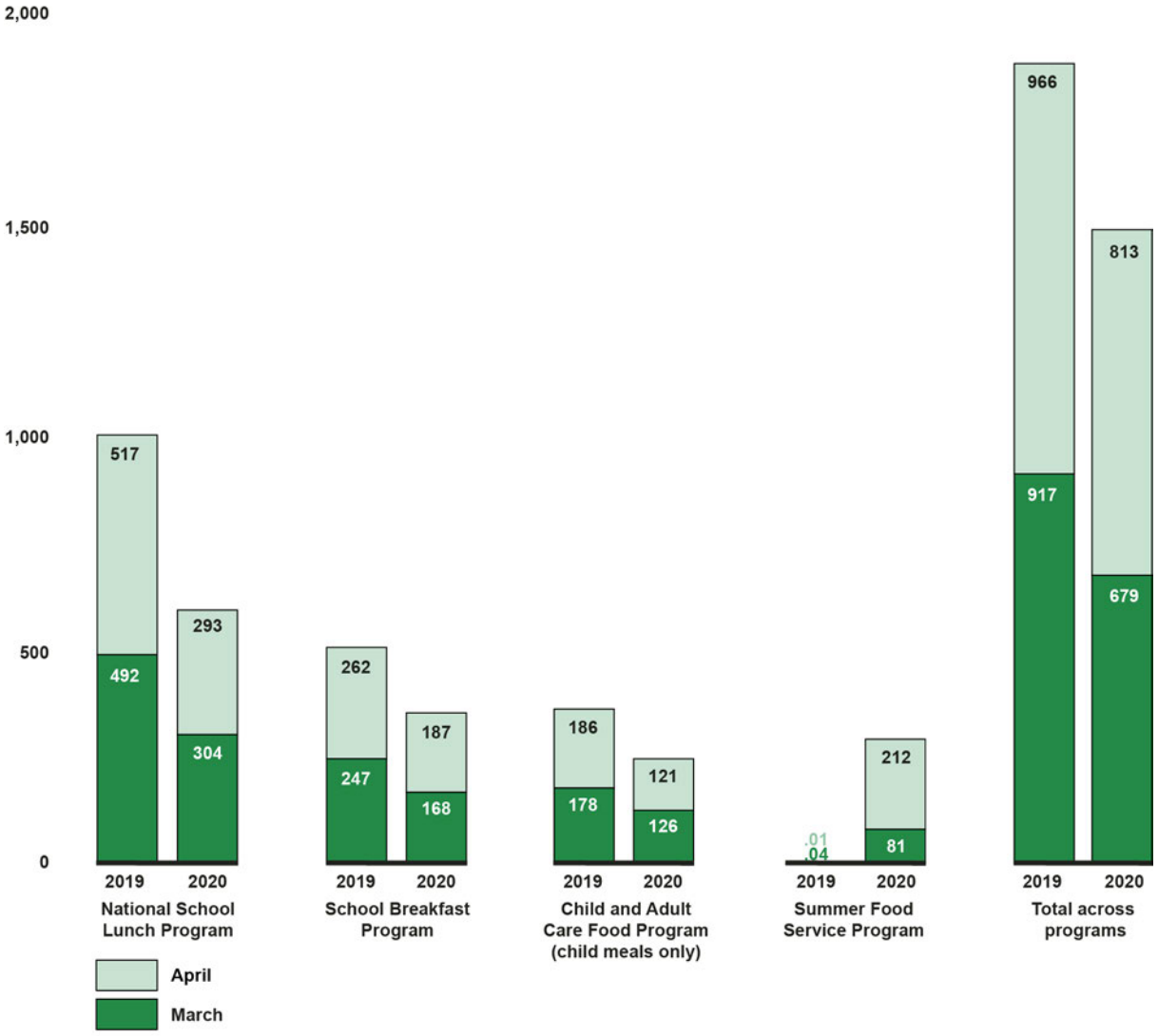
The most recent available data from FNS show that the number of meals served through the four largest child nutrition programs in March and April 2020 dropped by almost 400 million meals, or 21 percent, compared to March and April in 2019 (see figure). Although there was a large increase in meals provided through SFSP, this increase did not offset reductions in other programs, such as NSLP and SBP. SFSP typically operates from May through September for children on school vacation. It may also operate during unanticipated school closures, which FNS determined applied to the pandemic-prompted closures in the spring of 2020. To facilitate meal distribution, FNS waived the requirement that in order to provide free meals to all children, summer meal sites must be located in areas in which at least half the children are from low-income households, which contributed to the increase in SFSP meals in 2020. This waiver also applied to schools that continued to operate NSLP programs after schools closed through an option called the Seamless Summer Option.[359]

[358]Apportionment is the action by which the Office of Management and Budget (OMB) distributes amounts available for obligation in an appropriation or fund account. The Department of Agriculture (USDA) received an indefinite appropriation of necessary amounts for Pandemic EBT. OMB originally apportioned $8.9 billion for Pandemic EBT for fiscal year 2020. According to USDA, this amount increased to $9.7 billion to reflect increases in Pandemic-EBT participation by additionally approved states. The amount of Pandemic EBT benefits issued are FNS estimates based on state Pandemic EBT plans, as FNS reported that there have been difficulties separating Pandemic-EBT from Supplemental Nutrition Assistance Program (SNAP) benefit payments in real time. FNS stated that it is working with states to address this issue.

[359]The Seamless Summer Option allows schools to continue to provide meals in the summer and during unanticipated closures through the NSLP and SBP. FNS's data for NSLP and SBP do not distinguish meals provided through the Seamless Summer Option.

Total Meals Served Per Month in Key Child Nutrition Programs, March and April 2019 and 2020

Number of meals served (millions)



Source: GAO analysis of data from U.S. Department of Agriculture's Food and Nutrition Service. | GAO-20-701

Note: National School Lunch Program (NSLP) and School Breakfast Program (SBP) numbers include meals served through Seamless Summer Option program, which allows school food authorities operating NSLP and SBP to continue the same meal service rules and claiming procedures used during the regular school year throughout summer and during unanticipated school closures. Also, according to Food and Nutrition Service, the number of meals reported for any given month is subject to marginal revisions over time for a variety of reasons, including late claims and changes that come as a result of routine monitoring activity.

Reported challenges in providing meals: As we reported in June, FNS granted various waivers, as authorized by the Families First Coronavirus Response Act, in response to the pandemic that allowed school districts and other meal providers to provide meals in ways not typically allowed.

School districts provided meals in a variety of ways, such as using grab-and-go models, delivering meals directly to students' homes, and using bus routes to distribute meals.[360]

School districts reported various challenges operating meal programs during the pandemic, according to interviews and information gathered by national organizations representing school meal programs and summer meal sites. For instance, schools and other providers faced challenges obtaining pre-packaged or shelf-stable foods; additional food packaging and equipment, such as containers and equipment to store and keep meals cool during delivery; as well as personal protective equipment for staff. Further, according to officials from the School Nutrition Association (SNA), some food service staff did not work because they were at high risk for COVID-19 or needed to care for their children. [361]

Lack of funds to meet increased cost of providing meals is another reported challenge, according to organizations interviewed. For instance, covering the costs of additional supplies was more difficult because school meal programs had to forego revenue they would typically earn selling full-price meals and a la carte items, according to information from SNA. In March and April 2020, school districts served about 185 million fewer full-price meals through NSLP and SBP than in March and April 2019, based on the most recent available FNS data. [362] Further, given the decrease in total meals served in March and April, school districts received less in federal cash reimbursements. Officials from multiple national nutrition-focused organizations expressed concern that the $8.8 billion in supplemental funds provided by the CARES Act were only available for meal reimbursement and not for other expenses related to the increased costs associated with providing meals during the pandemic.

Potential challenges for the upcoming school year: As of July 31, 2020, FNS extended four key waivers implemented in the pandemic through the entire 2020-2021 school year for NSLP, SBP, and Child and Adult Care Food Program (CACFP), but not for summer meal programs (SFSP and the Seamless Summer Option). These waivers allow meals to be served in non-congregate settings, enable parent and guardian meal pickup, and provide flexibility in foods served and meal times. Additionally, as of July 31, 2020, FNS had not extended the area eligibility waiver specific to summer meals that allows sites to serve meals to all children regardless of the economic conditions in the local area.[363]

Over the summer, various entities raised concerns about added administrative challenges due to expiring waiver flexibilities and changing methods of meal delivery.[364] Specifically, if area eligibility

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[360]For example, see U.S. Department of Education Office of Safe and Supportive Schools, Readiness and Emergency Management for Schools (REMS) Technical Assistance Center, *Ensuring Continuity of Feeding and Food Distribution During the COVID-19 Pandemic*, May 21, 2020.

[361]The School Nutrition Association (SNA) is a national non-profit organization representing over 55,000 members involved in serving meals to children in schools.

[362]The percentage of total meals served made up by full-price meals dropped about 6 percentage points for NSLP and SBP in March and April 2020 combined compared to March and April 2019 combined (26 to 20 percent for NSLP and 15 to 10 percent for SBP).

[363]As of July 31, 2020, each of these key waivers for summer meal programs were set to expire at different times in the summer and fall of 2020, but all were set to expire by September 30, 2020.

[364]For instance, some of these administrative challenges are described in an August 11, 2020, letter to USDA jointly signed by numerous national, state, and local organizations. See: https://schoolnutrition.org/

waivers for summer meals expire and schools are expected to revert to serving meals under NSLP and SBP, schools will need to track each meal served by fee category (free, reduced-price, and full-price) and charge students accordingly in order to obtain federal reimbursement.[365] However, if schools do not deliver and track meals through a traditional cafeteria line, school districts would need to design new ways to track and collect payment, when appropriate, while also following protocols for social distancing to ensure the safety of children and school staff. School districts may also struggle with quickly enrolling children who are newly eligible for free or reduced-priced meals, as more households face financial hardships.

On August 31, 2020, USDA announced that, in response to stakeholder concerns about adequately serving children in need, it would extend waivers for summer meal programs through the end of the calendar year or until available funding ran out. USDA stated that based upon available data on meals served and analysis of remaining appropriated funds, it projected that it could offer this extension for the remaining months of 2020 rather than the entire school year. These waiver extensions allow schools and other organizations to provide meals with certain flexibilities that have been available since March, easing the administrative challenges of changing methods of meal delivery until waivers expire on December 31, 2020 or funding is exhausted.

Another challenge involves continued eligibility for Pandemic-EBT, which may be affected for some children in the upcoming school year. Specifically, the Families First Coronavirus Response Act requires that eligible children be from schools that are closed for at least 5 consecutive days in order for households to receive benefits, which may be problematic for students attending schools using hybrid models (e.g., in which students attend school some days and use virtual learning other days each week). According to FNS, the agency is currently reviewing the legal and policy considerations related to this and other issues that could affect Pandemic-EBT benefits through September of the upcoming school year.

GAO Methodology and Agency Comments

To conduct our work, we reviewed the most recent data available from FNS on meals served, which we determined were sufficiently reliable for our purposes. We also reviewed relevant federal laws, agency guidance and documents, and written responses from FNS to our questions. Additionally, we interviewed officials from two national organizations representing local providers of school, after school, and summer meals and snacks for children, SNA and the Boys and Girls Club of America, as well as officials from the Food Research and Action Center and No Kid

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uploadedFiles/5_News_and_Publications/5_Newsletters/Tuesday_Morning/TAM-08-18-20-Allied-Letter.pdf (accessed August 25, 2020).

[365]Schools participating in the Community Eligibility Provision (CEP) do not need to track meal prices by student. CEP approved schools can provide free meals to all students, and CEP is available to schools, groups of schools, and school districts that participate in NSLP and SBP and have at least 40 percent of students who are eligible for free meals. In the 2018-2019 school year, about 30 percent of schools in the NSLP provided meals under CEP. In March 2020, as a result of the COVID-19 pandemic, FNS issued a waiver extending the deadlines for the annual CEP process for school year 2020-21. Among other things, this waiver grants districts additional time to calculate identified student percentage and grants state agencies additional time to notify districts of CEP eligibility.

Hungry. The information gathered from these interviews is not intended to be representative, but provides examples of challenges meal providers are facing during the COVID-19 pandemic. We also reviewed information collected in May 2020 by SNA from various member organizations. We provided a draft of this enclosure to FNS and the Office of Management and Budget (OMB) for review and comment. FNS did not provide comments. OMB sent technical comments, which we incorporated as appropriate.

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Related GAO Products

Summer Meals: Actions Needed to Improve Participation Estimates and Address Program Challenges. GAO-18-369. Washington, D.C.: May 31, 2018.

Employer Tax Relief

Some information is available about how employers are claiming refundable tax credits, but the extent of claims for the first and second quarters of 2020 will remain unknown until the relevant forms have been filed and processed; the Internal Revenue Service and the Small Business Administration are collaborating on a data-sharing agreement to ensure the applicable tax credit recipients are not also receiving loans and are in compliance with law.

Entities involved: Department of the Treasury, including the Internal Revenue Service; and the Small Business Administration

Key Considerations and Future GAO Work

The federal government will start to know the extent of the use of employer tax credits for the first and second calendar quarters of 2020 once the Internal Revenue Service (IRS) processes the data after the July 31, 2020 filing deadline and catches up on paper returns received while they were shut down or working at reduced capacity.[366]

In June 2020, we reported that IRS and the Small Business Administration (SBA) had not finalized a data-sharing agreement that would allow IRS to use SBA data to help ensure that Paycheck Protection Program (PPP) loan recipients did not also inappropriately receive the Employee Retention Credit. Although SBA publicly released portions of the PPP data, more information, such as detailed identification information for loan recipients, is needed for IRS to ensure compliance with law. Officials at IRS said that finalizing the agreement is a priority.

We will continue to monitor each of these issues, and include updates in these reports as well as a longer-term report anticipated in 2021.

Background

As the COVID-19 pandemic contributed to a decline in the percentage of the U.S. population employed, Congress passed, and the President has signed into law, legislation intended to help employers support and retain affected employees.[367] Specifically, the enacted legislation generally allows employers to use tax credits to offset certain paid sick and family leave and wages paid to certain retained employees, and other employee-related expenses, as well as to delay payment of the employer share of social security tax. IRS is responsible for administering and ensuring compliance with the tax aspects of these provisions. IRS's general capacity to implement new initiatives such as these is an ongoing challenge cited in our 2019 High Risk Report.

[366] The total amount of refundable credits will not be known until all quarterly and annual returns are filed. Employers may apply for credits through December 31, 2020.

[367] The employment-population ratio represents the percentage of the population that is currently working. The March 2020 ratio was 60 percent, dropping to about 51 percent in April.

The Families First Coronavirus Response Act (FFCRA) and CARES Act provide tax credits to mitigate the cost of paid sick and family leave for smaller employers as well as an employee retention credit for all employers, among other tax relief. The Joint Committee on Taxation estimates that these provisions will lead to about $172 billion in foregone revenue for fiscal years 2020-2030.

- **Paid leave credits.** Businesses and tax-exempt organizations with fewer than 500 employees, as well as self-employed individuals, are eligible for refundable FFCRA credits.[368] The credits are equal to qualified leave wages, plus the employer share of Medicare taxes paid with respect to qualified wages and allocable health plan expenses, from April 1 through December 31, 2020. Credit recipients who receive PPP loans cannot count the wages paid for by the credit as payroll costs toward loan forgiveness.[369]

  Payroll tax credits may be claimed on the employer's employment tax return, typically Form 941, *Employer's Quarterly Federal Tax Return.* To receive immediate relief, employers may reduce their semiweekly or monthly payroll tax deposits by the amount of their credit.[370] If an anticipated credit amount remains after reducing deposits, the employer may receive an advance refund by filing Form 7200*, Advance Payment of Employer Credits Due to COVID-19*. Form 7200 must be submitted using electronic fax (e-fax).

- **Employee Retention Credit.** Under the CARES Act, employers of any size—including tax-exempt entities and self-employed individuals with employees—can receive the refundable Employee Retention Credit. The credit equals 50 percent of qualified wages (up to $10,000 per employee) paid from March 13 through December 31, 2020, including certain health care expenses.[371] Eligible employers are those who experience, in calendar year 2020, either (1) full or partial suspension of operations due to government orders limiting activity in response to COVID-19 during any calendar quarter, or (2) a decline in gross receipts of more than 50 percent, compared with the same quarter in 2019.

  PPP recipients are not eligible for the Employee Retention Credit, unless they repaid their PPP loans by May 18, 2020. Wages for which FFCRA credits are allowed are not included in wages for the Employee Retention Credit, among other exclusions from wages.[372] Employers can claim the credit on their employment tax returns and may reduce payroll tax deposits by the credit amounts, or file Form 7200 for advance refunds.

- **Deferred payroll tax payments for employer share of Social Security.** The CARES Act granted all employers the option to defer deposits and payments of the employer share of

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[368]Pub. L. No. 116-127, §§ 7001–7004, 134 Stat. 178, 210–219 (2020). A refundable tax credit reduces tax liability, dollar for dollar; if the credit exceeds tax liability, a refund is due. Full-time and part-time employees are counted. Both credits have maximum payouts. Self-employed individuals may not file for advances on their credit refunds.

[369]15 U.S.C. § 636(a)(36)(A)(viii)(II)(dd), (ee). PPP recipients must meet certain criteria for loan forgiveness.

[370]Internal Revenue Service, *COVID-19-Related Tax Credits: General Information FAQs,* Apr. 28, 2020, available online at https://www.irs.gov/newsroom/covid-19-related-tax-credits-general-information-faqs (accessed Aug. 20, 2020.)

[371]Pub. L. No. 116-136, § 2301, 134 Stat. at 347–351. For employers with more than 100 full-time employees in 2019, the credit is calculated on wages paid to employees who are not providing services. For smaller employers, all wages are countable.

[372]Employees counted under a Work Opportunity Tax Credit are not counted for purposes of the Employee Retention Credit.

Social Security tax that they would otherwise be required to make during the period beginning March 27 through December 31, 2020.[373] Self-employed individuals may defer half of their Social Security taxes due.[374] Deferred deposits are to be reported on Form 941.

In addition, on August 8, 2020, the President signed a memorandum that, in part, directed the Secretary of the Treasury to exercise his authority under section 7508A of the Internal Revenue Code to defer the withholding, deposit, and payment of certain employment taxes from September 1, 2020, to December 31, 2020 if an employee's wages are below a certain amount.[375]

Overview of Key Issues

IRS continues to process Form 7200s for COVID-19-related tax credit advance refunds. As of July 31, 2020, IRS said employers have claimed $435.48 million in advance credits and IRS has distributed this amount (see table).[376] We are continuing to examine what factors are affecting the efficacy of these provisions in achieving their intended purpose.

[373]Pub. L. No. 116-136, § 2302, 134 Stat. at 351–352. To be considered timely, deferred payments of 50 percent of tax are to be made by December 31, 2021, with the remainder due December 31, 2022. The employer share of social security tax is 6.2 percent of taxable earnings up to the cap on taxable income. The tax finances the Social Security trust funds.

[374]Self-employed individuals pay the employer and employee tax share, which is 12.4 percent of taxable earnings, up to the cap on taxable income.

[375]U.S. Presidential Memorandum, *Memorandum on Deferring Payroll Tax Obligations in Light of the Ongoing COVID-19 Disaster,* Aug. 8, 2020, available online at https://www.whitehouse.gov/presidential-actions/memorandum-deferring-payroll-tax-obligations-light-ongoing-covid-19-disaster/ (accessed Aug. 20, 2020.) The memorandum directs the Secretary of the Treasury to make this deferral available with respect to employees whose earnings during any bi-weekly pay period generally are less than $4,000 on a pre-tax basis, or the equivalent amount with respect to other pay cycles. It also directs the Secretary to "explore avenues, including legislation, to eliminate the obligation to pay the taxes deferred pursuant to the implementation of this memorandum."

[376]Multiple forms may be included in each e-fax submission. This may include duplicate submissions and aggregate submissions from the same employer. Information on each credit is not available until employers file Form 941 for the second quarter

Summary of IRS Processing Data for Form 7200			
	As of May 31, 2020	As of July 31, 2020	Change since May
E-fax submissions[a]	7,931[b]	18,054	10,123
Form 7200s reviewed[c]	6,189	18,984	12,795
Refunds issued ($ millions)	54.2	435.48	381.28

Source: GAO analysis of Internal Revenue Service data. | GAO-20-701

[a]Multiple forms may be included in each e-fax submission. This may include duplicate submissions and aggregate submissions from the same employer. Per credit information is not available until employers file Form 941 for the second quarter.

[b]This number differs from our June report when IRS officials said that the number of e-fax submissions was 8,754. In August, IRS officials said that number included the total number of Form 7200s received. They corrected this to 7,931, which is the total number of e-fax submissions received.

[c] "Form 7200s reviewed" figures include Forms 7200 and other submissions that might not include a Form 7200, such as blank cover sheets, PPP loan applications, and Forms SS-4. This number differs from our June report when IRS officials said that the number of Form 7200 reviewed was 7,185. In August, IRS officials clarified that number included cases pending assignment to a reviewer and cases where the review of the Form 7200 is still in progress. They corrected this to 6,189 to omit all cases actively in review, and only include completed reviews.

More information will be available, including the number of credit recipients and specific data by credit, after second quarter Form 941s, due July 31, 2020, are processed.[377] IRS officials said under normal circumstances both the paper and e-filed second quarter Form 941s would be processed by mid-September. However, because IRS facilities that process these forms were closed or not fully operational for months, IRS officials said they are experiencing a backlog and are unsure when the processing of paper Form 941s will be complete.[378]

IRS officials said they do not know yet if the pandemic is affecting employers' filing methods. As of August 19, 2020, both of the campuses that process these returns are open with reduced staffing to allow for social distancing. When paper Form 941s are sorted, IRS officials said they will be grouped by date received. Forms with refunds are to be prioritized.

Two industry groups said their members are not receiving any updates from IRS after they have submitted Form 7200s. However, IRS has already published guidance for staff answering calls related to Form 7200 filings. IRS designated 8,393 of the 18,984 Form 7200s reviewed through July 31, 2020 as "rejected"—due to incomplete information or computational errors—and required that letters or notices to the employers be sent for any such rejected submissions. Since IRS started sending mail on June 19, 2020, it has mailed 6,720 letters to employers with rejected returns.

Since April, IRS continues to update guidance for the Employee Retention Credit in the form of Frequently Asked Questions (FAQs). Although tax-exempt organizations are eligible to receive the credits, one industry group told us that an initial lack of explicit IRS guidance on the definition of "gross receipts" for the Employee Retention Credit caused confusion for some organizations. Until IRS issued guidance in these FAQs on June 19, 2020, organizations were not confident enough to file for the credit, according to a group representing charitable organizations. IRS officials told us

[377]IRS released a revised Form 941 in June 2020.

[378]Paper employment tax returns are received and processed in Kansas City, Mo. and Ogden, Utah. These facilities closed on March 26, 2020 and April 6, 2020, respectively and started reopening in June.

that employers could have filed for the credit before the definition was released using a definition applied in good faith, and noted that the FAQs are non-binding.

Given that PPP recipients are generally not eligible for the Employee Retention Credit, IRS is working to ensure employers are not taking advantage of both provisions. As of August 21, 2020 IRS and SBA are still working collaboratively to finalize a draft memorandum of understanding for SBA to provide data on PPP recipients to help ensure employers comply with requirements, according to IRS officials.[379] Both agencies anticipate finalizing the memorandum this summer.

IRS officials told us they are drafting a plan for the use of PPP data during Form 941 reviews and exploring opportunities to use this data to review Form 7200 filings before issuing advance credits. In July 2020, IRS issued proposed and temporary regulations regarding the recapture of erroneous refunds of the Employee Retention Credit and the leave credits.[380]

On August 28, 2020, IRS and Treasury issued guidance implementing the Presidential memorandum, which states employers can defer the withholding and payment of the employee portion of Social Security payroll tax or the railroad retirement tax equivalent for eligible employees for the period covered in the memorandum.[381] According to the guidance, the due date for employers to withhold and pay the tax is postponed until the period beginning January 1, 2021 and ending April 30, 2021.

GAO Methodology and Agency Comments

To conduct this work, we interviewed officials at professional associations for tax filers, employers, and agency officials. We also reviewed IRS data as of July 31, 2020, federal laws, and agency guidance and plans. We provided IRS, Treasury, the Small Business Administration (SBA), and the Office of Management and Budget with a copy of this enclosure. IRS and Treasury provided technical comments, which we integrated as appropriate. SBA and the Office of Management and Budget did not have any comments on this enclosure.

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[379]IRS is requesting loan-level information on all PPP recipients from SBA to ensure that employers are not inappropriately receiving both a PPP loan and the Employee Retention Credit.

[380]85 Fed. Reg. 45514, 45551 (July 29, 2020). A refund, a credit, or an advance of any portion of thesecredits to a taxpayer in excess of the amount to which the taxpayer is entitled is an erroneous refund for which the IRS must seek repayment.

[381]Internal Revenue Service, *Relief with Respect to Employment Tax Deadlines Applicable to Employers Affected by the Ongoing Coronavirus (COVID-19) Disease 2019 Pandemic,* Aug. 28, 2020, available online at: https://www.irs.gov/pub/irs-drop/n-20-65.pdf (accessed Aug. 28, 2020).

Unemployment Insurance Programs

As the unemployment insurance system continues to face a high number of initial claims, the Department of Labor continues to monitor states' implementation of the CARES Act unemployment insurance programs, has issued additional guidance, and has taken steps to address program integrity.

Entity involved: Department of Labor

Key Considerations and Future GAO Work

The unemployment insurance system continues to experience high numbers of initial claims in the wake of the COVID-19 pandemic. While enhanced benefits under the Federal Pandemic Unemployment Compensation program have helped workers and the economy, those benefits expired at the end of July 2020. According to recent research, expanded unemployment insurance likely helped stabilize spending, especially for low-income households—which in turn, has helped mitigate some of the negative effects of the pandemic on the U.S. economy.[382]

The Department of Labor (DOL) continues to monitor states' implementation of the CARES Act unemployment insurance programs, has issued additional guidance, and has taken steps to address program integrity. Its Office of Inspector General has designated unemployment insurance as a high priority program for addressing program integrity issues. In fiscal year 2019, Department of Labor reported that 10.6 percent of unemployment insurance benefits were paid improperly, and the inspector general estimates that, if improper payments continue at the current rate, at least $26 billion of the funding for the CARES Act unemployment insurance programs could be lost through fraud and improper payments.

As we continue our examination of the unemployment insurance (UI) program, we will consider the economic implications for workers as CARES Act UI programs expire. We will also continue work that will examine, among other issues, states' challenges in processing the record level of UI claims and addressing program integrity, as well as the Department of Labor's (DOL) related assistance in these areas. Additionally, we will continue to examine the number of states that borrow funds from the federal government to pay UI benefits. From January 1, 2020 through August 11, 2020, 13 states—California, Colorado, Connecticut, Hawaii, Illinois, Kentucky, Massachusetts, Minnesota, New Jersey, New York, Ohio, Texas, and West Virginia, as well as the U.S. Virgin Islands—took out such loans, totaling about $26 billion.[383] According to DOL, the need for these loans was especially acute as the pandemic had exacerbated shortfalls in states' funds that existed before the pandemic began, which were caused by many states not taking in enough

[382]See, for example, Natalie Cox et al., *Initial Impacts of the Pandemic on Consumer Behavior: Evidence from the Linked Income, Spending, and Savings Data* (Chicago, Illinois: University of Chicago Becker-Friedman Institute, July, 2020). See also, Diana Farrell et al., *Consumption Effects of Unemployment Insurance During the COVID-19 Pandemic* (JP Morgan Chase Institute, July 2020).

[383]According to Department of Labor, the U.S. Virgin Islands also had a residual loan balance that predated the pandemic, from the Great Recession.

funds to pay UI benefits according to the standard set in DOL regulations providing for interest-free loans to states.[384]

Background

The UI program is a federal-state partnership that provides temporary financial assistance to eligible workers who become unemployed through no fault of their own and helps stabilize the economy during recessions.[385] The regular UI program is funded primarily through federal and state taxes levied on employers. States design and administer their own UI programs within federal parameters, and DOL oversees states' compliance with federal requirements, such as ensuring that states pay benefits when they are due. To be eligible for UI benefits, applicants generally must be able and available to work, and be actively seeking work.[386]

In addition to the regular UI program, the CARES Act created three new, federally funded temporary UI programs that expanded UI benefit eligibility and enhanced benefits:

1. Pandemic Unemployment Assistance (PUA), available through December 2020, generally authorizes up to 39 weeks of UI benefits to individuals not otherwise eligible for UI benefits, such as the self-employed and certain gig economy workers, who are unable to work as a result of COVID-19; [387]
2. Federal Pandemic Unemployment Compensation (FPUC) generally authorized an additional $600 benefit that augmented weekly UI benefits available under the regular UI program, as well as CARES Act UI programs, through July 2020; [388] and
3. Pandemic Emergency Unemployment Compensation (PEUC), available through December 2020, authorizes an additional 13 weeks of UI benefits to those who exhaust their regular UI benefits. [389]

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[384]See 20 C.F.R. § 606.32.

[385]We refer to the UI program as the regular UI program and the benefits paid under the program as regular UI benefits.

[386]Federal law requires states to have, as a condition of eligibility for UI administrative grants, laws that require claimants to be able to work, available to work, and "actively seeking work" as a condition of eligibility for UI benefits. 42 U.S.C. § 503(a)(12).

[387]Pub. L. No. 116-136, § 2102, 134 Stat. at 313.

[388]Pub. L. No. 116-136, § 2104, 134 Stat. at 318.

[389]Pub. L. No. 116-136, § 2107, 134 Stat. at 323. In addition, the act also addressed other elements of the unemployment insurance system. For example, the act also authorized certain flexibilities for states in hiring additional state agency staff.

On August 8, 2020, the President signed a memorandum directing FEMA to provide up to $44 billion in lost wages assistance from the Disaster Relief Fund.[390] Pursuant to the presidential memorandum, upon receiving a FEMA grant, states and territories may provide eligible claimants $300 or $400 per week, which includes a $300 federal contribution.[391] As of September 9, 2020, FEMA had approved lost wages assistance grants to 48 states, the District of Columbia, and Guam.

Overview of Key Issues

Almost all states have implemented the three CARES Act UI programs and have received emergency administrative funding. According to DOL, as of July 1, 2020, all states, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, have signed agreements with DOL to implement the three CARES Act UI programs, and almost all were paying benefits under each of the programs.[392]

In addition to the CARES Act, the Families First Coronavirus Response Act (FFCRA) provided up to $1 billion in emergency grant funding to states in fiscal year 2020 for administrative purposes related to the regular UI program, according to DOL. The first half of the funding ($500 million), which was fully disbursed by DOL by April 23, 2020, was available to states that met requirements related to providing UI notifications and helping ensure claimants' access to the application process. The second half of the funding ($500 million) was available to states that experienced at least a 10 percent increase in quarterly UI claims over the same quarter of the previous calendar year. Additionally, to qualify for the second round of funding, states had to meet certain requirements related to easing UI eligibility requirements, such as waiving work search requirements, among other things. As of July 31, 2020, DOL had disbursed $498 million of the second round of funding.[393]

States have used the FFCRA emergency administrative funds to support claims processing, according to representatives of the National Association of State Workforce Agencies. Additionally, states have used these funds to, for example, hire and train new staff, hire contractors, contract with call centers and consultants, and enhance their IT systems. In addition, some states, such as

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[390]The White House, *Memorandum on Authorizing the Other Needs Assistance Program for Major Disaster Declarations Related to Coronavirus Disease 2019* (Aug. 8, 2020).

[391]According to FEMA, states that provide $400 per week in lost wages assistance would contribute $100 each week in state funds, while states providing $300 per week in lost wages assistance may count existing state funding used to pay regular UI benefits to satisfy the state match.

[392]By implementing the CARES Act unemployment insurance (UI) programs, we mean that the states or territories had signed agreements with the Department of Labor to operate the programs, and had begun paying benefits under the programs. For the purposes of these programs, the District of Columbia and various territories count as states. Although Colorado, New Hampshire and Virginia had agreements in place to operate Pandemic Emergency Unemployment Compensation (PEUC), they had not yet begun paying benefits under the program, as of July 1, 2020, according to DOL. Similarly, while the Virgin Islands had an agreement in place, it had not begun paying benefits under Pandemic Unemployment Assistance and PEUC.

[393]As of July 31, 2020, Puerto Rico was the only state that had not applied for the second round of funding, according to DOL.

Massachusetts, New Hampshire, Washington and West Virginia, have deployed National Guard units to help with claims processing or staffing call centers, according to media reports.

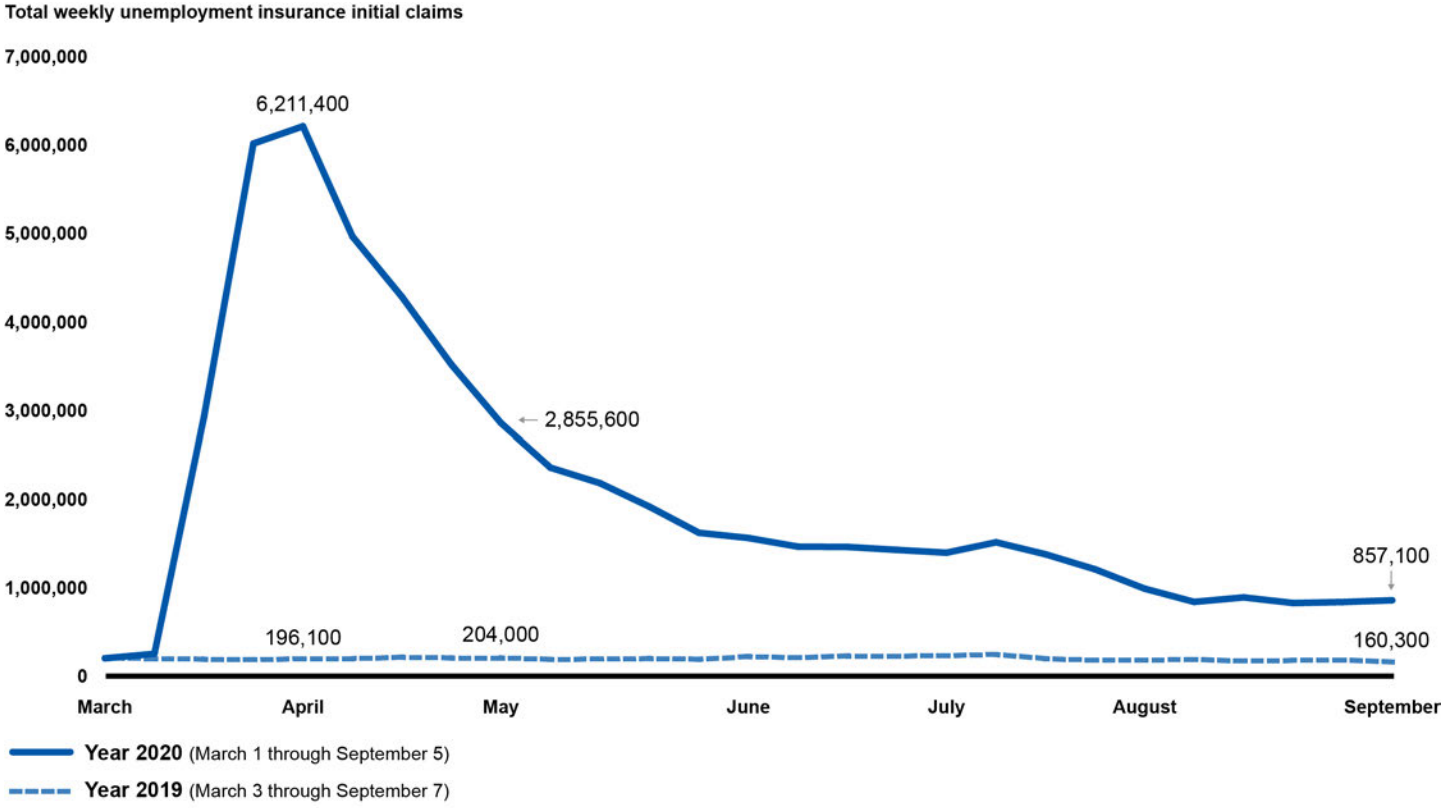
Initial regular UI claims remain persistently high. With about 13 million regular UI claims submitted for continuing unemployment during the week ending August 22, 2020, regular UI claims remain at historic levels.[394] While the number of initial claims in the regular UI program has declined somewhat compared to the early weeks of the pandemic in late March and early April, the number of initial claims remains persistently high (see figure below). Overall, initial weekly regular UI claims declined from a peak of over 6.2 million for the week ending April 4, 2020, to 857,148 during the week ending September 5, 2020.[395] Despite this overall decline, the volume of initial claims remains high compared to pre-pandemic numbers. For example, the 857,148 initial regular UI claims for the week ending September 5, 2020, was more than five times the volume of claims submitted during the corresponding week in 2019 (160,342). Additionally, while the initial claims volume has declined nationally, some states have experienced increases. For example, the average weekly initial claims increased between June and July in some states, including Arkansas and Nevada.[396] Overall, states continue to face case processing workloads that can be as high as five to six times pre-pandemic workloads, according to DOL.

[394]DOL also reported that about 14.6 million claims were made for continuing unemployment under the PUA program during the week ending August 22, 2020. Due in part to backlogs in state processing, the number of regular UI and PUA continued claims DOL reports each week includes claims from prior weeks. If an individual claims benefits for multiple weeks of unemployment during a single reporting period, each week is counted as a separate claim. Claiming benefits for multiple weeks of unemployment could be more prevalent in the PUA program because it is a new program that took time to implement and individuals are able to claim benefits retroactively. DOL also reported almost 2 million continued claims made under other unemployment programs, such as the PEUC program, for the week ending August 22, 2020.

[395]Initial claims counts presented are not seasonally adjusted, and the count for the week ending September 5, 2020 represents advance initial claims, which are preliminary and subject to revision. Due to a change in Department of Labor methods for seasonally adjusting UI claims counts, we now report non-seasonally adjusted counts, a change from our prior reports.

[396]To compare data across states, we pulled the initial claims from the Department of Labor's Weekly Claims and Extended Benefits Trigger Dataset and calculated the weekly average for each state for June and July. We reviewed the change and percentage change in average weekly initial UI claims from June 2020 to July 2020. The data covers the time period from May 31 through June 27; for July, the data covers June 28 through August 1. We compared June and July because the Department of Labor had not published all of August's weekly claims data by the time we completed our analysis.

Unemployment Insurance Initial Regular Weekly Claims, March through early September 2020, Compared to March through early September 2019



Source: Department of Labor data. | GAO-20-701

Note: The weekly counts of regular unemployment insurance (UI) initial claims shown in the figure are not seasonally adjusted. Initial claims counts are reported weekly by the Department of Labor (DOL) and are subject to revision. We present non-seasonally adjusted data, a change from our prior reports, in part because DOL changed its methods for seasonally adjusting UI claims counts beginning with the initial claims for the week ending August 29, 2020.

Expiration of the enhanced weekly benefit will likely have adverse effects for workers and the economy. The expiration of the additional $600 weekly UI benefits under FPUC at the end of July 2020 will likely affect unemployed workers and the economy negatively.[397] According to DOL data, regular UI generally replaces up to 50 percent of a person's income. However, with the $600 enhancement, some UI claimants received more in total UI benefits than they would have earned in their regular wages if they were still employed—while others received less.[398] In either case, individuals receiving enhanced benefits were better positioned to spend at pre-pandemic

[397]Unemployed workers who remain eligible for regular UI will continue to receive regular UI weekly benefits. According to DOL data, seven states and Puerto Rico had a maximum weekly benefit amount for regular UI in 2019 of less than $300; by contrast, Massachusetts had the highest maximum weekly benefit amount, at $1192.

[398]According to recent research that used estimates based on the Current Population Survey, issued before Federal Pandemic Unemployment Compensation expired, about 68 percent of UI claimants could receive benefits that exceeded their earnings. See Peter Ganong, Pascal Noel, and Joseph Vavra, "US Unemployment Insurance Replacement Rates During the Pandemic," University of Chicago Becker Friedman Institute Working Paper 2020-62, May 2020. The authors also found that the additional $600 weekly benefit would not replace income for high earners—i.e., those earning at or above $1,058 weekly—while noting that the current pool of unemployed workers disproportionately reflected low-income workers.

levels without accumulating debt or using retirement savings than they would have been without the enhanced benefit. According to a recent Census Bureau post, adults in lower-income and younger households who suffered job losses during the COVID-19 pandemic have less confidence than those in other households that they can pay next month's rent or mortgage on time and will suffer more food insecurity.[399] However, one recent survey showed that—among individuals who had applied for UI benefits—those who had been receiving the benefits had higher consumer confidence and were less anxious about bills, including rent and medical bills.[400]

For low-wage workers in particular, loss of the additional $600 weekly benefit may put them at risk of not being able to afford basic needs. The CARES Act's provisions providing temporary relief from evictions also expired at the end of July 2020.[401] With regard to nutrition assistance, generally, those who receive UI benefits may not qualify for the Supplemental Nutrition Assistance Program (SNAP), because UI is generally treated as income for purposes of SNAP eligibility, according to the Department of Agriculture, and in some cases, claimants' regular benefits may make them ineligible for SNAP after the expiration of FPUC.[402] Generally, to be eligible for SNAP, a household's gross income must not exceed 130 percent of the federal poverty level, and there are also generally net income limits and asset limits. At DOL's 2019 average weekly UI benefit amount of $367, or $1,468 monthly, a single-person household would exceed the SNAP monthly gross income limit of $1,354.[403] Such households that continue to receive regular UI may have few alternatives for nutrition assistance apart from food banks.[404] According to a coalition of

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[399]Brian Mendez-Smith and Mark Klee, "Census Bureau's New Household Pulse Survey Shows Who Is Hardest Hit During COVID-19 Pandemic," June 19, 2020, accessed on August 9, 2020, from https://www.census.gov/library/stories/2020/06/low-income-and-younger-adults-hardest-hit-by-loss-of-income-during-covid-19.html.

[400]Michael Karpman and Gregory Acs, *Unemployment Insurance and Economic Impact Payments Associated with Reduced Hardship Following CARES Act* (Washington, D.C.: Urban Institute, June 2020).

[401]The CARES Act prohibits landlords for a 120-day period, beginning March 27, 2020, from (1) initiating with the relevant court legal action to recover possession of a certain covered dwellings due to nonpayment of rent (i.e., evict a tenant) or (2) charging fees to such tenants for nonpayment of rent. Pub. L. No. 116-136, § 4024, 134 Stat. at 492. On September 1, 2020, the Centers for Disease Control and Prevention issued an order halting evictions to prevent the further spread of COVID-19. This moratorium is in effect through December 31, 2020 and covers renters who meet certain criteria. However, neither moratorium addresses how affected renters will continue to pay their rent, including back rent.

[402]In fiscal year 2018, about 1 percent of Supplemental Nutrition Assistance Program (SNAP) households were receiving UI, according to the Department of Agriculture (USDA), although receipt of unemployment insurance (UI) in households receiving SNAP benefits can be higher in recessions. According to a USDA study, an estimated 14.4 percent of SNAP households also received UI in 2009. According to the USDA, Disaster Unemployment Assistance—the regulations for which generally apply to Pandemic Unemployment Assistance—is considered federal major disaster and emergency assistance under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, is excluded from income, and thus, is not counted as a resource for SNAP purposes.

[403]According to USDA, this is the gross income limit for a single-person household in effect from October 1, 2019, through September 30, 2020. Gross income limits vary by household size; for example, they are $4,705 for an eight-person household. In addition, they are higher in Alaska and Hawaii, and are disregarded for households with an elderly or disabled member, which must meet only net income limits. Some UI claimants may meet SNAP income and asset limits and thereby qualify for SNAP.

[404]Nevertheless, the Center on Budget and Policy Priorities projects an increase in SNAP applications after the expiration of FPUC. See Center on Budget and Policy Priorities, "Pandemic Unemployment Insurance Provisions: What They Mean for Access to SNAP, Medicaid, and TANF," May 14, 2020, accessed on July 17, 2020, from https://www.cbpp.org/research/economy/pandemic-unemployment-insurance-provisions-what-they-mean-for-access-to-snap.

food banks, Feeding America, local partners are anticipating increased demand for their services, although they have also experienced reduced donations as well as a loss of volunteers.

Furthermore, enhanced benefits under FPUC likely limited the effects of labor market disruptions on consumer spending and helped stabilize the economy. For example, according to recent research, CARES Act stimulus payments to low-income households increased consumer spending sharply, but had modest effects on employment in the short run, perhaps because very little of the increased spending flowed to the most affected businesses.[405] These businesses, such as hotels and food services, require physical interaction and employed low-income workers but served high-income clients who reduced spending sharply in mid-March 2020.

Further, according to recent University of Chicago research, since mid-April, consumer spending has rebounded most rapidly for low-income households. The researchers observe that the recovery in low-income workers' spending in part reflected the fact that enhanced UI benefits represented a larger share of such workers' income as compared to high-income workers.[406] They also note that declines in income due to phasing out broad stimulus too quickly would result in declines in aggregate demand by low-income workers, which could pose further challenges to re-employment if more businesses in sectors catering to these workers close or scale down due to lower consumer demand.[407] As we have previously reported, research suggests that decreases in UI benefits can have ripple effects for the economy and for employment.[408]

Another UI program, Short-Time Compensation (STC), may offer an opportunity to further support workers. Under STC, which predates the pandemic and is operational in 25 states, participating employers allow workers to work reduced hours while receiving partial pay and partial UI benefits. There is some evidence of increased interest in this program among employers in some states. According to DOL, the number of employers participating in STC increased in 20 states between January and May 2020.[409] For example, Iowa's STC program has grown from fewer than 10 employers covering 800 workers before the pandemic to approximately 183 employers covering over 8,000 workers as of June 5, 2020, according to the director of the state agency responsible for UI benefits.

The CARES Act provides for federal funding of benefits for existing STC programs through 2020. For states without STC programs, the CARES Act allows them to enact such a program via state law and receive the federal funding. Alternatively, such states can create an STC program via an

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[405]Raj Chetty, John N. Friedman, Nathaniel Hendren, and Michael Stepner, "How Did COVID-19 and Stabilization Policies Affect Spending and Employment? A New Real-Time Economic Tracker Based on Private Sector Data," Opportunity Insights, June 17, 2020.

[406]Natalie Cox, Peter Ganong, et al., University of Chicago Becker-Friedman Institute, July 2020.

[407]To the extent that workers quickly find re-employment after the expiration of FPUC, any effects on spending would not be expected. However, it may be challenging for workers to find employment. According to Bureau of Labor Statistics data, job openings in June 2020 reflect an 18 percent decline as compared to June 2019.

[408]GAO, *Unemployment Insurance: States' Reduction in Benefit Duration Have Implications for Federal Costs*, GAO-15-281 (Washington, D.C.: April 22, 2015). UI benefits can be a source of economic stabilization, by increasing aggregate demand through a "multiplier effect" during downturns. The multiplier effect is derived from claimants' tendency to spend a high proportion of their benefits.

[409]In addition, DOL data show the number of employers participating in Short-Term Compensation increased in one state between January and March 2020, and in another state between January and June 2020.

agreement with DOL, in which case half of the funding is paid by the federal government, with the other half paid by employers.[410] However, according to DOL, no states have opted to do so yet.[411]

Some states seek federal loans to pay regular UI benefits. While initial regular claims have declined compared to the early weeks of the pandemic in March 2020, overall, the number of UI claims remains historically high, putting pressure on states' capacity to pay benefits. While the CARES Act UI programs are federally funded, regular UI is primarily funded through state and federal taxes on employers. When a state exhausts the funds available for regular UI benefits, it may borrow from the federal government. According to DOL data, even before the pandemic, many states were not taking in enough UI tax revenue to satisfy the solvency standard specified in DOL regulations providing for interest-free loans to states.[412] From January 1, 2020, to August 31, 2020, 13 states and the U.S. Virgin Islands had such loans, totaling about $26 billion.[413]

DOL is continuing to monitor states' implementation of CARES Act UI programs, provide guidance and technical assistance, and take steps to reinforce program integrity. To support its oversight of states' implementation of the CARES Act UI programs, DOL has developed a suite of monitoring tools for use by its regional offices that it expected to finalize in August 2020. According to DOL, although the monitoring tools have not yet been implemented, preliminary review of states' documentation and procedures has identified some issues regarding the PUA program in particular. For example, DOL found that a number of states did not have appropriate monetary determination processes for PUA claimants. According to DOL, the agency is working with the relevant states to address these issues.

DOL continues to issue guidance to support implementation of CARES Act UI programs and help state UI agencies and employers prepare for reopening of workplaces. Specifically, while not directly related to the CARES Act UI programs, the Occupational Safety and Health Administration (OSHA) has issued guidance for workplace protections to prevent the spread of COVID-19. As workplaces reopen, however, some individuals may choose not to return to work, for example, due to health and safety concerns for themselves or family members, or continued child care issues related to school closures. According to DOL, most states have laws that allow claimants to refuse offers of employment for good cause—which may include, but is not limited to, the degree of risk to an individual's health and safety—and still maintain UI benefits.[414] DOL has encouraged

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[410]Pub. L. No. 116-136, § 2108-2109, 134 Stat. at 328.

[411]In addition, the CARES Act also provides up to $100 million through two grant programs to support states in implementing and administering STC programs and promoting and enrolling employers. Pub. L. No. 116-136, § 2110, 134 Stat. at 331. According to DOL, Missouri, which had an existing program, is the only state that has applied for these grants to date.

[412]See 20 C.F.R. § 606.32 (2019).

[413]The 13 states are California, Colorado, Connecticut, Hawaii, Illinois, Kentucky, Massachusetts, Minnesota, New Jersey, New York, Ohio, Texas, and West Virginia. According to DOL, the U.S. Virgin Islands also had a residual loan balance that predated the pandemic, from the Great Recession.

[414]Specifically related to the COVID-19 pandemic, the Department of Labor (DOL) has issued guidance stating that if a person has left an employer due to pandemic health concerns related to that person or to the care of others and does not return, state law can be used to determine if this was a good cause separation. Department of Labor, *Unemployment Insurance Program Letter No. 10-20*, March 12, 2020. Although OSHA has issued guidance on returning to work, it is directed to employers. According to DOL, this guidance to employers should not be directly tied to whether an employee is eligible for UI.

states to ask employers to inform state UI agencies when workers decline suitable work without good cause, that is, for reasons that do not support their continued eligibility for benefits.[415]

Following a recommendation in our June 2020 report, DOL issued guidance on August 12, 2020, addressing potential risks that certain workers being paid wages with proceeds from the Paycheck Protection Program (PPP)—administered by the Small Business Administration—could also simultaneously be receiving UI benefits.[416] The guidance clarified that individuals working full-time and being paid through PPP are not eligible for UI, and that individuals working part-time and being paid through PPP would be subject to certain state policies, including policies on partial unemployment, to determine their eligibility for UI benefits. Further, the guidance clarified that individuals being paid through PPP but not performing any services would similarly be subject to certain provisions of state law, and noted that an individual receiving full compensation would be ineligible for UI.

In addition, DOL has taken some steps to address program integrity. According to DOL, these steps have included, for example, issuing guidance, promoting use of tools states can use to identify known suspicious and fraudulent claims activity; holding weekly conference calls to highlight states' promising practices; and gathering information on states' use of certain program integrity tools as part of its future monitoring activities. Additionally, in response to alleged fraud identified in the CARES Act UI programs, DOL officials stated that DOL has partnered with the DOL Office of Inspector General (OIG) to combat alleged fraud in several areas, such as preventing, detecting, and investigating alleged fraud, communicating fraud schemes, and identifying effective fraud prevention strategies. In addition, DOL has identified the self-certification of eligibility for PUA claims as an opportunity for fraud, and has reviewed states' documentation and processes regarding PUA eligibility.[417]

To address program integrity, the DOL OIG is undertaking a comprehensive effort to identify the types of UI fraud encountered by states, the tools states are using to detect UI fraud and improper payments, and their plans to recover overpayments, according to DOL OIG officials. The effort will involve more in-depth studies of selected states and a survey of the remaining states. The OIG will review determination of initial eligibility, continued claims for those no longer eligible for UI because they have returned to work, and individual refusals to return to work. The OIG anticipates issuing an interim report in fall 2020 and a final report in fall 2021.

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[415]Department of Labor, *Unemployment Insurance Program Letter*, No. 23-20 (May 11, 2020). Additionally, DOL has provided guidance to state UI agencies that explains that individuals who refuse to return to work when requested by their employer or refuse a suitable job offer do not qualify for Pandemic Unemployment Assistance. *Unemployment Insurance Program Letter*, No. 16-20, Change 1, Attachment 1 (April 27, 2020).

[416]Department of Labor, *Unemployment Insurance Program Letter*, No. 14-20, Change 1 (August 12, 2020).

[417]As part of its review, DOL requested and obtained state documentation, such as a copy of the self-certification form at the time of initial claim filing; a copy of the PUA monetary determination notice to claimants; and a copy of the certification form to determine ongoing eligibility, including the self-certification form for continued claims, among other documents.

GAO Methodology and Agency Comments

To conduct this work, we reviewed information DOL provided as of July 2020; reviewed relevant federal laws, agency guidance, and DOL Office of Inspector General reports; reviewed relevant economic research; and interviewed DOL officials, DOL Office of Inspector General officials, and representatives of the National Association of State Workforce Agencies and Feeding America.

We shared a draft of this report with DOL and Office of Management and Budget (OMB) officials. They provided technical comments, which we have incorporated as appropriate.

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Head Start

The Office of Head Start is awarding CARES Act funds to all grantees (based on their existing enrollment) to be used to address a variety of COVID-19 related needs, and it is finalizing plans for how it will collect detailed information on grantees' use of these funds and monitor what is spent.

Entity involved: Office of Head Start, within the Administration for Children and Families, within the Department of Health and Human Services

Key Considerations

In September 2019, we found issues with the Office of Head Start's (OHS) management of fraud risk and timely monitoring of grantees, and we made six recommendations to strengthen Head Start program oversight. These recommendations included that the Director of OHS (1) perform a fraud risk assessment for the Head Start program, to include assessing the likelihood and impact of such risks, and (2) establish procedures to monitor and evaluate internal OHS guidance so that timeliness goals for monitoring reviews are met.

OHS agreed with the first of these recommendations, but not the other; we maintain that both recommendations remain valid and both are still open, although the Department of Health and Human Services (HHS) is taking some steps to address them. For example, HHS told us in February 2020 that the Administration for Children and Families (ACF) is developing a Fraud Risk Assessment template for all of its programs (including the Office of Head Start) and planned to complete the initial Fraud Risk Assessment for its pilot program by June 30, 2020, after which it anticipates completing its initial Fraud Risk Assessment for OHS by March 31, 2021. Additionally, HHS said that for fiscal year 2020 OHS has updated its internal guidance to increase responsiveness to identified monitoring findings and to ensure grantee support.

Background

Established in 1965 and administered by OHS, the Head Start program—one of the largest federal early childhood programs—seeks to promote school readiness by supporting the comprehensive development of low-income children through educational, nutritional, health, social, and other services.[418] In fiscal year 2019, more than $10 billion was appropriated for payments under the Head Start Act, the majority of which is to be used for direct grants to approximately 1,600 public agencies, private nonprofit and for-profit organizations, tribal governments, and school systems for Head Start programs, which served about 1 million children, from birth to age 5.

The CARES Act provides an additional $750 million for making payments under the Head Start Act to prevent, prepare for, and respond to COVID-19 and to be allocated to each grantee in

[418]See 42 U.S.C. §§ 9831–9852c for the Head Start Act, as amended.

an amount relative to its proportion of all enrolled children in Head Start. Up to $500 million of these funds is available for the purpose of operating supplemental summer programs through noncompetitive grant supplements to existing grantees determined by OHS to be most ready to operate those programs.[419]

Overview of Key Issues

OHS issued updated guidance in May 2020 stating that all CARES Act funds would be awarded by formula to all Head Start grantees based on their funded enrollment to be used to address a variety of COVID-19 related needs and that none of the $500 million available for supplemental summer programs would be awarded specifically for that purpose. OHS officials said they made the decision not to award funds specifically for summer programs because many grantees could not provide supplemental summer programming as OHS had envisioned grantees would do under its prior April 2020 guidance, due to health and safety concerns; as such, grantees needed greater flexibility to address their communities' particular needs.[420] OHS officials said they made this decision in consultation with their Office of General Counsel.

This approach allows grantees to use CARES Act funds to make a variety of COVID-related expenditures, according to OHS officials. For example, funds may be used for personnel costs; minor renovations needed to establish isolated pick-up and drop-off locations; equipment and supplies for remote delivery of program services, including electronic tablets, notebook computers, phone cards, and internet access; personal protective equipment and materials; and enhanced cleaning procedures for Head Start facilities, among other things. Officials from the National Head Start Association, which represents the views of its Head Start grantee members, said they supported OHS's decision to provide grantees with flexibility to address COVID-related needs.

As of July 31, 2020, approximately $653.7 million in CARES Act funding had been awarded to approximately 1,452 grantees, according to OHS (see fig.).[421] Individual grant awards have ranged from about $11,000 to almost $10 million. OHS officials said they anticipate that all CARES Act funding will be awarded to grantees by September 30, 2020.

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[419]Pub. L. No. 116-136, div. B, tit. VIII, 34 Stat. 281, 558. The funds are to remain available through September 30, 2021. Congress may make part of a general appropriation available for a more particular purpose. In doing so, Congress may indicate a maximum amount that the agency may use for that particular purpose without requiring the agency to use those amounts for that purpose. See GAO, *Principles of Federal Appropriations Law*, 3rd ed., 2006 rev., ch. 6, § B.2, GAO-06-382SP (Washington, D.C.: Mar. 2006). The phrase "up to" in the CARES Act indicates that $500 million is the maximum amount available for the purpose of operating supplemental summer programs, but does not require OHS to distribute funding for this purpose. Supplemental summer programs refers to Head Start programs that would not typically operate over the summer.

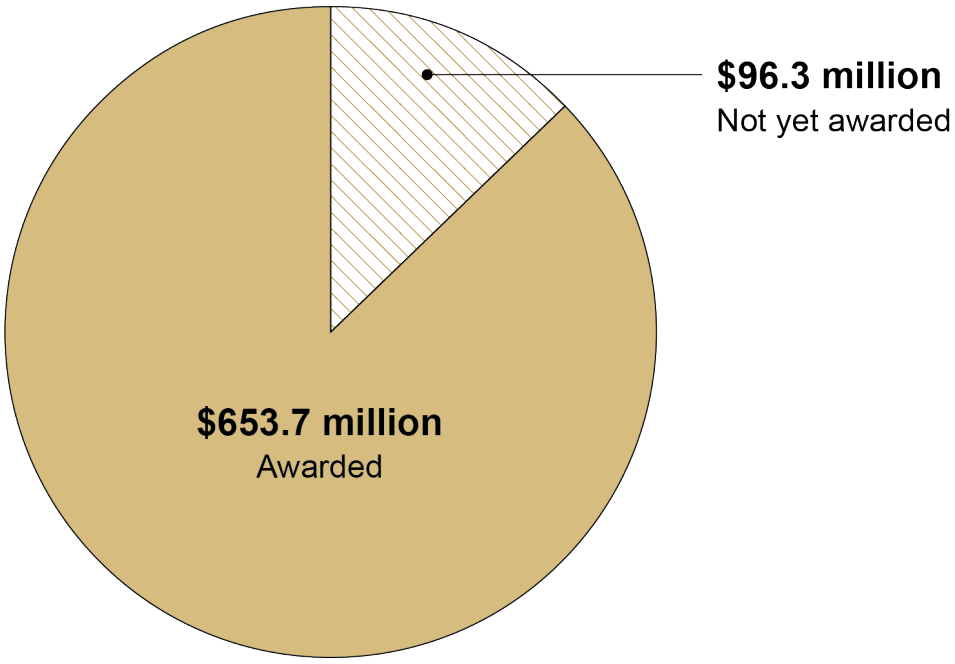
[420]OHS guidance states, however, that grantees planning to operate summer programs should continue to do so, if possible.

[421]An individual grantee may operate multiple Head Start programs and thus may receive more than one CARES Act award.

OHS officials said various factors have contributed to the length of time it has taken them to award CARES Act funds. Specifically, OHS initially spent time planning and developing guidance to award funds to grantees to provide supplemental summer programming. Once OHS officials realized that many grantees would not have the capacity to deliver summer learning experiences due to COVID-19, OHS made the decision to award grants to all grantees on a purely formulaic basis instead. Officials explained that the change in direction took time to get approved and required revisions to its grant making processes and management information systems to reduce the likelihood of errors.

Additionally, OHS officials decided to sync CARES Act awards with additional supplements for cost of living adjustments and quality improvement funding instead of disbursing these funds separately, which added more time but would reduce administrative burden, according to OHS officials.[422] Even if grantees have not yet received CARES Act funds, an OHS official noted that program guidance has allowed grantees to use their existing Head Start grant funds to make COVID-related expenditures and that grantees can make budget adjustments once they receive their CARES Act awards.

CARES Act Funds Awarded to Head Start Grantees, as of July 31, 2020



Source: Office of Head Start. | GAO-20-701

OHS has held webinars and developed and updated guidance and resources to help grantees implement program flexibilities for using their grant funds to address the impacts of COVID-19. For example, under ACF guidance, a grantee may transfer funds between budget categories without

[422]The Further Consolidated Appropriations Act, 2020 included $250 million in quality improvement funding for Head Start programs that OHS is awarding to all grantees based on funded enrollment. For more information on fiscal year 2020 quality improvement funding, see https://eclkc.ohs.acf.hhs.gov/policy/pi/acf-pi-hs-20-02.

prior approval so that it may spend funds as needed to respond to COVID-19. Also, OHS is allowing grantees to continue to pay wages and provide benefits for staff unable to work during center closures related to COVID-19 through September 30, 2020, and for grantees to engage families and deliver services remotely to the extent possible.[423]

OHS will track expenditures made using CARES Act funds through a separate accounting code, and is taking steps to collect detailed information on grantees' use of these funds, according to officials. For example, OHS will ask grantees to report the percentage of CARES Act funds they have spent or intend to spend on specific budget categories. Data will be collected in October to capture grantees' projected spending plans again near the end of the program year to capture their actual spending. OHS guidance states that grantees should use prudent judgment and their knowledge of their community circumstances to determine which expenses are necessary and reasonable to maintain services and to document that these expenses are related to the program's COVID-19 response.

OHS officials said they will collect detailed information on grantees' spending of CARES Act funds, beginning in fiscal year 2021, and will use existing monitoring strategies to oversee grantees' use of these funds. For example, OHS officials said they will develop a plan to identify the likelihood that CARES Act funds have been erroneously awarded by OHS or improperly used by grantees, similar to a plan they already have in place to oversee other disaster recovery funds. Specifically, OHS officials said they plan to ask grantees during monitoring about their use of CARES Act funds and any adjustments made to program service delivery in response to COVID-19. OHS staff will review documentation and ask grantees questions to understand whether expenditures were necessary and reasonable.

Additionally, these officials said they will update audit guidance to help ensure auditors conducting independent annual reviews of Head Start grantees are aware of the allowable uses of CARES Act funds. OHS officials also noted that the agency published a final rule, effective October 27, 2020, that could lead to better detection of risks to fiscal management and oversight.[424] Further, in addition to OHS efforts, officials at HHS's Office of Planning, Research, and Evaluation (OPRE) said they have ongoing data collection efforts regarding how COVID-19 has affected Head Start program operations. One of these studies will examine, among other things, how grantees intend to use CARES Act funding. For this study, OPRE officials said they expect to survey grantees in August 2020, interview grantees and staff in September and October, and issue a report in spring 2021.

OHS officials said they will implement their CARES Act monitoring plans in early September as part of a broader monitoring effort for the 2020 through 2021 program year. However, because

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[423]OHS guidance states that the continued payment of wages and benefits does not apply to program staff who would normally be laid off during annual end-of-year program closures for summer breaks in service.

[424]Head Start Designation Renewal System, 85 Fed. Reg. 53,189 (Aug. 28, 2020). The final rule revises several conditions of the Designation Renewal System, which is the process OHS uses to determine if a grantee will receive funds noncompetitively or will be required to compete for continued funds. The recently published final rule retains the requirement to compete if a going concern is identified in an audit report and adds a second criterion that requires competition if a grantee has two or more audit findings of material weakness or questioned costs related to their Head Start funds for a financial period within the current project period. 85 Fed. Reg. 53,190-53,191.

OHS is still finalizing its overall monitoring approach for CARES Act funds, implementing our 2019 recommendation that OHS perform a fraud risk assessment for the Head Start program could help provide assurances that the $750 million in CARES Act funding will be used by grantees as intended. In August 2020, OHS officials said that ACF's plan to complete the initial Fraud Risk Assessment for its pilot program was delayed from June 30, 2020 to December 31, 2020, but that it still anticipates completing its initial Fraud Risk Assessment for OHS by March 31, 2021. OHS officials said the fraud risk assessment will consider all aspects of the Head Start program, and will include CARES Act spending.

GAO Methodology and Agency Comments

To conduct this work, we reviewed relevant federal laws and the most recent agency guidance as of July 31, 2020, and interviewed officials from OHS and the National Head Start Association. We also obtained information from OPRE officials about their planned Head Start studies. To assess the reliability of the CARES Act award data, we discussed it with agency officials and reviewed it for missing information, outliers, or obvious errors. We determined that the data were sufficiently reliable for the purposes of this report. We provided the Office of Management and Budget (OMB) and HHS with a draft of this enclosure. OMB did not provide comments on this enclosure. HHS provided technical comments, which we incorporated as appropriate.

Contact information: Kathryn A. Larin, (202) 512-7215, larink@gao.gov

Related GAO Product

Head Start: Action Needed to Enhance Program Oversight and Mitigate Significant Fraud and Improper Payment Risks. GAO-19-519. Washington, D.C.: September 13, 2019.

Worker Safety and Health

In the Occupational Safety and Health Administration's effort to ensure safe and healthful conditions for workers during the COVID-19 pandemic, the agency has primarily relied on guidance, and few onsite inspections have been made.

Entity involved: Occupational Safety and Health Administration, within the Department of Labor

Key Considerations and Future GAO Work

Worker safety and health complaints have increased since February 2020, but in an effort to protect its inspectors from possible exposure, conserve resources, and ensure employers promptly address hazards, the Occupational Safety and Health Administration (OSHA) has made few on-site inspections. OSHA has primarily relied on guidance and existing standards to protect workers during the pandemic, and has issued four violations related to COVID-19.

As we continue our review of OSHA's efforts during the COVID-19 pandemic, we will consider OSHA's use of standards, guidance, and enforcement to ensure the safety and health of workers. We also plan to begin work related to concerns about the safety and health of workers at meat and poultry processing plants.

Background

The Department of Labor's (DOL) OSHA helps ensure safe and healthful working conditions for workers by setting mandatory workplace safety and health standards; conducting on-site inspections; investigating complaints and reports of injuries, illnesses, and deaths at worksites; and offering cooperative programs, training, guidance, and outreach, among other efforts.[425] Twenty-one states and Puerto Rico set and enforce their own workplace safety and health standards, under plans approved by OSHA.[426] OSHA is responsible for enforcement in the private sector in the remaining states, as well as in the federal sector.[427] For fiscal year 2020, OSHA's budget is over $581 million with almost 1,900 employees.

[425]OSHA carries out these activities under the Occupational Safety and Health Act of 1970, Pub. L. No. 91-596, 84 Stat. 1590 (codified as amended at 29 U.S.C. §§ 553, 651-678).

[426]These plans cover both private sector and state and local government employers. Five additional states and the U.S. Virgin Islands have plans that cover only state and local government employers; in these states, federal OSHA is responsible for enforcement in the private sector. State standards and their enforcement must be at least as effective as the federal standards in protecting workers and in preventing work-related injuries, illnesses, and deaths.

[427]Federal agencies are generally responsible for maintaining their own occupational safety and health programs, consistent with OSHA's regulations.

Overview of Key Issues

OSHA standards and guidance to address COVID-19: The COVID-19 pandemic presents new and unique occupational safety and health challenges because the virus is highly contagious and life threatening, given that the population has little immunity to the virus. In recent years, we reported on safety and health risks to workers in various industries.[428] However, COVID-19 places elevated infectious disease risks on workers if they have extensive interaction with people because social distancing is prescribed for prevention of COVID-19. Workers at higher risk include health care providers; emergency responders; and workers in the grocery, transportation, meat and poultry, and postal and shipping industries, among others.[429]

Certain OSHA standards for employers that were in place before COVID-19 can help prevent the spread of the virus at workplaces. These include standards requiring the use of personal protective equipment (PPE), such as respiratory protection, when job hazards warrant, as well as standards that require employers to maintain clean workplaces and provide access to bathrooms and handwashing stations.[430]

Under the Occupational Safety and Health Act of 1970 (OSH Act), each employer is required to provide a workplace free from "recognized hazards that are causing or are likely to cause death or serious physical harm."[431] OSHA may cite employers for failure to comply with this provision (referred to as the "general duty clause") in the absence of a specific standard. In addition, employers' recording and reporting of illnesses and deaths to OSHA can provide the agency with information needed to better respond to workplace risks.

While OSHA has not issued a standard specific to COVID-19 in the workplace, the agency has the authority to issue an "emergency temporary standard" (without going through the normal rulemaking process) if it determines that "employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards," and

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[428]See GAO, *Working Children: Federal Injury Data and Compliance Strategies Could Be Strengthened,* GAO-19-26 (Washington, D.C.: Nov. 2, 2018); W*orkplace Safety and Health: Better Outreach, Collaboration, and Information Needed to Help Protect Workers at Meat and Poultry Plants,* GAO-18-12 (Washington, D.C.: Nov. 9, 2017); *Workplace Safety and Health: Additional Data Needed to Address Continued Hazards in the Meat and Poultry Industry,* GAO-16-337 (Washington, D.C.: Apr. 25, 2016); and *Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence,* GAO-16-11 (Washington, D.C.: Mar. 17, 2016).

[429]OSHA developed guidance for classifying worker exposure risks into lower (caution), medium, high, and very high-risk categories and provides guidance and resources for protecting workers who perform job tasks at each risk level. OSHA officials also stated they use these categories to prioritize OSHA enforcement activities during COVID-19. For example, OSHA categorized hospitals and nursing homes as high risk, and meat and poultry processing plants as medium risk. According to OSHA officials, this categorization was adapted from a similar tool that OSHA and the Department of Health and Human Services developed during the response to the 2009 H1N1 influenza pandemic.

[430]Personal protective equipment may also include items such as gloves, eye protection, and face protection, among other things. For example, OSHA's personal protective equipment standard, 29 C.F.R. § 1910.132, includes general requirements for personal protective equipment. OSHA's respiratory protection standard, 29 C.F.R. § 1910.134, addresses requirements for respiratory protection. OSHA's sanitation standard, 29 C.F.R. § 1910.141, includes requirements to keep workplaces clean; provide washing facilities, to include running water, hand soap or a similar cleansing agent, and adequate means of hand drying; and other measures.

[431]29 U.S.C. § 654(a)(1).

that an emergency standard "is necessary to protect employees from such danger."[432] According to documentation provided by OSHA, the agency determined that an emergency temporary standard is not necessary at this time, given that the novel coronavirus is a new infectious pathogen and is the subject of an evolving multi-agency response.

OSHA decided that the best approach for responding to the pandemic is to enforce existing standards and the general duty clause to address infectious disease hazards, while also issuing detailed, industry-specific guidance that can be quickly amended and adjusted as understanding of COVID-19 grows. According to OSHA officials, this approach is more effective and the best use of OSHA resources, rather than promulgating a set of requirements for all employers in all industries based on limited information.

Beginning in March 2020, OSHA and the Centers for Disease Control and Prevention (CDC) issued a variety of COVID-19 guidance and safety tips for employers. For example, OSHA issued guidance on (1) how to prepare workplaces for prevention of COVID-19, (2) the fit-testing and use of respirators in health care, and (3) how to keep workers safe in other industries, such as retail, construction, and meatpacking. Guidance on farmworkers, manufacturing, meat and poultry processing, and seafood processing was issued jointly by OSHA and CDC. OSHA also refers employers to CDC guidance for workplaces and workers, including health and safety procedures for specific occupations.[433]

OSHA enforcement activity related to COVID-19: OSHA officials told us they began tracking COVID-19 workplace data in February 2020.[434] From February 1, 2020, through July 31, 2020, OSHA received reports of 1,076 hospitalizations and 558 fatalities related to COVID-19 (out of a total of 5,535 hospitalizations and 1,516 fatalities), as identified by employers. Industry officials from two national associations told us it is very difficult for employers to determine if an illness or death due to COVID-19 is "work-related" and therefore may be required to be reported to OSHA, or recorded in a log kept by the employer. These officials told us that while certain working conditions increase the risk of catching the virus, it is present in the community, and not inherently a workplace hazard. As a result, according to OSHA officials, it is not clear that all of the hospitalizations and fatalities related to COVID-19 that were reported to OSHA were actually work-related.

According to OSHA officials, the agency developed new ways of prioritizing and conducting worksite inspections and responding to complaints and referrals in response to the COVID-19 pandemic. OSHA officials said the reasons for the agency's new procedures and remote

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[432]29 U.S.C. § 655(c). In prior work, we have found OSHA faces legal and logistical challenges in issuing standards, including emergency temporary standards. Specifically, we found that between 1981 and 2010, the time it took OSHA to develop and issue standards ranged from 15 months to 19 years, and averaged more than 7 years. See GAO, *Workplace Safety and Health: Multiple Challenges Lengthen OSHA's Standard Setting*, GAO-12-330 (Washington, D.C.: Apr. 2, 2012).

[433]In April 2020, OSHA coordinated with the Department of Agriculture (USDA) to publish guidance for meat and poultry processing plants in response to COVID-19. In addition, in May 2020, OSHA worked with USDA in preparing to implement Executive Order 13917, "Delegating Authority Under the Defense Production Act with Respect to Food Supply Chain Resources During the National Emergency Caused by the Outbreak of COVID-19." According to OSHA officials, OSHA and USDA continue to coordinate efforts to protect workers at these facilities. For more information, see the enclosure on Federal Food Safety Inspections.

[434]Employers are required to report to OSHA all work-related amputations, losses of an eye, and in-patient hospitalizations within 24 hours, and to report all work-related fatalities within 8 hours.

inspections were protection of OSHA staff, availability of OSHA resources, public health concerns, and ensuring employers promptly address safety and health hazards. In April 2020 (and later updated in May 2020), OSHA provided enforcement guidance to its inspectors for handling complaints, referrals, severe illness reports, investigations, and inspections specifically related to COVID-19. OSHA's May 2020 updated guidance provided each OSHA area office enforcement discretion in conducting investigations. According to this guidance, fatalities and imminent danger exposures related to COVID-19 are to be prioritized for inspections. Complaints alleging exposures to COVID-19 for workers with a high/very high risk of transmission should warrant an on-site or remote inspection.

When on-site inspections are necessary, OSHA area offices are to evaluate potential risks to inspectors, ensure they are adequately trained, familiar with the most recent CDC guidelines, and have appropriate PPE. At times, OSHA has faced challenges in these efforts where there is a shortage of PPE. According to OSHA officials, OSHA has used the quickest way to respond to complaints—the phone/fax process, which was established in 2006. Officials said that using this process puts the employer on notice of the complaint immediately, and has allowed OSHA to quickly address hazards alleged in complaints, even while local stay-at-home orders were in place and many businesses were physically closed.

Since February 2020, OSHA has addressed most complaints and referrals through remote inspections and investigations.[435] From February 1, 2020, through July 31, 2020, OSHA received 23,981 complaints and referrals of workplace safety issues, including 8,524 related to COVID-19. According to OSHA officials, over this period, OSHA has conducted few on-site inspections due to the risk of COVID-19 exposure to OSHA inspectors; instead, most inspections and investigations are conducted remotely. From February 1, 2020, through July 31, 2020, OSHA conducted 15,701 phone/fax investigations (7,524 related to COVID-19); conducted 4,519 investigations in response to an employer-reported incident, such as a fatality, amputation, loss of an eye, or hospitalization (668 related to COVID-19); opened 8,585 inspections (781 related to COVID-19); and issued 19,695 violations (4 related to COVID-19).[436] In comparison, from February 1, 2019, through July 31, 2019, OSHA conducted 9,859 phone/fax investigations; conducted 4,085 investigations in response to an employer-reported incident; opened 17,808 inspections; and issued 25,514 violations.

OSHA has issued few violations related to the pandemic. As of July 31, 2020, OSHA had issued four violations to employers related to COVID-19, citing seven standards.[437] According to OSHA officials, as of July 31, 2020, OSHA had not issued any general duty clause citations related to COVID-19 because the evidence to date has not supported issuance of such a citation. OSHA officials also said that where evidence is insufficient to issue a general duty clause citation, instead the OSHA area office may issue a hazard alert letter recommending the implementation of protective measures to address COVID-19 hazards. As of July 31, 2020, according to OSHA officials, OSHA had

[435]OSHA may receive complaints and referrals from various sources, including employers, workers, other agencies, and other parties.

[436]These violations may not necessarily relate to the inspections opened during this time period as OSHA has up to 6 months after the occurrence of a violation to issue a citation.

[437]Because OSHA has up to 6 months after the occurrence of a violation to issue a citation, many investigations are still open and violations may be issued later, according to OSHA officials.

issued nine hazard alert letters to employers related to COVID-19 inspections, but these letters did not necessarily identify a COVID-19-related hazard.

Perspectives on OSHA's response to COVID-19: Worker and union representatives and government officials from at least one state have raised concerns that OSHA's response to COVID-19 is perceived as slow, lacks leadership, and is not sufficient to address risks from the current pandemic. Some worker advocates noted that OSHA's vacant Assistant Secretary for Occupational Safety and Health position—which has been unoccupied since 2017—may limit the effectiveness of the agency's response. Officials from one national nurses association expressed safety concerns about the relaxation of guidance for the proper fit, decontamination, and re-use of masks. Further, on May 18, 2020, the AFL-CIO union petitioned the U.S. Court of Appeals for the D.C. Circuit to compel OSHA to issue an emergency temporary standard. The court ruled in favor of OSHA on June 11, 2020, stating that OSHA's determination that an emergency temporary standard is not necessary at this time was reasonable.[438]

Industry representatives from three national associations told us they prefer that OSHA use guidance that the agency can update more nimbly and tailor to different industries, instead of promulgating a standard through rulemaking. Officials from one national meatpacking association said their members appreciate that OSHA's guidance allows companies to follow the recommendations "if possible" or "if feasible," because for some companies, they are not. These officials said each plant must find out what works for them in their process line, production area, and break room. For example, they said that it would be difficult to be efficient if workers were placed 6 feet apart in all processing plants, so the guidance allows a hierarchy of controls for companies to consider, such as using physical barriers between workers.

Certain states have taken action in response to COVID-19. For example, some states have issued executive orders or guidelines with worker safety protections in response to COVID-19. In addition, states approved to operate their own workplace safety and health programs may adopt standards that differ from OSHA's, provided the state standards are at least as effective as OSHA's standards in protecting the safety and health of workers. One such state, Virginia, issued an emergency temporary standard on worker safety and health in July 2020 in response to the COVID-19 pandemic. This emergency temporary standard requires employers to establish procedures to prevent COVID-19 exposures, among other things. Two worker advocates told us that California is the only state that already has a standard on aerosol transmission that can directly address the COVID-19 pandemic. California adopted an Aerosol Transmissible Diseases standard in 2009 aimed at protecting certain health care and other types of workers who may be exposed to infectious diseases transmitted by inhaling air that contains viruses, bacteria, or other disease-causing organisms.

[438]In re: American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), No. 20-1158, 2020 WL 3125324 (D.C. Cir. June 11, 2020).

GAO Methodology and Agency Comments

To conduct this work, we reviewed OSHA and CDC standards and guidance, relevant federal laws, and the most recent OSHA data as of July 31, 2020. We determined that OSHA's data were sufficiently reliable for the purposes of our reporting objectives. We interviewed OSHA officials, and worker advocate and industry representatives. We provided DOL and the Office of Management and Budget (OMB) with a draft of this enclosure. DOL provided technical comments which we incorporated as appropriate. OMB did not provide comments on this enclosure.

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Related GAO Products

Working Children: Federal Injury Data and Compliance Strategies Could Be Strengthened. GAO-19-26. Washington, D.C.: November 2, 2018.

Workplace Safety and Health: Better Outreach, Collaboration, and Information Needed to Help Protect Workers at Meat and Poultry Plants. GAO-18-12. Washington, D.C.: November 9, 2017.

Workplace Safety and Health: Additional Data Needed to Address Continued Hazards in the Meat and Poultry Industry. GAO-16-337. Washington, D.C.: April 25, 2016.

Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence. GAO-16-11. Washington, D.C.: March 17, 2016.

Workplace Safety and Health: OSHA Can Better Respond to State-Run Programs Facing Challenges. GAO-13-320. Washington, D.C.: April 16, 2013.

Workplace S*afety and Health: Further Steps by OSHA Would Enhance Monitoring of Enforcement and Effectiveness*. GAO-13-61. Washington, D.C.: January 24, 2013.

Workplace Safety and Health: Multiple Challenges Lengthen OSHA's Standard Setting. GAO-12-330. Washington, D.C.: April 2, 2012.

2020 Tax Filing Season

The COVID-19 pandemic required the Internal Revenue Service to halt certain essential filing season functions and customer service operations; thus, it now faces a large backlog of work including unprocessed tax returns—which may lead to delayed refunds to taxpayers—as well as increased refund interest payments and decreased revenue collection.

Entities involved: Department of the Treasury, including the Internal Revenue Service

Key Considerations and Future GAO Work

In February 2010, we suggested that Congress broaden the Internal Revenue Service's (IRS) math-error authority, which would allow the IRS to resolve some types of errors in taxpayer returns and deliver more timely refunds to taxpayers who need it most. As of July 2020, Congress and the President had expanded this authority in certain circumstances, but not as broadly as we suggested.

In June 2020, we reported that the unprecedented volume of new unemployment insurance (UI) claims in the wake of the COVID-19 pandemic posed major challenges for state officials to provide benefits and identify and prevent improper payments. Another area of concern is that some UI recipients may not have taxes withheld from their unemployment income and would be required to pay these taxes when they file in 2021. Individuals who receive UI benefits during 2020 are responsible for paying federal taxes on the income and must elect whether to have taxes withheld from their UI payments.

Given the historically high volume of UI claims since mid-March, the $600 weekly increase in benefits through the end of July, and extended duration of benefits, it is possible that individuals receiving UI benefits may be faced with unexpected income tax bills in 2021, including penalties and interest, when they file their 2020 tax returns. IRS officials stated that they have reminded taxpayers that UI benefits are taxable through news media stories, by posting information on IRS.gov, and via social media.

We have ongoing work to evaluate IRS's 2020 filing season performance and to evaluate the status of IRS's revenue collections and examinations.

Background

IRS's annual tax filing activities include processing over 240 million individual and business tax returns electronically or on paper, issuing over $400 billion in refunds, and providing customer service on return processing issues, such as suspected identity theft and math errors. The COVID-19 pandemic has affected IRS's ability to assist taxpayers on these issues, which typically require in-person, phone, and correspondence-based interactions. Beginning in mid-April 2020, IRS also became responsible for issuing more than 160 million economic impact payments;

according to IRS officials, that effort has not significantly hindered filing season operations. IRS has responded in several ways to protect filing season staff and taxpayers during the pandemic:

- **Filing deadline extension.** In an effort to provide taxpayers and IRS more time to carry out filing season responsibilities, IRS and Treasury postponed the tax filing and payment deadlines for taxpayers from April 15 to July 15, 2020, based on a federally declared disaster.[439]

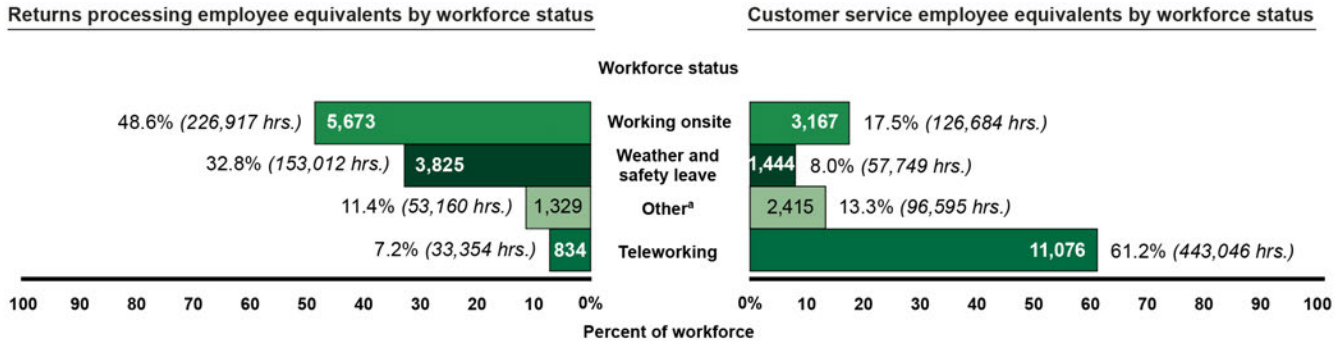
- **Service changes.** By April 9, 2020, IRS had closed all four return processing sites, all customer service sites, and all Taxpayer Assistance Centers due to local stay-at-home orders. IRS limited onsite work to mission-critical employees and directed all employees with portable work to telework. This effectively halted all non-automated filing season functions. Between April 27 and July 13, 2020, IRS implemented a phased reopening of sites and taxpayer services. As of late July 2020, IRS estimated that filing season processing was at about 61 percent capacity and customer service functions were at about 84 percent capacity, based on employee staffing levels.

- **Workforce changes.** As IRS closed offices and halted services, the agency put employees with non-portable work or who were ineligible or unable to telework on weather and safety leave.[440] Between March 1 and July 18, 2020, IRS paid $317.5 million in weather and safety leave for returns processing and customer service staff, compared with $4.9 million for fiscal year 2019. IRS officials stated that during the pandemic, the agency expanded telework, repurposed its laptops, and identified some paper-based work that could be digitized. This included scanning documents and sending them to teleworking employees to process. The figure below shows the distribution of the filing season workforce by status as of mid-July 2020.

[439]Department of the Treasury, Internal Revenue Service (IRS) Notice 2020-23, 2020-18 IRB 742 (Apr. 27, 2020). Notice 2020-23 amplified relief provided in Notice 2020-18 and Notice 2020-20. 2020-15 IRB 590 (Apr. 6, 2020); 2020-16 IRB 660 (Apr. 13, 2020). The Secretary of the Treasury has statutory authority to postpone filing and payment deadlines for taxpayers affected by federally declared disasters. 26 U.S.C. § 7508A. On March 13, 2020, the President instructed the Secretary of the Treasury to provide relief from tax deadlines to Americans who have been adversely affected by the COVID-19 emergency, as appropriate, pursuant to 26 U.S.C. § 7508A(a).

[440]In December 2016, Congress passed the Administrative Leave Act of 2016 (enacted as part of the National Defense Authorization Act for Fiscal Year 2017, Pub. L. No. 114-328), which mandated new categories of paid leave including "weather and safety leave." Office of Personnel Management guidance states that agencies may use this leave category if any condition prevents employees from safely traveling to and performing work at an approved location.

Internal Revenue Service Filing Season Workforce Status (Week Ending July 18, 2020)



Source: Internal Revenue Service filing season workforce status for week ending July 18, 2020. | GAO-20-701

Note: Employee equivalent calculated by dividing total hours by 40 in each category and rounding to the nearest whole number.

[a]Time charged to any other payroll codes, including annual and sick leave.

In March 2020, the Families First Coronavirus Response Act (FFCRA) and the CARES Act appropriated a total of $765.7 million to the IRS to respond to COVID-19.[441] As of late July 2020, IRS reported that it had obligated $300 million and expended $173 million of this additional funding.

Overview of Key Issues

We identified the following areas of concern for IRS filing season operations:

Financial impacts to taxpayers and the government.

- **Refunds delayed.** IRS was generally able to process electronic returns during the pandemic, but it continues to face significant delays in processing paper-based returns and issuing associated refunds, as discussed below. For example, in early May 2020, IRS processed individual paper returns in 47 days on average compared with an average of 15 days during the same timeframe in 2019. Similarly, processing time for business returns, generally longer than for individual returns, also increased. For example, in early May 2020, IRS processed business employer quarterly tax returns in 53 days on average compared with an average of 26 days in early May 2019.
- **Higher volume of interest payments on tax refunds.** During the first 10 months of fiscal year 2020, IRS had paid more in interest on taxpayer refunds than it did in all of fiscal year 2019 due, in part, to the nature of the postponed filing season deadline and delays in processing tax returns. For example, from October 2019 through July 2020, IRS paid 32 percent more in refund interest to corporations ($1.2 billion) than it did in all of fiscal year 2019 ($924.6 million). For the current fiscal year through July 2020, IRS has paid about $2.2 billion in total refund interest to individuals and businesses. In comparison, IRS paid about $2.1 billion in

[441]FFCRA, Pub. L. No. 116-127, 134 Stat. 178 (2020); CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020).

refund interest for all of fiscal year 2019. With IRS's postponement of the tax filing deadline to July 15, 2020, interest for individual refunds began accruing as of the original filing deadline of April 15, 2020, and interest on business-related refunds began accruing 45 days after the applicable filing date. IRS will continue to pay refund interest through the end of fiscal year 2020. For example, in August 2020, IRS announced that it had sent nearly 14 million individuals refund interest payments with an average payment of $18 per person. As discussed below, IRS also has a significant backlog of paper-based returns awaiting processing; any returns with refunds will also be eligible for interest payments.

- **Revenue collections and enforcement down.** As of mid-July 2020, IRS had collected about $2 trillion in revenue from tax payments, which is about 8.8 percent less than as of mid-July 2019 (about $2.2 trillion). IRS officials said these collections are delayed due to the filing deadline extension and other relief provided to taxpayers. IRS did not have an estimate on how these delays will affect revenue collections. In addition, IRS paused several of its enforcement efforts due to the pandemic. We have ongoing work in this area.

Operational impacts.

- **Considerable backlog.** For the first 9 weeks of the 2020 filing season, IRS's return processing was generally on par with last year. However, as a result of closing its return processing centers and reduced staffing, IRS now faces a significant backlog of primarily paper-based work. As of late July, this backlog includes about 9.2 million returns awaiting processing, and about 7.9 million pieces of unopened mail including tax returns and check payments. The backlog inventory also includes about 3.6 million returns that were suspended due to errors and require review, about 1.1 million returns with suspected identity theft that require IRS to contact and verify the identity of the taxpayer, and about 41,400 returns that require IRS to verify income, withholding, or eligibility for refundable credits before releasing a refund. In late July 2020, IRS estimated that it would address unprocessed individual returns by December 2020 and business returns by September 2021. IRS expects to open remaining mail by October 2020, and resolve other returns currently being held no later than December 2020.
  As we previously suggested to Congress, providing IRS broader math-error authority, with appropriate safeguards against misuse of that authority, could help IRS process some returns flagged for review and prevent costly and lengthy reviews. The challenges associated with addressing this significant backlog may affect IRS's ability to appropriately prepare for the 2021 filing season.

- **Limited customer service.** In mid-July 2020, IRS reported that its live phone customer service was still extremely limited due to the pandemic. Live telephone assistance was completely unavailable between April 5 and May 9. Since IRS began answering telephone calls in May, the average weekly phone wait times through mid-July were between 7 and 32 minutes, compared with 9 and 18 minutes in 2019. Similarly, IRS's in-person customer service remained severely limited due to health and safety requirements. Further, as IRS continues to work through the backlog of its returns processing and mail, taxpayers may continue to experience delays in refunds and continue to call IRS for status updates.

GAO Methodology and Agency Comments

To conduct this work, we reviewed 2020 filing season performance, customer service, and refund interest data as of July 2020, reviewed federal laws and agency guidance, and interviewed IRS officials. We provided Treasury, the Office of Management and Budget (OMB), and IRS with a draft of this enclosure. IRS provided technical comments which we incorporated as appropriate. Treasury and the Office of Management and Budget did not comment on this enclosure.

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Related GAO Product

Recovery Act: IRS Quickly Implemented Tax Provisions, but Reporting and Enforcement Improvements Are Needed. GAO-10-349. Washington, D.C.: February 10, 2010.

Paycheck Protection Program

The Paycheck Protection Program closed to new applicants on August 8, 2020, and as of that date, lenders had made over 5.2 million loans totaling more than $525 billion. The Small Business Administration has started accepting loan forgiveness applications. In response to our recommendation that the Small Business Administration develop and implement plans to identify and respond to risks in the program, the agency has begun to develop oversight plans but has not yet finalized or implemented them.

Entities involved: Small Business Administration, Department of the Treasury

Key Considerations and Future GAO Work

In June 2020, we recommended that the Small Business Administration (SBA) develop and implement plans to identify and respond to risks in the Paycheck Protection Program (PPP) to ensure program integrity, achieve program effectiveness, and address potential fraud, including in loans of $2 million or less. In response to our recommendation, SBA has begun to develop oversight plans but has not yet finalized or implemented them.

Since June 2020, the PPP loan forgiveness process has begun, but uncertainty about the lender's role in the process and the complexity of the process could result in additional difficulties and delays for borrowers in obtaining loan forgiveness.

We have additional work underway on the borrowers that received the PPP loans and the safeguards SBA has implemented to help ensure that lenders and borrowers complied with program requirements.

Background

The CARES Act and the Paycheck Protection Program and Health Care Enhancement Act appropriated a total of $670 billion for PPP under SBA's largest guaranteed loan program, its 7(a) small business lending program.[442] PPP loans, made by lenders but guaranteed 100 percent by SBA, are low interest (1 percent) and fully forgivable if certain conditions are met.[443]

[442]*See* Pub. L. No. 116-136, §§ 1102(b), 1107(a)(1), 1112, 134 Stat. 281, 293, 301; Pub. L. No. 116-139, § 101(a), 134 Stat. 620, 620 (2020).

[443]As originally implemented by SBA, at least 75 percent of the loan forgiveness amount must have been for payroll costs. In addition, the CARES Act required loans to be used within an 8-week period. However, the Paycheck Protection Program Flexibility Act of 2020 modified this to at least 60 percent and allowed borrowers to incur those expenses over a 24-week period. Pub. L. No. 116-142, § 3, 134 Stat. 641, 641-42 (2020). Under the Flexibility Act, the covered period for PPP loans is the earlier of 24 weeks after origination or December 31, 2020.

As of August 8, 2020 (the close of the program's application period), lenders had made over 5.2 million PPP loans totaling more than $525 billion.[444]

Overview of Key Issues

Cases of potential PPP fraud. Since May 2020, the Department of Justice has publicly announced charges in over 40 fraud-related cases associated with PPP funds. The charges—filed across the United States and investigated by a range of law enforcement agencies—include making false statements and engaging in identity theft, wire and bank fraud, and money laundering.

Loan forgiveness process. As established by the CARES Act and implemented in SBA's interim final rules, the PPP loan forgiveness process involves three steps (see figure below). First, the borrower is to submit a complete loan forgiveness application and associated supporting documents to the lender.[445] The date by which a borrower may apply for loan forgiveness varies because the borrower may submit the loan forgiveness application any time on or before the maturity date of the loan—including before the end of the 8- or 24-week covered period—if the borrower has used all of the loan funds for which the borrower is requesting forgiveness.[446] Next, no later than 60 days from receipt of a borrower's complete loan forgiveness application, the lender is to review the application and make a decision regarding loan forgiveness.[447] According to SBA officials, SBA had received about 56,000 loan forgiveness decisions from lenders as of September 8, 2020. Finally, no later than 90 days from receipt of the lender's decision on loan forgiveness, SBA is to send the appropriate forgiveness amount to the lender, subject to any SBA review of the loan or loan application.[448]

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[444]Totals exclude loans that have been canceled. According to SBA, canceled loans may include, but are not limited to, duplicative loans, loans not closed for any reason, and loans that were fully paid off.

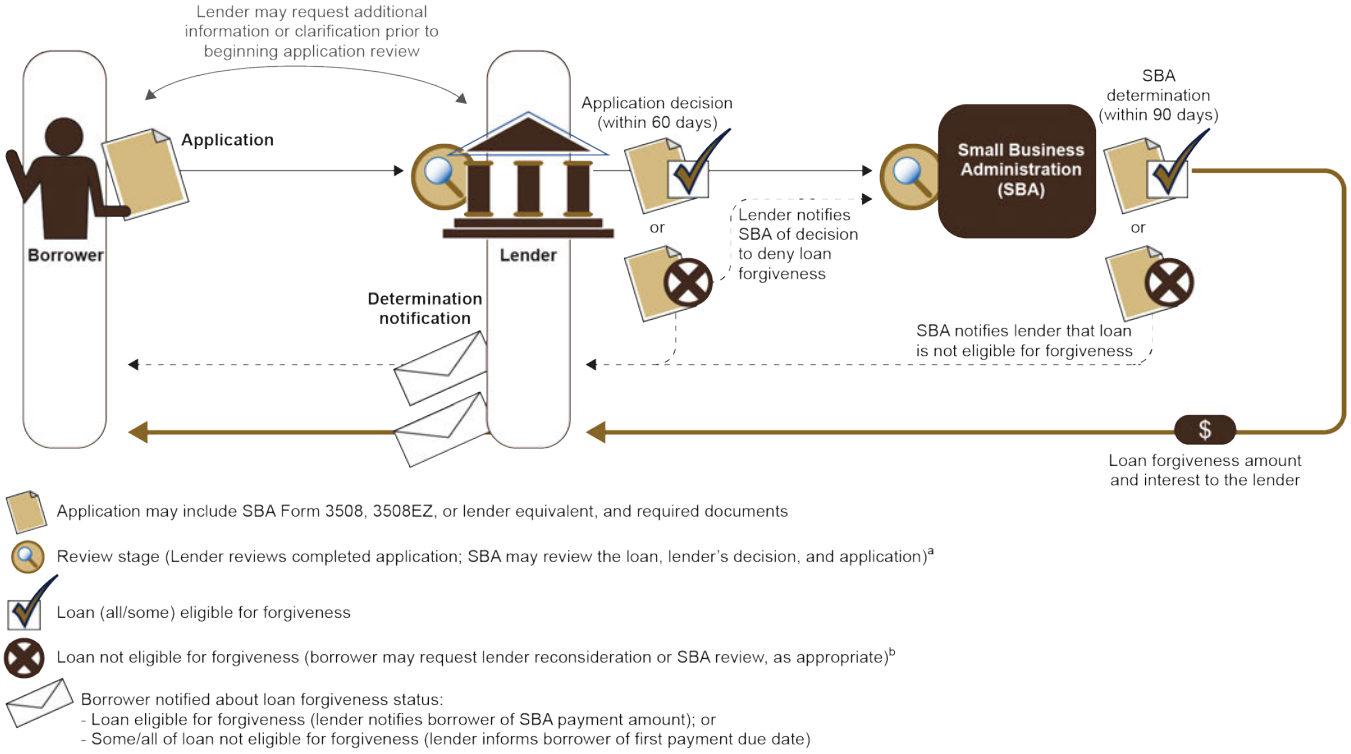
[445]There are two types of SBA loan forgiveness applications: SBA Form 3508 and SBA Form 3508EZ (which is limited to borrowers such as self-employed individuals, independent contractors, and sole proprietors who had no employees at the time of the PPP loan application and borrowers that met certain conditions such as not reducing annual salary or hourly wages of any employee by more than 25 percent). In addition, lenders can develop their own forms as long as they are equivalent to SBA's forms. With the SBA Form 3508, each borrower must submit a Schedule A that includes costs and adjustments for a loan forgiveness calculation. With both forms, the borrower must submit documentation verifying payroll and non-payroll expenses. Borrowers might also need to produce other documentation if they are using Form 3508 or if the loan is selected for SBA review.

[446]For loans made before June 5, 2020, the maturity is 2 years; however, borrowers and lenders may mutually agree to extend the maturity of such loans to 5 years. For loans made on or after June 5, 2020, the maturity is 5 years. For purposes of loan forgiveness, the covered period is generally the 24-week period beginning on the date the lender disburses the PPP loan. Alternatively, a borrower that received a PPP loan before June 5, 2020, may elect for the covered period to end 8 weeks after the date of disbursement of the PPP loan.

[447]If the lender denies a borrower's request for loan forgiveness, the borrower may subsequently request that SBA review the lender's decision.

[448]If SBA determines that the borrower was ineligible for the PPP loan based on the provisions of the CARES Act, SBA rules or guidance available at the time of the borrower's loan application, or the terms of the borrower's PPP loan application, the loan will not be eligible for forgiveness. For example, the borrower may have lacked an adequate basis for the certifications that it made in its PPP loan application, in which case SBA would not forgive the loan.

Paycheck Protection Program Loan Forgiveness Process



Source: GAO. | GAO-20-701

[a]Independent of the lender's loan forgiveness application review, SBA may conduct a review of selected loans at any time.

[b]SBA posted an interim final rule governing appeals of SBA Paycheck Protection Program loan review decisions on August 11, 2020. 85 Fed. Reg. 52,883 (Aug. 27, 2020).

Loan forgiveness challenges. We identified additional difficulties and delays for borrowers in obtaining loan forgiveness:

- **Need for additional rules and guidance.** As SBA did for the loan application process, the agency has issued rules and guidance on the loan forgiveness process on a rolling basis. SBA posted interim final rules on the loan forgiveness process and on loan review procedures on May 22, 2020, and revised these rules to reflect changes made by the Paycheck Protection Program Flexibility Act in an additional interim final rule posted on June 22, 2020.[449] The agency also posted a procedural notice on the loan forgiveness process on July 23, 2020, and responses to frequently asked questions on loan forgiveness on August 4, 2020. Finally, on August 11, 2020, SBA posted an interim final rule on appealing SBA loan review decisions, including its decisions related to loan forgiveness.

[449]In its initial interim final rule posted on April 2, 2020, SBA provided some information on loan forgiveness for both borrowers and lenders, such as the percentage that borrowers had to spend on payroll costs to be eligible for forgiveness. *See* 85 Fed. Reg. 20,811 (Apr. 15, 2020). In addition, SBA has provided information on loan forgiveness in responses to frequently asked questions posted on an ongoing basis and released separate PPP loan forgiveness FAQs on August 4, 2020.

However, questions remain about the process, including the extent of SBA's review of lenders' loan forgiveness decisions. According to SBA officials, SBA intends to put all lender decisions granting full or partial loan forgiveness through an automated review tool provided by one of its contractors, and—when requested by borrowers—to review lenders' decisions to deny loan forgiveness. However, as of August 14, 2020, SBA was still developing its processes for reviewing lenders' forgiveness decisions.

- **Lender role in loan forgiveness potentially unclear.** Under SBA's interim final rules, the lenders make the final decision about loan forgiveness.[450] Representatives of the four lender associations we interviewed initially had questions or concerns about lenders' role in reviewing borrowers' loan forgiveness applications. According to representatives of two of the associations, the guidance SBA issued in July and August answered their questions. However, representatives of two associations still had questions about the level of review required and the extent to which lenders could rely on borrower certifications and calculations. Representatives of another lending association stated that it was a conflict of interest for lenders to be heavily involved in loan forgiveness because it was in their best interest for the loans to be forgiven.
  SBA's interim final rules on loan review procedures and the procedural notice posted on July 23, 2020, state that the borrower is responsible for providing an accurate calculation of the loan forgiveness amount, and the rule states that the borrower is to attest to the accuracy of its reported information and calculations on the loan forgiveness application. However, the interim final rules and notice also state that lenders are expected to perform a good-faith review, in a reasonable amount of time, of the borrower's calculations and supporting documents concerning amounts eligible for loan forgiveness before making their decision on loan forgiveness.[451]
  The interim final rule on loan review procedures and the procedural notice state that SBA reserves the right to direct a lender to deny an application or to review the lender's decision. As noted previously, SBA was still developing its processes for reviewing lenders' loan forgiveness decisions as of August 14, 2020.
  Finally, representatives of two associations commented that the resource demands and the lack of clarity surrounding the application and forgiveness processes have led to lender fatigue with the program. Representatives noted that this lender fatigue could result in members being less likely to participate should there be future rounds of the program. According to SBA officials, lenders receive fees for originating and administering PPP loans, and the process for loan forgiveness is more complex than the loan origination process because the CARES Act has specific requirements for loan forgiveness.

- **Complexity of loan forgiveness process creates burden.** In part because the CARES Act includes specific requirements for loan forgiveness, applying for loan forgiveness is more time consuming than applying for the PPP loan itself and requires more lender review.

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[450]The CARES Act requires lenders to issue a decision within 60 days of receiving a PPP loan forgiveness application. Pub. L. No. 116-136, § 1106(g), 134 Stat. at 301 (2020).

[451]The interim final rules and procedural notice do not clearly define the extent of review required, but one rule provides an example. The loan review procedures interim final rule states that minimal review of calculations based on a payroll report by a recognized third-party payroll processor would be reasonable. By contrast, if payroll costs are not documented with such recognized sources, it notes that more extensive review of calculations and data would be appropriate. *See* 85 Fed. Reg. 33,010, 33,013 (June 1, 2020).

SBA estimated that the loan application would take 8 minutes to complete, and its interim final rules and guidance have stated that lenders could rely on the applicant's certifications regarding its eligibility and use of the loan proceeds. In contrast, SBA estimates on its loan forgiveness applications that borrowers will need 3 hours to fill out the standard form, or 20 minutes for the abbreviated application.[452] And, as previously discussed, lenders are to do a good-faith review of loan forgiveness applications and make a decision about whether the loan should be forgiven. As noted previously, SBA officials told us that loan forgiveness is more complex than the loan origination process because the CARES Act has specific requirements for loan forgiveness. In addition, OMB officials stated that it makes sense for the loan forgiveness process to take longer than the application process to ensure the necessary accountability to warrant forgiveness and prevent fraud.

Representatives of all four lender associations we interviewed stated they had concerns about the complexity of the loan forgiveness process and the amount of time it would take borrowers and lenders. Although SBA states on its standard loan forgiveness application that it will take borrowers 3 hours to complete, representatives from one association heard from lenders that it could take 15 hours for some borrowers to complete. To help applicants with these applications, there are free online forgiveness calculators that borrowers can use to populate their loan forgiveness applications.[453] Representatives from a lender association estimated it could take 50-75 hours for lenders to review a complex forgiveness application and the supporting documentation.[454]

Representatives of all four lender associations we interviewed favored simplifying the process for smaller loans, citing the resources that could be saved for borrowers and lenders. Legislation has been proposed that would simplify the loan forgiveness process for borrowers with loans under a certain threshold.

- **Wait to transmit lender decisions to SBA.** On August 10, 2020, SBA activated the platform that lenders would use to transmit their loan forgiveness decisions to SBA. According to the July 23, 2020, procedural notice on loan forgiveness, SBA contracted with a company to make available a secure platform for lenders to submit loan forgiveness decisions, supporting documentation, and requests for forgiveness payments.[455] According to representatives of the four associations we interviewed, some borrowers were ready to submit their applications to lenders prior to that date. If these applications were complete, the clock would start on the 60 days lenders had to make a decision on loan forgiveness. In addition, organizations such as the American Institute of CPAs advised borrowers in July 2020 to delay submitting their applications for loan forgiveness until SBA released more guidance.

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[452]Some borrowers, such as the self-employed with no employees, are eligible to use the abbreviated form without meeting additional criteria. Others may need to conduct calculations to determine whether they are eligible to use the abbreviated form. For example, borrowers who are not self-employed with no employees must determine if they did not reduce annual salary or hourly wages of any employee by more than 25 percent.

[453]For example, the American Institute of CPAs offers a free PPP loan forgiveness calculator on its website.

[454]Although some lenders plan to contract with vendors to electronically accept and facilitate the review of the loan forgiveness applications, representatives of the lender associations we spoke with told us that other lenders, especially smaller ones, plan to review the applications manually.

[455]The PPP Forgiveness Platform also allows lenders to monitor the status of forgiveness requests and respond to any SBA inquiries or loan reviews.

GAO Methodology and Agency Comments

To conduct this work, we reviewed interim final rules and guidance issued by SBA and Treasury and interviewed SBA officials. In addition, we interviewed officials from four associations that represent a variety of lenders (American Bankers Association, National Association of Federally-Insured Credit Unions, National Association of Government Guaranteed Lenders, and Opportunity Finance Network) and from the American Institute of CPAs. Their views are not generalizable to other associations that represent lenders and accountants but offered important perspectives.

We provided a draft of this enclosure to SBA, Treasury, and the Office of Management and Budget (OMB). SBA provided technical comments that are summarized in the Agency Comments and Our Evaluation section of this report. Treasury and OMB provided technical comments that we incorporated as appropriate.

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Eviction Moratoriums

Eviction moratoriums have helped keep renters housed, but do not address longer-term issues for renters and property owners related to unpaid rent.

Entities involved: Consumer Financial Protection Bureau, Department of Agriculture, Department of Housing and Urban Development, Department of Veterans Affairs, Fannie Mae and Freddie Mac (the enterprises), and the Federal Housing Finance Agency

Key Considerations and Future GAO Work

In an effort to ensure short-term housing stability during the pandemic, section 4024 of the CARES Act temporarily halted evictions of renters from certain properties for the non-payment of rent for 120 days.[456] The moratorium was in effect through July 24, 2020, leaving potentially millions of renters at risk of housing instability. On September 1, 2020, the Centers for Disease Control and Prevention issued an order halting evictions to prevent the further spread of COVID-19. This moratorium is effective September 4, 2020, through December 31, 2020, and covers renters that meet certain requirements.[457]

Like the section 4024 moratorium, the September 2020 moratorium does not address longer-term issues, including how renters would continue to pay their rents (including back rents) or how property owners (landlords) would pay their mortgages and other expenses.[458] Some have

[456]Pub. L. No. 116-136, § 4024, 134 Stat. at 492. The CARES Act defines federally backed mortgages (1 to 4 units) and federally backed multifamily mortgages (5 or more units) as those purchased or securitized by the housing enterprises Fannie Mae and Freddie Mac, as well as those made, insured, guaranteed, supplemented, or assisted in any way by federal government agencies, principally the Department of Housing and Urban Development, a component of which is the Federal Housing Administration; the Department of Agriculture, a component of which is the Rural Housing Service; and the Department of Veterans Affairs. The enterprises are currently under the conservatorship of the Federal Housing Finance Agency. Federal programs funding rental units that were covered by section 4024 include, among others, Public Housing, the Section 8 Housing Choice Voucher program, Section 8 project-based housing, Section 202 housing for the elderly, and Section 811 housing for people with disabilities. Under the CARES Act, a tenant must be given a notice of 30 days to vacate the property, and the notice may only be issued after the expiration of the 120-day eviction moratorium. Further, Section 4022 of the CARES Act placed a foreclosure and eviction moratorium on single-family properties with federally backed mortgages. Under the moratorium, owners of these properties may not be foreclosed upon and persons occupying the properties, including renters, may not be evicted in connection with the foreclosure. Pub. L. No. 116-136, § 4022, (c)(2) 134 Stat. at 491. The agencies and enterprises extended their foreclosure-related eviction moratoriums under Section 4022 for single-family properties until December 31, 2020.

[457]Department of Health and Human Services, Centers for Disease Control and Prevention, *Temporary Halt in Residential Evictions to Prevent the Further Spread of COVID-19* (Sept. 1, 2020), printed in the Federal Register at 85 Fed. Reg. 55292 (Sept. 4, 2020).

[458]The September 2020, moratorium "does not relieve any individual of any obligation to pay rent, make a housing payment, or comply with another obligation that the individual may have under a tenancy, lease, or similar contract." Further, "nothing in [the] order precludes the charging or collecting of fees, penalties, or interest as a result of the failure to pay rent of other housing payment on a timely basis, under the terms of the applicable contract." Section 4024 of the CARES Act did not relieve renters of their obligation to pay rent, but did prohibit landlords from charging fees or penalties for late rent payments.The September 2020 moratorium noted that the Centers for Disease Control and Prevention had been informed by the Department of Housing and Urban Development (HUD) that its grantees (states, cities, communities, and nonprofits) that received Emergency Solutions Grants or Community Development Block Grant funds under the CARES Act could use these funds to provide temporary rental assistance, homelessness

suggested more comprehensive measures are needed to help ensure housing and financial stability, such as emergency rental assistance or other income support for tenants, or a federal lending facility (emergency lending program) for landlords.

We have additional work underway on the populations covered by the eviction moratoriums and the extent to which they provided comprehensive housing protection and contributed to housing stability.

Background

Section 4024 of the CARES Act prohibited evictions of any renter living in any property with a federally backed mortgage, or tenants living in rental units participating in specified federal programs, for the nonpayment of rent for 120 days from enactment, or through July 24, 2020. The moratorium covered at least 17 million (or about 39 percent) of all renter households.[459]

Under the September 2020 moratorium, a landlord, owner of a residential property, or other person with a legal right to pursue eviction shall not evict any covered person from any residential property through December 31, 2020. A covered person generally includes an individual who expects to earn no more than $99,000 and joint-filers who expect to earn no more than $198,000 in 2020, and who meet additional criteria, including a substantial loss of household income.[460] The moratorium potentially covers up to 44 million renter households.[461]

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prevention, or other aid to individuals who were experiencing financial hardship because of the pandemic and were at risk of being evicted. Similarly, according to the moratorium, the Department of the Treasury had informed the Centers for Disease Control and Prevention that the funds allocated through the Coronavirus Relief Fund could be used to fund rental assistance programs to prevent eviction.

[459]This estimate assumes that 2.8 million single-family rental units and 9.6 million multifamily rental units are financed with federally backed mortgages and that at least 4.8 million households receive federal rental assistance. See Urban Institute, *The CARES Act Eviction Moratorium Covers All Federally Financed Rentals—That's One in Four U.S. Rental Units*, Apr. 2, 2020, accessed July 11, 2020, https://www.urban.org/urban-wire/cares-act-eviction-moratorium-covers-all-federally-financed-rentals-thats-one-four-us-rental-units; GAO-20-625; and HUD, *Picture of Subsidized Households*, accessed July 13, 2020, https://www.huduser.gov/portal/datasets/assthsg.html. The estimate does not account for all renter households living in properties financed with Low-Income Housing Tax Credits, and therefore likely is an underestimate of total households covered by the CARES Act eviction moratoriums. In another study, the Federal Reserve Bank of Atlanta estimated that the number of federally backed rental units ranged from an estimated 12.3 million (28.1 percent) to an estimated 20 million (45.6 percent). See Federal Reserve Bank of Atlanta, *Housing Policy Impact: Federal Eviction Protection Coverage and the Need for Better Data*, accessed September 3, 2020, https://www.frbatlanta.org/community-development/publications/partners-update/2020/covid-19-publications/200616-housing-policy-impact-federal-eviction-protection-coverage-and-the-need-for-better-data#src18.

[460]More specifically, a covered person means "any tenant, lessee, or resident of a residential property who provides to their landlord, the owner of the residential property, or other person with a legal right to pursue eviction or a possessory action, a declaration under penalty of perjury indicating that: (1) the individual has used best efforts to obtain all available government assistance for rent or housing; (2) the individual either (i) expects to earn no more than $99,000 in annual income for calendar year 2020 (or no more than $198,000 if filing a join tax return), (ii) was not required to report any income in 2019 to the U.S. Internal Revenue Service, or (iii) received an Economic Impact Payment (stimulus check) pursuant to Section 2201 of the CARES Act; (3) the individual is unable to pay the full rent or make a full housing payment due to a substantial loss of household income, loss of compensable hours of work or wages, a lay-off, or extraordinary out-of-pocket medical expenses; the individual us using best efforts to make timely partial payments that

Additionally, some states and localities implemented their own eviction moratoriums. As of September 1, 2020, 18 states had eviction moratoriums in place, 10 of which are scheduled to expire before December 31, 2020 and eight of which are tied to the end of the declared emergency.[462]

Overview of Key Issues

Eviction moratoriums provided short-term relief to a subset of renters. Many stakeholders credited the patchwork of federal, state, and local eviction moratoriums with keeping millions of renters housed during the pandemic, with some noting their limiting effect on eviction filings in some states and localities. While many states and localities took steps to protect renters during the pandemic, according to Eviction Lab, a housing data collection and research organization, many of these state provisions are limited (for example, in Arizona, courts can still process evictions, but tenants cannot be physically removed from their homes if they have a COVID-19 hardship) and as noted, many states never had, or no longer have, moratoriums in place.[463] The section 4024 moratorium ensured equivalent protection for all covered renters through July 24, 2020.[464] The September 2020 moratorium potentially covers more renters than the section 4024 moratorium and is effective through the end of 2020. Additionally, the moratorium does not apply in any state, local, territorial, or tribal area with a moratorium on residential evictions that provides the same or greater level of public-health protection than the moratorium's requirements.

Some landlords continued to file for evictions. Some stakeholders have noted that some landlords continued to file, and some local courts continued to process, evictions, including those

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are as close to the full payment as the individual's circumstances may permit, taking into account other nondiscretionary expenses; and eviction would like render the individual homeless—or force the individual to move into and live in close quarters in a new congregate or shared living setting—because the individual has no other available housing options." Renter households who choose to take advantage of this moratorium must declare under penalty of perjury that they meet these criteria.

[461]This estimate is according to the 2018 American Community Survey and is the most recent estimate of the number of renter households in the U.S. It may include renters that may not qualify for the moratorium, such as those who exceed the income limitation.

[462]Evictions generally are governed by state and local law. As a result, there is not comprehensive data on eviction filings and eviction rulings. It was beyond the scope of this report to assess those moratoriums and the extent to which they are more comprehensive than the federal moratoriums. Notwithstanding this, according to a group of legal researchers, 18 states continue to have eviction moratoriums in place, 10 of which are scheduled to expire before December 31, 2020 (the end of the September 2020 moratorium) and eight of which are tied to the end of the declared emergency. In addition, 27 states issued eviction moratoriums that have since expired, and six states did not issue any eviction moratoriums. This analysis includes Washington, D.C. See Emily Benfer et. al., *COVID-19 Eviction Moratoria by State, Commonwealth, and Territory*, accessible at https://docs.google.com/spreadsheets/u/1/d/e/2PACX-1vTH8dUIbfnt3X52TrY3dEHQCAm60e5nqo0Rn1rNCf15dPGeXxM9QN9UdxUfEjxwvfTKzbCbZxJMdR7X/pubhtml. These data are widely cited by researchers, policymakers, and the media.

[463]See Eviction Lab, *COVID-19 Housing Policy Scorecard*, accessible at https://evictionlab.org/covid-policy-scorecard/. Eviction Lab at Princeton University is a research organization that tracks and publishes a dataset on evictions going back to 2000 (see www.evictionlab.org).

[464]Based on our estimates, about 61 percent of renters were not covered by the CARES Act moratorium. Some of these renters may have benefited from or may continue to benefit from state or local protections.

resulting from the non-payment of rent that might be covered by the CARES Act moratorium. [465] Further, in June 2020, we reported that tenants in single-family properties in particular could have difficulty determining whether their residence has a federally backed mortgage. As a result, they may have been unaware of the protections under the CARES Act. However, information was not readily available to determine the extent that evictions were occurring in these properties. It is too soon to assess the implementation of the September 2020 moratorium.

Data suggest some renters may not be able to pay their rent in coming months. Since February 2020, the national economy has been in a recession. Historical data on mortgage and consumer credit delinquency rates show that a household's ability to pay its debts generally decreases in an economic downturn.[466]

Additionally, according to Census Bureau's Household Pulse Survey, in July 2020, an estimated 18 percent of renters reported they did not pay their rent in the previous month, up from an estimated 14 percent in May.[467] Survey data also indicate disproportionately more non-White renters reported missing their last month's rent payment compared to White renters.[468]

Some stakeholders also have observed lower and declining rent payments since May 2020.[469] By one estimate, only about 73 percent of renters in older, non-luxury ("class C") apartments

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[465]See Jeff Ernsthausen, Ellis Simani, and Justin Elliott, *Despite Federal Ban, Landlords Are Still Moving to Evict People During the Pandemic*, (New York: ProPublica, Apr. 16, 2020), accessed July 27, 2020, https://www.propublica.org/article/despite-federal-ban-landlords-are-still-moving-to-evict-people-during-the-pandemic, and National Housing Law Project, *Protecting Renter and Homeowner Rights During Our National Health Crisis*, accessed July 27, 2020, https://www.nhlp.org/campaign/protecting-renter-and-homeowner-rights-during-our-national-health-crisis-2/. Similarly, for the second quarter of 2020, Fannie Mae reported that 68 percent of renters (± about 3 percent) were unfamiliar with programs that allow renters facing financial hardship due to COVID-19 to lower or delay their rent payments. See Fannie Mae, *National Housing Survey: Covid-19: The Need for Consumer Outreach and Home Purchase/Financing Digitization.*

[466]See Board of Governors of the Federal Reserve System, *Charge-Off and Delinquency Rates on Loans and Leases at Commercial Banks*, https://www.federalreserve.gov/releases/chargeoff/delallsa.htm#fn1.

[467]This change was statistically significant at the 99 percent confidence level. The 2020 Household Pulse Survey, an experimental data product, is an interagency federal statistical rapid response survey to measure household experiences during the COVID-19 pandemic. The survey is conducted by the Census Bureau in partnership with five other agencies from the Federal Statistical System. Response rates have ranged from 1.3–3.8 percent. The Census Bureau acknowledges that nonresponsive bias is likely to be an issue, but measures such as the demographic distribution of the survey respondents compared to benchmarks will be produced for data users to consider in their analyses. Fannie Mae similarly reported that 36 percent of renters were somewhat or very concerned with their ability to pay their bills in the next month (from April–July, 2020), and 15 percent of renters had or planned to request lowered or delayed rent payments (± about 3 percent). See Fannie Mae*, National Housing Survey,* 2020.

[468]For example, across the 12-week survey, an estimated 10–13 percent of White renters did not make their last rent payment, compared to an estimated 23–29 percent of Black renters and 16–25 percent of Hispanic renters. These estimates have a margin of error of ± 4 percentage points or less at the 95 percent confidence level. Additionally, an estimated 35–48 percent of Black renters and 39–49 percent of Hispanic renters reported having low or slight confidence in their ability to pay rent next month, compared to about 19–24 percent of White renters. These estimates have a margin of error of less than ± 7 percentage points at the 95 percent confidence level.

[469]For example, the National Multifamily Housing Council estimated that full and partial rent payments to multifamily landlords for April–August 2020 lagged payments made for April–August 2019. In another survey, Apartment List found that for May–August, 2020, about one in three of Americans did not make a full, on-time housing payment. In the first week of August 2020, an estimated 11 percent of survey respondents made a partial payment toward their monthly housing (rent or mortgage) payment; an additional 22 percent of respondents had not made any payment. Apartment

made their August rent payments on time, compared to 82 percent for renters in luxury ("class A") apartments and 79 percent of all renters.[470]

Finally, about 40 percent of renters reported using sources other than income—such as credit cards, unemployment insurance benefits, and economic impact payments—during June and July to meet spending needs over the last 7 days.[471] As previously discussed, the September 2020 moratorium does not relieve renters from the obligation to pay accrued rent or associated fees, penalties, or interest that may contribute to such cash flow struggles and reliance on other sources of payment.

The continued nonpayment of rent could have spillover effects on the larger economy. While many landlords may be managing short-term reductions in rental payments, continued partial or non-payment may force some into forbearance or foreclosure, adding stress to the housing finance system.[472]

GAO Methodology and Agency Comments

To conduct this work, we analyzed trends in data from industry groups and federal agencies, including Census Bureau and the Department of Housing and Urban Development (HUD). We also reviewed documentation from federal agencies and states on eviction moratoriums. In

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List is an apartment listing website that also publishes research, analysis, and data on the U.S. rental market (see www.apartmentlist.com).

[470]See RealPage, Apartment Rent Payments Close to Normal in Early August, accessed August 20, 2020, https://www.realpage.com/analytics/apartment-rent-payments-close-normal-early-august/; and National Multifamily Housing Council. RealPage provides software and data analytics to the real estate industry (see www.realpage.com).

[471]Estimates are from the Census Bureau's Pulse Survey and have a margin of error of less than ± 2 percentage points at the 95 percent confidence level.

[472]Section 4023 of the CARES Act provides mortgage forbearance of multifamily properties for up to 90 days. During the forbearance period, landlords are prohibited from evicting tenants for nonpayment of rent. Pub. L. No. 116-136, §4023, 134 Stat. at 491. Roughly 2 percent (1,600 loans) of the outstanding balance on multifamily loans securitized by Fannie Mae and Freddie Mac were in forbearance as of late July–early August, 2020. According to Freddie Mac, most loans in forbearance are small balance loans that have fewer units, meaning each tenant experiencing stress will have a larger effect on small property operators. HUD, in Notice H 20-07, issued July 1, 2020, noted that many borrowers and lenders would negotiate additional forbearance relief beyond the 90-day period provided in the CARES Act. HUD announced it would condition, as a matter of policy, its approval of a forbearance extension on the borrower's agreement to similarly extend the Section 4023 renter protections. The Federal Housing Finance Agency announced in late June that Fannie Mae and Freddie Mac were allowing servicers to extend existing forbearance agreements with owners of multifamily properties with enterprise-backed mortgages by an additional 3 months (for a total forbearance of up to 6 months). While the properties are in forbearance, the landlord must suspend all evictions of renters unable to pay rent.Pursuant to an executive order signed by President Trump on August 8, 2020, the Department of the Treasury and HUD were to identify available federal funds to provide temporary financial assistance for renters and homeowners who were struggling to pay rent or make mortgage payments as a result of financial hardships caused by COVID-19. The executive order also directed HUD to take action, including encouraging and providing assistance to public housing authorities, affordable housing authorities, landlords, and federal grant recipients to minimize COVID-19-related evictions and foreclosures. Similarly, the executive order directed the Federal Housing Finance Agency, in consultation with the Department of the Treasury, to review existing authorities and resources that might be used to prevent COVID-19-related evictions and foreclosures.

addition, we reviewed studies by and interviewed a number of stakeholders, including housing industry and advocacy groups, think tanks, and researchers who represent and provide a variety of perspectives.

We provided a draft of this enclosure to the Consumer Financial Protection Bureau, the Department of Agriculture, HUD, the Department of the Treasury, the Department of Veterans Affairs, Fannie Mae, Freddie Mac, the Federal Housing Finance Agency, and the Office of Management and Budget for their review and comment. HUD provided general comments which are summarized in the Agency Comments and Our Evaluation section of this report. In its comments, HUD noted its efforts to inform renters, landlords, and other stakeholders of the CARES Act protections available to them, for example through a consumer call center and website developed jointly with the Consumer Financial Protection Bureau and the Federal Housing Finance Agency. Additionally, the Department of the Treasury, the Federal Housing Finance Agency, Fannie Mae and Freddie Mac, and the Office of Management and Budget provided technical comments, which we incorporated as appropriate. The Consumer Financial Protection Bureau, Department of Agriculture, and Department of Veterans Affairs did not provide comments.

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Economic Injury Disaster Loan Program

After an initial backlog in processing applications, the Small Business Administration decreased its processing times for loans and advances made under the Economic Injury Disaster Loan program, but various challenges remain related to the communication of program information and potential fraud.

Entities Involved: Small Business Administration

Key Considerations and Future GAO Work

In response to the COVID-19 pandemic, the Small Business Administration's (SBA) Economic Injury Disaster Loan (EIDL) program provided direct loans and advances to small businesses. But in our June 2020 report, we found that the agency encountered challenges processing program applications in a timely manner and communicating with applicants. Challenges remain around transparency and communication. In addition, SBA's Office of Inspector General (OIG) warned SBA of potential widespread fraud within the program in a July 2020 report based on its preliminary review, and suggested that SBA strengthen or implement additional internal controls to address potential fraud.[473] In response to this report, SBA maintained that it had robust controls in place and took some actions to address suspicious activities related to financial institutions receiving EIDL deposits. SBA's OIG agreed that those actions were responsive to its suggestions. SBA's OIG's work on the program, including investigations of fraudulent activities, is ongoing. We continue to be concerned about the potential for fraud in the program and are currently conducting work on the program, including on internal controls and fraud prevention.

Background

To assist small businesses adversely affected by COVID-19, the CARES Act, along with the Paycheck Protection Program and Health Care Enhancement (PPPHCE) Act, appropriated funds to the existing EIDL program so that SBA could provide more loans and advances, a new component of the program.[474] Specifically, Congress appropriated $50 billion in loan credit subsidies for EIDL loans and $20 billion for advances.[475] On July 11, 2020, SBA announced that it had fully allocated

[473]Small Business Administration, Officer of Inspector General, *Serious Concerns of Potential Fraud in Economic Injury Disaster Loan Program Pertaining to the Response to COVID-19,* 20-16 (Washington, D.C.: July 28, 2020).

[474]The program requires businesses to repay these loans, but businesses do not have to repay the advances.

[475]The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, deemed coronavirus a disaster under the Small Business Act, which made businesses experiencing economic injury caused by COVID-19 eligible for EIDLs. As a result, SBA began using existing $1.1 billion in loan credit subsidy to provide EIDLs to these affected businesses. The $1.1 billion in loan credit subsidy supported between $7 and $8 billion in EIDL loans. Loan credit subsidy covers the government's cost of extending or guaranteeing credit and is used to protect the government against the risk of estimated shortfalls in loan repayments. SBA also provided advances using the $10 billion Congress appropriated under the CARES Act. On April 16, 2020, SBA announced that the lending authority for EIDL loans and the funding for

the $20 billion in funding for EIDL advances and would stop making advances to new applicants. The agency continues to accept applications for EIDL loans.[476]

Overview of Key Issues

As of August 22, 2020, SBA had accepted about 14.5 million applications for EIDL loans related to COVID-19 and approved about 3.5 million of these applications totaling about $184 billion (or an average of about $53,300 per loan). According to SBA officials, the agency has approved more EIDL loans for COVID-19 than for all disasters combined in its history. SBA received about 10.1 million applications for EIDL advances related to COVID-19, and approved about 5.8 million of these applications totaling $20 billion (or an average of about $3,500 per advance). Some challenges remain as SBA continues to administer EIDL loans.

Processing times. SBA's cumulative average processing time for EIDL loan applications has been declining since June 20, 2020, and as of August 22, 2020, SBA had processed EIDL loan applications, on average, in about 29 days. Between March 15, 2020, and August 22, 2020, the cumulative average processing time for EIDL loan applications ranged from about 5 to 55 days for those approved for loans and from 1 to 34 days for those declined for loans. From March 29, 2020, and until SBA stopped accepting applications on July 11, 2020, SBA's cumulative average processing time for EIDL advance applications was 18 days.

According to SBA officials, the large number of applications contributed to initially long processing times for loans and advances. For example, SBA's data show that it took SBA more than 3 months to process over 5 million loan applications that it accepted between March 15, 2020, and April 15, 2020, when SBA closed its application portal due to a lapse in appropriations. SBA officials said that interest in the advances led to a significant increase in EIDL applications, and that the number of EIDL applications it accepts weekly has declined since SBA stopped accepting requests for advances. SBA officials said the agency implemented new technology in mid-April 2020 to help it process applications more quickly. SBA data also show that the agency increased the number of staff in its processing and disbursement center through additional hiring and the use of contractors.

Transparency and communication. Some businesses continue to report a lack of transparency and communication from SBA regarding the EIDL program. As we reported in June 2020, SBA was not transparent about program information including the loan limits it put in place. Representatives from two small business associations told us in July 2020 that their members reported SBA had not provided additional information about the program, such as loan limits and how loan amounts are calculated.

EIDL advances had been exhausted. Under the PPPHCE Act, Congress appropriated another $10 billion for advances and $50 billion in loan credit subsidy for EIDL loans. Additionally, Congress made agricultural enterprises eligible for EIDL loans and advances. SBA began accepting new applications from only agricultural enterprises on May 4, 2020. On June 15, 2020, SBA reopened the application portal to all eligible applicants.

[476]Applicants requested advances as part of the EIDL loan application.

SBA officials told us that when SBA first began to provide EIDL loans for COVID-19 in mid-March 2020, it limited the loans to 6 months of working capital up to a maximum of $500,000. SBA officials said that on April 3, 2020, the agency lowered the limit to $15,000 for 3 days before raising the limit again to $500,000, and for applications that were previously subject to the $15,000 loan limit, SBA increased the limit to $500,000. Subsequently, on May 4, 2020, SBA officials said SBA decreased the limit to a maximum of $150,000, where it has remained.[477] SBA officials previously told us that they took these steps to assist as many small businesses as possible. SBA data as of July 19, 2020, show that the agency approved about 7,000 EIDL loans in the amount of $500,000 for businesses with an economic injury greater than $500,000; it also approved about 459,000 EIDL loans in the amount of $150,000 for businesses that had an economic injury greater than $150,000.

Internal controls and fraud risk. In July 2020, SBA's OIG issued a preliminary review of the EIDL program and warned SBA about indicators of widespread potential fraud and deficiencies with SBA's internal controls. SBA's OIG reported that it has received thousands of complaints of suspected fraud from financial institutions receiving EIDL deposits and from its complaint hotline. SBA's OIG also reported potential internal control deficiencies, including that SBA potentially gave EIDL loans and advances to ineligible businesses and made duplicate payments.

SBA's OIG suggested that the SBA Administrator (1) assess vulnerabilities for the purpose of strengthening or implementing internal controls to address notices of potential fraud and (2) create an effective process and method for lenders to report suspected fraud to SBA and to recover funds.

In response to the SBA's OIG report, SBA maintained that it had robust internal controls in place, such as checks to identify duplicate applications and verify bank account information for advances and evaluation of fraud alerts and related applications by loan officers. Also in response to the SBA OIG's report, SBA provided guidance to banks on how to report suspicious fraud activity to SBA and issued an Informational Notice to financial institutions to alert them to the potential types of suspicious activity related to EIDL program deposits and encourage them to examine certain transactions carefully. SBA's OIG agreed that those actions were responsive to its suggestions.

SBA's OIG's work on the program, including investigations of fraudulent activities, is ongoing. In addition, the Department of Justice, in conjunction with other federal agencies, have announced charges related to EIDL fraud. SBA officials told us that the CARES Act changes to ease EIDL program requirements, such as acceptance of an applicant's self-certification for eligibility of the advances, helped to expedite processing but increased fraud risk, which SBA tried to mitigate through internal controls. We continue to be concerned about the potential for fraud in the program and are currently conducting work on the program, including on internal controls and fraud prevention.

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[477]The size of a given borrower's loan is based on economic injury, or the change in the borrower's financial condition attributable to the effect of the disaster, resulting in the inability of the borrower to meet its obligations or to pay ordinary and necessary operating expenses. Currently, SBA generally calculates economic injury by presuming 6 months of lost gross profit. For example, a business with $100,000 in annual revenue and $50,000 in cost of goods sold has $50,000 in gross profit, or about $4,200 per month. The economic injury for this business would be $4,200 multiplied by 6, or about $25,000. If the business received $2,000 in advances, SBA would approve a loan for $23,000, after subtracting for the amount of advances.

GAO Methodology and Agency Comments

To conduct this work, we reviewed SBA documentation on the programs and interviewed SBA officials. In addition, we interviewed representatives from two small business associations. Their views are not generalizable to other small business associations but offered important perspectives.

We provided SBA and the Office of Management and Budget (OMB) with a draft of this enclosure. SBA and OMB provided technical comments, which we have incorporated as appropriate.

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Federal Reserve Emergency Lending Programs

Since early June 2020, seven additional emergency lending programs (or facilities) supported through CARES Act-appropriated funds became operational, resulting in a total of nine operational CARES Act facilities as of September 4, 2020. Modifications to the initial terms of the Main Street facilities serving small- and mid-size businesses continued into June and, according to Board of Governors of the Federal Reserve System officials, contributed to the facilities not becoming operational—that is, not accepting loans—until early July. The Main Street facilities serving nonprofits became operational in early September. Overall, the CARES Act facilities' transactions and purchases of assets have been relatively limited.

Entities involved: Federal Reserve System, Department of the Treasury

Key Considerations and Future GAO Work

In June 2020, we reported that Board of Governors of the Federal Reserve System (Federal Reserve) officials told us they have taken actions to address two recommendations we made in July 2011 regarding lending facilities they implemented in response to the 2007-2009 financial crisis—strengthening procedures related to high-risk borrowers, and estimating and tracking losses within and across all facilities. Both recommendations remain relevant for the recently established facilities because they are similarly operated. We continue to review these actions as part of our more detailed review of the Federal Reserve facilities.

Background

The CARES Act appropriated $500 billion to the Department of the Treasury (Treasury) and authorized at least $454 billion of that total for Treasury to support the Federal Reserve in establishing lending facilities.[478] The act also placed certain restrictions on corporations' stock repurchases, dividends, and executive compensation, among others, when the businesses receive a direct loan from facilities supported with Treasury's CARES Act funding.

[478]The facilities are authorized under section 13(3) of the Federal Reserve Act that permits the Federal Reserve to provide emergency lending and are approved by the Secretary of the Treasury. Section 13(3) facilities must comply with requirements relating to loan collateralization and taxpayer protection, among others. Of the $500 billion appropriated under Section 4027 of the CARES Act, $25 million shall be made available to the Special Inspector General for Pandemic Recovery.

Overview of Key Issues

CARES Act facilities. As of September 4, 2020, nine Federal Reserve lending facilities supported by Treasury's CARES Act funding were operational. (See table below.)

- The Federal Reserve proposed small- and mid-size for-profit business Main Street Lending facilities in early April 2020, but these facilities did not begin accepting loans until early July. In late April and in early June 2020, the Federal Reserve modified the terms of these Main Street Lending facilities based on stakeholder input, such as lowering the minimum loan amount to $250,000 and extending the time frame for paying back loans to 5 years. The term sheets for these facilities were finalized on June 8, 2020, and lender registration for participation in the facilities opened on June 15, 2020. The small- and mid-size for-profit business Main Street Lending facilities started accepting loans on July 6, 2020.
- The Federal Reserve published draft terms for comments on two Main Street nonprofit facilities and, with Treasury's approval, authorized them in July 2020. These two facilities started accepting loans on September 4, 2020.

Federal Reserve Lending Facilities with CARES Act Funding				
Name of facility	**Purpose**	**Facility activity**	**Activity dates (can be extended)**	**Transaction volume, as of August 15, 2020 ($ billions)**
1. Primary Market Corporate Credit Facility 2. Secondary Market Corporate Credit Facility	Support large businesses	Primary market facility: purchase qualifying bonds, and purchase portions of qualifying syndicated loans or bonds at issuance. Secondary market facility: purchase qualifying corporate bonds, certain bond portfolios, and U.S.-listed exchange-traded funds in the secondary market.	June 29, 2020 through Dec. 31, 2020 May 12, 2020 through Dec. 31, 2020	0 12.15
3. Main Street New Loan Facility 4. Main Street Priority Loan Facility 5. Main Street Expanded Loan Facility 6. Main Street Nonprofit Organization New Loan Facility 7. Main Street Nonprofit Organization Expanded Loan Facility	Support small- and mid-sized businesses Support small-and mid-sized nonprofit organizations	New loan and priority loan facilities: purchase 95 percent participation interests in newly issued eligible loans that eligible lenders make to eligible small- and mid-sized for-profit borrowers. Expanded loan facility: purchase 95 percent participation interests in a new extension of credit under an existing eligible loan made by an eligible lender to an eligible small- and mid-sized for-profit borrower. Nonprofit new loan facility: purchase 95 percent participation interest in newly issued eligible loans that eligible lenders make to eligible nonprofit organization borrowers. Nonprofit expanded loan facility: purchase 95 percent participation interest in a new extension	July 6, 2020 through Dec. 31, 2020, for facilities supporting small- and mid-sized businesses	0.35 in total for the facilities supporting small- and mid-sized businesses Facilities supporting nonprofit organizations became operational on Sept. 4, 2020

		of credit under an existing eligible lender to eligible nonprofit organization borrowers.		
8. Municipal Liquidity Facility	Support states and certain counties, cities, multi-state entities, and revenue bond issuers	Purchase eligible notes directly from eligible issuers at time of issuance.	May 26, 2020 through Dec. 31, 2020	1.20
9. Term Asset-Backed Securities Loan Facility	Support consumers and businesses	Provide nonrecourse loans to U.S. companies secured by qualifying asset-backed securities generally backed by recently originated consumer and business loans.	June 17, 2020 through Dec. 31, 2020	2.27

Source: GAO analysis of Federal Reserve documents and data. | GAO-20-701

As of August 15, 2020, Treasury had committed $195 billion, or about 43 percent, of the $454 billion from the CARES Act available to support the facilities and disbursed $102.5 billion of that commitment.[479] As of the same date, the seven facilities in operation had conducted almost $16 billion in transactions—with the Secondary Market Corporate Credit Facility accounting for $12.15 billion.

The facilities' purchases of assets have been relatively limited. For example, as of September 2, 2020, the Municipal Liquidity Facility has conducted only two transactions.[480] Officials from associations representing state and local government finance professionals told us that their members are able to obtain lower rates in the marketplace.

According to Federal Reserve officials, the relatively limited demand for the facilities is tied to improvements in the functioning of the markets that the facilities are intended to serve. For example, they said that businesses might not use the Main Street facilities because they were able to meet their credit needs by borrowing in the private-sector market or through the Paycheck Protection Program in the early stages of the pandemic. The officials said that the Main Street facilities are intended to provide financing where it is not otherwise available, and they expect growing demand for Main Street loans if the economy declines. Officials from associations representing small businesses and community banks told us that a minimum loan amount of

[479]To implement these facilities, the Federal Reserve is using legal entities known as special purpose vehicles (SPVs) to purchase qualifying assets from, or initiate lending to, eligible institutions, and Treasury also has made equity investments in the SPVs with CARES Act funds. For the subsidies of Treasury loan programs under Section 4003 of the CARES Act (Economic Stabilization Program), total obligations of budget authority are recorded on a net present value basis. As a result, total Economic Stabilization Program subsidy obligations are $30.45 billion with outlays of $19.18 billion, of which most relate to the Federal Reserve facilities.

[480]The Federal Reserve revised the pricing for the Municipal Liquidity Facility on August 11, 2020, including reducing the interest rate spread on tax-exempt notes for each credit rating category by 50 basis points.

$250,000 for Main Street loans has generally been a factor in their members' decisions to not consider participating in these loans. We will continue to monitor the use of the facilities in our future work.

All of the CARES Act facilities will cease purchasing eligible assets by or on December 31, 2020, unless the facilities are extended by the Federal Reserve and Treasury.[481] In the most recent periodic reports to Congress on the lending facilities, the Federal Reserve Board stated it continues to expect that the facilities will not result in losses to the Federal Reserve.[482]

Non-CARES Act facilities. The Federal Reserve also established four facilities that do not receive support through CARES Act appropriated funds. (See table.) These facilities aim to provide liquidity to the financial sector and businesses. As of August 15, 2020, all four of these facilities were operational and have conducted more than $281 billion in transactions—with the Paycheck Protection Program Liquidity Facility and the Primary Dealer Credit Facility accounting for about $90 billion and close to $129 billion, respectively. The non-CARES Act facilities will terminate on specific dates in 2020 or 2021, unless extended.[483]

[481]For most facilities that include an SPV, the responsible Federal Reserve Banks will continue to fund the SPV after the facility's termination date until the SPV's underlying assets mature or are sold.

[482]According to Federal Reserve officials, the expectation of the facilities incurring no losses for the Federal Reserve takes into account Treasury's guarantees appropriated under the CARES Act.

[483]The Primary Dealer Credit Facility will remain available to primary dealers until December 31, 2020, unless extended; Money Market Mutual Fund Liquidity Facility and Paycheck Protection Program Liquidity Facility will not make credit extensions after December 31, 2020, unless extended; and the Commercial Paper Funding Facility will terminate on March 17, 2021, unless extended.

Federal Reserve Lending Facilities without CARES Act Funding				
Name of facility	**Purpose**	**Facility activity**	**Activity dates (can be extended)**	**Transaction volume, as of August 15, 2020 ($ billions)**
1. Commercial Paper Funding Facility	Serve as funding backstop to provide liquidity for U.S. issuers of commercial paper	Purchase commercial paper from eligible companies; eligible issuers include U.S. issuers of commercial paper, including municipal issuers and U.S. issuers with a foreign parent company	Apr. 14, 2020 through March 17, 2021	4.27
2. Money Market Mutual Fund Liquidity Facility	Assist money market mutual funds in meeting demands for redemption by investors	Make non-recourse loans available to eligible financial institutions that are secured by high-quality assets purchased by the financial institution from money market mutual funds	Mar. 23, 2020 through Dec. 31, 2020	58.01
3. Paycheck Protection Program (PPP) Liquidity Facility	Facilitate lending by eligible borrowers that provide loans to small businesses under the Paycheck Protection Program	Lend to institutions eligible for making PPP loans on a non-recourse basis, taking PPP loans as collateral[a]	Apr.16, 2020 through Dec. 31, 2020	90.50
4. Primary Dealer Credit Facility	Provide support to primary dealers to facilitate the availability of credit to businesses and households	Provide loans to primary dealers in exchange for collateral	March 20, 2020 through Dec. 31, 2020	128.82

Source: GAO analysis of Federal Reserve documents and data. | GAO-20-701

[a]The Federal Reserve established the PPP Liquidity Facility under its section 13(3) authority to encourage participation in the PPP established under the CARES Act. See “Paycheck Protection Program” in appendices for more information on the PPP.

GAO Methodology and Agency Comments

To conduct this work, we reviewed Federal Reserve documentation on each facility, including term sheets and related press releases, reports to Congress on the facilities, and the most recent agency transaction data on the facilities available, as of August 15, 2020. We also interviewed Federal Reserve officials, officials of industry and state-and-local government associations, and obtained updated information from Treasury. We provided a copy of this enclosure to the Federal

Reserve, Treasury, and the Office of Management and Budget for review. They provided technical comments that we incorporated, where appropriate.

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Related Publication

Federal Reserve System: Opportunities Exist to Strengthen Policies and Processes for Managing Emergency Assistance. GAO-11-696. Washington, D.C.: July 21, 2011.Financial Assistance to Aviation and Other Eligible Businesses

Financial Assistance to Aviation and Other Eligible Businesses

The Department of the Treasury continues to provide assistance out of the $78 billion available to help the nation's aviation industry and other businesses critical to national security recover from the economic effects of the COVID-19 pandemic.

Entities Involved: Department of Transportation, Department of the Treasury

Key Considerations and Future GAO Work

In both ongoing and planned work, we will continue to monitor CARES Act financial assistance to the aviation sector and other eligible businesses and gather stakeholder perspectives on how the assistance has helped with recovery.

Background

The COVID-19 pandemic, resulting in several stay-at-home orders, continues to affect the U.S. aviation industry. For example, passenger demand for air travel remains low, impacting demand for other aviation sectors, such as airline service companies. In August 2020, major U.S. passenger carriers reported to the Department of Transportation (DOT) that 80 percent fewer passengers flew on scheduled flights in June 2020 compared to June 2019.

The CARES Act authorized the Department of the Treasury (Treasury) to provide financial assistance in the form of payroll support payments and loans to eligible recipients primarily within the aviation industry. As of July 31, 2020, Treasury has obligated approximately 85 percent ($27.2 billion) of the $32 billion appropriated for payroll support to passenger air carriers, cargo air carriers, and certain contractors to continue paying wages, salaries, and benefits, and expended about 96 percent ($26.2 billion) of those obligated funds.[484] Also, as June 30, 2020, the amount of funding passenger carriers and aviation contractors applied for has exceeded available levels, whereas cargo carriers have applied for less than 25 percent of funding available for this category of businesses.

As required by statute, as a condition of signing an award agreement with Treasury, Payroll Support Program (PSP) recipients must agree that they will refrain from conducting involuntary furloughs or reducing pay rates and benefits until September 30, 2020, and must also agree that they will refrain from share buybacks and dividend payments until September 30, 2021, among other conditions. [485]

[484]Pub. L. No. 116-136, § 4112, 134 Stat. 281, 498 (2020).

[485]CARES Act, § 4114(a), 134 Stat. at 499. For example, as authorized by the CARES Act, DOT is requiring passenger air carriers receiving financial assistance to maintain minimum scheduled passenger service through September 30, 2020. During this time, carriers must serve points in the United States that they served before March 1, 2020, with some

Under the CARES Act, Treasury is also authorized to provide up to $46 billion in loans, loan guarantees, and other investments to provide liquidity to:

- passenger and cargo air carriers;
- businesses certified to perform aviation inspection, repair, replace, or overhaul services;
- ticket agents;
- and businesses critical to maintaining national security, including non-aviation sector businesses.

Recipients must meet a number of conditions, some of which are similar to those under PSP.[486]

Since our last report, Treasury officials told us that they have focused on the loan program.[487] As of August 20, 2020, Treasury has made one loan for up to $700 million to a business designated as critical to maintaining national security, and has also signed letters of intent with 10 passenger carriers to provide loans that could total over $20 billion.[488]

Overview of Key Issues

Since our June report, Treasury has continued to sign agreements to award PSP funds, with the timing and volume of agreements and awards varying by recipient group.[489] As of July 31, 2020, according to data from Treasury's website, it had executed 580 PSP agreements—representing 336 passenger carriers, 34 cargo carriers, and 210 aviation contractors.[490] Among those anticipated awards, some trends in timing and amounts received included (see figure):

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exemptions, in accordance with section 4114(b) of the CARES Act. DOT made no announcement by its internal deadline of August 1, 2020, as to whether it would extend these minimum service obligations beyond September 30, 2020.

[486]Among other requirements, recipients are required, until September 30, 2020, to maintain employment levels as of March 24, 2020, to the extent practicable, and in any case shall not reduce their employment levels by more than 10 percent from the levels on such date. CARES Act, § 4003(c)(2)(G), 134 Stat. at 471.

[487]As we reported in June 2020, Treasury officials said that implementation of the loan program followed that of the Payroll Support Program since the CARES Act directs Treasury to prioritize implementation of the Payroll Support Program, and because the loan program presents a number of complexities not found in the Payroll Support Program.

[488]As of June 1, 2020, amounts sought through applications from passenger air carriers, eligible businesses, and ticket agents exceeded available loan levels, while applications from cargo carriers and businesses critical to maintaining national security were less than 10 percent of available loan levels. We have ongoing work examining loans made through this program, as well as Treasury's overall implementation of the program, that we plan to issue in winter 2020.

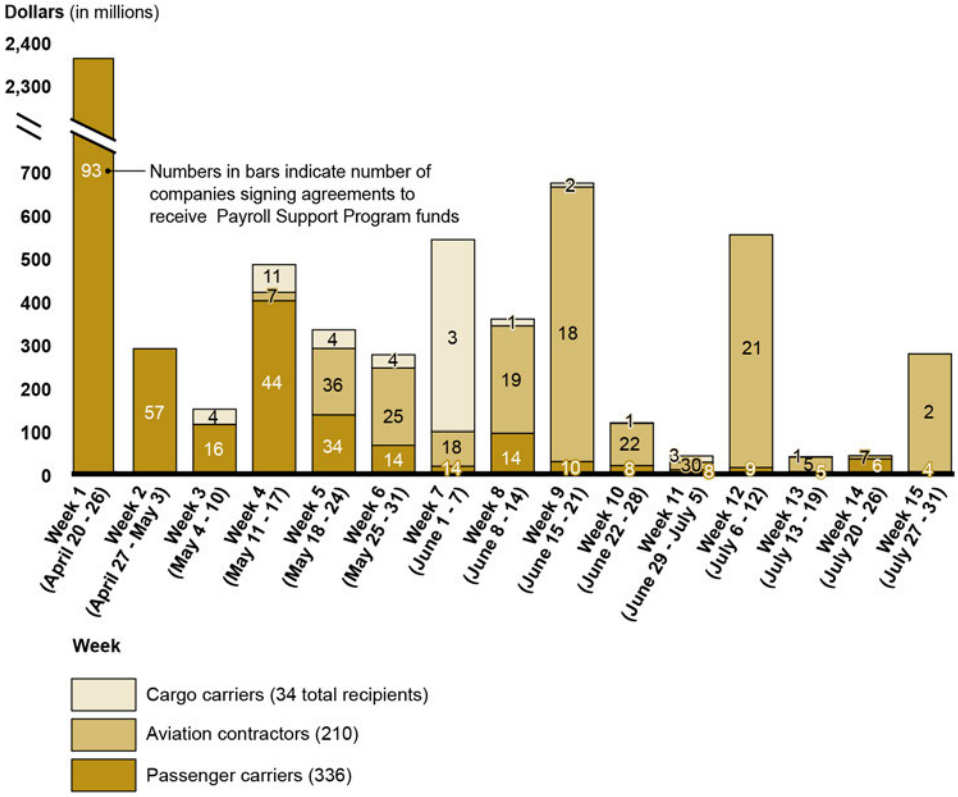
[489]The CARES Act required Treasury to make initial PSP payments no later than 10 days after the date of enactment of the CARES Act to businesses that submitted requests that were approved by the Treasury Secretary. Pub. L. No. 116-136, § 4113(b)(2), 134 Stat. at 498-499.

[490]Treasury continued to execute PSP agreements with all three types of recipients through late August 2020.

- Passenger carriers, namely the largest ones, were among the earliest recipients. Treasury officials said they prioritized these applications because these companies were the largest employers among applicants, and therefore they represented a significant amount of the jobs at stake. Additionally, Treasury officials said these carriers' applications were relatively complete and straightforward to review because these carriers are required to regularly submit employee and salary data to DOT.[491]
- Almost 150 passenger carriers signed financial assistance agreements in April, including 11 large commercial airlines that anticipated receiving collectively over $23 billion in aid, whereas most cargo carriers signed agreements in May and most aviation contractors signed agreements in June.
- According to Treasury, many applications from smaller carriers and contractors had application issues, such as incomplete information on the company's corporate structure. Treasury officials said these issues took time to address before they could determine that the applications met statutory requirements.

[491] Under section 4113 of the CARES Act, for air carriers that report salary and benefit information to DOT, the amount of a PSP award is equal to the reported amounts for the second and third quarters of 2019. In contrast, for other firms, the PSP award is an amount certified by the company in its application for the period from April 1, 2019, through September 30, 2019.

Timing and Anticipated Award Amounts for the Department of the Treasury's Payroll Support Program, by Type of Recipient, as of July 31, 2020



Source: GAO analysis of U.S. Department of the Treasury data. | GAO-20-701

Note: The CARES Act was signed into law on March 27, 2020, and the first Payroll Support Program agreements were signed on April 20, 2020.

Overall, all aviation industry associations representing businesses eligible for PSP we met with told us that PSP funds have provided critical support to recipients, meeting its intent by helping them retain employees. Two associations said members were able to hire back employees who had been furloughed or laid off before PSP funds were disbursed. Also, some associations told us the funding was crucial to retaining highly trained employees in positions for which the industry had been experiencing a workforce shortage, a topic we have reported on in prior work.

However, most aviation industry associations, particularly those representing regional and small aviation companies, told us their members experienced challenges with the PSP process. Noted challenges included confusion about eligibility and other requirements, lack of direct contact at Treasury to get answers to time-sensitive issues, lack of a mechanism to check on the status of an application, and a long time needed for Treasury to award some of the PSP funds. For example, a few members of associations we interviewed stated in late June and early July that they had not heard from Treasury as to whether they would receive funds, despite applying in April. Regarding these identified challenges, Treasury officials said that they published email addresses where applicants could direct questions and communicated with potentially hundreds of applicants on the program. Treasury officials also said they notified applicants if there was an update on the status of an application.

Treasury faced what officials described as an unprecedented challenge of standing up a new financial assistance program in a condensed time frame, and Treasury started to award PSP funds in a matter of weeks. As shown in the figure above, Treasury signed agreements with over half of all PSP recipients by late May. However, industry associations reported some actions their members took while their PSP applications were under review. For example:

- A few associations told us that members furloughed and laid off employees, and in one case, filed for bankruptcy after applying for PSP funds.
- Two associations told us members were able to get financial support via other means, such as private loans, but not knowing the timeline for when they may hear from Treasury has added anxiety to an already uncertain situation.
- According to our analysis of Treasury data and information from 15 states,[492] four of the top 11 aviation contractors slated to receive the largest PSP awards announced approximately 8,000 potential employee furloughs and layoffs after the PSP application deadline and before each contractor signed a PSP agreement with Treasury.[493] One of these contractors also issued such an announcement in two of these states after signing an agreement with Treasury to receive PSP funds.[494]

Conversely, some associations we spoke to did not experience challenges in applying for PSP. Members from two associations representing larger companies told us that the process to submit an application was straightforward. Regardless, associations told us that despite the large undertaking of creating a new financial program, Treasury officials have generally been cooperative and helpful. In addition, according to some, they have responded to questions in a timely fashion.[495]

Moving forward, associations told us that the ongoing uncertainty about the spread of COVID-19 will lead some companies to adjust business plans, including laying off employees, when

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[492]We identified 11 aviation contractors with the largest anticipated payroll support award amounts as of July 31, 2020, according to Treasury data, and matched them to Worker Adjustment and Retraining Notification Act (WARN Act) notices from the 15 states with the largest enplanement numbers (aggregated by airports within the state) in calendar year 2019 based on data from the Federal Aviation Administration. Our rationale for this selection is that the top 15 states for enplanements cover 77 percent of all enplanements and the top 11 aviation contractors anticipate receiving 58 percent of all PSP funds. The WARN Act requires advance notification of mass layoffs, among other things. Pub. L. No. 100-379, 102 Stat. 890 (1988).

[493]Three additional contractors announced anticipated furloughs and layoffs after the passage of the CARES Act but before the PSP deadline. The remaining four contractors did not report any potential employee furloughs or layoffs in these time frames in any of the states, which were California, Florida, Texas, Georgia, New York, Illinois, Colorado, North Carolina, Virginia, Washington, Nevada, Arizona, New Jersey, Pennsylvania, and Michigan.

[494]This contractor announced that layoffs would take place on October 1, 2020. Also, PSP recipients must file quarterly compliance reports to Treasury containing key information, such as any changes in employee headcount numbers, through at least 2022. The first set of compliance reports for some recipients were due on August 14, 2020.

[495]As of August 12, 2020, Treasury had posted six frequently asked questions and three other guidance documents on its website.

PSP funding and conditions end after September 2020.[496] Several large passenger carriers have announced potential and planned furloughs for employees in fall 2020 amidst a need to restructure, as they expect the recovery will take at least a few years.[497] For example, in August, American Airlines announced its plans to furlough about 17,500 pilots, flight attendants, and mechanics, and, in September, United Airlines announced its plans to furlough about 15,000 employees, both beginning October 1, 2020.

GAO Methodology and Agency Comments

To conduct this work, we reviewed the most recent Treasury data on airline financial assistance as of July 31, 2020, which we found to be reliable for the purposes of this engagement, and reviewed federal laws and agency guidance related to the CARES Act. We also analyzed state data on eligible employer furlough and layoff notices for a selection of aviation contractors that had signed PSP agreements with Treasury. In addition, we interviewed DOT and Treasury officials, and a non-generalizable sample of 11 aviation industry associations, to include perspectives from commercial, regional, ultra-low-cost, and on-demand passenger carriers; large and regional cargo carriers; and aviation contractors.

We provided DOT, Treasury, and the Office of Management and Budget with a draft of this enclosure. DOT and Treasury provided technical comments, which we incorporated as appropriate. OMB did not provide comments on this enclosure.

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Related GAO Products

Aviation Maintenance: Additional Coordination and Data Could Advance FAA Efforts to Promote a Robust, Diverse Workforce. GAO-20-206. Washington, D.C.: Feb. 6, 2020.

Aviation Workforce: Current and Future Availability of Airline Pilots. GAO-14-232. Washington, D.C.: Feb. 28, 2014.

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[496]While PSP recipients do not have a deadline with which they must use payroll funds, some of the terms and conditions laid out have established end dates, such as refraining from conducting involuntary terminations or furloughs of employees until September 30, 2020. As of July 31, 2020, DOT and Treasury had established plans to monitor recipients' compliance with conditions for receiving payroll support funding, but monitoring had not yet begun. We have ongoing work examining Treasury's monitoring compliance with conditions for receiving payroll support funding that we plan to issue in winter 2020.

[497]Labor unions representing airline and contractor employees have also advocated for an extension of PSP, stating that without one, the aviation sector could lose experienced workers critical to the industry.

Agriculture Spending

The U.S. Department of Agriculture continues to spend CARES Act funds for direct payments to agricultural producers and food purchases for redistribution to food banks, nonprofits, and other entities.

Entities involved: U.S. Department of Agriculture, including its Agricultural Marketing Service and Farm Service Agency

Key Considerations and Future GAO Work

Our work on U.S. Department of Agriculture's (USDA) implementation and oversight of a range of CARES Act funds, including any implementation challenges, is ongoing.

We will continue to examine the department's

- self-certification process, verification of eligibility, and disbursement of direct payments to producers; and
- contracting processes and decisions for the purchase and redistribution of food products.

Background

COVID-19 has caused disruptions in the U.S. food supply chain, from the farms where raw agricultural commodities are produced, to the food processing and distribution network that enables these commodities to be used by consumers.[498] As a result of COVID-19, prices for many major agricultural commodities, including livestock (cattle, hogs, poultry, and dairy), significantly decreased, which has meant a loss in income for many producers. In addition, the closure of institutions (schools, restaurants, hotels, for example) made it difficult for agricultural producers to market their commodities, leading to the spoilage of crops, dumping of milk, and euthanization of livestock.

As we reported in June 2020, to address the effects of the COVID-19 pandemic on agricultural producers, USDA received funding from the CARES Act and accessed funding generally available to the agency through its Commodity Credit Corporation Charter Act authorities.[499] Departmental allocations, obligations, and expenditures of these CARES Act funds are described in the table below.

[498]COVID-19 affected consumer prices for food. In May 2020, the U.S. Bureau of Labor Statistics reported that April 2020 saw the sharpest increase in grocery store prices since 1974.

[499]The CARES Act, Pub. L. No. 116-136, div. B, tit. I, 134 Stat. 281, 505 (2020). Also Commodity Credit Corporation Charter Act, 15 U.S.C. §§ 714-714p.

U.S. Department of Agriculture CARES Act Allocations, Obligations, and Expenditures as of July 31, 2020			
	Amount Allocated ($ billions)	Obligations ($ billions)	Expenditures ($ billions)
Coronavirus Food Assistance Program, direct payments[a]	9.5	4.1	3.4
Coronavirus Food Assistance Program, food purchases[b]	3.0	2.6	1.3

Source: U.S. Department of Agriculture (USDA). I GAO-20-701.

Note: According to USDA, actual expenditures (or purchases) are determined by the payments USDA makes on invoices it receives from contractors.

[a]These funds are to provide support for agricultural producers of specialty crops (such as fruits, vegetables, and tree nuts), producers that supply local food systems (such as farmers markets, restaurants, and schools), and livestock producers, including dairy producers. CARES Act, Pub. L. No. 116-136, div. B, tit. I, 134 Stat. at 505. In addition, USDA added $6.5 billion from its Commodity Credit Corporation for a total of $16 billion in direct payments to producers.

[b]These funds are for USDA to purchase and distribute up to $3 billion in agricultural products using authorities outlined in the Commodity Credit Corporation Charter Act, 15 U.S.C. §§ 714-714p, and the Families First Coronavirus Response Act to provide for families in need, Pub. L. No. 116-127, div. A, tit. I §1101(g), 134 Stat. 178, 179 (2020).

Overview of Key Issues

In this report, we provide updates on issues identified in our June 2020 report. Specifically, USDA's Coronavirus Food Assistance Program (CFAP) which encompasses the agency's response to COVID-19 (through direct payments and food purchases also referred to as the Farmers to Families Food Box Program).

Coronavirus Food Assistance Program—direct payments. USDA continues to spend CARES Act funds for direct payments to agricultural producers. The Farm Service Agency (FSA) began taking applications on May 26, 2020, and on July 10, 2020,[500] USDA announced updates to its final rule in the *Federal Register*, adjusting payment rates and expanding the list of eligible commodities, among other things. On August 14, 2020, USDA again expanded the list of eligibility commodities and extended the deadline for applications to September 11, 2020.[501]

As of August 17, 2020, USDA had paid more than $9 billion to 541,073 approved applicants, with livestock producers accounting for roughly half the payments, $3.9 billion paid out for beef cattle, and nearly $564 million for hogs.[502] At that time, payments for dairy (milk) producers totaled

[500]U.S. Department of Agriculture, "Coronavirus Food Assistance Program: Correction," 85 Fed. Reg. 41,328 (July 10, 2020) and "Notice of Funding Availability; Coronavirus Food Assistance Program (CFAP) Additional Eligible Commodities," 85 Fed. Reg. 41,321 (July 10, 2020).

[501]U.S. Department of Agriculture, "Notification of Funding Availability; Coronavirus Food Assistance Program (CFAP) Additional Eligible Commodities," 85 Fed. Reg. 49,589 (Aug. 14, 2020).

[502]All payment data related to CFAP is from the USDA CFAP Dashboard, https://www.farmers.gov/cfap/data, accessed on August 17, 2020.

nearly $1.7 billion, while corn growers received $1.6 billion and soybean producers received more than $457 million.

Coronavirus Food Assistance Program—food purchases. USDA also continues to spend funds for food purchases for redistribution to food banks, nonprofits, and other entities as part of its new Farmers to Families Food Box Program. In the first phase of the program, May 15 to June 30, 2020, USDA awarded (thus obligating) about $1.2 billion in contracts. For the second phase of the program, which began on July 1, 2020, USDA entered into 16 contracts in addition to the approximately 190 contracts from the first phase of the program.[503] In total, as of July 31, 2020, USDA had obligated more than $2.6 billion dollars, according to USDA. On July 24, 2020, USDA announced a third round of the program for food purchases that would spend the balance of the $3 billion allocated for the program.[504] Finally, on August 25, 2020, the administration and USDA announced that they intend to add up to $1 billion to the program. USDA reported that since May 15, 2020 it had delivered more than 74 million food boxes to non-profits, food banks, and other entities throughout the country (as of August 27, 2020).

As we reported in our June 2020 report, according to USDA, the Farmers to Families Food Box Program has represented a completely different way of doing business for USDA. USDA officials said that they consider the program a success having implemented an innovative, multi-billion dollar system for purchases and redistribution in weeks. However, according to officials, there were numerous implementation challenges created by the need to move quickly including: limited time to design and implement the program, lack of suppliers and recipient agencies, limited staff, and use of a new contracting methodology for the Agricultural Marketing Service, among others.

In July 2020, USDA reiterated what was stated on its website—it would oversee the program throughout the contract period by conducting audits of, among other things, contractors' plans for ensuring that the food deliveries are safe for consumption. According to USDA, the program conducts a range of oversight activities, for example, producing reports to track delivery progress to contractors, state-by-state and nationwide, and conducting ongoing evaluations regarding potential fraud risks.[505] As it relates to the Farmers to Families Food Box program, internal controls include the plans, methods, policies, and procedures used to fulfill the mission, goals, and objectives of the program, and they could focus on not only contracting but other aspects of the program. However, the implementation challenges of limited time and staff impacted USDA's oversight of the program in the areas of documenting participation and developing a schedule of reviews of internal controls for the program:

- *Documenting Participation.* USDA said that, due to the speed of setting up the program, it did not have time to set up data collection methods that would allow it to identify, for each contract awarded, the distribution of food purchases by type of farmer, commodity, or other characteristics. USDA also said that at the time it sent out a request for proposals, it did not request demographic information to know whether contractors were women-owned,

[503]In the second round of the program, contractors were expected to provide services from July 1 to August 31, 2020. The sum of these 16 contracts was $202 million (of funds obligated).

[504]In the third round of the program, contractors would provide services from September 1 to October 31, 2020.

[505]As part of its technical comments in response to a draft of this report, USDA stated that desk audits, and in some cases when safety allows it, on-site audits are conducted to verify contracting terms are being met.

minority-owned, veteran-owned, or new/beginning farmers. However, USDA said that it does track information such as the name, city, box type and other information for non-profits, food banks, and other entities. USDA said that an independent review found that close to 40 percent of contracts were held by small- to medium-sized operations. Having these data on program participation would have allowed USDA to better understand program participation and allow for better external oversight of the program.

- *Program Reviews*. According to USDA, it also did not have time to evaluate internal controls for its implementation efforts prior to the first two rounds of the program; and also cited limited staff resources. Specifically, USDA said in July 2020 that it developed the Farmers to Families Food Box Program as a short-term solution to hardships faced by the American farmer due to the COVID-19 outbreak. According to USDA, it had not determined a schedule for programmatic reviews and evaluation of the program at the time of our inquiry.[506]

  For the third round of the program, as a result of feedback from industry associations, recipient organizations, Congress and others, USDA made program changes. One of those changes impacted non-profits, food banks, and other entities. Specifically, USDA required contractors to, among other things, cover all costs including the "last mile" which includes delivery of the food box to the recipient.[507] Including costs for the "last mile" was meant to ensure that non-profits, food banks, and other entities did not incur costs to provide food boxes.
  The non-profits, food banks, and other entities are a key stakeholder group in the program. A program review focused on the perspectives of this group, could, for example, have allowed USDA to incorporate changes for it earlier in the program's implementation. An earlier change could have prevented non-profits, food banks, and other entities from incurring costs to transport, store, or refrigerate food boxes prior to providing it to recipients, a problem described in media reports and a congressional hearing.

In summary, USDA developed and began implementing the Farmers to Families Food Box Program in weeks and, according to the department, delivered millions of food boxes. Getting food out quickly was a necessity to provide food to the public and to address farmers' surplus food because of institutional closings. USDA implemented some changes for its third round, as previously described. However, USDA has not yet collected certain data on program participants or established a schedule for programmatic reviews and evaluations over the program. By not taking these actions before the third round of funding, USDA missed opportunities to identify what aspects of the program worked well and potentially to make more informed programmatic decisions for the Farmers to Families Food Box Program.

In September 2020, we noted that there are opportunities to identify successes and challenges that could be used to inform future similar efforts or if the program is extended; and

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[506]In its technical comments on a draft of this report, USDA stated that in early August 2020, the Agricultural Marketing Service initiated an internal review of the Farmers to Families Food Box Program to verify that procurements were properly accounted for and that payments made to vendors were based on appropriate documentation provided by the non-profit organizations who distributed the food to the public.

[507]According to USDA, the "last mile" is defined as the final movement of goods from a transportation or distribution hub to the final delivery destination—the individual user of the food box.

recommended that USDA conduct an evaluation of the Farmers to Families Food Box Program after the third round of the program.[508] Should USDA consider additional versions of the program, its experience with the Farmers to Families Food Box Program would provide useful additional lessons learned.

GAO Methodology and Agency Comments

To conduct this work, we reviewed the most recent USDA delivery data on its website as of August 27, 2020; reviewed federal laws, agency policy and other guidance, and expenditure data provided to us by USDA; as of July 31, 2020, and reviewed written responses to our questions by USDA officials in the Agricultural Marketing Service and Farm Service Agency.

We provided a draft of the report and this enclosure to the Office of Management and Budget and USDA for review and comment. USDA stated that it appreciated the opportunity to respond to the draft report and was providing technical comments to clarify the information related to the Farmers to Families Food Box Program discussed in this enclosure; we incorporated those technical comments, as appropriate. The Office of Management and Budget did not comment on this enclosure.

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[508]GAO, *Agriculture Spending: Opportunities Exist for USDA to Identify Successes and Challenges of the Farmers to Families Food Box Program to Inform Future Efforts*, GAO-20-711R (Washington, D.C.: Sept. 16, 2020). USDA provided comments on this report and did not explicitly agree or disagree with our recommendation. However, USDA said in its comments that (1) in August 2020 it initiated a review to verify that procurements were properly accounted for and payments to vendors were based on appropriate documentation; (2) the costs for reviewing a temporary program may outweigh the benefits; and (3) an evaluation may be redundant given the reviews of others such as the USDA Office of Inspector General. We agreed that the types of reviews that USDA cites are important to assuring that funds are properly spent and contractors are monitored for compliance. Such reviews are an expected component of on-going monitoring in a program. We continue to believe that by conducting an overall evaluation of the Farmers to Families Food Box Program after the third round of the program, USDA would have better assurance it has identified successes and challenges which could inform future efforts to address similar situations.

Federal Food Safety Inspections

The U.S. Department of Agriculture continues to spend CARES Act funds—more than $7.5 million spent from $33 million appropriated—to maintain staffing for federal inspections of meat and poultry plants, as well as to provide personal protective equipment and supplies.

Entities involved: Food Safety and Inspection Service within the U.S. Department of Agriculture.

Key Considerations and Future GAO Work

Our work on U.S. Department of Agriculture's (USDA) implementation and oversight of a range of CARES Act funds, including any implementation challenges, is ongoing. We will continue to examine the department's capacity to ensure the continuity of food safety inspections.

As mentioned above, USDA received CARES Act funds for food safety inspections; however, the Food and Drug Administration (FDA) did not receive CARES Act funds for similar activities. We plan to conduct work on FDA's response to COVID-19 in the area of food safety inspections and other activities.

Background

COVID-19 has caused disruptions in the U.S. food supply chain, from the farms where raw agricultural commodities are produced, to the food processing and distribution network that enables these commodities to be used by consumers.[509] As a result of COVID-19, 120 meat and poultry plants, and other establishments closed as of July 1, 2020, according to USDA documentation. Of those establishments, eight of them closed due to insufficient employees, while four of them closed because of local or state public health restrictions.[510] The 7,850 inspectors and other staff from the USDA's Food Safety and Inspection Service (FSIS) work in 6,458 federally inspected meat and poultry plants, and other establishments. These inspectors help ensure the safety and wholesomeness of meat and poultry that enter interstate commerce. Some of these inspectors have been exposed to COVID-19.[511] According to an April 2020 interim guidance from the Centers for Disease Control and Prevention and the Occupational Safety and

[509]COVID-19 continues to affect consumer prices for food. In May 2020, the U.S. Bureau of Labor Statistics reported that April 2020 saw the sharpest increase in grocery store prices since 1974.

[510]Most (105) of the remaining establishments closed because they did not have enough orders or sales while a few (3) others closed due to a lack of animals to slaughter, or product to process, according to USDA documentation.

[511]According to data collected by the Food and Environment Reporting Network, as of July 21, 2020, at least 504 meatpacking and food processing plants (370 meatpacking and 134 food processing) and 71 farms and production facilities have had confirmed cases of Covid-19. At least 45,945 workers (36,896 meatpacking workers, 4,449 food processing workers, and 4,600 farmworkers) have tested positive for Covid-19 and at least 188 workers (168 meatpacking workers, 14 food processing workers, and six farmworkers) have died.

Health Administration, close conditions may contribute to potential exposures to COVID-19. For more information, see “Worker Safety and Health” in appendix I.

As we reported in June 2020, the CARES Act provided funding to USDA to respond to coronavirus with regard to food safety inspections. Departmental allocations, obligations and expenditures of these CARES Act funds are described in the table below.

U.S. Department of Agriculture CARES Act Allocations, Obligations, and Expenditures as of July 31, 2020			
	Allocations ($ in millions)	Obligations ($ in millions)	Expenditures ($ in millions)
Food Safety and Inspection Service Inspections[a]	33.0	12.7	7.6

Source: U.S. Department of Agriculture. I GAO-20-701.

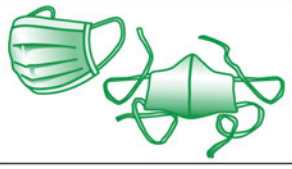
[a]These funds are for, among other things, to hire temporary and intermittent workers, relocate inspectors, and cover the costs of overtime. Pub. L. No. 116-136, div. B, tit. I, 134 Stat. 281, 506. According to USDA officials, the agency also used these funds for personal protective equipment and supplies.

Overview of Key Issues

USDA officials told us that, as of July 2020, they continued to use CARES Act funds to cover additional hours for part-time inspectors; costs to bring in additional inspectors from other USDA offices, and associated travel costs; and costs for nonreimbursable overtime that may increase during the response to COVID-19. According to a USDA FSIS official, nonreimbursable overtime occurs when an inspector has already worked a full shift and needs to work additional hours to fill in at another establishment that is not in overtime status. FSIS raised the ceiling on the number of hours part-time inspectors can work in a year, according to USDA officials. In addition, USDA officials said that the agency has used other employees—who have been trained in inspection from other parts of FSIS, the Agricultural Marketing Service, and the Animal and Plant Health Inspection Service—to ensure federal inspection requirements are met.

FSIS inspection personnel are required to wear face coverings or masks and face shields, according to the agency. The figure below shows the agency's purchases of protective equipment for inspectors and other FSIS staff. USDA officials said that the agency received 80,000 cloth face coverings from the Department of Health and Human Services facilitated by the Federal Emergency Management Agency. In addition, according to officials, FSIS plans to purchase an additional 417,290 disposable masks and cloth face coverings, which will enable the agency to have sufficient supplies of masks through the end of January 2021. The agency also recently, as of July 31, 2020, purchased 300 kits comprised of face shields that are compatible with inspectors' earmuffs and ordered an additional 8,000 face shields with anticipated delivery by the end of August and September 2020, according to officials.

U.S. Department of Agriculture Food Safety and Inspection Service's Protective Equipment Purchases by Type, Quantity, and Cost, as of July 13, 2020

	Disposable masks and cloth face coverings	Face shields	Anti-fog wipes and spray kits
			
Quantity	3,010,600	33,520	16,000
Cost	$1,778,090	$312,321	$288,612

Source: U.S. Department of Agriculture Food Safety and Inspection Service officials. | GAO-20-701

The use of such protective equipment has brought about a new challenge among workers—heat stress—especially in slaughter establishments, according to USDA officials. The additional protective gear, such as face shields, that FSIS inspection personnel are wearing to protect against COVID-19 can trap heat close to the body and may contribute to heat stress. In response, in June 2020 FSIS announced to inspection personnel that FSIS will provide vented helmets, neck cooling scarves, and electrolyte fluid replacement drinks to help prevent heat-stress illness. According to officials, the agency recently purchased evaporative cooling hard hat pads, cooling hat liners, and evaporative cooling bandanas to combat heat stress.

USDA continues to track USDA inspectors' absences because of COVID-19 related illness or quarantine. USDA employs 7,850 FSIS inspectors and staff. As of July 1, 2020, 495 FSIS employees (including inspectors) had a COVID-19 diagnosis confirmed by test or medical professional, 443 of them returned to work, 40 employees are currently self-quarantining, and five employees had died, according to USDA documentation. USDA data provided to us do not identify where—such as the workplace—FSIS employees contracted COVID-19. USDA officials said that as of July 2020, there were no establishments that had to close because of a lack of available USDA inspectors. According to officials, if an establishment is closed, then the agency may assign inspectors to an adjacent or nearby establishment or place them on administrative leave if no other assignment is available. The agency has maintained all required inspection services to ensure that establishments can operate, according to USDA officials.

GAO Methodology and Agency Comments

To conduct this work, we reviewed the most recent USDA data as of July 31, 2020; reviewed the CARES Act, agency policy, and other guidance, and expenditure data; and reviewed written responses to our questions by USDA officials in the Food Safety and Inspection Service. We provided a draft of this enclosure to USDA and the Office of Management and Budget for review and comment. USDA provided technical comments that we incorporated as appropriate. The Office of Management and Budget did not have comments on this enclosure.

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K-12 Education

Education Stabilization Fund spend rates remain low and federal guidance on reassessing schools' operating status should be cogent, clear, and internally consistent.

Entities involved: Department of Education and Centers for Disease Control and Prevention

Key Considerations and Future GAO Work

We reported in June 2020 that the Department of Education (Education) quickly had to establish procedures for allocating and disbursing Education Stabilization Fund (ESF) amounts, as well as provide guidance to recipients, which included information about recordkeeping and reporting. We also reported then that recipients' understandable desire to spend the money quickly may increase the risks of noncompliance with spending and accountability requirements.

Education moved quickly to obligate nearly 90 percent of ESF funds by May 31 and nearly 99 percent by July 31.[512] However, ESF spend rates remain low and few recipients have drawn down their grants.[513] Education officials and organizations representing state governments and state educational agencies noted a number of contributing factors for low spend rates, including

- developing new health and safety procedures for physically reopening schools;
- typical grant management processes that recipients have to undertake, such as preparing funding applications for sub-awardees;
- waiting on passage of state budgets;
- uncertainty about potential future aid packages; and
- supply chain issues for needed products.

As states and school districts ramp up their spending in the coming months, we will continue to monitor Education's oversight of and recipients' use of ESF funds.

Since June 2020, we have identified the lack of cogent, clear, and consistent federal guidance on the operating status of K-12 schools as an area of concern. The Centers for Disease Control and Prevention (CDC) and Education have provided information and guidance to help state and local school district officials to fulfill their role as key decision makers regarding local K-12 education issues, including how and when to reopen schools for in-person learning. Returning safely is

[512]The following components of the Education Stabilization Fund (ESF) were included in the calculations: (1) Elementary and Secondary School Emergency Relief Fund, (2) Governor's Emergency Education Relief Fund, (3) formula grants for U.S. territories, and (4) ESF discretionary grants.

[513]For the ESF, federal expenditures occur when the recipients spend the funds and draw down against the obligated amount.

important as it could help protect America's 50 million students and 6 million teachers and staff, and slow the spread of COVID-19.

On July 23, the CDC announced updated guidance to help schools, school districts, and states consider how to return to in-person instruction in the fall as well as reassess their operating status throughout the school year as local health conditions change.[514] However, for weeks afterward, its guidance on screening for children and employees for entering schools was internally inconsistent, and sometimes had been shared by Education in ways that are incomplete, potentially adding to confusion. We raised these incongruences with the agencies during the course of our work. Education updated its website to better align with CDC guidance. In response to our recommendation that the Director of the CDC ensure that its guidance related to schools' operating status is cogent, clear, and internally consistent, CDC said it was in the process of making corrections to eliminate inconsistencies.

Background

The Education Stabilization Fund provides emergency funding to address the effects of the COVID-19 pandemic on education.[515] Education quickly obligated the vast majority of these funds by May 31, 2020. Of the approximately $31 billion appropriated to the ESF, approximately $17 billion was appropriated to provide aid to states, the District of Columbia, and Puerto Rico across two emergency relief funds—the Elementary and Secondary School Emergency Relief Fund (ESSER Fund) and the Governor's Emergency Education Relief Fund (GEER Fund)—as well as through the ESF discretionary grants and formula grants to other U.S. territories.[516] Educational institutions may also be eligible for other types of federal financial assistance under COVID-19 relief laws. For example, as of August 9, 2020, over 15,000 charter and private schools received at least $5.9 billion in federal loans under the Paycheck Protection Program (PPP).[517] (See table below.)[518]

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[514]See Centers for Disease Control and Prevention, *COVID-19: Schools and Childcare Programs; Plan, Prepare, and Respond*, accessed August 6, 2020, https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/index.html. The federal government has continued to make additional updates as needed. For example, on August 18, 2020 the Department of Homeland Security's Cybersecurity and Infrastructure Security Agency added teachers, administrators, and a variety of support staff to its list of Essential Critical Infrastructure Workers.

[515]CARES Act, Pub. L. No. 116-136, § 18001, 134 Stat. 281, 564 (2020).

[516]Pub. L. No. 116-136, §§ 18001(a)(1) (formula grants to U.S. territories, referred to in the law as outlying areas), 18001(a)(3) (ESF discretionary grants), 18002 (GEER Fund), 18003 (ESSER Fund), 134 Stat. at 564-567.

[517]*See* Paycheck Protection and Health Care Enhancement Act, Pub. L. No. 116-139, § 101(a), 134 Stat. at 620; CARES Act, Pub. L. No. 116-136, §§ 1102(b)(1), 1107(a)(1), 134 Stat. at 293, 301.

[518]The Special Inspector General for Pandemic Recovery (SIGPR) refers to the practice of receiving assistance from more than one CARES Act relief program as "multi-dipping." In its August 3, 2020 Initial Report to Congress, SIGPR recommended that Congress consider the various CARES Act relief programs, how they overlap, whether the overlap is in the public interest, and whether legislative clarity is warranted.

K-12 Charter and Private Schools Receiving Paycheck Protection Program (PPP) Loans, as of August 9, 2020		
Loan Amounts($)	**Number of Recipients**	**Percent**
All	15,948	100
less than 10,000	1,275	8
10,000 to 49,999	3,323	21
50,000 to 99,999	2,192	14
100,000 to 199,999	2,638	17
200,000 to 299,999	1,514	9
300,000 to 399,999	957	6
400,000 to 499,999	680	4
500,000 to 599,999	553	3
600,000 to 699,999	402	3
700,000 to 799,999	365	2
800,000 to 899,999	256	2
900,000 to 999,999	218	1
1,000,000 to 1,499,999	704	4
1,500,000 to 1,999,999	362	2
2,000,000 to 2,499,999	197	1
2,500,000 to 2,999,999	100	1
3,000,000 to 3,499,999	73	0
3,500,000 to 3,999,999	45	0
4 million or more	94	1

Source: GAO analysis of Small Business Administration data. | GAO-20-701

Note: To assess the reliability of SBA's public and loan-level PPP data, we interviewed knowledgeable SBA officials; reviewed related SBA documentation; and checked the data for missing records, outliers, and obvious errors. We determined that the data were sufficiently reliable to describe, among other things, PPP loans by business size and type.

Overview of Key Issues

Federal Expenditure Rate. Of the approximately $17 billion appropriated through the ESF to states and territories, $16.5 billion has been obligated and $907 million has been expended, as of July 31, 2020.

Allocations, Percent Obligated, and Percent Expended, by Education Stabilization Fund Component, as of July 31, 2020

Education Stabilization Fund (ESF) Component	Allocation ($ millions)	Percent obligated as of July 31, 2020	Percent expended as of July 31, 2020
Elementary and Secondary School Emergency Relief Fund	13,229	100	3
Governor's Emergency Education Relief Fund	2,953	98	17
ESF discretionary grants	308	59	0
Formula grants for U.S. territories	154	100	11

Source: GAO analysis of applicable CARES Act provisions and Department of Education data. | GAO-20-701

As the new academic year begins, states and districts will be drawing down their CARES Act funding to help pay for initiatives to help them reimagine and restart operations. The Congressional Budget Office estimated that outlays for the ESF would occur over a number of years, from fiscal year 2020 to 2026, with more than half the funds expended by the end of fiscal year 2021.[519]

Education officials and organizations that represent state governments and state educational agencies said that the slow spend rate is due to a number of factors, including time needed to develop health and safety protocols for physically reopening schools; typical grant management processes, such as preparing funding applications for sub-awardees; waiting on passage of state budgets; and supply chain issues for needed products. The organizations also said that ESF recipients are carefully considering the time frames for availability of different federal funds to determine which they should spend first.

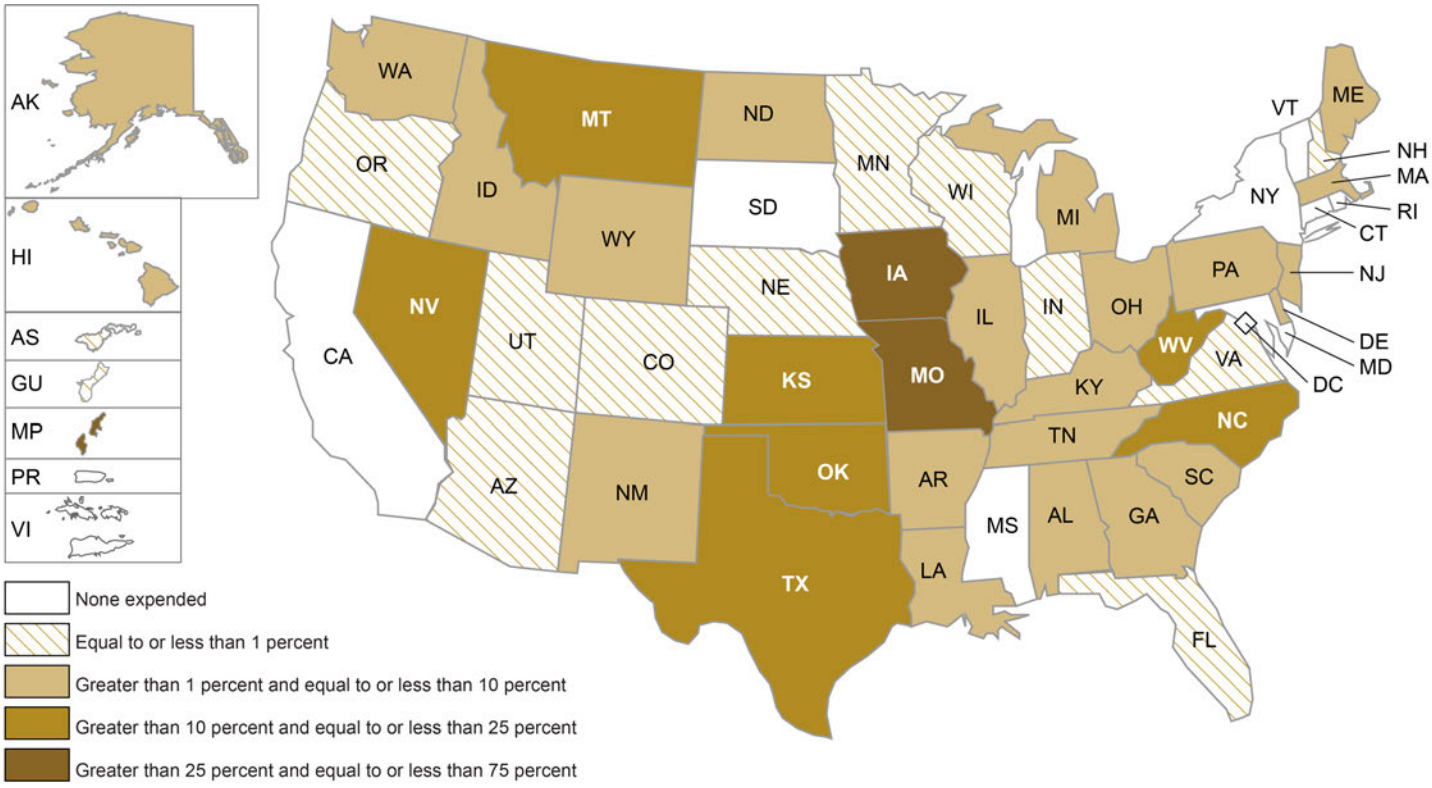
Uncertainty about possible future federal relief packages and confusion about aspects of Education's April and May spending guidance prior to issuance of its July 1 Interim Final Rule[520] have also contributed to states' slowness in spending funds, according to representatives of state government and education organizations.[521] See figure below for information on the percent of each recipient's allocation of ESF funds expended as of July 31, 2020.

[519]Congressional Budget Office estimates for the Education Stabilization Fund were inclusive of all component funds, including those intended to aid institutions of higher education.

[520]CARES Act Programs; Equitable Services to Students and Teachers in Non-Public Schools, 85 Fed. Reg. 39,479 (July 1, 2020). On September 4, 2020, in *NAACP v. DeVos*, the U.S. District Court for the District of Columbia issued an opinion and an order vacating the Interim Final Rule. Accordingly, the Interim Final Rule is no longer in effect.

[521]These concerns primarily related to the amount of money districts would need to set aside to provide "equitable services" —like reading tutors and technology—to private school students and teachers in their districts.

Federal Expenditures as a Percent of Allocated Education Stabilization Funds, as of July 31, 2020



Source: GAO analysis of Department of Education data. | GAO-20-701

Note: Percentages were calculated using allocations and expenditures for three components of the Education Stabilization Fund: (1) Elementary and Secondary School Emergency Relief Fund, (2) Governor's Emergency Education Relief Fund, and (3) formula grants for U.S. territories. Education awarded Education Stabilization Fund discretionary grants to 11 states as of July 31, 2020, totaling approximately $181 million. Education had not expended any funds associated with these awards as of July 31, 2020 and, therefore, they are not included in the figure.

Inconsistent guidance for K-12 schools. The lack of cogent, clear, and consistent federal guidance on reassessing the operating status of K-12 schools is an area of concern. State and local school district officials tasked with reassessing their operating status and ensuring their school buildings are safe generally rely on such guidance and recommendations from federal, state, and local public health and education officials, and count on it to be consistent.

On July 23, the CDC announced updated guidance to help schools, school districts, and states consider how to safely reopen school buildings in the fall, as well as reassess their operating status throughout the school year as local health conditions change.[522] The guidance includes sections for school and program administrators on preparing for a safe return and operating schools safely. It also includes sections for parents and caregivers containing decision tools and checklists designed to give families information on why the Administration believes it is critical to send children safely back to school in person, how to weigh the risks and benefits of available educational options, and how to plan for the 2020-21 school year.

[522]See Centers for Disease Control and Prevention, *Coronavirus Disease 2019: Schools and Childcare Programs; Plan, Prepare, and Respond*, accessed August 6, 2020, https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/index.html.

However, weeks after CDC announced updated guidance, its guidance on screening for children and employees for entering schools was internally inconsistent, and sometimes has been shared by Education in ways that are incomplete, potentially adding to confusion. For example:

- CDC's updated guidance, *Screening K-12 Students for Symptoms of COVID-19: Limitations and Considerations* does not recommend that schools conduct daily symptom screening for all K-12 students, noting that since some people with COVID-19 are asymptomatic, there are limitations to such screenings. However, guidance that contradicted the July 23, 2020 updates remained accessible on CDC's website several weeks later. Specifically, its *Considerations for K-12 Schools Readiness and Planning Tool* still directed schools to develop a plan to conduct daily health checks (e.g., temperature screening or symptom checking) of staff and students. Further, a CDC decision tool for physically reopening, *Schools During the Covid-19 Pandemic,* explicitly stated that schools should not physically open unless they are able to screen students and employees upon arrival for symptoms and history of exposure and are ready to protect children and employees at higher risk for severe illness.

- CDC guidance on what to do if a student or staff member tests positive for COVID-19 is also inconsistent. In its *FAQs for School Administrators on Reopening Schools*, the CDC notes that in most instances, a single case of COVID-19 in a school would not warrant closing the entire school. However, in the *K-12 Schools and Childcare Programs FAQs for Administrators, Teachers, and Parents,* the CDC notes that if a student or staff member is confirmed to have COVID-19, "you will likely dismiss students and most staff for 2-5 days."

- Relatedly, Education's website and technical assistance center contained incomplete summaries of CDC's mitigation strategies. Specifically, neither summary included wearing cloth masks or staying 6 feet apart when possible—strategies CDC identified as key for slowing the spread of COVID-19. We discussed this with Education, and as of August 7, 2020, the summaries were removed from both websites. The websites still include direct links to CDC's guidance.

In commenting on a draft of this report, CDC stated that it strives to ensure that all content is consistent and up to date. It noted that updating these documents is an iterative and ongoing process and, as a result, there can be periods of time where some documents are updated and others are not. CDC further stated that it is working to update its decision tools and re-opening guidance to remove inconsistencies, and that it has removed the decision tool, *Schools During the Covid-19 Pandemic,* from its website.

Certain federal guidance appears misaligned with risk-based decision-making. The CDC and the Secretary of Education have both stated that school reopening plans should be tailored to the needs of local communities. Many school districts have developed hybrid plans that call for students to learn remotely for part of the time or have announced plans for remote-only learning—including most of the nation's largest school districts. Yet, CDC's updated July guidance begins with a statement urging schools to reopen in person, and information encouraging schools to reopen in person is embedded throughout CDC's guidance.

Further, the White House has urged that all schools "fully reopen," and suggested that current or future federal funds may be withheld from school districts that do not return to in-person

education. The Secretary of Education also stated that "American investment in education is a promise to students and their families. If schools are not going to reopen and not fulfill that promise, they shouldn't get the funds. Then give [the funds] to the families to decide to go to a school that is going to meet that promise."[523] Education officials told us these comments were policy or rhetorical statements. Regardless, such statements do not appear to align with a risk-based decision-making approach, and appear incongruent with the Secretary's own statements that returning to in-person education is a state and local decision. Although the decision to physically reopening schools is primarily a state and local issue, state and local school district officials look to the federal government for leadership and clear guidance including recommendations about how to do so safely. Beyond serving as safe places for tens of millions of children to learn and millions of teachers to work each day, public school facilities play an integral role in society for community members who rely on them as community centers, voting places, and emergency shelters. Returning to in-person instruction safely and securely is of paramount concern to all, and is key to sustaining economic recovery, particularly given the large numbers of parents of school-age children in the workforce.[524]

As we reported in June 2020, in the midst of a nationwide emergency, clear and consistent communication—across all levels of government, with health care providers, and to the public—is key. As schools make their plans for the fall and continue to reassess those plans throughout the school year as local health conditions change, cogent, clear, and consistent federal guidance is critical to helping state and local officials make safe, risk-based decisions for their students, teachers, staff, and communities.

GAO Methodology and Agency Comments

To conduct this work, we reviewed relevant federal laws, estimates from the Congressional Budget Office, and Education and CDC guidance. We also interviewed Education officials regarding program implementation and analyzed Education spending data. To assess the reliability of Education's spending data, we reviewed information on the sources of these data, and we followed up with knowledgeable individuals as needed to answer questions about the appropriate use and potential limitations of these data. We found these data to be sufficiently reliable for our purposes.

To identify K-12 public charter schools and private schools that received PPP loans, we matched the recipient list to the Common Core of Data from the National Center for Education Statistics and did a keyword search of the recipient data received from the Small Business Administration on August 9, 2020. To assess the reliability of SBA's public and loan-level PPP data, we interviewed knowledgeable SBA officials; reviewed related SBA documentation; and checked the data for

[523]DeVos, Betsy. Interview by Chris Wallace. Fox News Sunday, Fox News. https://www.foxnews.com/transcript/infectious-disease-expert-on-us-response-to-new-surge-of-coronavirus-cases-secretary-devos-on-challenge-of-reopening-americas-schools. July 12, 2020.

[524]According to the Department of Labor, Bureau of Labor Statistics, in 2019, about 72 percent of women and over 90 percent of men with children under 18 were either working or looking for work.

missing records, outliers, and obvious errors. We determined that the data were sufficiently reliable for our purposes.

To collect the perspectives of state and local stakeholders, we interviewed officials from the National Governors Association, National Association of State Budget Officers, Council of Chief State School Officers, National Association of State Treasurers, and Government Finance Officers Association.

To conduct our work on guidance for K-12 schools, we reviewed CDC's guidance on reopening schools, as well Education's information for schools on COVID-19. We also reviewed the Administration's public statements about school reopening guidance and interviewed Education officials.

We provided CDC, Education, and the Office of Management and Budget (OMB) with a draft of this enclosure. CDC and Education provided general comments, which are summarized in the Agency Comments and Our Evaluation section of this report. All three agencies provided technical comments, which we incorporated as appropriate.

In its comments, CDC agreed with GAO's recommendation, noting that it strives to ensure that all content is consistent and up to date. CDC said that, in many instances, inconsistencies such as the ones we found are the result of periodic reviews and updates to these materials, and that updating these documents is an iterative and ongoing process.

CDC further stated that it is working to update its re-opening guidance to align with its updated guidance, and that it has removed the decision tool, *Schools During the Covid-19 Pandemic,* from its website.

In its comments, Education stated that it continues to be proud of the Department's accomplishments in meeting the timeline set forth under the CARES Act and in awarding funds efficiently to states. Education noted that the agency worked in consultation and collaboration with CDC on school reopening resources, has updated Education's COVID-19 web page, and is always working to improve it.

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Transit Industry

The Federal Transit Administration continues to distribute CARES Act funding, with nearly all funds obligated thus far going to transit agency operating costs.

Entities involved: Federal Transit Administration, U.S. Department of Transportation

Key Considerations and Future GAO Work

We will continue to monitor CARES Act grants to transit agencies in ongoing and planned work.

Background

Millions of Americans rely on public transportation systems for mobility and access to jobs, education, and essential services, such as medical care and grocery shopping. Within the Department of Transportation (DOT), the Federal Transit Administration (FTA) provides grants to state Departments of Transportation, local public transit systems, and tribes to support and expand services. These services may include buses, subways, light rail, commuter rail, trolleys and ferries in urban, rural, and tribal areas. The CARES Act appropriates $25 billion to the FTA to support the transit industry through its Urbanized Area and Rural Area formula programs.[525]

- FTA allocated the $25 billion on April 2, 2020, and posted information on allocation amounts to urbanized areas, states, and tribes to its website. Transit operators who receive grants from these allocations may use the funds for any expenses incurred related to COVID-19 on or after January 20, 2020, and there is no limit on the amount of funds recipients may use for operating expenses.[526]
- As of July 31, 2020, FTA had awarded 587 grants, and obligated about 86 percent of CARES Act transit funding (see table). Over $7.6 billion has been disbursed to transit agencies, covering 314 awards. FTA officials reported that an additional 209 grants were in progress. Officials said that as of July 31, 2020, 93 percent of obligated funds had gone to operating expenses, though capital and planning expenses are also eligible.
- As of July 31, 2020, FTA allocated $30 million for tribal transit recipients, of which $14.7 million has been obligated and $1 million expended.

[525]Pub. L. No. 116-136, 134 Stat. 281, 599 (2020).

[526]Funding to large and small urban areas ($22.7 billion) and rural areas ($2.2 billion) is provided, with no required local funding. Within the funds appropriated to the Rural Area formula program, $30 million is set aside for tribal transit programs, and an additional $75 million is set aside for administration and oversight of the funds. All normal Urbanized Area and Rural Area program requirements apply to CARES Act funds, with the exception that operating and certain capital expenses do not need to be included in a transportation improvement program, long-range transportation, statewide transportation plan, or a statewide transportation improvement program.

FTA Allocations, Obligations and Expenditures for CARES Act Transit Industry Funding, as of July 31, 2020a

State[b]	*Dollars in millions*		
	Allocations[c]	**Obligations as of July 31, 2020**	**Expenditures[d] as of July 31, 2020**
Alabama	131.2	104.3	4.9
Alaska	145.4	13.8	0
Arizona	313.5	302.3	44.9
Arkansas	82.7	71.7	3.6
California	3,738.1	2,984.7	586.1
Colorado	325.3	271.6	111.3
Connecticut	489.1	243.5	15.1
Delaware	66.5	61.2	0
Florida	958.6	603.7	139.1
Georgia	522.2	457.4	83.3
Hawaii	107.6	107.6	17.6
Idaho	62.4	56.8	2.7
Illinois	1,618.4	1,575.6	271.8
Indiana	238.4	234.9	34.9
Iowa	107.2	93.7	13.2
Kansas	91.5	68.9	6.7
Kentucky	138.5	86	10
Louisiana	163.3	143.7	41.3
Maine	85	42.3	12.2
Maryland	696.3	392	0
Massachusetts	1,044	1,007.8	299
Michigan	353.2	274.9	13.9
Minnesota	309.8	303.6	0.5
Mississippi	75.2	57.9	2

Missouri	256.3	286.9	31.8
Montana	51.9	43.3	3.8
Nebraska	62.9	64	14.6
Nevada	161.5	158.7	48.7
New Hampshire	38.8	24.3	2.1
New Jersey	1,752.2	1,477.6	362.6
New Mexico	134.2	126.1	5.6
New York	4,150.9	4,426.1	3,756.1
North Carolina	320.3	88.5	13.5
North Dakota	34.1	30.1	2.9
Ohio	478	446.6	199.4
Oklahoma	113.7	106	3.3
Oregon	285.8	286.9	91.9
Pennsylvania	1,140	931.6	99.7
Rhode Island	104.4	35.1	12
South Carolina	123.6	36.8	10.6
South Dakota	36.6	33.2	5.6
Tennessee	229.7	154.3	16.5
Texas	1,179.7	1,051	640.5
Utah	219.7	203.3	40.8
Vermont	21	13.1	0.1
Virginia	456.4	178.7	19
Washington	699	628.1	345.1
West Virginia	59.2	55.7	7.6
Wisconsin	209.8	173	0.8
Wyoming	28.6	18.6	2.4
States Total[b]	**24,211.7**	**20,638.1**	**7,450.8**

American Samoa	1.1	1.1	0
District of Columbia	535.7	876.8	221
Guam	2.7	2.7	0
Northern Mariana Islands	1	0	0
Puerto Rico	168.6	0.7	0
Virgin Islands	4.1	0	0
Territories Total	**713.3**	**881.3**	**221**
TOTAL[e]	**24,925**	**21,519.4**	**7,671.7**

Source: GAO analysis of data from the Federal Transit Administration | GAO-20-701

[a]Of the total $25 billion appropriated to FTA for responding to COVID-19, up to $75 million is set aside in the CARES Act for administration and oversight of the funds.

[b]Funding to localities or lower-level government entities within each state is included in that state's total. [if applicable]

[c]FTA allocates funding to urbanized areas greater than 200,000 in population directly to urbanized areas, not states. As some urbanized areas cross state boundaries, the amounts identified by state are the amount of the formula funds attributable to transit service within the state. These funds are awarded directly to transit agencies and obligations are attributed to where the transit agency is headquartered. Therefore obligations in a state may exceed the amount allocated to a state.

[d]FTA refers to these expenditures as disbursements.

[e]Numbers may not add up due to rounding.

Overview of Key Issues

Challenges for transit funding recipients. According to FTA and transit agency officials, CARES Act funding recipients have faced some challenges related to receiving or spending funds:

- FTA officials said that grant recipients have reported challenges in understanding the expanded list of activities eligible for CARES Act funding. Previously, urbanized area recipients could not use FTA funding to support operations. To include those activities in a CARES Act grant application, recipients have had to familiarize themselves with operating assistance eligibility requirements. To support these recipients, FTA has provided technical assistance through webinars, guidance on its website, and one-on-one support through its regional offices.

- According to FTA officials, rural and tribal areas have also reported challenges providing essential services, such as meal delivery, using FTA-funded assets. FTA has since provided that, as part of the Emergency Relief efforts authorized by 49 U.S.C. § 5324, FTA urban and rural area formula funds, including CARES Act funds, may be used to provide these essential services. In addition, some rural and tribal recipients have had to reassess their plans for expending funds, because they were not anticipating the influx of CARES Act funding.

- Seven members of the American Public Transportation Association, representing small, medium, and large transit agencies, told us they experienced decreased revenue and increased costs during the COVID-19 pandemic, which they offset using funds from the CARES Act. Specifically, these agencies all said they experienced reduced revenue from passenger fares, and almost all reported decreased revenue from other local sources, such as sales and property taxes. In some cases, transit agencies said decreased revenue coincided with increased operational costs. Most of the transit agencies said they experienced increased labor costs and provided personal protective equipment to employees.
- Each of the seven transit agencies said they were concerned they may not be able to sustain their current operational expenses in the short term, and most of the agencies said they were concerned that these challenges could persist into the future. Specifically, most of the transit agencies expressed concerns that the COVID-19 pandemic could have persistent negative effects on the local tax revenues on which they rely.

FTA support and oversight of funding. FTA continues to provide support to transit agencies while implementing the transit assistance provisions of the CARES Act:

- The seven transit agencies we contacted generally said they had not experienced challenges related to the allocation or distribution of CARES Act funds. FTA officials said that FTA has continued its outreach to grant recipients through industry calls, and regional staff are in regular contact with recipients as they develop CARES Act grant applications.
- FTA officials continue to report no challenges with monitoring CARES Act grants, due to the funds being provided through existing programs that have procedures for administration and oversight. Officials noted that FTA is currently updating the oversight guidance for these programs to include information on CARES Act requirements, and will oversee the funding through its Triennial and State Management Review programs. In addition, daily reports on the status of CARES Act obligations and funding disbursed to transit agencies are sent to the Office of the Administrator.

GAO Methodology and Agency Comments

To conduct this work, we reviewed FTA data on transit industry funding as of July 31, 2020, which we found to be reliable for the purposes of describing allocations, obligations, and expenditures. We also reviewed federal laws and agency documents, including program funding notices, and DOT and FTA officials provided us with written responses about how they are implementing provisions of the CARES Act. Our interview questions were also sent to 10 transit agency members of the American Public Transit Association, which were selected based on the size (four large, three medium, and three small transit agencies). Seven of these 10 transit agencies submitted written responses for this report describing challenges they've experienced with the pandemic and CARES Act grants. We provided DOT and the Office of Management and Budget (OMB) with a draft of this enclosure. DOT and OMB did not provide comments on this enclosure.

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Related GAO Products

Public Transportation: Enhanced Federal Information Sharing on Coordination Could Improve Rural Transit Services. GAO-20-205. Washington, D.C.: January 7, 2020.

Emergency Transportation Relief: Federal Transit Administration and FEMA Took Actions to Coordinate, but Steps Are Needed to Address Risk of Duplicate Funding. GAO-20-85. Washington D.C.: November 13, 2019.

DOT Discretionary Grants: Problems with Hurricane Sandy Transit Grant Selection Process Highlight the Need for Additional Accountability. GAO-17-20. Washington, D.C.: December 14, 2016.

Coronavirus Relief Fund

Guidance and oversight are critical to ensure that the $150 billion in COVID-19 relief disbursed through the Coronavirus Relief Fund to states, localities, tribal governments, the District of Columbia, and U.S. territories are used appropriately.

Entities involved: Department of the Treasury, including its Office of Inspector General; and the Office of Management and Budget

Key Considerations and Future GAO Work

We reported in June 2020 that the Department of the Treasury (Treasury) quickly had to disburse Coronavirus Relief Fund (CRF) payments to states, the District of Columbia, localities, tribal governments, and five U.S. territories. Given the statutory requirement to disburse CRF payments within 30 days, Treasury made payments while it was still developing guidance and recipient accountability measures, increasing the risk of noncompliance with those spending and accountability requirements.[527]

Treasury officials told us that they are working with the Office of Management and Budget (OMB) to develop additional guidance, in particular Single Audit Act guidance for the CRF, which OMB plans to publish in the fall of 2020 as an addendum to its 2020 Single Audit Act's Compliance Supplement. To help ensure the timeliness and efficiency of audits of CRF recipients, we recommend the Director of OMB, in consultation with the Department of the Treasury, issue the addendum to the 2020 Compliance Supplement as soon as possible, as many single audit efforts are underway.

We plan to continue following the use of, and recipient reporting on, CRF payments.

Background

The CRF, created by the CARES Act, provides funding to states, localities, tribal governments, the District of Columbia, and five U.S. territories to help cover the 2020 costs of responding to the COVID-19 pandemic.[528] As required by the act, recipients may use CRF payments only to offset costs that

[527]Pub. L. No. 116-136, § 5001, 134 Stat. at 502.

[528]CARES Act, Pub. L. No. 116-136, § 5001, 134 Stat. 281, 501-04 (2020), (codified at 42 U.S.C. § 801). Localities with populations exceeding 500,000 could opt to receive disbursements directly from Treasury. These direct disbursements were deducted from the state's allocation. The five U.S. territories that received CRF payments, as specified in the CARES Act, are Puerto Rico, U.S. Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa.

- are necessary expenditures incurred due to the COVID-19 pandemic;
- were not accounted for in the budgets most recently approved for the states or other eligible governments prior to enactment of the CARES Act on March 27, 2020; and
- are incurred from March 1, 2020 to December 30, 2020.

As of July 31, 2020, Treasury had disbursed almost $149.5 billion of the $150 billion CRF.[529]

Overview of Key Issues

Guidance on eligible costs. Treasury began issuing guidance on its interpretation of the eligible use of CRF payments in April 2020, when most of the CRF funds were disbursed. Since that time, Treasury has provided guidance to CRF recipients on eligible uses for CRF funds and, according to Treasury officials, participated in periodic forums hosted by stakeholder groups and the White House Intergovernmental Affairs Office where they discussed and answered questions related to the CRF. However, officials from associations representing state and local governments told us CRF recipients have reported a lack of clarity in Treasury guidance on the eligible use of the funds, including

- *how states are to transfer funds to local governments*.[530] According to association officials, some states delayed transferring CRF funds to sub-recipients, such as local governments, because they needed additional guidance regarding the eligible use of the CRF payments, including reporting and compliance requirements.
- *when guidance has been updated or revised.* Treasury only recently began alerting CRF recipients when it updated the guidance and consistently identifying new or revised information. According to Treasury officials, Treasury has disseminated guidance to CRF recipients primarily by posting information on its web page, including periodically updating its frequently asked questions (FAQ) document. For example, Treasury updated its guidance document on June 30 to clarify the period in which costs must be incurred by recipients to be eligible. Treasury also updated the FAQ document on July 8, to clarify that states should transfer CRF funds to local governments that did not receive direct CRF payments. Both the Treasury guidance and the FAQ documents indicated the date of the last update, but neither identified which information was new or revised.

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[529]Litigation is pending before a federal appeals court regarding whether Alaska Native regional and village corporations are eligible for CRF Tribal Set-Aside payments. *Confederated Tribes of the Chehalis Reservation v. Mnuchin*, Case No. 20-cv-5204 (D.C. Cir. July 14, 2020). Until the litigation is resolved, Treasury is subject to an injunction issued by the district court judge that bars it from disbursing CRF payments to Alaska Native regional and village corporations. *Confederated Tribes of the Chehalis Reservation v. Mnuchin*, Case No. 20-cv-01002 (D.D.C. July 7, 2020). Thus, a portion of the Tribal Set-Aside has not been disbursed.

[530]States may transfer CRF payments to a local government, as long as the locality uses the funds for eligible expenses.

Officials from associations representing state and local governments told us that although Treasury was generally accessible and responsive to questions, their members said it was challenging to continually monitor Treasury's web page for updates and search the CRF guidance documents for any changes or additions. We discussed these concerns with Treasury officials on July 30, 2020, and, when Treasury next updated its CRF FAQ document on August 10, 2020, it clearly identified which information in the guidance was new and notified individual recipients of the change. Treasury officials told us they plan to continue these actions moving forward.

Guidance on record keeping and reporting. The CARES Act directs Treasury's Office of Inspector General (Treasury OIG) to monitor and conduct oversight of the receipt, disbursement, and use of funds made available to CRF recipients.[531] Treasury OIG provided CRF prime recipients with guidance on reporting and record keeping in July 2020.[532]

- The guidance requires prime recipients of CRF payments to submit interim reports in July 2020 of costs incurred during the period from March 1, 2020 through June 30, 2020.[533]
- Prime recipients are to submit final reports for that quarter, as well as subsequent quarterly reports, through a new online portal, beginning in September 2020.
- The quarterly reporting requirement continues through either the calendar quarter after the recipient has expended all the CRF funds on eligible COVID-19 related costs, or the calendar quarter ending September 30, 2021, whichever comes first.

According to the guidance, the quarterly reporting will include the total amount of CRF payments received and the amount of CRF funds obligated and expended, by project or activity. Treasury OIG officials said they plan to use the quarterly reports to inform their risk assessments and the focus of their audit efforts. The officials also said that the recipient reporting data will be publicly reported on the Pandemic Response Accountability Committee website.[534]

Oversight of CRF. Treasury OIG's oversight function under the CARES Act includes the authority to recoup CRF payments that were not used appropriately.[535] Continued oversight is especially

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[531]Pub. L. No. 116-136, § 5001, 134 Stat. at 503 (codified at 42 U.S.C. § 801(f)).

[532]Department of the Treasury Office of Inspector General, *Memorandum for Coronavirus Relief Fund Recipients*, OIG-CA-20-021 (July 2, 2020) and *Memorandum for Coronavirus Relief Fund Recipients*, OIG-CA-20-025 (July 31, 2020). The memoranda define prime recipients as all 50 states, units of local governments, the District of Columbia, U.S. territories, and tribal governments that received a direct CRF payment from Treasury.

[533]The interim report includes summary information on recipient expenditures, including the amounts transferred to other governments and amounts spent on various categories of eligible costs. Treasury posted on its web page summaries of the interim reports submitted by the states, localities, the District of Columbia, and the territories. As of August 2020, Treasury had not posted information from the interim reports submitted by tribal governments.

[534]Treasury is publicly reporting the amounts of CRF payments to prime recipients on the USAspending.gov website.

[535]Pub. L. No. 116-136, § 5001(f), 134 Stat. at 503-04, (codified at 42 U.S.C. § 801(f)). The CARES Act requires Treasury OIG to recoup CRF payments if it determines that recipients did not use them in accordance with the requirements in the CARES Act.

important given the limited time Treasury and its OIG had to implement up-front guidance on recipient reporting and record keeping and to assess risks.

Treasury OIG officials told us they are developing an oversight plan for the CRF, which will include conducting a risk assessment to determine which recipients to audit, and hiring additional staff. The officials said their current oversight efforts include assessing Treasury's CRF policies and procedures related to making CRF payments and the accuracy of payments, among other aspects of its administrative activities. Treasury has coordinated with its OIG to assist in the OIG's oversight role and responsibilities and Treasury officials said they expect to retain an active role in policy matters relating to the CRF, including providing additional guidance and responding to questions related to eligible use of funds after Treasury has disbursed all CRF payments.

Audit requirements. The Single Audit Act establishes requirements for states, the District of Columbia, local governments, U.S. territories, Indian tribes, and nonprofit organizations that receive federal awards to undergo single audits of those awards annually (unless a specific exception applies), when their expenditures of the award meet a certain dollar threshold.[536] The audits required by the act are critical to the federal government's ability to help safeguard federal funds. Specifically, a single audit may identify deficiencies in the award recipient's compliance with applicable provisions of laws, regulations, contracts, or grant agreements and in its financial management and internal control systems. Correcting such deficiencies can help reasonably assure the effective use of federal funds and reduce the likelihood of federal improper payments.

Auditors who conduct single audits follow guidance in the Single Audit Act's Compliance Supplement, which OMB updates and issues annually in coordination with federal agencies. In a May 28, 2020 FAQ, Treasury provided guidance that CRF payments are considered federal financial assistance subject to single audits. OMB's 2020 Compliance Supplement, issued in August 2020, specified that OMB is still working with federal agencies to identify the needs for additional audit guidance for new COVID-19 related programs, including the CRF, as well as existing programs with compliance requirement changes. OMB plans to publish an addendum to this Supplement in the fall of 2020. According to an official from the National Association of State Auditors, Comptrollers and Treasurers, many single audit efforts are already underway. Given that some auditors usually start their interim testing in April for June 30 year-end single audits, further delays in issuing this guidance could adversely affect auditors and the results and timing of their work, and may lead to inconsistent reporting.

GAO Methodology and Agency Comments

To conduct this work, we reviewed Treasury data as of July 31, 2020; reviewed federal laws, and Treasury, Treasury OIG, and OMB guidance; and interviewed Treasury and Treasury OIG officials.

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[536]The Single Audit Act is codified, as amended, at 31 U.S.C. §§ 7501-06, and implementing OMB guidance is reprinted in 2 C.F.R. Part 200 (2020). Federal award recipients that expend $750,000 or more in federal awards in a fiscal year are required to undergo a single audit, which is an audit of an entity's financial statements and federal awards, or a program-specific audit, for the fiscal year. 31 U.S.C. § 7502; 31 C.F.R. § 200.501 (2020).

To determine the reliability of the data, we reviewed relevant documentation, compared the data to other published data, and interviewed knowledgeable Treasury officials. We found the data were sufficiently reliable for the purposes of our reporting objective. We also interviewed officials from the following associations representing state and local governments: the National Governors Association, the National Association of State Budget Officers, the National Association of Counties, the National Association of State Treasurers, and the Government Finance Officers Association.

We provided a draft of this report to Treasury and OMB for review and comment. Treasury provided technical comments, which we incorporated as appropriate. OMB had no comments on this enclosure and neither agreed nor disagreed with our recommendation.

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Airport Grants

The Federal Aviation Administration continues to provide funding to help the nation's airports respond to and recover from the economic effects of the COVID-19 pandemic. As of July 31, 2020, the agency has processed grant applications for 3,213 U.S. airports, totaling about $8.7 billion.

Entities involved: Federal Aviation Administration, within the U.S. Department of Transportation.

Key Considerations and Future GAO Work

We will continue to monitor CARES Act grants to airports in ongoing and planned work.

Background

U.S. airports are important contributors to the U.S. economy and fulfill a variety of vital roles, from supporting scheduled commercial air service to supporting freight transportation and disaster relief. Approximately 3,300 airports in the United States are part of the national airport system and are eligible to receive federal Airport Improvement Program (AIP) grants to fund infrastructure projects. As we reported in February 2020, from fiscal years 2013 through 2017, airports received an average of $3.2 billion annually in federal AIP grants.

Historic decreases in passenger demand for air travel due to the COVID-19 pandemic are significantly affecting U.S. airports' abilities to generate the revenue needed for operating and infrastructure costs. According to recent data filed with U.S. Department of Transportation (DOT), U.S airlines carried 89 percent fewer passengers in May 2020 than in May 2019. The CARES Act provided $10 billion to support U.S. airports of all sizes experiencing severe economic disruption caused by the COVID-19 pandemic (see table).[537]

[537]Pub. L. No. 116-136, 134 Stat. 281, 596-597. The CARES Act gives the Federal Aviation Administration (FAA) the authority to retain up to 0.1 percent of the $10 billion (up to $10 million) provided for Grants-in-Aid for Airports to fund the award and oversight by FAA of grants made under the CARES Act.

CARES Act Airport Grants

Funding groups	Funds appropriated (in dollars)[a]	Formula applied
Increase federal share for 2020 Airport Improvement Program (AIP) grants	At least 500 million	Increase the federal share to 100 percent for grants awarded for airport infrastructure projects under fiscal year 2020 AIP and supplemental discretionary grants.[b]
Commercial service airports (i.e., publicly owned airports with at least 2,500 passengers per year and scheduled air service)	At least 7.4 billion	The total allocation to an airport is determined by a formula that considers an airport's passenger boardings, the airport sponsor's debt service, and the sponsor's ratio of unrestricted reserves to debt service for 2018.[c]
Primary airports (i.e., large, medium, and small hub and non-hub airports with more than 10,000 passenger boardings per year)	Up to 2 billion	Allocated based upon statutory AIP entitlement formulas.
General aviation airports (i.e., airports with less than 2,500 passenger boardings per year and no scheduled air service)	At least 100 million	This funding is allocated based on the categories these airports are placed in given activity measures (e.g., volume and type of flights) and other factors in the most current National Plan of Integrated Airport Systems (NPIAS).

Source: GAO analysis of CARES Act. | GAO-20-701

[a]The CARES Act gives the Federal Aviation Administration (FAA) the authority to retain up to 0.1 percent of the $10 billion (up to $10 million) provided for Grants-in-Aid for Airports to fund the award and oversight by FAA of grants made under the CARES Act.

[b]National system airports are eligible to receive federal funding from AIP grants for infrastructure development. The distribution of federal AIP grants is based on a combination of formula funds—also referred to as entitlement funds—that are available to national system airports, and discretionary funds that FAA awards for selected eligible projects. Entitlement funds are apportioned by formula to airports and may generally be used for any eligible airport improvement or planning project. Discretionary funds are approved by FAA based on FAA selection criteria and a priority system, which FAA uses to rank projects based on the extent to which they reflect FAA's nationally identified priorities. The federal share for AIP grants generally ranges from 75 percent to 95 percent.

[c]The FAA used fiscal year 2018 Certification Activity Tracking System (CATS) data, reported as of March 14, 2020, to calculate allocations under the CARES Act formulas. More specifically, the allocation to a commercial service airport is determined by a formula that considers an airport's passenger boardings for calendar year 2018 (50 percent), the airport sponsor's debt service (25 percent), and the sponsor's ratio of unrestricted reserves to debt service (25 percent), both for fiscal year 2018.

Certain airport owners—also known as airport sponsors—accepting CARES Act grant funds must continue to employ, through December 31, 2020, at least 90 percent of the number of individuals employed as of March 27, 2020. According to the Federal Aviation Administration (FAA), the 130 largest U.S. airports are subject to this requirement. Combined, these airports served approximately 96 percent of commercial service passenger boardings in the United States in 2018.

However, airports with limited commercial service or that primarily serve general aviation flights are exempt from this requirement.[538]

Allocations, obligations, and expenditures. In April 2020, within weeks of the enactment of the CARES Act, FAA finalized grant allocation amounts totaling nearly $10 billion—about three times U.S. airports' annual average for federal AIP grants in recent years.[539] As of July 31, 2020, FAA has obligated over $8.7 billion and expended nearly $1.6 billion to reimburse airports for eligible airport costs, according to FAA officials (see table). While AIP grants are used to fund infrastructure projects, airport sponsors may use CARES Act funds for any purpose for which airport revenues may be lawfully used, including airport operating expenses and debt service.

[538]Specifically, nonhub and nonprimary airports are excluded from the workforce retention requirement. As a result, nonhub primary commercial service airports (airports with more than 10,000 annual passenger boardings, but less than .05 percent of total annual passenger boardings), nonprimary commercial service airports (airports with at least 2,500 and no more than 10,000 passenger boardings each year), general aviation airports (public-use airports that do not have scheduled service or have scheduled service with less than 2,500 passenger boardings each year), and reliever airports (airports designated by FAA to relieve congestion at commercial service airports) are all exempt from the workforce retention requirement.

[539]Specifically, FAA assigned $500 million to increase the federal share for grants awarded for airport infrastructure projects under fiscal year 2020 AIP and supplemental discretionary grants, and allocated $9.1 billion to the remaining grant funding groups (see table above). FAA has not yet allocated $350 million of the up to $2 billion in grant funding available to primary airports. FAA officials stated that this funding may be used to increase the federal share to 100 percent for grants awarded for airport infrastructure projects, or distributed to commercial service airports.

Federal Aviation Administration Allocations, Obligations, and Expenditures for CARES Act Airport Grants

State[a]	*Dollars in millions*		
	Allocations[c]	**Obligations as of July 31, 2020[d]**	**Expenditures as of July 31, 2020[d]**
Alabama	54	59	13
Alaska	124	128	1
Arizona	225	228	7
Arkansas	51	53	8
California	1,089	1,077	152
Colorado	367	343	134
Connecticut	30	30	0
Delaware	0	0	0
Florida	896	900	272
Georgia	411	418	89
Hawaii	133	134	14
Idaho	44	39	1
Illinois	447	444	0
Indiana	97	97	19
Iowa	70	55	2
Kansas	53	42	2
Kentucky	77	77	28
Louisiana	84	85	19
Maine	36	21	3
Maryland	108	112	88
Massachusetts	171	177	61
Michigan	257	251	34
Minnesota	158	12	1
Mississippi	35	36	5

Missouri	152	132	12
Montana	74	63	10
Nebraska	65	53	9
Nevada	231	238	44
New Hampshire	15	16	4
New Jersey	161	13	3
New Mexico	25	25	0
New York	411	560	7
North Carolina	284	270	36
North Dakota	85	71	8
Ohio	109	109	39
Oklahoma	42	44	2
Oregon	140	133	31
Pennsylvania	239	229	89
Rhode Island	24	24	0
South Carolina	97	85	7
South Dakota	36	36	2
Tennessee	124	130	9
Texas	812	757	163
Utah	93	97	6
Vermont	9	9	0
Virginia	310	311	27
Washington	310	289	89
West Virginia	9	10	2
Wisconsin	83	67	1
Wyoming	50	34	5
States Total[b]	**9,011**	**8,625**	**1,558**

American Samoa	1	1	0
Guam	21	21	11
Northern Mariana Islands	23	23	0
Puerto Rico	43	43	10
Virgin Islands	41	39	3
Territories total[b]	**129**	**127**	**25**
TOTAL[b]	**9,140**[c]	**8,752**[d]	**1,583**[d]

Source: GAO analysis of data from the Federal Aviation Administration | GAO-20-701

[a]Each state and territory total reflects the sum of funding to airports within each state and territory. State totals for Arizona, Nevada, North Dakota, and South Dakota include funding to seven tribal entities. Federal Aviation Administration (FAA) officials stated that totals for the State of New York include funding provided to The Port Authority of New York and New Jersey, and that no other combined grants cross state lines.

[b]Numbers may not add up due to rounding.

[c]Allocations include CARES Act funding allocated by formula grants to commercial service, primary, and general aviation airports, but do not include the $500 million allocated to airports to increase the federal share for grants awarded for airport infrastructure projects under fiscal year 2020 Airport Improvement Program (AIP) and supplemental discretionary grants, or $350 million in other grant funds not yet allocated. Allocations also exclude up to $10 million provided to fund FAA's award and oversight of grants (see below).

[d]Obligations and expenditures include CARES Act funds in the form of formula grants to commercial service, primary, and general aviation airports, as well as funds to increase the federal share for grants awarded for airport infrastructure projects under fiscal year 2020 AIP and supplemental discretionary grants. The CARES Act gives FAA the authority to retain up to 0.1 percent of the $10 billion (up to $10 million) provided for Grants-in-Aid for Airports to fund the FAA's award and oversight of those grants.

Overview of Key Issues

Program implementation and grant allocation. According to FAA officials, FAA continues to process grant applications, obligate funds, and review invoices to reimburse airport sponsors. More specifically, as of July 31, 2020, FAA has processed grant applications for 3,213 U.S. airports (including territories and tribes), totaling about $8.7 billion. As described above, the grant formula for $7.4 billion in funds to commercial service airports contained in the CARES Act, which accounts for almost 75 percent of the $10 billion in airport funds provided, is based upon an airport's passenger boardings, debt service, and ratio of unrestricted reserves to debt service. In order to implement this formula, FAA used publicly available financial data to determine grant allocations that airports had submitted and certified, but had not previously been used for this purpose.[540]

[540]FAA used fiscal year 2018 Certification Activity Tracking System (CATS) data, reported as of March 14, 2020, to calculate allocations under the CARES Act formula for the $7.4 billion to commercial service airports. More specifically, the total allocation to an airport is determined by a formula that considers an airport's passenger boardings for calendar year 2018 (50 percent), the airport sponsor's debt service (25 percent), and the sponsor's ratio of unrestricted reserves to debt service (25 percent), both for fiscal year 2018.

According to FAA, making these allocations expeditiously required the agency to make decisions necessary to implement the grant formula, and to rely upon airports' certified financial data filings for commercial service airports, without the opportunity for airports to provide additional information in all cases.[541] For example, there may have been instances of zeroes or blank fields in the data that could have affected a given airport's allocation. FAA officials said that it is not unusual for airports to report $0 in unrestricted reserves or debt service, depending on an airport's specific financial structure. In addition, as a result of the formula in the CARES Act, commercial service airports with high amounts of reserves relative to debt service received a higher share of grant funds allocated on that basis.

As we previously reported, FAA has taken actions to limit some airports' initial grant amounts, to address instances in which airports received grant allocations that far exceeded their operating budgets.[542] FAA officials stated that airport grant allocations were derived directly from the formulas provided in the CARES Act and emphasized that, with regard to the potential for missing data, airports reported the financial data used to allocate airport grants and certified its accuracy. FAA does not anticipate making changes to its April 2020 grant allocations.

Airport funding uses and needs. According to FAA officials and airport association representatives, airports are typically using CARES Act grant funds for payroll and debt service expenses. Airport association representatives told us that airports face ongoing declines and future uncertainty in revenue and that the federal funding provided has been essential. In addition, FAA issued guidance in May 2020 to airports clarifying that the decision to provide tenants with rent abatement in the context of the COVID-19 pandemic is a local decision, and in June 2020 sent airport directors a memo encouraging them to provide such relief. Representatives from one airport association stated that doing so would further reduce airport revenues, necessitating additional federal funds.

Representatives from airport associations explained that declines in passenger boardings have a multiplying effect on declines in airport revenues, as passengers contribute to parking, food, and retail revenue, in addition to flight revenue. Because passenger boardings drive these effects, representatives from airport associations told us that allocations of any additional federal funding for commercial service airports should be based on passenger boardings, rather than debt service or reserves.[543]

Representatives from airport associations told us that additional federal funds would be needed for airports to continue to pay their employees after the workforce retention requirements expire

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[541]Specifically, FAA officials stated that airports had an opportunity to provide additional information within 120 days of the end of a given airport's fiscal year 2018 or when the airport's audit of financial statements indicated a correction should be made.

[542]More specifically, FAA limited each airport's initial CARES Act grant to no more than four times its annual operating expenses, unless the remaining amount would be less than $1 million. According to FAA, the 27 airports affected by this limit would need to provide justification for accessing additional allocated funds. FAA also stated that, based on the CARES Act allocation formula for commercial service airports (i.e., 50 percent of the funds based on passenger boardings and the remaining funds allocated based on debt service and unrestricted reserves), it is expected that some airports may be allocated higher amounts despite handling fewer passengers, and vice versa.

[543] Representatives from one airport association told us that general aviation airports should receive separate additional funding allocated based on factors such as pre-existing AIP entitlement formulas or application to FAA.

after December 2020. Airport association representatives noted that airports have been able to use the flexibilities in the CARES Act funding to ensure that they maintain their workforce and meet financial debt commitments in light of passenger boardings and revenue declines due to COVID-19, as debt service and operating expenses are generally not allowable uses of federal funding for airports.

Program challenges and monitoring. FAA has identified challenges to administering and monitoring CARES Act airport grants, such as the need to implement a new grant program with expanded allowable uses of funds (relative to AIP grants) under expedited time frames and with a large amount of funds and grant recipients. According to officials, FAA staff are reviewing all reimbursement requests from airports to help ensure that only eligible costs are reimbursed with CARES Act funding. FAA officials told us that the agency is also reviewing quarterly reports from airports subject to the workforce retention requirement, and that no airports have thus far requested a waiver.[544] FAA officials indicated that they plan to hire additional staff to help manage the workload and seek contracting support to help analyze data.

GAO Methodology and Agency Comments

To conduct this work, we reviewed FAA data on airport funding as of July 31, 2020, which we found to be reliable for the purposes of describing allocations, obligations, and expenditures; reviewed federal laws and agency guidance related to the CARES Act; and interviewed DOT and FAA officials, as well as representatives of airport associations. We provided DOT and the Office of Management and Budget (OMB) with a draft of this enclosure. DOT and OMB did not provide comments on this enclosure.

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Related GAO Product

GAO, *Airport Infrastructure: Information on Funding and Financing for Planned Projects*, GAO-20-298, (Washington, D.C.: Feb. 13, 2020).

[544]The CARES Act gives the Secretary of Transportation the authority to waive the workforce retention requirement if the Secretary determines the airport is experiencing economic hardship as a direct result of the requirement or the requirement reduces aviation safety or security.

International Trade

While U.S. trade has declined overall, imports of COVID-19-related products have increased, and the U.S. government has modified tariffs to reduce the cost of certain such products from China.

Entities involved: Office of the U.S. Trade Representative

Key Considerations and Future GAO Work

We plan to monitor the effect of COVID-19 on international trade and the medical supply chain.

Background

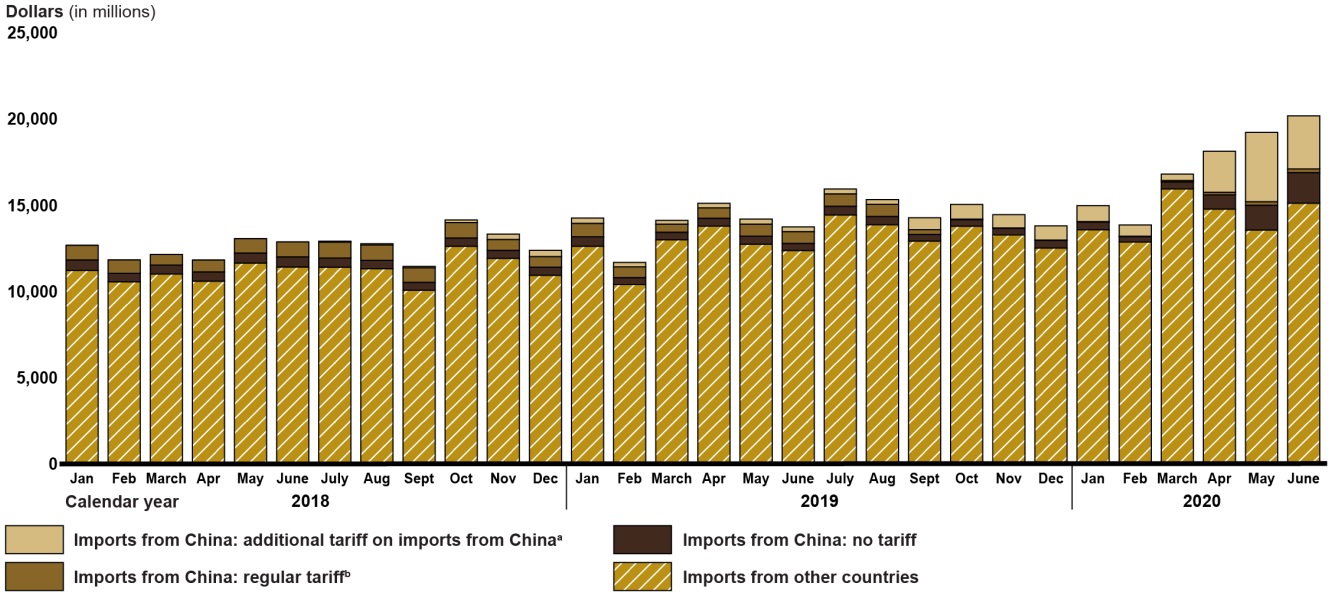
The COVID-19 pandemic has disrupted businesses around the world. The World Trade Organization reported on June 23, 2020, that international trade fell sharply as the COVID-19 pandemic upended the global economy, estimating a drop of almost 19 percent from 2019. In the face of disrupted international supply chains, U.S. demand increased for imports of COVID-19-related products such as face masks, ventilators, gloves, and hand sanitizers. Some imports of these products from China are subject to additional tariffs imposed by the Office of the U.S. Trade Representative (USTR) at the direction of the President under Section 301 of the Trade Act of 1974, which may increase the cost of these products in the U.S.

Overview of Key Issues

COVID-19's effects on U.S. international trade. Overall, U.S. trade has declined since the outbreak of COVID-19, but available data indicate that imports in categories of COVID-19-related products have increased.[545] (See figure.)

[545]To gain insight into the import values of the COVID-19 related products, we used the Harmonized Tariff Schedule (HTS) codes the United States International Trade Commission (USITC) identified. See USITC, *COVID-19 Related Goods: U.S. Imports and Tariffs*, Investigation No. 332-576, USITC Publication 5073 (Washington, D.C.: June 2020). The HTS is a hierarchical structure for describing all goods in trade for duty, quota, and statistical purposes. The U.S. government tracks imported goods at the HTS 10-digit level, also referred to as statistical reporting numbers. Some HTS numbers represent more than one product and some contain products which are not directly relevant to COVID-19 responses. Therefore, the numbers presented overestimate the value of U.S. imports of COVID-19-related products. Nevertheless, they are useful indicators for tracking import trends of such products.

Value of Import Categories Containing COVID-19-Related Products (January 2018 to June 2020)



Source: GAO analysis of U.S. Census Bureau trade statistics. | GAO-20-701

Notes: Census trade statistics, a widely used source for analysis of U.S. international trade, do not contain precise data on imports of COVID-19 related products. As a result, we estimated the import value of all HTS product categories containing Harmonized Tariff Schedule of the United States (HTS) statistical reporting numbers listed in *COVID-19 Related Goods: U.S. Imports and Tariffs*, Investigation No. 332-576, USITC Publication 5073 (Washington, D.C.: June 2020). Some HTS categories represent more than one product and some categories contain products which are not directly relevant to COVID-19 responses. Therefore, the values presented overestimate the imports of products directly relevant to COVID-19 responses. Nevertheless, they are useful indicators for tracking import trends of such products.

[a]These tariffs were imposed under Section 301 of the Trade Act of 1974. See 19 U.S.C. § 2411.

[b]Imports from China that paid a regular tariff were not subject to the additional tariffs on goods from China.

Decline in U.S. overall international trade. U.S. imports and exports have experienced large declines since the outbreak of COVID-19, but trade in goods recently rebounded. Compared to 2019, overall goods imports for consumption declined 26 percent and domestic exports 36 percent in May 2020.[546] In June 2020, monthly goods imports and exports, albeit still lower than one year ago, rebounded roughly 10 percent and 13 percent from May 2020. Trade in services also experienced declines, with imports declining 32 percent and exports 25 percent in June 2020 from one year ago. These declines were particularly prominent in transport and tourism, with the latter, for example, declining more than 93 percent. Unlike trade in goods, imports and exports of services did not experience as notable a rebound from May 2020.

Increase in imports of COVID-19-related product categories. Available data indicate that imports of product categories the U.S. International Trade Commission (USITC) identified for the COVID-19 response have increased continuously since February 2020. Monthly imports of these products increased from the previous year by about 20 percent each in February, March, and April 2020; by roughly 35 percent in May 2020; and by roughly 47 percent in June 2020. Specifically, imports from China have increased significantly since March 2020, while imports from other

[546]These import values reflect seasonally unadjusted imports for consumption and do not include imports to free trade zones or bonded warehouses. Export values reflect seasonally unadjusted domestic exports and do not include re-exports.

countries declined. Imports from China accounted for close to 25 percent of overall COVID-19-related product categories imported in June 2020 compared to roughly 5 percent in March 2020. Fewer COVID-19-related product categories from China are imported duty-free because some imports from China are subject to additional tariffs.[547]

USTR considering easing tariffs on medical-care products from China. USTR—in response to the threat of COVID-19, and in consultation with the Department of Health and Human Services—is taking steps to minimize the effect of additional tariffs on imports from China on the public health response to the pandemic. Eliminating these tariffs may reduce the price and increase the quantity of imports.[548] As part of its tariff-exclusion process, USTR said it has prioritized the review of exclusion requests for COVID-19-related products.[549]

USTR requested and received more than 1,100 public comments on additional modifications to the tariffs on imports from China for COVID-19–related products in an online docket, which closed June 25, 2020.[550] The most frequently cited product categories in the public comments received covered electrical equipment for medical devices, hand sanitizer, and medical-grade face masks.[551] As of July 10, 2020, USTR officials told us they had not decided if they would take any action, such as increasing or decreasing the tariff rate or excluding tariffs on certain products, in response to the public comments.

According to a June 2020 USITC report, 116 of 203 product categories identified for COVID-19 response were subject to the additional tariffs on imports from China.[552] Of the 116, USTR had wholly or partially excluded 42, while 74 were entirely subject to these tariffs (see figure).

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[547]Starting in July 2018, the U.S. imposed additional tariffs on a wide variety of products imported from China, as part of an ongoing trade action under Section 301 of the Trade Act of 1974. The tariff rates have changed over time and are currently either 7.5 or 25 percent. Under Section 301, USTR had found that certain acts, policies, and practices of the government of China related to technology transfer, intellectual property, and innovation are unreasonable or discriminatory, and burden or restrict U.S. commerce. For further information, see USTR, *2020 Trade Policy Agenda* and *2019 Annual Report*.

[548]USTR noted, on the other hand, that, eliminating the tariffs may also harm domestic manufacturers and may make it more difficult to decrease dependence on other nations for critical medical supplies in the future.

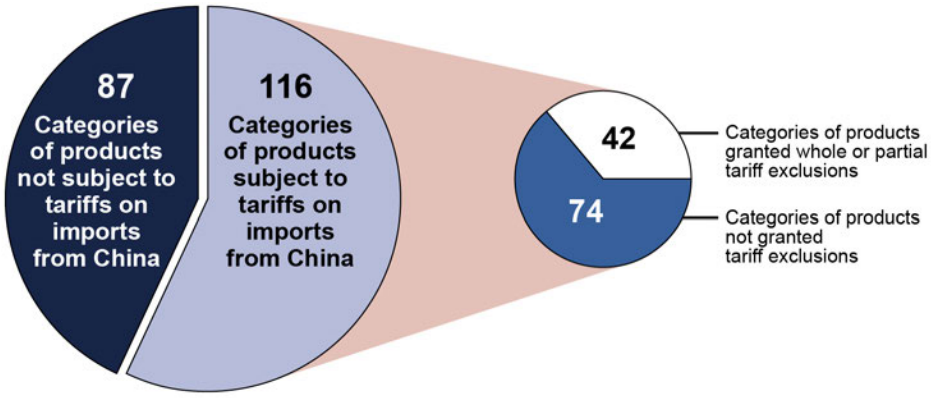
[549]USTR has a process for U.S. importers to obtain temporary tariff relief on specific products from China—known as product exclusions—if the request meets certain criteria. According to USTR, certain medical products—such as ventilators, oxygen masks, and nebulizers—were never subject to tariffs on products from China. USTR stated that it has assessed medical necessity in reviewing product exclusion requests.

[550]See 85 Fed. Reg. 16,987 (Mar. 25, 2020). According to USTR, this was a separate process from its ongoing tariff exclusion process. USTR received comments through the Regulations.gov docket USTR-2020-0014.

[551]When these comments were submitted, the products were classified under HTS numbers 8544.42.9090, 3824.99.9297, and 6307.90.9889, and subject to tariffs on imports from China. Separate from its request for public comments on COVID-19-related products, USTR has granted partial tariff exclusions for certain products classified within these HTS numbers, such as for "face masks, and particulate facepiece respirators, of textile fabric."

[552]USITC identified 203 statistical reporting numbers representing categories of COVID-19-related products based on the HTS at the 10-digit level.

Office of the U.S. Trade Representative Additional Import Tariff Exclusions for Some Products from China Related to the COVID-19 Response, as of June 2020



Source: U.S. International Trade Commission data. | GAO-20-701

Note: Categories refer to statistical reporting numbers related to COVID-19 that the U.S. International Trade Commission identified based on the Harmonized Tariff Schedule (HTS). The HTS comprises a hierarchical structure for describing all goods in trade for duty, quota, and statistical purposes; the 10-digit level is referred to as the statistical reporting number. HTS numbers can represent more than one product. The product exclusions granted by the U.S. Trade Representative are temporary. For example, see 84 Fed. Reg. 69,012 at 69,013 (Dec. 17, 2019).

GAO Methodology and Agency Comments

To conduct this work, we reviewed the most recent trade statistics from the Census Bureau and reviewed agency announcements and guidance from the USTR and USITC. We found the data to be sufficiently reliable to describe trade in general and trade in COVID-19-related products and to describe imports from China subject to tariffs. We provided USTR and the Office of Management and Budget (OMB) with a draft of this enclosure. USTR provided comments, also summarized in the Agency Comments and Our Evaluation section of this report, cautioning about overestimating the amount of trade for COVID-19-related products due to the data limitations. We clarified that we present the values of imports in categories containing such products as an indicator of import trends. We also incorporated technical comments, as appropriate. OMB did not comment on this enclosure.

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Repatriation of U.S. Citizens

In response to the COVID-19 pandemic, the Department of State used existing authorities to transfer $260 million for efforts to evacuate and repatriate U.S. citizens.

Entities involved: Department of State

Key Considerations and Future GAO Work

We are conducting an ongoing review of the Department of State's efforts to repatriate American citizens during the ongoing COVID-19 crisis, including identifying lessons learned.

Background

According to the Department of State (State), the U.S. government has no higher priority than the protection of American citizens. A major element of State's efforts to support this priority has been the repatriation of U.S. citizens in response to the COVID-19 pandemic.[553] Specifically, U.S. embassies and consulates around the globe assisted U.S. citizens in returning to the United States, beginning in late January 2020.

To communicate with U.S. citizens during an emergency such as the pandemic, State uses various mechanisms, such as posting information on embassy and consulate websites and sending out alerts through the Smart Traveler Enrollment Program (STEP).[554] State also provided information on Travel.State.Gov, its website for American travelers, including "COVID-19 Frequently Asked Questions for U.S. Citizens" (posted on March 15, 2020, according to agency officials) and "What the Department of State Can and Can't Do in a Crisis" (last updated on April 7, 2020).[555] The documents address topics such as (1) whether government-assisted evacuation flights are free, (2) use of the military to provide flights for evacuations, and (3) the availability of emergency financial assistance in the form of loans to those in need. Additionally, during the pandemic, State set up a 24-hour call center to provide answers to U.S. citizens' questions about repatriation; as of June 10, 2020, the center had answered over 75,000 calls, according to State officials.

[553]Repatriation is the process of sending a person back to their country of birth or citizenship.

[554]STEP is the database that the Message Alert System for Citizens Overseas Tool uses to communicate via email.

[555]Department of State, Bureau of Consular Affairs, *International Travel: Emergencies,* accessed July 9, 2020, https://travel.state.gov/content/travel/en/international-travel/emergencies.html.

Prior to receiving supplemental appropriations, State exercised pre-existing authorities to transfer a cumulative $260 million in emergency funds to respond to COVID-19 abroad.[556] State used these funds to support the authorized and ordered departures, evacuations, and repatriation of U.S. citizens, legal permanent residents, and federal government employees, according to State officials. State officials told us that as of July 22, 2020, State had obligated $190 million in emergency funds for repatriation and evacuation expenses and had not yet obligated the remaining $70 million.

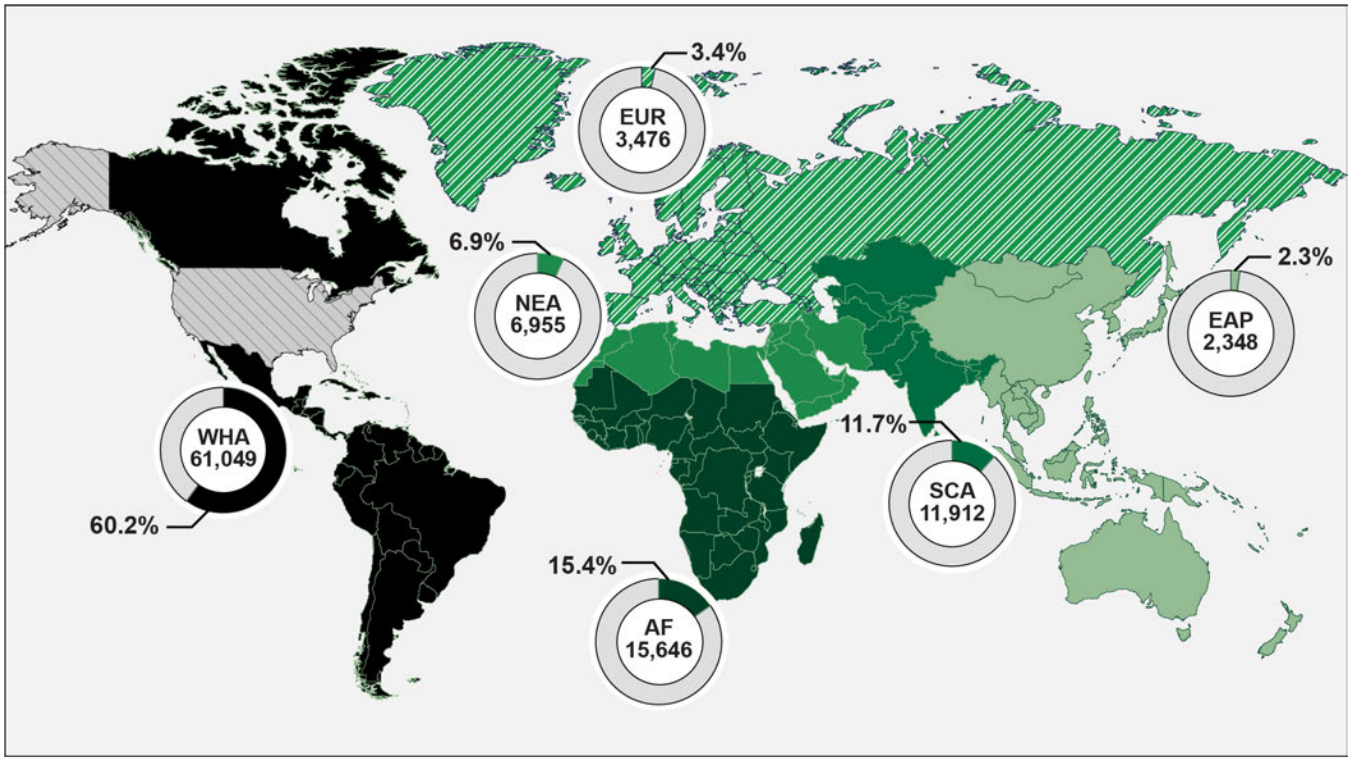
Overview of Key Issues

In total, from January 27 through June 10, 2020, State repatriated 101,386 Americans on 1,140 flights from 136 countries and territories. As the map below shows, more than 60 percent of U.S. citizens were repatriated from areas of the Western Hemisphere. These flights were primarily State-funded charter and contract flights, according to State officials.[557]

[556]According to State officials, State exercised existing authorities to transfer $260 million into the Emergencies in the Diplomatic and Consular Services fund, including $10 million from fiscal year 2019 Diplomatic Programs balances and $250 million from fiscal year 2019 Worldwide Security Protection–Overseas Contingency Operations funds within the Diplomatic Programs account.

[557]For approximately half of these flights, U.S. citizens paid airlines directly for contracted commercial flights when regularly scheduled flights were unavailable, as countries closed their borders and imposed other restrictions that halted normal air travel. However, in these cases, the U.S. government assisted in engaging foreign governments to overcome specific requirements and facilitate repatriations.

Map Showing Numbers and Percentages of Repatriated U.S. Citizens, by Department of State Regional Bureau, January 27–June 10, 2020



Legend: WHA = Bureau of Western Hemisphere Affairs; NEA = Bureau of Near Eastern Affairs; EUR = Bureau of European and Eurasian Affairs; SCA = Bureau of South and Central Asian Affairs; AF = Bureau of African Affairs; EAP = Bureau of East Asian and Pacific Affairs.

Source: GAO analysis of Department of State data. | GAO-20-701

State set up several task forces to oversee its repatriation efforts. On January 24, 2020, State set up a task force to evacuate U.S. citizens from Wuhan, China, and on February 15, 2020, State set up another task force to evacuate U.S. citizens from the Diamond Princess cruise ship in Japan. On March 19, 2020, State established its Repatriation Task Force to coordinate and support State's efforts to repatriate U.S. citizens and legal permanent residents stranded overseas because of the COVID-19 pandemic, according to State officials. The Repatriation Task Force's activities included coordinating evacuation and repatriation operations using a combination of State-funded chartered flights, commercial flights, as well as flights operated by the Department of Homeland Security's U.S. Immigration and Customs Enforcement and the Department of Defense, when available.[558] According to State officials, when there was a significant threat of COVID-19 contagion (including during the Wuhan and Diamond Princess evacuations), State used its existing biocontainment transportation capability to minimize risk in repatriating U.S. persons.

As the table below shows, State officials reported that they faced several challenges in repatriating U.S. citizens and that they took steps to address these challenges.

[558]Our analysis of State's repatriation flight data indicated that, as of June 5, 2020, Department of Homeland Security flights accounted for 1.4 percent of the flights and 1.1 percent of passengers and that Department of Defense flights accounted for 3.1 percent of the flights and 4.2 percent of passengers.

Challenges Department of State (State) Officials Reported Facing in Repatriating U.S. Citizens and Steps They Reported Taking to Address These Challenges

Challenge faced in repatriating U.S. citizens	Steps taken to address challenge
Identifying, locating, and communicating with citizens who wanted to be repatriated	State collaborated with other government partners, mounting an outreach campaign via traditional and social media to get U.S. citizens overseas enrolled in State's Smart Traveler Enrollment Program. State and overseas U.S. missions also made extensive use of their Internet presence, social media, email, and cell phones to publicize State's efforts and, as necessary, established direct contact with individual citizens seeking repatriation options.
Responding to restrictions placed by foreign governments on internal and international travel, including border closures, curfews, quarantine requirements, and requirements for nonstandard documentation or other extraordinary exit requirements such as medical certifications and testing	State engaged governments through traditional diplomacy and new strategies. State officials indicated that these approaches generally overcame the barriers.
Securing options for cruise ships that encountered difficulties in docking, refueling and resupplying, or disembarking passengers and crew in ports around the world	Overseas posts worked closely with the cruise lines, engaging host country governments and locating ports willing to accept the ships. State also convened a team with officials from across the department to provide oversight and coordination.
Answering incoming-call volume that outstripped embassies' and consulates' capacity to respond	State used its National Passport Information Center to create a 24-hour call center to answer repatriation and other emergency questions. Many posts also forwarded their switchboards to the center, facilitating faster response times.
Providing diplomatic intervention to help air carriers obtain timely landing permissions in each country where evacuation or repatriation occurred and obtain timely overflight permits for each country along the flight paths	State's Repatriation Task Force maintained communications with State regional offices and contracted airlines regarding the flights and coordinated all flight clearance requirements. Additionally, the Directorate of Operational Medicine maintained a 24-hour task force to monitor the progress of the directorate's flight planning and missions.[a]

Source: GAO interview with State officials. | GAO-20-701

[a]State's Directorate of Operational Medicine provided 47 repatriation flights—5.6 percent of all repatriation flights from January 29 through May 5, 2020, according to State officials.

GAO Methodology and Agency Comments

To conduct this work, we reviewed State and Department of Defense documents on repatriation efforts, interviewed State and Department of Health and Human Services officials, and reviewed congressional notifications and agency fact sheets related to COVID-19 repatriation response efforts. We used State's repatriation data from January 27 through June 10, 2020, to report the number of U.S. citizens repatriated overall; the number of countries and territories from which

they were repatriated; and the number and percentage of repatriated U.S. citizens reported by each of State's regional bureaus. On the basis of our review of related documentation and information from knowledgeable State officials, we determined that the data were sufficiently reliable for our purposes.

We provided a draft of this enclosure to State and the Office of Management and Budget for review and comment. State provided technical comments that we incorporated as appropriate. The Office of Management and Budget did not provide comments on this enclosure.

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Related GAO Products

Embassy Evacuations: State Department Should Take Steps to Improve Emergency Preparedness. GAO-17-714. Washington, D.C.: July 17, 2017.

State Department: Wide Range of Emergency Services Provided to American Citizens Overseas, but Improved Monitoring Is Needed. GAO-09-989. Washington, D.C.: September 24, 2009.

Appendix II: Scope and Methodology

To understand the federal process to stabilize the health care supply chain, including testing supplies, we reviewed information contained in interagency senior leadership briefs, as well as the testimony of key federal officials. We interviewed or obtained written responses from the Assistant Secretary for Preparedness and Response (ASPR), the Federal Emergency Management Agency (FEMA), the Department of Defense (DOD), and the Supply Chain Advisory Group about agency actions to increase supply, including contracting decisions, and how they made distribution decisions.[559] Further, we interviewed and obtained information from Centers for Disease Control and Prevention (CDC), FEMA, and Office of the Assistant Secretary for Health (OASH) officials regarding their actions and challenges related to testing capacity, including those related to testing supplies.

With respect to testing, we also assessed monthly trends in testing levels by analyzing national testing data for June, July and August 2020 that we downloaded from HHS's website.[560] We assessed the reliability of these data by interviewing agency officials and reviewing HHS's documentation of the data sources and known limitations on its website. We determined that these data were sufficiently reliable for our purpose.

To understand states' experiences related to the COVID-19 response—including personal protective equipment availability, acquisition, and distribution, as well as COVID-19 testing—we interviewed senior officials from departments of health and emergency preparedness from eight states. We selected these states based on a variety of criteria, including that the states reported a range of COVID-19 case counts per capita, were located in different FEMA regions, and reported different levels of public health and state preparedness. The eight states are California, Colorado, Idaho, Massachusetts, Nebraska, New Jersey, New Mexico, and South Carolina.[561] In addition, we conducted an interview with the National Emergency Management Association which offered perspectives of the association and individual perspectives of two additional states—Kansas and Iowa.

To understand federal efforts with regard to vaccine and therapeutic development, manufacturing, and distribution, we reviewed the most recent Department of Health and Human Services (HHS), DOD, and Department of Veterans Affairs (VA) information available on efforts as of August 2020. Specifically, we reviewed agency documentation that included clinical trial information from the National Institutes of Health's (NIH) clinical trial website, information on awards for vaccine and therapeutic development and manufacturing made under Operation Warp Speed from HHS, and information that was posted on the Biomedical Advanced Research and Development Authority's (BARDA) website. [562] We also reviewed relevant federal laws and interviewed HHS and DOD officials. Additionally, we reviewed presentation materials from two committees advising HHS on the equitable allocation of and potential priority groups for a vaccine. Further, we reviewed

[559]In addition to officials at FEMA headquarters, we interviewed officials from six FEMA regional offices.

[560]Testing data were available for download on https://healthdata.gov/dataset/covid-19-diagnostic-laboratory-testing-pcr-testing-time-series, accessed September 4, 2020.

[561]Massachusetts provided written responses only, but for reporting purposes, we refer to all our interactions with these states as interviews.

[562]Data included information from NIH's ClinicalTrials.gov website accessed August 5, 2020 and information from BARDA's https://medicalcountermeasures.gov/ website accessed August 18, 2020.

documentation from public health organizations, including immunization program managers, on federal planning for vaccine distribution and public health messaging.

To understand the completeness and accuracy of health disparities data, we reviewed the most recent agency data on indicators of COVID-19 reported by CDC and the Centers for Medicare & Medicaid Services (CMS) as of August 5, 2020, federal laws, and agency guidance and documentation. We also interviewed or obtained written responses from HHS officials, including those from its Office of Minority Health, CDC, and Indian Health Service.

For additional perspectives on actions and challenges with regard to the federal public health response, we interviewed or obtained responses from national public health associations listed as key stakeholders in the U.S. Government COVID-19 Response Plan, as well as laboratory, public health industry, and health care provider groups.[563] These include the Association of Public Health Laboratories, Association of State and Territorial Health Officials, Council of State and Territorial Epidemiologists, National Association of County and City Health Officials, the American Clinical Laboratory Association, Association of Public Health Laboratories, National Independent Laboratory Association, the COVID Tracking Project, the National Governors Association, the American Medical Association, the American Hospital Association, the American Nurses Association, and the American College of Emergency Physicians.

To review how the Department of the Treasury (Treasury) and Internal Revenue Service (IRS) administered payments, we reviewed Treasury and IRS data as of July 31, 2020, examined federal laws and agency guidance, and interviewed Treasury and IRS officials. We assessed the reliability of the data by reviewing relevant Treasury and IRS documents, reviewing GAO's prior use of the data sources, and interviewing agency officials. We determined the data were sufficiently reliable to describe the number and amount of payments disbursed. To assess IRS's efforts to communicate about the economic impact payments (EIP), we reviewed its communications plan and materials and interviewed officials involved with that effort.

We spoke with five selected IRS outreach partners, including the AARP, Feeding America, the United Way, the Code of Support Foundation, and the National Low Income Housing Coalition. These organizations were selected for their work on a national scale and work with constituencies such as low-income families, veterans, and seniors. This sample is not representative, but the interviews provided us with illustrative examples of how organizations worked with IRS to reach traditionally underserved communities and what aspects of the IRS communications plan worked well, and also highlighted potential areas for improvement.

To conduct our work on unemployment insurance, we reviewed information that the Department of Labor (DOL) provided as of August 2020; reviewed relevant federal laws, agency guidance, and DOL Office of Inspector General reports; reviewed relevant economic research; and interviewed DOL officials, DOL Office of Inspector General officials, and representatives of the National Association of State Workforce Agencies and Feeding America.

[563]The U.S. Government COVID-19 Response Plan, known as the PanCap Adapted, outlines plans for the COVID-19 response, including roles for key stakeholders.

To assess federal aid to states, localities, territories, and tribes to address the COVID-19 pandemic, we examined the four COVID-19 relief laws enacted as of September 1, 2020 and identified programs that provide funding to states, localities, territories, or tribes.[564] From these, we selected six programs with appropriations or estimated expenditures of at least $10 billion: (1) the Coronavirus Relief Fund, (2) Medicaid, (3) FEMA Disaster Relief Fund, (4) the Education Stabilization Fund, (5) transit grants, and (6) airport grants.[565] To assess actual expenditures as of May 31, June 30, and July 31, 2020, for these programs, we reviewed data from CMS, the Department of Education (Education), FEMA, the Department of Transportation, and Treasury. To assess the reliability of agency expenditure data, we reviewed information on the sources of these data, and we followed up with knowledgeable individuals as needed about the appropriate use and potential limitations of these data. We found these data to be sufficiently reliable for our purposes. We also reviewed Congressional Budget Office estimates of expenditures.

In addition, we reviewed federal laws and agency guidance and interviewed officials from Education, Treasury, and Treasury's Office of Inspector General. To collect the perspectives of state and local stakeholders, we interviewed officials from the National Governors Association, the National Association of State Budget Officers, the National Association of Counties, the National Association of State Treasurers, the Council of Chief State School Officers, and the Government Finance Officers Association.

To conduct our work on guidance for K-12 schools, we reviewed CDC's guidance on reopening schools, as well Education's information for schools on COVID-19. We also reviewed the Administration's public statements about school reopening guidance and interviewed Education officials.

To review key actions taken to provide support to industry and the economy, we reviewed actions taken by the Small Business Administration (SBA) through the Paycheck Protection Program (PPP), and we reviewed the state of the housing market (focusing on the rental market and evictions). We also reviewed agency rules and guidance, documentation from federal agencies and other stakeholders on eviction moratoriums, and studies on the state of the housing market by universities and other researchers and the Federal Reserve, among others. We also obtained and analyzed the following data:

- **PPP.** We obtained and analyzed SBA's loan-level PPP data as of August 8, 2020. Using these loan-level data, we analyzed the number and dollar amount of the loans by various characteristics of the businesses that received the loans, including business size and type,

[564]The four COVID-19 relief laws enacted as of September 1, 2020 are the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, 134 Stat. 146; Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020); CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); and Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020). We refer to the supplemental funding appropriated by these laws as "COVID-19 relief funds."

[565]We did not include loans available to states and localities through the Federal Reserve's Municipal Liquidity Facility in the total amount of aid. According to Congressional Budget Office estimates, these loans would have no budgetary effect for the federal government. We did not select aid for expenses associated with COVID-19 testing ($11 billion), established in the Paycheck Protection Program and Health Care Enhancement Act, as a selected program because it was part of a larger appropriation for HHS, but the aid for expenses is included in the total amount of aid to states, localities, territories, and tribes.

number of employees, and location (by state). To facilitate the geographic comparison, we adjusted the reported number and dollar amount of SBA loans by state using data on the number of small businesses and small business employees by state from SBA's 2020 Small Business Profile. To assess the reliability of SBA's loan-level PPP data, we interviewed knowledgeable SBA officials; reviewed related SBA documentation; and checked the data for missing records, outliers, and obvious errors. To assess the reliability of SBA's state-level data on small businesses, we reviewed relevant documentation. We determined that the data were sufficiently reliable to describe the geographic distribution of PPP loans, changes in PPP loan size over time, PPP loans by business size and type, and the extent of canceled loans.

- **Housing market.** We analyzed housing market data from industry groups and researchers—S&P/Experian's Bankcard Default Index (default rate), Eviction Lab Eviction Tracking System (number of evictions), and the National Multifamily Housing Council Rent Payment Tracker and Apartment List Monthly Housing Payment Survey (rental payment rates). In addition, we obtained and analyzed data from several federal sources: (1) the Census Bureau's 2020 Household Pulse Survey (rental payments and renter confidence in the ability to pay), (2) Fannie Mae's National Housing Survey (renter confidence in ability to pay bills), (3) Fannie Mae's Multifamily MBS COVID-19 Forbearance List and Freddie Mac's Multifamily Securitization Forbearance Report (securitized loans in forbearance), and (4) the Department of Housing and Urban Development's (HUD) Picture of Subsidized Households data (number of subsidized units available). To assess the reliability of these data, we conducted various reliability checks (as appropriate for each source), including reviewing technical documentation associated with the data, interviewing knowledgeable staff, and comparing the data to other publicly available data. We determined that these data were sufficiently reliable to describe the state of the housing market, including trends in rental payments and evictions.

In addition, we interviewed SBA officials about PPP. We also interviewed representatives of stakeholder groups, including representatives from four associations that represent a variety of lenders and one association that represents accountants, to obtain their views on PPP; and interviewed housing industry and advocacy groups, think tanks, and researchers to obtain a variety of perspectives on the state of the housing market. Their views are not generalizable to other groups but offered important perspectives.

To identify agencies' federal contract obligations and competition on contracts in response to COVID-19, we reviewed Federal Procurement Data System-Next Generation data through July 31st, 2020.[566] We identified contract obligations related to COVID-19 using the National Interest

[566]Data from FPDS.gov accessed on August 3, 2020. For purposes of this report, competition rate is the percentage of total obligations associated with contracts awarded competitively. We calculated competition rates as the percentage of obligations on competitive contracts and orders over all obligations on contracts and orders annually. Competitive contracts included contracts and orders coded in the Federal Procurement Data System-Next Generation as "full and open competition," "full and open after exclusion of sources," and "competed under simplified acquisition procedures" as well as orders coded as "subject to fair opportunity" and as "fair opportunity given," and "competitive set aside." Noncompetitive contracts included contracts and orders coded in the Federal Procurement Data System-Next Generation as "not competed," "not available for competition," and "not competed under simplified acquisition procedures," as well as orders coded as an exception to "subject to fair opportunity," including "urgency," "only one source," "minimum guarantee," "follow-on action following competitive initial action," "other statutory authority," and "sole source." Even for contracts identified as noncompetitive, agencies may have solicited more than one source.

Action code, as well as the contract description field.[567] For contract actions over $1 million, we removed obligations that were identified in the contract description as not related to COVID-19. We assessed the reliability of federal procurement data by reviewing existing information about the Federal Procurement Data System-Next Generation and the data it collects—specifically, the data dictionary and data validation rules—and performing electronic testing. We determined that the data were sufficiently reliable for the purposes of describing agencies' reported contract obligations in response to COVID-19.

To identify agencies' international efforts in response to COVID-19, we reviewed information from the Department of State, U.S. Agency for International Development, and CDC, including strategy and guidance documents; congressional notifications; and information on allocations, obligations, and the types of assistance provided with supplemental funding. We also reviewed challenges to implementation of assistance efforts identified by agency officials.

To conduct our work on federal oversight of COVID-19 testing payments for uninsured individuals, we reviewed federal laws, Medicaid data from CMS and provider payments data from the Health Resources and Services Administration (HRSA). To determine the reliability of data from CMS's Medicaid expenditure reporting system, we discussed the system with CMS officials and conducted data reliability checks on state-reported expenditure data. We determined that the data were sufficiently reliable for reporting COVID-related expenditures in Medicaid and HRSA payments to providers for testing uninsured individuals for COVID-19.

To determine how CDC is collecting data on nursing home COVID-19 cases and deaths, we reviewed CDC data reported by nursing homes, agency guidance, and other relevant information on HHS's response to the COVID-19 pandemic, and we spoke to CMS and CDC officials. We analyzed the CDC data on COVID-19 reported by nursing homes for the week ending June 21, 2020.[568] We analyzed the CDC data as they were reported by nursing homes to CDC. We did not otherwise independently verify the accuracy of the information with these nursing homes. We assessed the reliability of the dataset used in our analysis by checking for missing values and obvious errors and reviewing relevant CMS and CDC documents. We determined the data were sufficiently reliable for reporting what CDC knows regarding the number of COVID-19 cases and deaths in nursing homes after May 8, 2020.

To assess HHS's efforts to mitigate cybersecurity threats to the department and healthcare sector, we relied on prior GAO reports and HHS's actions to implement recommendations we issued in them. Specifically, we used prior GAO reports to describe deficiencies we found in CMS, FDA, and CDC's implementation of information security program and technical controls, and the corrective actions they have taken to strengthen cybersecurity within the department. In addition, we used prior GAO reports to describe HHS's efforts to measure and report on the healthcare sector's use of the NIST cybersecurity framework. We summarized HHS's actions to implement the recommendations we made to the department in those GAO reports.

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[567]Our prior work has identified some inconsistencies in the information agencies report in the contract description field in the Federal Procurement Data System-Next Generation, as well as other data limitations with certain fields in the system. See GAO-20-75 and GAO-17-496.

[568]The CDC data on COVID-19 in nursing homes were accessed on July 23, 2020 from https://data.cms.gov/Covid19-nursing-home-data.

To update the status of recommendations made to agencies and matters for congressional consideration made in our June 2020 report, we interviewed agency officials and monitored bills in Congress.[569] We report the status of relevant bills that had, at a minimum, been reported out of a committee of jurisdiction as of July 2020.

We conducted this performance audit from May 2020 to September 2020 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[569]GAO, *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts*, GAO-20-625 (Washington, D.C.: June 25, 2020)

Appendix III: List of Ongoing GAO Work Related to COVID-19, as of September 9, 2020

Repatriation Program COVID-19 Response

Oversight of Unemployment Insurance during COVID-19

Higher Education Aid and Student Loan Flexibilities in Response to COVID-19

Early Care and Education and the Coronavirus Pandemic Response

Agency Information Technology Preparedness in Response to Coronavirus Pandemic

Tracking Funds and Associated Activities Related to Federal Response to COVID-19

Diagnostic Testing

Strategic National Stockpile

Worker Safety in the Pandemic

Distance Learning Challenges for English Learners and Students with Disabilities

Business/Employer Tax Provisions

Nutrition Assistance

Agencies' Telework Readiness and Use of Telework for Employees

Internal Revenue Service Administration of Economic Impact Payments

Housing Finance System in the Pandemic

Military Health System COVID Response

COVID-19-Related Grant Flexibilities

Bureau of Prisons' Emergency Preparedness & Response

TSA Measures to Prevent COVID-19 at Checkpoints

Nursing Home Infection Prevention and Control

Biodefense Preparedness and Response for COVID-19

Federal Agencies' Reentry

Agencies' Human Capital Flexibilities in Response to Coronavirus Pandemic

Immigration Detention Facilities and Operations

Federal Emergency Management Agency Response to COVID-19

Department of Veterans Affairs' (VA) COVID-19 Procurement Response

Election Funding and Administration during the Pandemic

Defense Production Act

Effects of COVID-19 on Dedicated Fees

School Meals during the Pandemic

VA's Civilian Public Health Response to the COVID-19 Pandemic

CARES Act Housing Protections

Bureau of Indian Education Distance Education

Child Welfare

Department of the Interior and Department of the Treasury's (Treasury) Actions for Tribal Governments in Response to the Pandemic

Department of State Repatriation

Small Business Administration's Implementation of the Paycheck Protection Program

Indian Health Service Response to COVID-19

Vaccine Development

Nurse Loan Repayment Program

Coronavirus Economic Stabilization Act Loans and Investments Programs

Coast Guard COVID-19 Response Efforts

Human Pandemic Preparedness Plan for Food Safety Inspections

Farmer Food Purchases and Redistribution Program

CARES Act Assistance to Farmers

Customs and Border Patrol

Medicaid Waivers and Flexibilities for COVID-19

Immigration Courts Response

Department of Defense Depot COVID-19 Impacts

Economic Injury Disaster Loans and Advances

Federal Air Marshal Service Response

Treasury Debt Management Response

Services for Older Adults

Characteristics of Paycheck Protection Program Loans

Aviation Operations in a Pandemic Environment

International Humanitarian Assistance

United States Postal Service

Behavioral Health Impacts

Unemployment Support for Contingent Workers

CARES Act Aviation Loans

VA's preparedness for, response to, and recovery from COVID-19

Operation Warp Speed

HHS Medicare waivers for COVID-19 (including telehealth)

Vaccine Distribution and Communication

VA Nursing Homes

Community Behavioral Health Demonstrations

VA COVID-19 Supplemental Funding

VA Access to Community Care

State and Local Fiscal Conditions & Federal Implications

Bureau of Prisons' Response to COVID-19

VA COVID-19 Financial Controls

Pandemic Learning Loss

Strategic National Stockpile Internal Controls

COVID-19 Contracting Flexibilities

Agencies' COVID-19 Contract Planning and Review of Contractor Qualifications

Department of State & U.S. Agency for International Development Continuity of Operations

Appendix IV: Status of GAO's June 2020 Recommendations

In our June 2020 report, we made three recommendations—one each to the Department of Labor (DOL), Internal Revenue Service (IRS), and Small Business Administration (SBA).[570] To date, the status of these recommendations is as follows:

Recommendation 1. The Secretary of Labor should, in consultation with SBA and the Department of the Treasury (Treasury), immediately provide information to state unemployment agencies that specifically addresses SBA's Paycheck Protection Program (PPP) loans, and the risk of improper payments associated with these loans.

Status: Closed

Comment: Following our recommendation, DOL issued guidance on August 12, 2020, that clarified that individuals working full-time and being paid through PPP are not eligible for unemployment insurance (UI), and that individuals working part-time and being paid through PPP would be subject to certain state policies, including state policies on partial unemployment to determine their eligibility for UI benefits. Further, the guidance clarified that individuals being paid through PPP but not performing any services would similarly be subject to certain provisions of state law, and noted that an individual receiving full compensation would be ineligible for UI.

Recommendation 2. The Commissioner of Internal Revenue should consider cost-effective options for notifying ineligible recipients on how to return payments.

Status: Open

Comment: IRS agreed with this recommendation. Treasury and IRS have taken steps to implement this recommendation and are considering further actions. Currently, IRS has instructions on its website requesting that individuals voluntarily mail the appropriate economic impact payment amount sent to the decedent or incarcerated individual back to IRS, for both electronic and paper check payments. The envelopes in which paper checks were sent also have a checkbox to indicate if the recipient is deceased, which then could be mailed back to the Bureau of the Fiscal Service (BFS). Treasury has also held and canceled payments to decedents along with those that have been returned.

Of the $1.2 billion in economic impact payments sent to decedents, as of July 31, 2020, around 57 percent, (just over $700 million) has been recovered.[571] There are also likely more returned payments in unopened mail that IRS has yet to process. Treasury and IRS continue to review and monitor data on the number of payments that were sent to decedents and prisoners and have since been recovered to determine whether further action may be warranted.

[570]GAO, *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts*, GAO-20-625 (Washington, D.C.: Jun. 25, 2020)

[571]In August, we reported that Treasury and IRS had sent $1.6 billion to deceased individuals. Treasury and IRS have since updated that amount to $1.2 billion to account for payments that were either screened prior to printing, or printed and canceled before mailing.

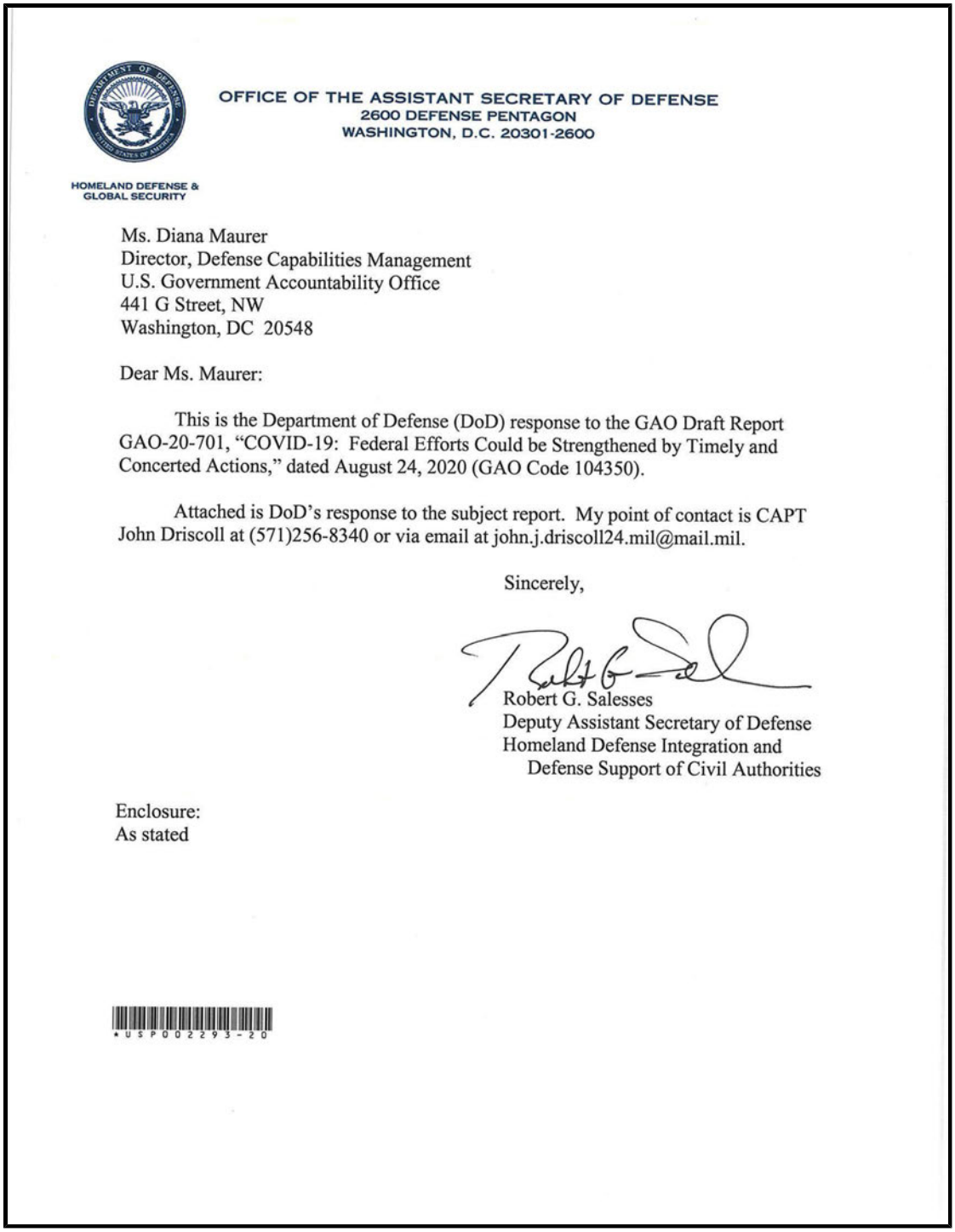
Treasury was considering sending letters to request the return of outstanding checks and the repayment of amounts already paid by direct deposit or by checks that have been cashed. However, Treasury has not moved forward with this effort because, according to Treasury, Congress is currently considering legislation that would clarify or change the eligibility requirements of the payments, including payments to the deceased and incarcerated.

Recommendation 3. The Administrator of the Small Business Administration should develop and implement plans to identify and respond to risks in PPP to ensure program integrity, achieve program effectiveness, and address potential fraud, including in loans of $2 million or less.

Status: Open

Comment: As of August 2020, SBA had begun developing oversight plans for the PPP but had not yet finalized or implemented them. Specifically, SBA is currently working with Treasury to finalize plans for reviewing PPP loans. For example, SBA officials told us that a contractor would use an automated review tool to flag potentially questionable loans over $2 million and that the contractor would conduct manual reviews of flagged loans. According to SBA officials, SBA would then complete the reviews with a combination of contract and federal staff, and another contractor would perform a quality assurance review on a sample of loans. However, as of August 14, 2020, SBA was still working with Treasury and contractors to finalize the specific review procedures its contractors and staff would follow.

Appendix V: Comments from Department of Defense



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
2600 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-2600

HOMELAND DEFENSE & GLOBAL SECURITY

Ms. Diana Maurer
Director, Defense Capabilities Management
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Maurer:

This is the Department of Defense (DoD) response to the GAO Draft Report GAO-20-701, "COVID-19: Federal Efforts Could be Strengthened by Timely and Concerted Actions," dated August 24, 2020 (GAO Code 104350).

Attached is DoD's response to the subject report. My point of contact is CAPT John Driscoll at (571)256-8340 or via email at john.j.driscoll24.mil@mail.mil.

Sincerely,

Robert G. Salesses
Deputy Assistant Secretary of Defense
Homeland Defense Integration and
Defense Support of Civil Authorities

Enclosure:
As stated

*USP002293-20

GAO DRAFT REPORT DATED AUGUST 24, 2020
GAO-20-701 (GAO CODE 104350)

"COVID-19: FEDERAL EFFORTS COULD BE STRENGTHENED BY TIMELY AND CONCERTED ACTIONS"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATION

RECOMMENDATION 4: The GAO recommends that the Secretary of Health and Human Services and the Secretary of Defense should establish a time frame for documenting and sharing a national plan for distributing and administering COVID-19 vaccine, and in developing such a plan ensure that it is consistent with best practices for project planning and scheduling and outlines its approach for how efforts will be coordinated across federal agencies and nonfederal entities. (Recommendation 4)

DoD RESPONSE: DoD partially concurs with the recommendation. Prioritization of vaccine administration is being considered by the Advisory Committee on Immunization Practices (ACIP), with assistance and input from the National Academy of Medicine (NAM). In response to a request from the NIH and CDC, the National Academies of Sciences, Engineering, and Medicine (NASEM) and the NAM formed a committee that will develop an overarching framework to assist policymakers in the U.S. and global health communities in planning for equitable allocation of vaccines against COVID-19. The findings from the NAM committee will be shared with ACIP, and may help inform the committee's deliberations related to recommendations on vaccine priority groups and ensuring equity in vaccination in the United States Vaccine prioritization policies formulated by recommendations from ACIP will then be approved by the CDC Director, who will provide these policy recommendations to the Secretary for Health and Human Services. Subsequently, these recommendations on vaccine prioritization are provided for interagency coordination and approval. The timeline regarding this process depends in part on clinical trial results. DoD is supporting HHS in developing plans for nation-wide distribution and administration of any FDA-authorized or approved vaccine or therapeutic to counter COVID-19.

RECOMMENDATION 12: The GAO recommends that the Secretaries of Homeland Security and Defense should (1) revise the criteria in the 2019 National Interest Action Code Memorandum of Agreement to clearly identify steps they will take to obtain input from key federal agencies prior to extending or closing the National Interest Action code, (2) establish timelines for evaluating the need to extend a National Interest Action code, and (3) define what constitutes a consistent decrease in contract actions and routine contract activity to ensure the criteria for extending or closing the National Interest Action code reflects government-wide needs for tracking contract actions in longer term emergencies, such as a pandemic. (Recommendation 12)

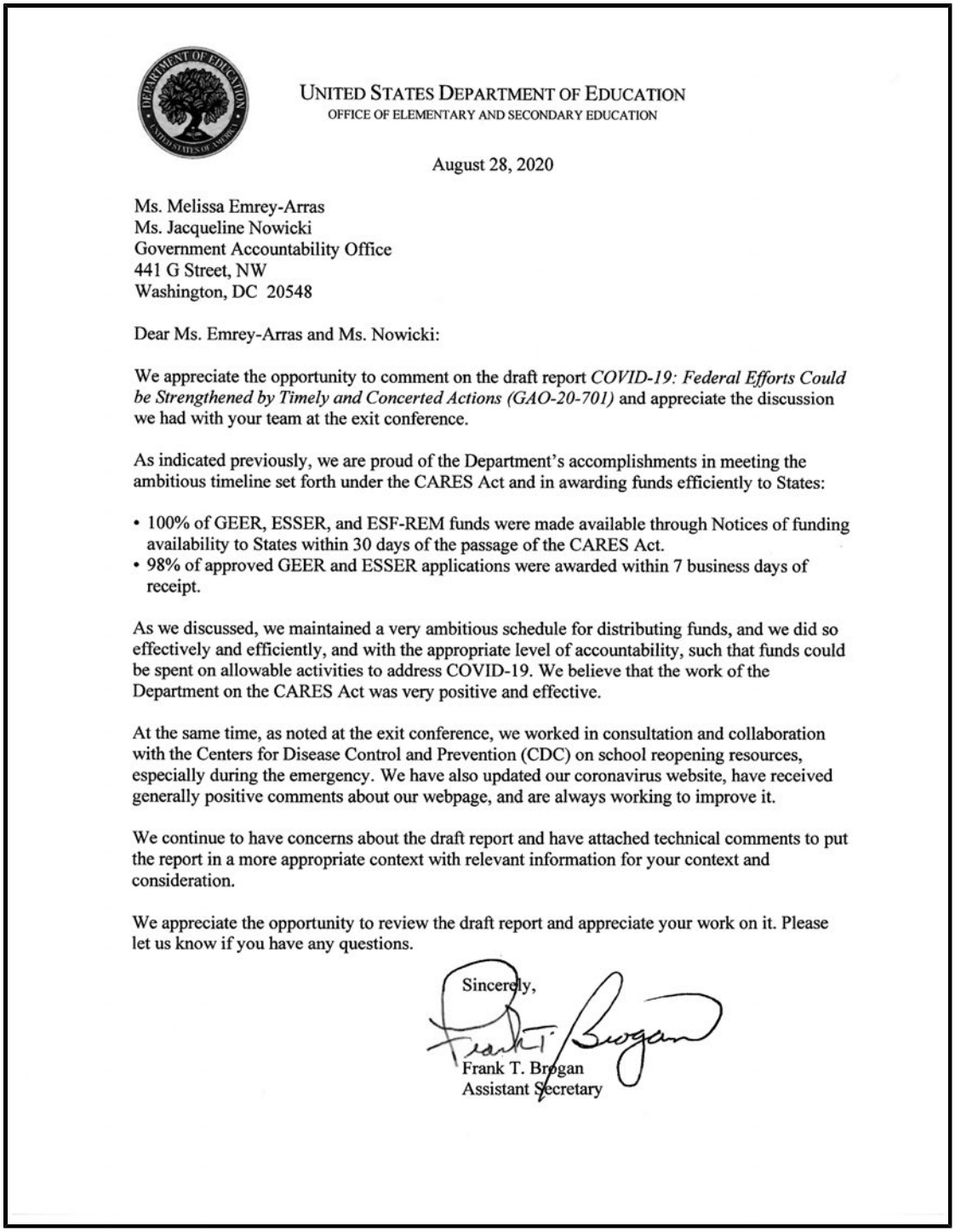
DoD RESPONSE: DoD non-concurs with the recommendation. Each disaster and contingency where an NIA code is applied is a unique situation, and the COVID-19 pandemic further

differentiates itself in both its nationwide scope and length of time. However, DoD and the Department of Homeland Security (DHS) believe the criteria in the MOA for applying an end date to NIA codes are sufficient and are applied judiciously with each NIA code established. DoD specifically non-concurs on parts (2) and (3) of the recommendation to quantify each criteria, so as not to limit the government's flexibilities, not only for end dating the NIA code for COVID-19, but for future NIA codes as well. However, to the broader intent of recommendation 12 regarding communication with the Federal agency community, DoD and DHS are committed to annually reviewing the MOA for any necessary updates. Although the MOA already includes a description of the communication methods employed with Federal agencies, the MOA signature parties will review to determine if a description of additional procedures used should be included.

RECOMMENDATION 13: The GAO recommends that the Secretaries of Homeland Security and Defense should extend the COVID-19 National Interest Action code beyond September 30, 2020. (Recommendation 13)

DoD RESPONSE: DoD concurs with the recommendation. DoD and DHS are reviewing the current end date of September 30, 2020, in accordance with the MOA in order to extend it. As previously shared with GAO, the extension will be discussed at the monthly Federal Integrated Award Environment Change Control Board meeting on August 27, 2020. The new end date for the NIA code for COVID-19 will be communicated to the Federal Procurement Data System.

Appendix VI: Comments from Department of Education



UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF ELEMENTARY AND SECONDARY EDUCATION

August 28, 2020

Ms. Melissa Emrey-Arras
Ms. Jacqueline Nowicki
Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Emrey-Arras and Ms. Nowicki:

We appreciate the opportunity to comment on the draft report *COVID-19: Federal Efforts Could be Strengthened by Timely and Concerted Actions (GAO-20-701)* and appreciate the discussion we had with your team at the exit conference.

As indicated previously, we are proud of the Department's accomplishments in meeting the ambitious timeline set forth under the CARES Act and in awarding funds efficiently to States:

- 100% of GEER, ESSER, and ESF-REM funds were made available through Notices of funding availability to States within 30 days of the passage of the CARES Act.
- 98% of approved GEER and ESSER applications were awarded within 7 business days of receipt.

As we discussed, we maintained a very ambitious schedule for distributing funds, and we did so effectively and efficiently, and with the appropriate level of accountability, such that funds could be spent on allowable activities to address COVID-19. We believe that the work of the Department on the CARES Act was very positive and effective.

At the same time, as noted at the exit conference, we worked in consultation and collaboration with the Centers for Disease Control and Prevention (CDC) on school reopening resources, especially during the emergency. We have also updated our coronavirus website, have received generally positive comments about our webpage, and are always working to improve it.

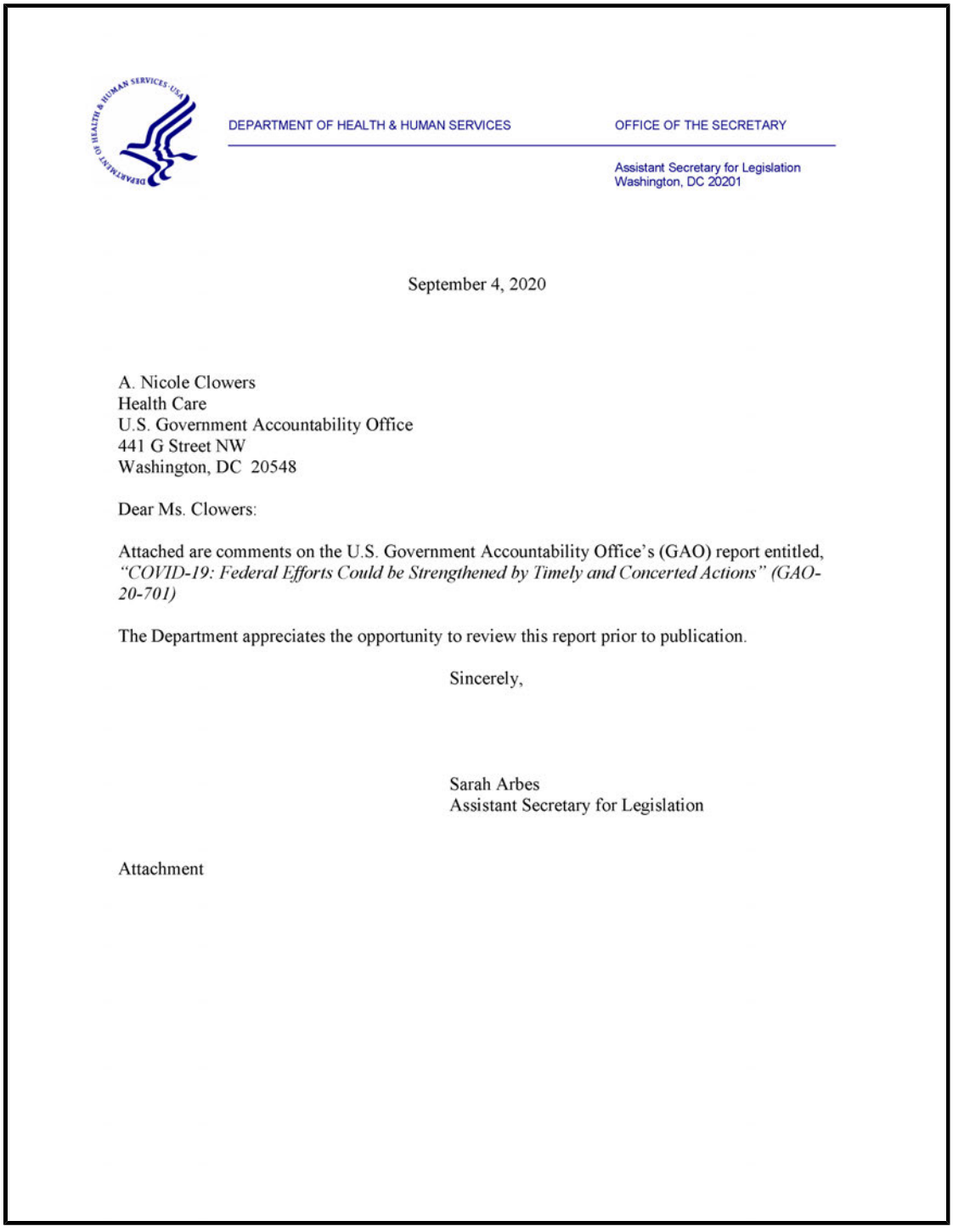
We continue to have concerns about the draft report and have attached technical comments to put the report in a more appropriate context with relevant information for your context and consideration.

We appreciate the opportunity to review the draft report and appreciate your work on it. Please let us know if you have any questions.

Sincerely,

Frank T. Brogan
Assistant Secretary

Appendix VII: Comments from Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

September 4, 2020

A. Nicole Clowers
Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Clowers:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *"COVID-19: Federal Efforts Could be Strengthened by Timely and Concerted Actions" (GAO-20-701)*

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Sarah Arbes
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT ENTITLED – COVID-19: FEDERAL EFFORTS COULD BE STRENGTHENED BY TMELY AND CONCERTED ACTIONS (GAO-20-701)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. We write, however, to correct the record on key issues that GAO fails to understand regarding three of its recommendations.

1. The Secretary of Health and Human Services and the Administration of the Federal Emergency Management Agency – who head agencies leading the COVID-19 response through Unified Coordination Group—should develop and communicate a comprehensive supply management plan for identifying and addressing ongoing medical supply gaps, including testing supplies, resulting from COVID-19. The plan should incorporate work with stakeholders, such as state, local, tribal, and territorial governments, and detailed actions for increasing domestic production of critical medical supplies, such as the use of Defense Production Act authorities, and the conditions under which federal agencies would consider additional support. **(Recommendation 1)**

2. The Secretary of Health and Human Services and the Administrator of the Federal Emergency Management Agency – who head agencies leading the COVID-19 response through the Unified Coordination Group—should immediately document roles and responsibilities for supply chain management functions transitioning to the Department of Health and Human Services, including continued support from other federal partners, to ensure sufficient resources exist to sustain and make the necessary progress in stabilizing the supply chain, and address emergent supply issues for the duration of the COVID-19 pandemic. **(Recommendation 2)**

GAO's recommendation suggesting that HHS currently lacks a comprehensive supply management plan is incorrect. In response to the pandemic, HHS, FEMA, and other federal partners launched the most comprehensive supply management effort undertaken by our nation since World War II, and developed the most sophisticated and comprehensive database for supply chain logistics our nation has ever had. Through these efforts, the Administration has been highly successful in identifying gaps in supply needs across the nation, and taking swift action to ensure those needs are met. In addition to ASPR and FEMA, the Supply Chain Task Force (SCTF) orchestrated a comprehensive four-pronged strategy to preserve medical supplies, accelerate industrial manufacturing and distribution, expand industry, and allocate resources to the right place at the right time. Any fair assessment of nationwide supply data shows that the SCTF's effort have been remarkably successful. Unfortunately, your report and recommendations prioritize anonymous anecdotes about minor and temporary coordination issues over a fair assessment of the federal government's historic achievements in increasing supply availability and executing the logistics required to fill identified supply chain gaps.

To the extent that the GAO's recommendation for the establishment of a "comprehensive supply management plan" is meant to suggest that the federal government should federalize all supply procurement and distribution, that suggestion is misguided and unsupported by

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT ENTITLED – COVID-19: FEDERAL EFFORTS COULD BE STRENGTHENED BY TMELY AND CONCERTED ACTIONS (GAO-20-701)

your report. As part of the whole-of-government response to the pandemic, HHS (led by ASPR) and FEMA have worked closely to provide critical guidance to states on managing and procuring PPE and other supplies. ASPR, FEMA, and DoD have made critical investments to expand domestic manufacturing of PPE, and the agencies have also coordinated deliveries to front line healthcare providers with commercial distributors to minimize delays and ensure supplies go where they are most needed. Recently, the Administration, through HHS, is announcing it has now distributed almost $2.5 billion of a planned $5 billion distribution to nursing homes to support increased testing, staffing, and personal protective equipment (PPE) needs. Further, the Administration, through HHS, released 1.5 million N95 respirators from the Strategic National Stockpile (SNS) for distribution to approximately 3,336 nursing home facilities across the United States.

As a whole, these efforts have been remarkably successful. HHS and FEMA have successfully collaborated for months to facilitate the distribution of PPE, ventilators, and other life-saving equipment to combat the COVID-19 pandemic. As of August 31, HHS, FEMA, and the private sector coordinated delivery of or are currently shipping 230 million N95 masks, 1 million surgical and procedural masks, 42.2 million eye and face shields, 403 million gowns and coveralls, and over 25.4 billion gloves. As of September 1, the federal government has approximately 124,207 total ventilators available in the Strategic National Stockpile. While the mission has necessitated moving these materials quickly, HHS and FEMA are in the process of producing such documented responsibilities.

HHS engages with state, local, and tribal partners on supply challenges regularly. That is because states, localities, and private hospital systems have always been understood to have primary responsibility for meeting supply needs, and the federal government has always been understood to play a supporting, supplementation role. The SNS, for example, was not designed to provide emergency supplies for every locality in the United States, and was never intended to be relied upon as the single solution for pandemic response.[1] The unprecedented challenges caused by the COVID-19 pandemic led the SCTF and its partners to execute an unprecedentedly comprehensive effort to obtain and understand nationwide supply chain data, to enhance the production and procurement of supplies, and to execute supply chain logistics to distribute supplies to fill identified gaps. This Administration is proud of the work it has done to identify and fill gaps in state and local response, and to support the response efforts that have been managed and executed at the state and local level. The supply chain results achieved by ASPR, FEMA, the SCTF, and their partners through execution of this operational model repudiate any suggestion that a wholesale change to the model would be warranted.

[1] HHS, with support from FEMA and the DoD, is currently implementing a next generation of the SNS that will be capable of backstopping gaps in the healthcare and medical supply chain for approximately 90 days.

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT ENTITLED – COVID-19: FEDERAL EFFORTS COULD BE STRENGTHENED BY TMELY AND CONCERTED ACTIONS (GAO-20-701)

State, local, and tribal partners have indicated they would like to pursue joint acquisitions with federal agencies like ASPR. HHS and ASPR, however, lack a revolving fund (and accompanying working capital fund "WCF") that would permit such procurements; HHS has informed Congress that it lacks this authority.

Even without a revolving fund, however, HHS and its federal partners have successfully worked with states to help them modify instances in which they have made requests for materials that far exceed actionable or reasonable requirements. For example, Montana requested 2 million N95 respirators and an additional 2,000 KN95 masks for a state with a population slightly over 1 million; Ohio requested 15 million N95 respirators for a state population slightly below 11 million; Utah requested over 2 million N95 respirators, 6 million surgical masks, and 2 million face shields for a state with a population slightly over 3 million, and Massachusetts requested 750,000 PAPRs. These examples illustrate a pattern of states requesting materials that substantially exceed their reasonable requirements. Some states have also attempted to procure material from the SNS, which is provided without charge, in an effort to meet their long-term stockpiling needs, rather than applying them as immediate stop-gap measures. ASPR believes FEMA experiences a similar phenomenon, as states are responsible for only 25% of the cost of material provided by FEMA. Simply put, anonymous anecdotes from states indicating that not all of their requests were met does not indicate that any wholesale change to the Administration's supply chain management is warranted. To the contrary, it is a sign that HHS and its federal partners are properly executing their jobs and ensuring that federal supplementation resources are flowing to meet actual needs.

In addition to supporting and supplementing state, territorial, tribal, and local efforts to secure PPE and other medical equipment, ASPR, in collaboration with the National Ebola and Special Pathogens Training and Education Centers (NETEC), and Project ECHO (Extension for Community Healthcare Outcomes), launched a series of COVID-19 Clinical Rounds on March 24th. This initiative supports a series of three weekly teleECHO programs designed to let clinicians share their experiences in treating COVID-19 and to provide a mentoring network for those on the frontline of the response:

1) Critical Care: Lifesaving Treatment and Clinical Operations;
2) Emergency Department: Patient Care and Clinical Operations; and
3) EMS: Patient Care and Operations.

The aim is to create peer-to-peer learning networks where clinicians who have more experience treating patients with COVID-19 share their challenges and successes with clinicians across the U.S. and around the world with a wide variety of experience treating COVID-19. Each Clinical Rounds session includes brief presentations from experienced expert clinicians; the presentations have included representatives from Bellevue Hospital in New York City, Emory University, University of Minnesota, University of Washington, and Nebraska Medicine, among others. Representatives from more than 15 relevant national

professional organizations round out the panel of expert discussants. The majority of each session is spent in discussion related to Q&A generated by the participants. As of mid-April more than 7500 people from all 50 states and more than 30 countries have participated in the sessions. Additional information can be found at CLINICAL ROUNDS.

HHS appreciates the feedback GAO has provided and welcomes the opportunity to consider any recommendations it may have that would improve the execution of its mission. That said, HHS does not concur with Recommendations 1 or 2 as currently stated.

3. The Secretary of Health and Human Services and the Administrator of the Federal Emergency Management Agency –who head agencies leading the COVID-19 response through the Unified Coordination Group—should work with relevant federal, state, territorial, and tribal stakeholders, to devise interim solutions, such as systems and guidance and dissemination of best practices, to help states enhance their ability to track status of supply requests and plan for supply needs for the remainder of the COVID-19 pandemic response. **(Recommendation 3)**

As mentioned in HHS's technical comments, GAO cites to interviews with "public health and emergency response officials from eight states" as a basis for a number of conclusions regarding the federal response. GAO has not shared with HHS the names or positions of the officials it interviewed. Without this basic information, these anonymous assertions are impossible to respond to as HHS cannot determine if the officials' confusion is a result of federal communications or internal intrastate government communications. Furthermore, the communication record between the federal government and states has been robust. Since January 2020, there have been 35 all-Governors' calls organized by the Trump Administration to drive COVID-19 collaboration, including 32 with the Vice President. In addition, the White House and Federal agencies have had over 156,000 State, local, and Tribal participants in over 340 COVID-19 briefings since January 2020.

HHS personnel coordinate with a variety of state, territorial, and local officials, but have no control over how those state governors and other officials disseminate this information to state personnel. It is unclear whether the officials GAO interviewed are in a position to understand the larger COVID-19 response, both nationally and within their state. It is also unclear whether the officials are among those that regularly communicate with the federal government or only have indirect knowledge of federal response efforts. Finally, ASPR and FEMA hold regular trainings and distribute communications to state emergency response officials. These individuals should be familiar with FEMA cost share requirements as a basic requirement of their job. Indeed, HHS, in coordination with FEMA, has issued a significant amount of guidance to all state and local officials regarding navigating the pandemic response. A few antidotal complaints from unnamed state officials should not overshadow the significant efforts the federal government has made to ensure that state and local governments are aware of the supply distribution infrastructure.

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT ENTITLED – COVID-19: FEDERAL EFFORTS COULD BE STRENGTHENED BY TMELY AND CONCERTED ACTIONS (GAO-20-701)

HHS requests that GAO provide it with, at a minimum, the title of the state personnel it interviewed and preferably the name of the person interviewed so that HHS can better respond to the allegations and so that, to the extent necessary, HHS can address any problems or confusion the individual reported. HHS, otherwise, does not concur with this recommendation.

4. The Secretary of Health and Human Services and the Secretary of Defense should establish a time frame for documenting and sharing a national plan for distribution and administering COVID-19 vaccine, and in developing such a plan ensure that it is consistent with best practices for project planning and scheduling and outlines its approach for how efforts will be coordinated across federal agencies and nonfederal entities. **(Recommendation 4)**

The warp speed development of a safe and effective vaccination for the novel coronavirus is a remarkable achievement for this country and its scientists. Never before has such a vaccination been targeted for completion in such a short timeframe. Several factors, however, complicate the publication of a firm vaccine distribution timeline and impact the administration and distribution of a vaccine. As the stage 3 clinical trials conclude, any plan may need to evolve based upon the results of these trials. For example, the number of doses that may need to be administered, as well as the vaccine storage requirements, cannot be known until clinical trials are concluded and a vaccine candidate or candidates are identified. Thus, it would be impractical to issue a plan that may need to be modified within days or weeks of release. Moreover, the release of a plan with incomplete or incorrect information may result in costly implementation delays or, even worse, mistakes in the administration of the vaccine. Attached are preparatory materials recently provided to state and local public health officials by the CDC. HHS commits to providing GAO with a copy of the vaccine distribution plan when it is finalized.

Balancing these challenges with the needs to prepare for the eventual distribution and administration of a vaccine, HHS is actively developing the frameworks with federal, state, local, territorial, and tribal partners, Advisory Committee on Immunization Practices (ACIP), and leading academic partners like National Academies of Sciences, Engineering, and Medicine (NASEM) and how the framework could fit into various situations. HHS will soon send a report to Congress outlining a distribution plan that takes these issues into consideration.

HHS believes Operation Warp Speed is on track, if not ahead, in reaching its objective of having tens of millions of doses of safe and effective COVID-19 vaccines approved by the end of 2020. Recent Operation Warp Speed developments related to the manufacture and distribution of COVID-19 vaccines include:

- On August 14, 2020, HHS and the Department of Defense (DoD), in support of Operation Warp Speed, announced that McKesson Corporation will be a central distributor of future COVID-19 vaccines and related supplies needed to administer the

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT ENTITLED – COVID-19: FEDERAL EFFORTS COULD BE STRENGTHENED BY TMELY AND CONCERTED ACTIONS (GAO-20-701)

pandemic vaccinations. The Centers for Disease Control and Prevention (CDC) is executing an existing contract option with McKesson to support vaccine distribution. The company also distributed the H1N1 vaccine during the H1N1 pandemic in 2009-2010. The current contract with McKesson, awarded as part of a competitive bidding process in 2016, includes an option for the distribution of vaccines in the event of a pandemic. Detailed planning is underway to ensure rapid distribution as soon as the FDA authorizes one or more vaccines. Once these decisions are made, McKesson will work under CDC's guidance to ship COVID-19 vaccines to administration sites.

- On August 11, 2020, HHS and DoD, in support of Operation Warp Speed, announced an agreement with Moderna, Inc. to manufacture and deliver 100 million doses of the company's COVID-19 vaccine candidate. The federal government will own these vaccine doses. Moderna will manufacture the vaccine doses while clinical trials are underway. Manufacturing in parallel with clinical trials expedites the traditional vaccine development timeline and builds toward the U.S. government's Operation Warp Speed goal to begin delivering safe and effective vaccines to the American people by the end of the year. If the U.S. Food and Drug Administration (FDA) authorizes use as outlined in agency guidance, the vaccine doses would be distributed and used as part of a COVID-19 vaccination campaign. The vaccine, called mRNA-1273, has been co-developed by Moderna and scientists from the National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health. NIAID has continued to support the vaccine's development including nonclinical studies and clinical trials. In addition, BARDA has supported phase 2/3 clinical trials, vaccine manufacturing scale up and other development activities for this vaccine. The Phase 3 clinical trial, which began July 27, is the first government-funded Phase 3 clinical trial for a COVID-19 vaccine in the United States.

- On August 5, 2020, HHS and DoD announced an agreement with the Janssen Pharmaceutical Companies of Johnson & Johnson, to demonstrate large-scale manufacturing and delivery of the company's COVID-19 vaccine candidate. Under the terms of the agreement, the federal government will own the resulting 100 million doses of vaccine. The vaccine doses could be used in clinical trials or, if the U.S. Food and Drug Administration (FDA) authorizes use as outlined in agency guidance, the doses would be distributed as part of a COVID-19 vaccination campaign. This manufacturing demonstration project will take place while clinical trials are underway. Working in parallel this way expedites the traditional vaccine development timeline. This step builds toward the U.S. government's Operation Warp Speed goal to begin delivering millions of doses of safe and effective vaccines to the American people by the end of the year.

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT ENTITLED – COVID-19: FEDERAL EFFORTS COULD BE STRENGTHENED BY TMELY AND CONCERTED ACTIONS (GAO-20-701)

The Biomedical Advanced Research and Development Authority (BARDA), part of the HHS Office of the Assistant Secretary for Preparedness and Response, collaborated with the DoD Joint Program Executive Office for Chemical, Biological, Radiological and Nuclear Defense and Army Contracting Command, to provide approximately $1 billion to support the manufacturing demonstration project including the ability to deliver vaccine doses to government-designated locations across the country. The government also can acquire additional doses up to a quantity sufficient to vaccinate 300 million people.

The agreements with Moderna and Janssen include fill-finish manufacturing in U.S.-based facilities. This fill-finish manufacturing step ensures vaccine doses are packaged and ready to ship immediately, subject to successful clinical trials and FDA authorization. If these doses are used in a COVID-19 vaccination campaign, the vaccine would be available to the American people at no cost. As is customary with government-purchased vaccines, healthcare professionals could charge for the cost of administering the vaccine.

5. The Director of the Centers for Disease Control and Prevention should determine whether having authority to require states and jurisdictions to report race and ethnicity information for the COVIS-19 cases, hospitalizations, and deaths is necessary for ensuring more complete data, and if so, seek such authority from Congress. **(Recommendation 5)**

6. The Director of the Centers for Disease Control and Prevention should involve key stakeholders to ensure the complete and consistent collection of demographic data. **(Recommendation 6)**

CDC

CDC concurs with these recommendations. CDC appreciates GAO's findings and recommendations.

The Administration, HHS, and CDC share GAO's concern regarding the disproportionate outcomes of COVID-19 on the African American community and other minorities. We recognize that addressing the needs of disproportionately impacted communities is a priority. Consistent with these recommendations, CDC commits to having discussions, both internally and with external stakeholders, to assess whether it should seek authority from Congress to require states and jurisdictions to report race and ethnicity information for the COVID-19 cases.

Beyond mandating the reporting of race and ethnicity data, CDC has taken a number of actions to improve data collection and address the needs of minority communities that are disproportionately impacted by COVID-19. CDC recently released an 'all of response' Health Equity Strategy (www.cdc.gov/coronavirus/2019-ncov/downloads/

community/CDC-Strategy.pdf) that provides an evidence-based, comprehensive and coordinated framework for reducing COVID-19 disparities. The Strategy includes building on plans for collecting and reporting timely, complete, representative, and relevant data on testing, incidence, vaccination, and severe outcomes among populations at highest risk.

CDC has been working closely with states, counties, cities, territories, tribes, and other partners to improve data collection and reporting and continues to make progress to ensure key data are available to identify those most affected by this pandemic. COVID-19 is a nationally notifiable condition, with state, local, and territorial health departments **voluntarily** sending case reports to CDC through the National Notifiable Diseases Surveillance System to help monitor and mitigate the adverse effects of this pandemic. Case report forms are completed by hospitals, healthcare providers, and laboratories and **while they are required by state law for nationally notifiable diseases, completion of demographic data, including race and ethnicity, is voluntary**. Currently, the total proportion of case reports with complete race and ethnicity data is 48 percent, compared to 14 percent on April 2, 2020.

On June 4, 2020, in an effort to improve data collection, HHS announced new guidance that specifies additional data that must be reported to HHS by laboratories submitting COVID-19 test results, including demographic data, such as race, ethnicity, and sex. The guidance, *COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115* (www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf), which took effect August 1, 2020, standardizes reporting to give public health officials access to comprehensive and nearly real-time data to inform decision making and public health action in their response to COVID-19.

In addition to case-based reporting, CDC uses two other primary sources of data to report on race and ethnicity information. The Coronavirus Disease 2019 (COVID-19)-Associated Hospitalization Surveillance Network (COVID-NET) collects data on COVID-19-associated hospitalizations; completeness of race and ethnicity data in COVID-NET is 93.6 percent as of August 1, 2020. The National Vital Statistics System reports death certificate data from state vital statistics offices, which is collected by the National Center for Health Statistics for all deaths occurring in the U.S. Current estimates indicate that at least 75 percent of certificates are complete within eight weeks of when the death occurred.

Data on race and ethnicity and COVID-19 is shared with the public through several online tools and reports on the CDC website. For example, the CDC COVID Data Tracker includes demographic trends of COVID-19 cases and deaths by race/ethnicity (www.cdc.gov/ covid-data-tracker/index.html#demographics). In addition, CDC has published several high profile MMWRs reporting on the impact of COVID-19 among racial and ethnic populations.

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT ENTITLED – COVID-19: FEDERAL EFFORTS COULD BE STRENGTHENED BY TMELY AND CONCERTED ACTIONS (GAO-20-701)

The most recent COVID-19 supplemental package signed by President Trump, the *Paycheck Protection Program and Health Care Enhancement Act, Public Law 116-139* (www.congress.gov/bill/116th-congress/house-bill/266/text), is also helping us advance our efforts to close the racial/ethnic disparity gap. Secretary Azar is working with other departments and agencies to report data on COVID-19 testing, positive diagnoses, hospitalizations, and deaths disaggregated by race, ethnicity, age, sex, geographic region, and other relevant factors. These *Reports to Congress on Paycheck Protection Program and Health Care Enhancement Act Disaggregated Data on U.S. Coronavirus Disease 2019 (COVID-19) Testing* (the Reports) were shared on June 14, 2020, July 15, 2020, and August 14, 2020. Updated reports will be provided to Congress every 30 days until the end of this public health emergency.

In addition, CDC is supporting local activities in African American, Hispanic/Latino, American Indian and Alaska Native, and Asian American, Pacific Islander, and Native Hawaiian communities to deliver COVID-19 prevention messages and community mitigation strategies. This includes engaging Historically Black Colleges and Universities and minority-serving organizations who will collaborate with trusted community organizations and leaders on testing for COVID-19, facilitating contact tracing, promoting face coverings and social distancing, and identifying mental health issues associated with COVID-19.

CDC's COVID-19 Tribal Support Section is the technical assistance arm of CDC's response, focused on American Indian and Alaska Native communities. The unit provides tailored field-based and remote assistance to tribal communities in infection control and prevention, contact tracing, health and risk communications, and more. Further, CDC has conducted Listening Sessions with Latinx leaders from the faith-based community; organizations whose mission is centered on serving Hispanic/Latinx; and national and local organizations that address the needs of farmworkers. We are also collaborating with HHS' Office of Minority Health and Office of Minority Health and Health Equity (OMHHE) to implement a grant program supporting – in part – contact tracing efforts in Hispanic communities. These broad-based community engagements and collaborations aim to ensure equitable access to testing, health care, and future COVID-19 vaccines.

CDC recently hosted webinars on June 2, 2020, (*COVID-19 Response: Promising Practices in Health Equity* https://youtu.be/2jGvVbfaLiQ) and July 29, 2020, (*Promising Practices in Health Equity* www.youtube.com/watch?v=e2XXXyb7C28) where presenters discussed actions to mitigate the disproportionate impact on racial and ethnic minorities and what steps can be integrated into longer-term strategies to strengthen future responses and advance health equity. CDC is working with existing program grantees to enhance outreach to populations at increased risk of complications from COVID-19 and is also engaging with community and faith-based organizations to develop educational public service announcements.

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT ENTITLED – COVID-19: FEDERAL EFFORTS COULD BE STRENGTHENED BY TMELY AND CONCERTED ACTIONS (GAO-20-701)

Finally, HHS has an ongoing dialogue with FEMA about the COVID-19 response and regularly shares best practices, such as optimizing ventilator use (www.hhs.gov/coronavirus/optimizing-ventilator-use/index.html). The HHS Office for Civil Rights and OMHHE are partnering with FEMA to address health disparities for the COVID-19 response.

7. The Director of the Centers for Disease Control and Prevention should take steps to help ensure its ability to comprehensively assess the long-term health outcomes of persons with COVID-19, including by race and ethnicity. **(Recommendation 7)**

CDC

CDC concurs with GAO's recommendation.

Monitoring long-term health outcomes of persons with COVID-19, including by race and ethnicity, is key to ensuring people remain healthy. For some people who recover from COVID-19, symptoms like fatigue, shortness of breath, muscle pain, confusion, headaches have been reported in external reporting systems and special studies. The Centers for Disease Control and Prevention's plan to monitor long-term health outcomes of persons with COVID-19 will include identifying health care surveillance systems that can electronically report health conditions (i.e. heart disease, pulmonary conditions, brain and neurological issues, etc.) to state and local health departments. A strike team is being convened to develop a plan on how best to collect this data.

8. The Director of the Centers for Disease Control and Prevention should ensure that federal guidance related to reassessing schools' operating status is cogent, clear, and internally consistent. **(Recommendation 11)**

CDC Response

CDC concurs with GAO's recommendation.

CDC continues to update our guidance, resources, and tools as more data, information, and evidence become available. Based on our current understanding of COVID-19, CDC is updating the *K – 12 Schools Readiness and Planning Tool*, see enclosure for this and other referenced websites. Updates to this tool will align with guidance in our *Screening K-12 Students for Symptoms of COVID-19 Limitations and Considerations*. In many instances the inconsistencies referenced by GAO are the result of guidance, resources, and tools undergoing periodic reviews and updates to those materials occurring at different times. Updating these documents is an iterative and ongoing process. Accordingly, there can be periods of time where some documents are updated and posted publicly while other related materials are still in the process of being updated to reflect current understanding of COVID-19.

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On July 23, 2020, CDC released *Screening K-12 Students for Symptoms of COVID-19 Limitations and Considerations* to provide guidance to K-12 schools on symptom screening as part of a school reopening process. Consistent with CDC's March 6, 2020 guidance, and based on the best evidence available to date, CDC does not currently recommend that schools conduct universal symptom screenings. However, given the wide range of symptoms reported by people infected with COVID-19 and because some people with SARS-CoV-2 infection are asymptomatic, CDC recommends that K-12 schools strongly encourage parents or caregivers to monitor their children for signs of infectious illness every day and that students who are sick should not attend school in-person.

CDC has removed the decision tool, *Schools during the COVID-19 Pandemic*, from the public domain and is also in the process of revising all FAQs to be consistent with our current understanding of COVID-19 and the considerations for school administrators that CDC released on August, 24, 2020. CDC strives to ensure that all content is consistent and up to date. As new content, resources, and tools are approved and posted, CDC works to update all other webpages.

Enclosures: Documentation for Recommendation 11:

1. Updated K – 12 Schools Readiness and Planning Tool
2. Screening K-12 Students for Symptoms of COVID-19 Limitations and Considerations
3. Operating Schools during COVID-19: CDC's Considerations

9. The Secretary of Health and Human Services, in consultation with CMS and CDC, should develop a strategy to capture more complete data on confirmed COVID-19 cases and deaths in nursing homes retroactively back to January 1, 2020, and to clarify the extent to which nursing homes have reported data before data before May 8, 2020. To the extent feasible, this strategy to capture more complete data should incorporate information nursing homes previously reported to CDC or to state or local public health offices. **(Recommendation 14)**

HHS partially concurs with GAO's recommendation.

GAO recommends that HHS develop a strategy to capture more complete data on COVID-19 cases and deaths in nursing homes retroactive to January 1, 2020. HHS agrees that capturing more complete data on confirmed COVID-19 cases and deaths in nursing homes would be useful to determine how many total nursing homes were affected by COVID-19, the extent of morbidity and mortality, and whether incidence of COVID-19 in nursing homes has changed since the early months of the pandemic. Critically, given

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that federal government guidance applied nationally, more complete data would be useful when examining which state-level orders policies and practices were correlated with increased morbidity and mortality among nursing home residents.

However, retroactively collecting this data may be overly burdensome on healthcare providers, particularly as they continue to respond to the COVID-19 pandemic. Any strategy to capture more complete data on confirmed COVID-19 cases and deaths in nursing homes before May 8, 2020 must take into account this reporting burden. In balancing these priorities, HHS concurs that capturing more complete data on confirmed COVID-19 cases and deaths in nursing homes retroactively back to January 1, 2020 would be useful, but does not believe immediately devoting substantial agency or healthcare provider resources to retroactive data collection would be prudent while the pandemic response is on-going. Accordingly, HHS partially concurs on this recommendation.

Capturing more complete data on nursing home deaths is particularly important in states, like New York, New Jersey, Pennsylvania, and Michigan, where a high percentage of nursing home residents contracted or died of COVID-19 in the first months of the pandemic. For example, the State of New York's early directive to send thousands of COVID-19 patients into nursing homes appears to have had a direct impact on the number of deaths occurring in those facilities. Additional data on those deaths would help HHS fashion additional strategies and warnings for States contemplating similar directives. As the State with the highest number of COVID-19 deaths in the United States, New York had 32,592 victims, of which over 6,500 were nursing home residents. The actual number of COVID-19 deaths among nursing home residents is likely much higher. Overall, New York's death rate by population is the second highest in the country with 1,680 deaths per million people. Moreover, New Jersey's death rate by population is 1,733 deaths per million people – the highest in the nation. Based on current, but admittedly incomplete data, New Jersey has the second highest number of average deaths per 1,000 nursing home residents at 121.1.

In contrast, Texas's death rate by population is 380 deaths per million people; and Texas has just over 11,000 deaths, though its population is 50 percent larger than New York and has many more recorded cases of COVID-19 – 577,537 cases in Texas versus 430,885 cases in New York. Florida's COVID-19 death rate is 480 deaths per million; with total deaths of 10,325 and a population slightly larger than New York. Collecting more complete data at the federal level is important to understanding what went wrong in states with high per capita death rates among nursing home residents.

More complete federal data is also important given variations in state reporting of COVID-19 cases and deaths at nursing homes and allegations of under-reporting in hard hit states. For example, New York reported 195 nursing home resident deaths from early

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June to mid-July, well after the pandemic's peak in New York. Data for the same time period reported to CDC counts 323 deaths, 65% higher than the New York reported total. The disparity between state and federal nursing home death reporting may be even greater prior to implementation of COVID-19 reporting requirements on May 8, 2020.

10. Based on imminent cybersecurity threats, The Secretary of Health and Human Services should expedite implementation of our prior recommendations regarding cybersecurity weaknesses at its component agencies. **(Recommendation 15)**

OCIO

HHS concurs with the recommendation to review, prioritize and act on GAO's cybersecurity recommendations.

Appendix VIII: Comments from Department of Homeland Security

U.S. Department of Homeland Security
Washington, DC 20528

Homeland Security

September 8, 2020

Gene L. Dodaro
Comptroller General of the United States
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Re: Management Response to Draft Report GAO-20-701, "COVID-19: Federal Efforts Could be Strengthened by Timely and Concerted Actions"

Dear Mr. Dodaro:

Thank you for the opportunity to review and comment on this draft report. The U.S. Department of Homeland Security (DHS or the Department) appreciates the U.S. Government Accountability Office's (GAO) work in planning and conducting its review and issuing this report. We write, however, to correct the record on key issues that GAO fails to take into account.

The Coronavirus Disease 2019 (COVID-19) pandemic has required the Federal Emergency Management Agency's (FEMA or the Agency) to manage and acquire critical supplies, prioritize resources, and coordinate a deeply collaborative interagency response requiring a Whole-of-America effort. Throughout the COVID-19 response, FEMA has held true to its principle that emergency response works best when it is locally executed, state managed, and federally supported. Since March 13, 2020, over 5,000 individual FEMA responders have deployed more than 7,680 times to 168 COVID-19 related events (i.e., activations, emergencies, disasters). In addition, FEMA has provided more than $24 billion in obligations to its state, local, territorial, and tribal partners (SLTT) for COVID-19 related activities. The first $1 billion of that total was obligated in just 11 days.

The Department appreciates GAO and Congress's ongoing interest in helping the federal government respond to the unprecedented challenges caused by the pandemic. However, GAO's recommendations concerning (1) supply chain management, and (2) coordination with relevant federal, state, territorial, and tribal stakeholders on supply planning and

delivery do not fully account for the pioneering work that FEMA has already done in these areas, nor consider optimal operational frameworks.

(1) GAO recommends that FEMA create a "comprehensive supply management plan." In fact, FEMA has engaged in the most comprehensive supply management effort our nation has undertaken since World War II and has developed the most sophisticated and comprehensive database for supply chain logistics in our nation's history. Through these efforts, FEMA has been highly successful in identifying gaps in supply needs across the nation, and taking swift action to ensure those needs are met. Supply needs that were met through FEMA's efforts include personal protective equipment (PPE), testing supplies and swabs, and medical equipment such as ventilators, among others.

Shortly after the pandemic began to impact the United States, FEMA, under the Unified Coordination Group, and in conjunction with its federal partners, rapidly assembled task forces to address some of the most pressing challenges created by the pandemic, including addressing medical supply gaps. The Supply Chain Task Force (SCTF) was formed to orchestrate a comprehensive four-pronged strategy to preserve medical supplies, accelerate industrial manufacturing and distribution, expand industry, and allocate resources to the right place at the right time. The SCTF's effort has been remarkably successful, yet GAO's draft report and recommendations prioritize anonymous anecdotes about minor and temporary coordination issues over a fair assessment of the SCTF's historic achievements in increasing supply availability and executing the logistics required to fill identified supply chain gaps.

To be clear, to the extent that the GAO's recommendation for the establishment of a "comprehensive supply management plan" is meant to suggest that FEMA or the federal government should federalize all supply procurement and distribution, that suggestion is misguided and unsupported by the draft report. States, localities, and private hospital system have always been understood to have primary responsibility for meeting supply needs, and the federal government has always been understood to play a supporting, supplementation role. The Strategic National Stockpile (SNS), for example, was not designed to provide emergency supplies for every locality in the United States, and was never intended to be relied upon as the single solution for pandemic response.[1] The unprecedented challenges caused by the COVID-19 pandemic led the SCTF and its partners to execute an unprecedentedly comprehensive effort to obtain and understand nationwide supply chain data, to enhance the production and procurement of said supplies, and to execute supply chain logistics to distribute supplies to fill identified gaps. This

[1] The Department of Health and Human Services (HHS), with support from FEMA and the Department of Defense (DoD), is committed to a vision in which the next generation of the SNS will be capable of backstopping gaps in the healthcare and medical supply chain for approximately 90 days.

Administration is proud of the work it has done to identify and fill gaps in State and local response, and to support the response efforts that have been managed and executed at the State and local level.

The coordination for PPE and resource requests for this pandemic has been overwhelmingly successful. As of August 31, 2020, FEMA, HHS, and the private sector coordinated delivery of, or are currently shipping: 230 million N95 masks, 1 billion surgical and procedural masks, 42.2 million eye and face shields, 403 million gowns and coveralls and over 25.4 billion gloves. These efforts are a testament to the successful collaborative efforts between FEMA, it's interagency partners, and the Agency's SLTT partners. These supply chain results achieved by FEMA, the SCTF, and their partners through execution of this operational model repudiate any suggestion that a wholesale change to the model would be warranted. As the Supply Chain Stabilization Task Force leader noted in his interview with GAO on August 12, 2020, most states now have 60 or more days' worth of medical supplies available in their warehouses. Thus, even if a state has outstanding requests for supplies, it does not necessarily mean that supply shortages are the constraining factor. GAO should support any specific recommendations that it may have for changes—as opposed to the vague and undefined talking points delivered in the draft report—with comprehensive data, not isolated anecdotes.

Testing supplies provide another good example. FEMA has worked to bolster the U.S. medical infrastructure and support the Administration's April 2020, "Testing Blueprint: Opening Up America Again." The Administration comprehensively required all states to provide draft testing plans, which it comprehensively evaluated and provided responsive recommendations. In support of that comprehensive set of plans, FEMA procured and delivered more than 41 million swabs and 32 million units of transport media during a time in which the demand for these supplies expanded by nearly 60-fold. The vast majority of recipients of these supplies have reported no quality issues. This expansion and distribution of available testing supplies is an unprecedented accomplishment, achieved through a comprehensive and unrelenting effort. But to the extent that GAO means to suggest by its call for a "comprehensive" effort that the federal government should mandate a one-size-fits-all solution that would be equally applicable to New York City and North Dakota, that is neither supported by lessons from historic response efforts, nor by actual data concerning this response.

With these facts in mind, the Department cannot concur with GAO's recommendation for the establishment of a "comprehensive supply management plan." The recommendation does not include specific action points to be taken that detail a "comprehensive" plan which supplement the already existing

guidance and information shared numerous times with GAO's audit team throughout this engagement.

(2) One recommendation in the draft report suggests FEMA should work with relevant federal, state, territorial, and tribal stakeholders to help states track the status of supply requests. FEMA already robustly coordinates with its SLTT partners, and this recommendation once again appears to prioritize anonymous anecdotes over verifiable data and history.

(3) To be clear, FEMA Regional Administrators coordinate closely with Governors, State Emergency Managers, and State Public Health officials to receive, process, and deliver upon resource requests, as in other Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) disasters. This coordination is nothing new for FEMA's SLTT partners, who recurrently interact with FEMA on disaster response. The Agency recognized early on that due to the unprecedented scope of the pandemic, some of its SLTT partners were experiencing challenges navigating funding issues and understanding eligibility for assistance in the context of a pandemic. The draft report characterizes several interviews as "officials from the majority of FEMA regional offices we interviewed also described states' confusion about reimbursement, cost share responsibility, and concerns about potential duplication of benefits." Without knowing more about the particular instances of a state's alleged confusion, and what level of experience or knowledge the interviewed state officials possessed regarding reimbursement and federal cost share generally, the misunderstanding does not represent FEMA's failure to disseminate the appropriate information regarding these emergency issues out to SLTT partners. All of FEMA's SLTT partners should be familiar with the division of costs outlined in the Stafford Act, and the fact that the authority to adjust the federal cost share resides with the President. FEMA also put out a substantial amount of supplemental public guidance to assist with navigating this particular pandemic response, directly responsive to the states' confusion highlighted above, which GAO seemingly ignores:

- March 19, 2020, Fact Sheet, "Eligible Emergency Protective Measures;"
- July 1. 2020, Fact Sheet, "Coordinating Public Assistance and Other Sources of Federal Funding;"
- A FEMA.gov webpage, "Bringing Resources to State, Local, Tribal & Territorial Governments" – designed to specifically to assist SLTT governments during COVID-19.

Additionally, the Stafford Act prohibits FEMA from duplicating financial assistance, a fact that FEMA's traditional SLTT partners should be aware of as well. As demonstrated by the aforementioned publicly-facing fact sheets, the Agency actively works to share information and alleviate confusion across SLTT

partners and FEMA Regional staff, who are responsible for assisting partners with understanding eligible types of work under the Public Assistance program. GAO's anecdotal and anonymous sources simply do not provide actionable information indicating that any misunderstandings that may have occurred were firmly attributable to FEMA.

Several interviews GAO highlights emphasize confusion about the coordination of the shipment of PPE, particularly, when and where it would be arriving to a state. With the lack of specific instances and details, it is impossible for FEMA to comment on any alleged issues with deliveries or shipments of PPE. The Agency continues to emphasize with emergency response being locally executed, state-managed, and federally supported, and efforts to track coordination efforts of local points of delivery require coordination not only from FEMA, but SLTT partners. As information, requests for assistance at the state, local, and county level historically are, and should be, first routed to the state or territory. Any needs which cannot be met by the state or territory may then be directed to FEMA regional offices. If the requests cannot be filled by FEMA regionally, they are directed to FEMA's National Response Coordination Center (NRCC) in Washington, D.C. for tracking and action. Following this set of well-established processes ensures that all priority requests are coordinated with the State's response, and resources are appropriately tracked and prioritized. If inquiries about deliveries or tracking were received, FEMA frequently guided state officials to check FEMA's Crisis Management System Web Emergency Operations Center (WebEOC) and other official systems for relevant updates.

The draft report contained 15 recommendations to federal agencies, including five with DHS equities, one with which the Department concurs (Recommendation 13) and four with which it non-concurs (Recommendation 1, 2, 3 and 12). Attached find our response to each recommendation. DHS also provided technical comments under a separate cover for GAO's consideration.

Again, thank you for the opportunity to review and comment on this draft report. Please feel free to contact me if you have any questions. We look forward to working with you again in the future.

Sincerely,

JIM H CRUMPACKER

Digitally signed by JIM H CRUMPACKER
Date: 2020.09.08 16:10:30 -04'00'

JIM H. CRUMPACKER, CIA, CFE
Director
Departmental GAO-OIG Liaison Office

Attachment

Attachment: Management Response to Recommendations Contained in GAO 20-701

Recommendation 1: The Secretary of Health and Human Services in coordination with the Administrator of the Federal Emergency Management Agency—who head agencies leading the COVID-19 response through the Unified Coordination Group—should immediately document roles and responsibilities for supply chain management functions transitioning to the Department of Health and Human Services, including continued support from other federal partners, to ensure sufficient resources exist to sustain and make the necessary progress in stabilizing the supply chain, and address emergent supply issues for the duration of the COVID-19 pandemic.

Response: Non-concur. In fact, FEMA and its interagency partners continue to collaborate on plans regarding supply chain management and stabilization, as they have done since the beginning of the COVID-19 pandemic. DHS, FEMA, and HHS have articulated COVID-19-related response logistics and supply roles and responsibilities among the agencies, both in terms of working groups and Lines of Effort. In addition, FEMA's NRCC remains at the highest activation, Level 1, with FEMA and HHS operating as fully integrated federal partners, as the response to the pandemic continues.

We request that GAO consider this recommendation resolved and closed as implemented.

Recommendation 2: The Secretary of Health and Human Services in coordination with the Administrator of the Federal Emergency Management Agency—who head agencies leading the COVID-19 response through the Unified Coordination Group—should develop and communicate a comprehensive supply management plan for identifying and addressing ongoing medical supply gaps, including testing supplies, resulting from COVID-19. The plan should incorporate work with stakeholders, such as state, local, tribal, and territorial governments, and detail actions for increasing domestic production of critical medical supplies, such as the use of Defense Production Act authorities, and the conditions under which federal agencies would consider additional support.

Response: Non-concur. This recommendation lacks the consideration of facts shared with GAO's audit team during its fieldwork regarding the current operational framework FEMA is working under, and future planning occurring between the agency and in conjunction with its interagency partners. Without a more articulable recommendation on what a comprehensive plan would look like beyond what was already provided to GAO, and several points outlined in the Management response letter, the Department cannot concur with the recommendation.

We request that GAO consider this recommendation resolved and closed as implemented.

Recommendation 3: The Secretary of Health and Human Services and the Administrator of the Federal Emergency Management Agency—who head agencies leading the COVID-19 response through the Unified Coordination Group—consistent with their roles and responsibilities, should work with relevant federal, state, territorial, and tribal stakeholders, to devise interim solutions, such as systems and guidance and dissemination of best practices, to help states enhance their ability to track status of supply requests and plan for supply needs for the remainder of the COVID-19 pandemic response.

Response: Non-concur. Regional Administrators continue to coordinate closely with Governors, State Emergency Managers and State Public Health officials to receive, process, and deliver upon resource requests, as in other Stafford Act disasters. As outlined in the Department's technical comments previously provided to GAO's audit team and this management response letter, supplies were initially delivered to state-specified points, and from that point, is further distributed by states. Information regarding supplies which is not distilled down to the relevant individuals at the state and local level is due to the states not providing sufficient information, not the Agency.

We request that GAO consider this recommendation resolved and closed as implemented.

Recommendation 12: The Secretaries of Homeland Security and Defense should (1) revise the criteria in the 2019 National Interest Action [NIA] Code Memorandum of Agreement [MOA] to clearly identify steps they will take to obtain input from key federal agencies prior to extending or closing the National Interest Action code, (2) establish timelines for evaluating the need to extend a National Interest Action code, and (3) define what constitutes a consistent decrease in contract actions and routine contract activity to ensure the criteria for extending or closing the National Interest Action code reflects government-wide needs for tracking contract actions in longer term emergencies, such as a pandemic.

Response: Non-concur. Without the agreement of the other signatory agencies, DHS cannot concur with revising the criteria in the 2019 National Interest Action (NIA) code MOA to identify steps that will be taken to obtain input from key federal agencies prior to extending or closing the NIA code. DoD and DHS have worked with the General Services Administration (GSA) to ensure agencies are notified prior to the extension or end dating of an NIA code. Moreover, DHS, on its own, cannot agree to establish timelines for evaluating the need to extend the NIA code, or establish criteria for opening and closing the NIA code.

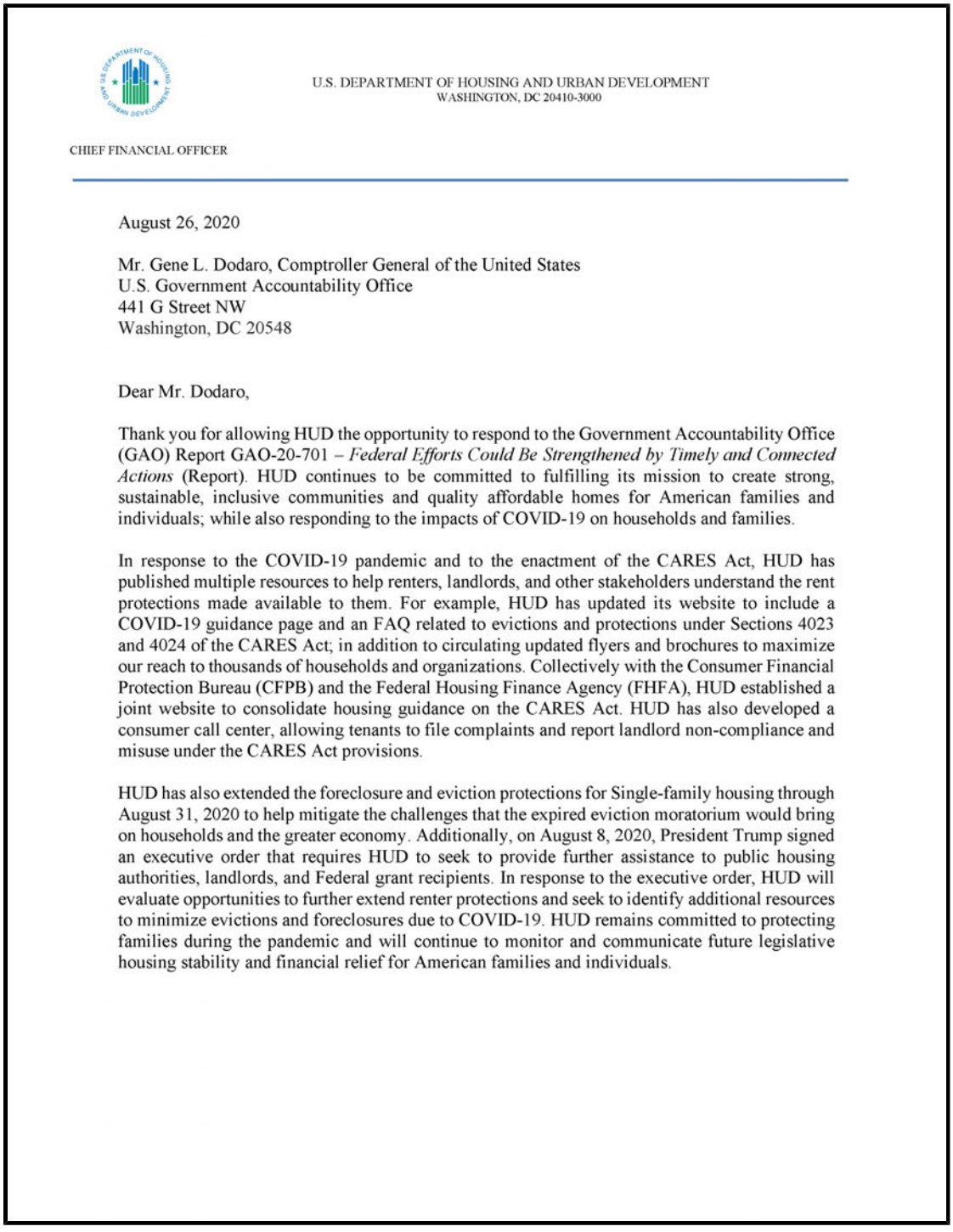
However, DHS's Office of the Chief Procurement Officer (OCPO), in considering the recommendation's intent, will confer with DoD and GSA to consider revisions to the MOA. During the next annual MOA review, DHS will discuss revisions with DoD and GSA, that would clarify: (1) the process and timelines for establishing, extending or

closing the NIA code and communication with appropriate CFO ACT agencies; and (2) the various criteria considered when closing an NIA code. Despite these considerations, the OCPO maintains that NIA codes are not meant to track 'long term' actions. By statute and Office of Management and Budget policy, other systems have been designated to perform this purpose. The appropriate mechanism for tracking expenditure funds used to respond to and recover from national emergencies and disasters is USASpending.gov. Estimated Completion Date: March 31, 2021.

Recommendation 13: The Secretaries of Homeland Security and Defense should extend the COVID-19 National Interest Action code beyond September 30, 2020.

Response: Concur. DoD and DHS had already been reviewing whether to extend the code, in accordance with the MOA, and previously informed GAO that it will be extended. DoD and DHS discussed the extension at a Governmentwide meeting on August 28, 2020, during which DHS asked GSA to extend the NIA code. We request that GAO consider this recommendation resolved and closed as implemented.

Appendix IX: Comments from Department of Housing and Urban Development



U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, DC 20410-3000

CHIEF FINANCIAL OFFICER

August 26, 2020

Mr. Gene L. Dodaro, Comptroller General of the United States
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dodaro,

Thank you for allowing HUD the opportunity to respond to the Government Accountability Office (GAO) Report GAO-20-701 – *Federal Efforts Could Be Strengthened by Timely and Connected Actions* (Report). HUD continues to be committed to fulfilling its mission to create strong, sustainable, inclusive communities and quality affordable homes for American families and individuals; while also responding to the impacts of COVID-19 on households and families.

In response to the COVID-19 pandemic and to the enactment of the CARES Act, HUD has published multiple resources to help renters, landlords, and other stakeholders understand the rent protections made available to them. For example, HUD has updated its website to include a COVID-19 guidance page and an FAQ related to evictions and protections under Sections 4023 and 4024 of the CARES Act; in addition to circulating updated flyers and brochures to maximize our reach to thousands of households and organizations. Collectively with the Consumer Financial Protection Bureau (CFPB) and the Federal Housing Finance Agency (FHFA), HUD established a joint website to consolidate housing guidance on the CARES Act. HUD has also developed a consumer call center, allowing tenants to file complaints and report landlord non-compliance and misuse under the CARES Act provisions.

HUD has also extended the foreclosure and eviction protections for Single-family housing through August 31, 2020 to help mitigate the challenges that the expired eviction moratorium would bring on households and the greater economy. Additionally, on August 8, 2020, President Trump signed an executive order that requires HUD to seek to provide further assistance to public housing authorities, landlords, and Federal grant recipients. In response to the executive order, HUD will evaluate opportunities to further extend renter protections and seek to identify additional resources to minimize evictions and foreclosures due to COVID-19. HUD remains committed to protecting families during the pandemic and will continue to monitor and communicate future legislative housing stability and financial relief for American families and individuals.

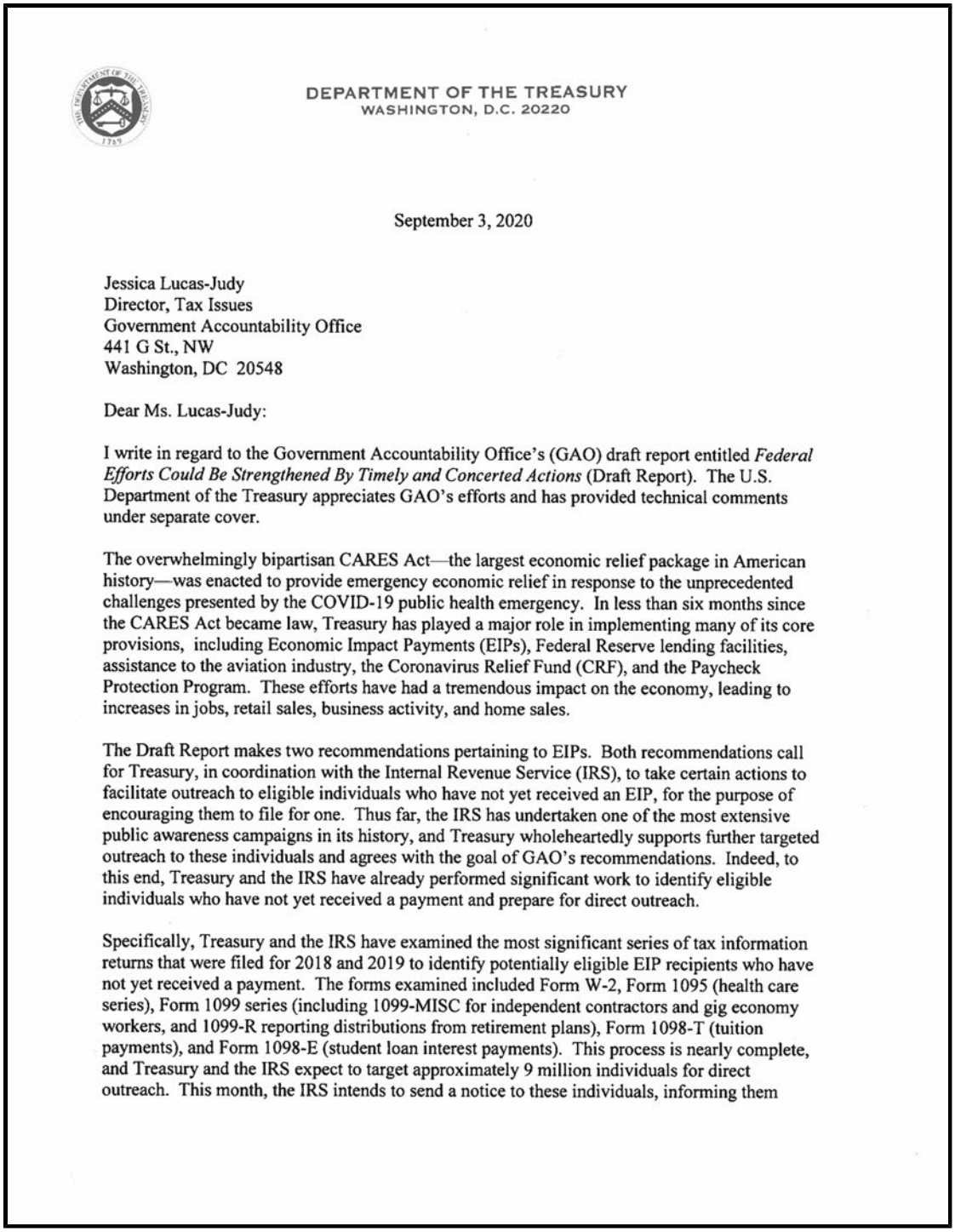
Again, thank you for the opportunity to review the Report.

Sincerely,

Irving L. Dennis
Chief Financial Officer

cc:
Brian D. Montgomery, Deputy Secretary
Andrew Hughes, Chief of Staff
Dana Wade, FHA Commissioner, Assistant Secretary for Housing
Seth Appleton, Principal Executive Vice President for Ginnie Mae
Hunter Kurtz, Assistant Secretary for Public and Indian Housing
John Gibbs, Acting Assistant Secretary for Community Planning and Development
Anna Maria Farías, Assistant Secretary for Fair Housing and Equal Opportunity
Michael B. Williams, Acting General Counsel
George Tomchick, Deputy Chief Financial Officer
MelaJo Kubacki, Assistant Chief Financial Officer for Financial Management

Appendix X: Comments from Department of the Treasury



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

September 3, 2020

Jessica Lucas-Judy
Director, Tax Issues
Government Accountability Office
441 G St., NW
Washington, DC 20548

Dear Ms. Lucas-Judy:

I write in regard to the Government Accountability Office's (GAO) draft report entitled *Federal Efforts Could Be Strengthened By Timely and Concerted Actions* (Draft Report). The U.S. Department of the Treasury appreciates GAO's efforts and has provided technical comments under separate cover.

The overwhelmingly bipartisan CARES Act—the largest economic relief package in American history—was enacted to provide emergency economic relief in response to the unprecedented challenges presented by the COVID-19 public health emergency. In less than six months since the CARES Act became law, Treasury has played a major role in implementing many of its core provisions, including Economic Impact Payments (EIPs), Federal Reserve lending facilities, assistance to the aviation industry, the Coronavirus Relief Fund (CRF), and the Paycheck Protection Program. These efforts have had a tremendous impact on the economy, leading to increases in jobs, retail sales, business activity, and home sales.

The Draft Report makes two recommendations pertaining to EIPs. Both recommendations call for Treasury, in coordination with the Internal Revenue Service (IRS), to take certain actions to facilitate outreach to eligible individuals who have not yet received an EIP, for the purpose of encouraging them to file for one. Thus far, the IRS has undertaken one of the most extensive public awareness campaigns in its history, and Treasury wholeheartedly supports further targeted outreach to these individuals and agrees with the goal of GAO's recommendations. Indeed, to this end, Treasury and the IRS have already performed significant work to identify eligible individuals who have not yet received a payment and prepare for direct outreach.

Specifically, Treasury and the IRS have examined the most significant series of tax information returns that were filed for 2018 and 2019 to identify potentially eligible EIP recipients who have not yet received a payment. The forms examined included Form W-2, Form 1095 (health care series), Form 1099 series (including 1099-MISC for independent contractors and gig economy workers, and 1099-R reporting distributions from retirement plans), Form 1098-T (tuition payments), and Form 1098-E (student loan interest payments). This process is nearly complete, and Treasury and the IRS expect to target approximately 9 million individuals for direct outreach. This month, the IRS intends to send a notice to these individuals, informing them

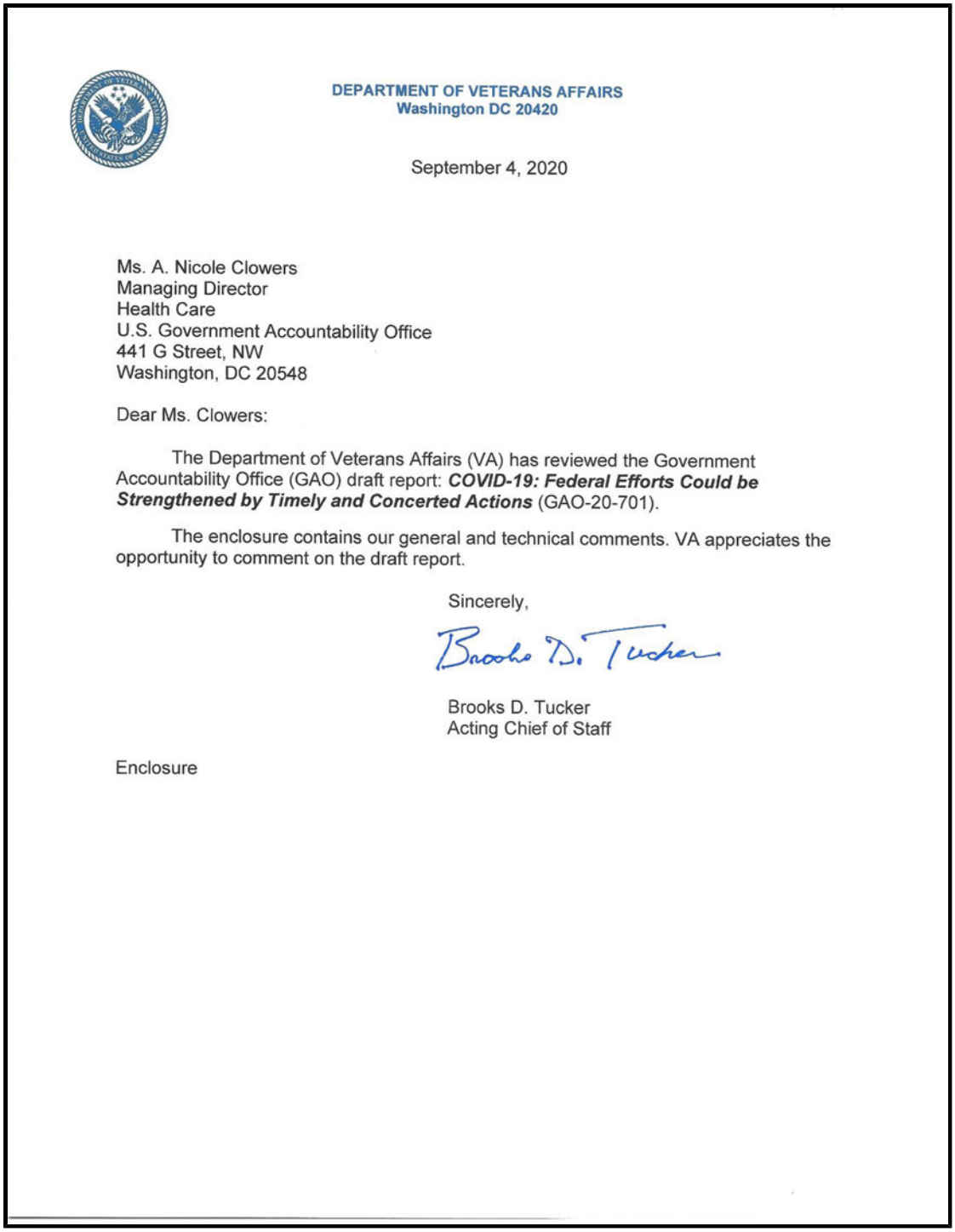
about EIPs and what actions they should take to claim an EIP. In addition, Treasury and the IRS continue to work with EIP outreach partners—such as Volunteer Income Tax Assistance/Tax Counseling for the Elderly, Low Income Taxpayer Clinics, and other community organizations serving individuals experiencing homelessness—to inform taxpayers of how and when to file for an EIP.

Thank you again for the opportunity to review the Draft Report and for your consideration of our comments.

Sincerely,

Frederick W. Vaughan
Principal Deputy Assistant Secretary
Office of Legislative Affairs

Appendix XI: Comments from Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

September 4, 2020

Ms. A. Nicole Clowers
Managing Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Clowers:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***COVID-19: Federal Efforts Could be Strengthened by Timely and Concerted Actions*** (GAO-20-701).

The enclosure contains our general and technical comments. VA appreciates the opportunity to comment on the draft report.

Sincerely,

Brooks D. Tucker

Brooks D. Tucker
Acting Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
COVID-19: Federal Efforts Could be Strengthened by Timely and Concerted Actions
(GAO-20-701)

General Comments

Thank you for the opportunity to review the GAO draft report. Overall, VA agrees with the GAO report and its assessment that several Federal agencies worked together to mitigate supply chain issues and will need to continue working together to plan for continued distribution of medical material and for the development, distribution and administration of vaccines. VA suggests more than one or two Federal agencies are needed to accomplish this goal, including a whole government approach to diversify sourcing, increase medical supply manufacturing in the United States, address the issue of dependence on overseas manufacturing and reduce the risk to national security.

Effective and efficient contingency planning and execution also requires a whole government approach and working with industry to refine models for optimizing readiness and offsetting costs. Further, Federal agencies need to partner with Congress on these efforts. Congressional support to establish Veteran Health Administration's (VHA) Regional Readiness Centers will not only sustain VA's capacity to treat Veterans beyond COVID-19, but it will strengthen VA's ability to execute its Fourth Mission.

VA is unified with our Federal partners in leading the medical response to combat the COVID-19 pandemic. Even before the first confirmed COVID-19 case in the United States, VA began comprehensive response and operations planning to protect its Veterans, their families and the workforce.

In this unprecedented and historic national emergency, VA is meeting enrolled Veterans' needs with excellence: After COVID-19 appeared in the U.S., VA has managed its resources effectively and as of June 15, 2020, cared for more than 17,000 Veterans diagnosed with the virus. Also, VA is providing extensive Fourth Mission support to the Nation, serving as a backstop to America's health care system by helping states and territories with their response to the virus; providing care, services and supplies to non-Veterans by deploying medical professionals to non-VA nursing homes; and by making beds available in VA facilities to treat non-Veteran COVID-19 patients to ease the stress on some local hospital networks.

Enclosure

VA IS DELIVERING EXCELLENCE FOR VETERANS DURING COVID-19

VA performed extensive preparations for COVID-19, including the release of a Strategic Response Plan to provide guidance to our medical centers about creating a safe environment in our health care facilities. The plan was used in conjunction with a series of preparatory exercises at VA medical centers to ensure VA facilities were able to activate emergency operations plans effectively; address surveillance, conduct screening and triage; implement infection control and prevention; prepare for patient surge and impacts on staffing; optimize logistics; create alternate care sites; and optimize health care at VA facilities.

VA took early, proactive steps to ensure the safety of patients and staff against COVID-19 by initiating screening measures and limiting visitation. VA has also maintained Centers for Disease Control and Prevention (CDC) guidelines for testing, physical distancing and using protective gear such as masks, eye protection, gowns and gloves. Particular attention has been made to ensure the safety of our most vulnerable populations in all Community Living Centers (CLC) and Spinal Cord Injury (SCI) units, where every patient and staff person have been and will continue to be tested for COVID-19. VA has been open throughout the pandemic for all care where clinical urgency outweighs the risk of COVID-19.

As of August 25, 2020, VA has diagnosed 49,778 Veterans nationwide with COVID-19 among its 9.2 million patients enrolled in VA health care. Among those Veterans, 87.5% are convalescent (14 days post-positive test). On June 29, 2020, VA launched a digital COVID-19 screening tool to streamline Veteran access to medical care during the coronavirus pandemic. The tool, designed with Veteran and staff input, enables the screening of more than 10,000 people each day.

As of August 17, 2020, VA has tested more than 546,000 Veterans and employees for COVID-19, one of many aggressive steps used to prevent transmission of the virus.

- Testing is a critical piece of VA's public health response to protect and care for Veterans, their families, health care providers and staff during the COVID-19 pandemic.
- VA's testing policies and procedures have helped to limit the spread of the virus within our medical facilities, significantly, while universal COVID-19 testing for patients and staff, as well as other safeguards at VA's CLCs and SCI units, has minimized the COVID-19 exposure risk for some of our most vulnerable patient populations.

VA's nationwide COVID-19 employee infection rate stands at a mere 1 percent of its workforce. In addition, it is possible that many of these VA employees tested positive for coronavirus due to exposure in the community and not related to workplace exposure. In March, VA tested an average of 631 people a day for COVID-19. As of August 17, 2020, VA is currently testing an average of 6,300 people daily, approximately a 900 percent increase.

VA increased inpatient and critical care capacity by more than 3,000 beds and ensured available resources and expertise for all patients who required ventilation by maintaining and cross-leveling more than 4,000 ventilators and anesthesia machines throughout the system.

From March 29, 2020, to August 10, 2020, VHA has onboarded 36,596 new hires, including 6,856 registered nurses and nurse practitioners.

Since the onset of the pandemic, VA has rapidly expanded access to virtual care in order to protect Veterans and to ensure continued access to medical care. VA has seen a 1,309% increase in video telehealth usage. To achieve this level of access, VA vastly expanded the information technology infrastructure to better support virtual care.

VA IS BUILDING TRUST AND LEADING THE WAY FORWARD

Veterans' trust in VA has reached a record high of 90% during this national emergency.

Trust scores among female Veterans rose 10 percentage points, and female Veterans are now choosing to enroll in VA at nearly the same rate as male Veterans.

In alignment with White House and CDC guidance, on May 18, 2020, VA began expanding services at 20 sites, implementing a phased approach centered on Veteran safety. As of mid-June, more than 100 VA medical facilities and medical centers have reinstated at least one in-person service within their direct health care delivery system after certain services were temporarily on hold or reduced due to the COVID-19 pandemic.

In addition, VA announced it has resumed in-person compensation and pension exams in select locations across the country as part of the effort to expand operations.

VA has resumed committal and memorial services that were discontinued during the pandemic at all but two cemeteries in New York. Those services will resume June 22, 2021.

VA also continues its work with strategic partners to enhance Veterans' access to care, including partnerships with cellular carriers to make video telehealth visits free of data costs. In the same way, VA is engaging industry partners to identify opportunities to enhance connectivity and access in rural and underserved areas.

Enclosure

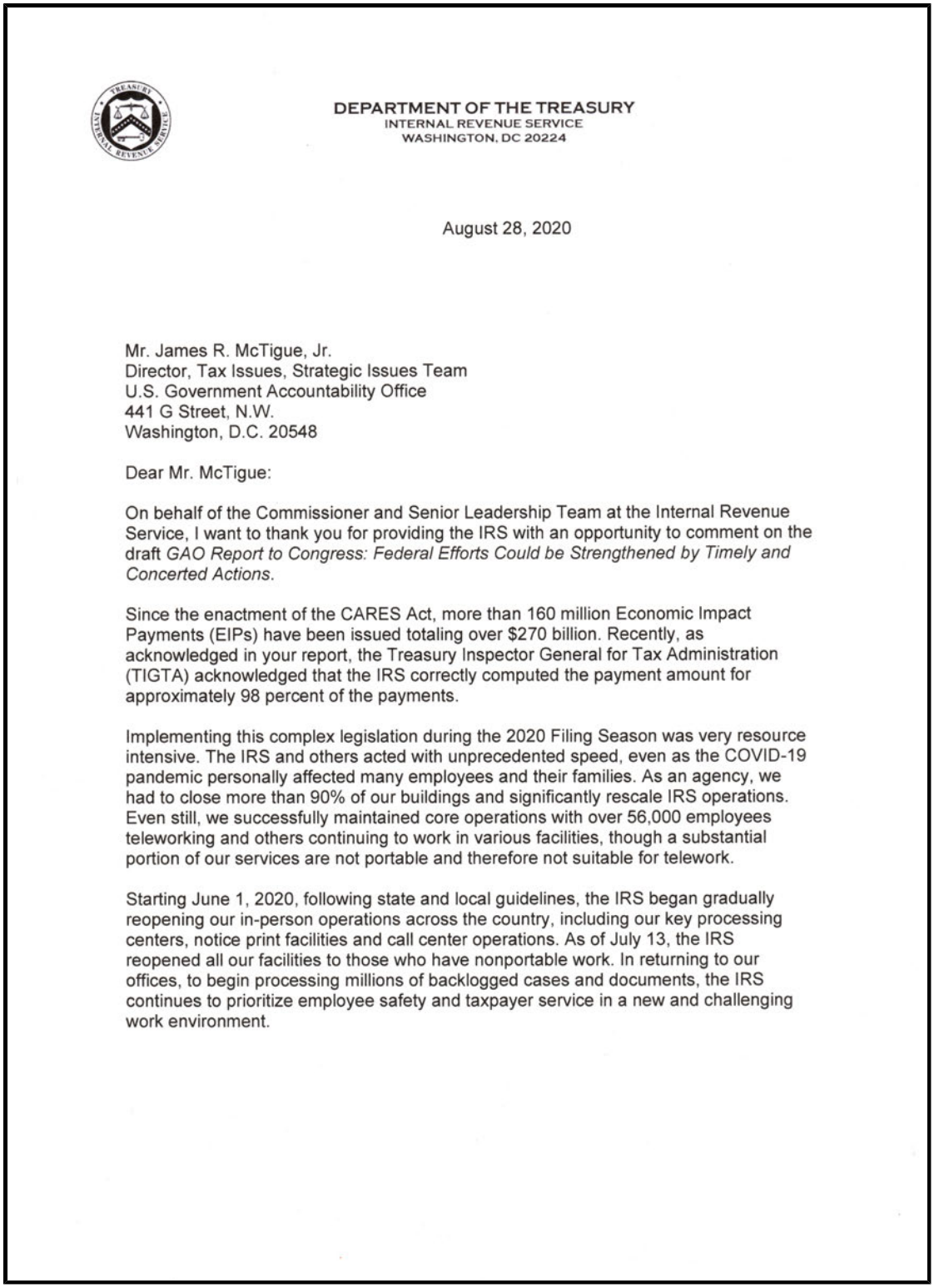
VA IS SUPPORTING STATES AND COMMUNITY ENTITIES DURING COVID-19

VA has assisted 46 states and the District of Columbia with the COVID-19 response, working closely with the Federal Emergency Management Agency (FEMA) and the Department of Health and Human Services (HHS) to fulfill a wide range of external Fourth Mission assignments, including deploying medical professionals to non-VA nursing homes and making beds available in VA facilities to treat non-Veteran COVID-19 patients to ease the stress that some local hospital networks faced.

As of August 24, 2020, VA has 32 active FEMA missions supporting non-VA elder care facilities and has already completed 47 FEMA missions. These missions have included sending nursing and infectious disease control teams into various facilities as well as providing beds at VA facilities for facilities which had particularly sick patients or needed overflow capacity. In total, VA has provided 1,657 VA staff members to support non-VA facilities.

Both VA's geriatrics expertise and its best-in-class long term care model are widely recognized, and VA's early actions to protect Veteran safety have proven effective. For example, on March 10, 2020, VA announced that all its CLCs and Spinal Cord Injury and Disorder units would adopt a "no visitor" stance (except in compassionate cases), suspend new admissions (except transfers, after being screened for COVID-19) and that all staff would be screened daily for COVID-19. VA also conducted robust contact tracing for anyone who tested positive to isolate and contain the virus. These techniques have now been adopted by many outside organizations as a national best practice.

Appendix XII: Comments from Internal Revenue Service



DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, DC 20224

August 28, 2020

Mr. James R. McTigue, Jr.
Director, Tax Issues, Strategic Issues Team
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. McTigue:

On behalf of the Commissioner and Senior Leadership Team at the Internal Revenue Service, I want to thank you for providing the IRS with an opportunity to comment on the draft *GAO Report to Congress: Federal Efforts Could be Strengthened by Timely and Concerted Actions*.

Since the enactment of the CARES Act, more than 160 million Economic Impact Payments (EIPs) have been issued totaling over $270 billion. Recently, as acknowledged in your report, the Treasury Inspector General for Tax Administration (TIGTA) acknowledged that the IRS correctly computed the payment amount for approximately 98 percent of the payments.

Implementing this complex legislation during the 2020 Filing Season was very resource intensive. The IRS and others acted with unprecedented speed, even as the COVID-19 pandemic personally affected many employees and their families. As an agency, we had to close more than 90% of our buildings and significantly rescale IRS operations. Even still, we successfully maintained core operations with over 56,000 employees teleworking and others continuing to work in various facilities, though a substantial portion of our services are not portable and therefore not suitable for telework.

Starting June 1, 2020, following state and local guidelines, the IRS began gradually reopening our in-person operations across the country, including our key processing centers, notice print facilities and call center operations. As of July 13, the IRS reopened all our facilities to those who have nonportable work. In returning to our offices, to begin processing millions of backlogged cases and documents, the IRS continues to prioritize employee safety and taxpayer service in a new and challenging work environment.

While we acknowledge your recommendations, we will defer to Treasury for a response on those specific items. We are providing comments to statements in the draft report.

The IRS has expended enormous effort to find every person who is entitled to an EIP, and to ensure that each such person gets every dollar they are entitled. This effort will continue in advance of the October 15 deadline to use the Non-Filers tool, and we continue to urge everyone to share this information with people who aren't required to file a tax return. We realize that notwithstanding those efforts we have not been able to identify everyone, and that in a small percentage of cases we did not pay all of the EIP to which a recipient is entitled, usually because we did not have all relevant information.

We have coordinated outreach efforts with thousands of community-based organizations and have provided materials in more than two dozen languages. Given the extremely high demand for EIP assistance, we have continued to prioritize and increase resource allocations to eligible individuals, including those who may be waiting on some portion of their payment. To help with this, we have allocated additional IRS resources to ensure eligible recipients receive their full payments during this challenging time. We will continue to work toward providing relief for those remaining individuals who have not received their full payments.

If you have any questions, please contact me at Thomas.A.Brandt@IRS.gov.

Thank you.

Sincerely,

Thomas A. Brandt

Thomas A. Brandt
IRS Chief Risk Officer

Attachment

Appendix XIII: Comments from Office of the United States Trade Representative

Office of the United States Trade Representative (USTR) Comments on Government Accountability Office (GAO) Draft Report: ***COVID-19: Federal Efforts Could be Strengthened by Timely and Concerted Actions*** (GAO-20-701)

General Comments:

The report's discussion of tariff reductions on imports of medical products ignores the effect on domestic manufacturers of these products:

The report indicates that eliminating or easing tariffs on COVID-19 related products will likely reduce the price and increase the quantity of imports of these products. However, the report fails to recognize that eliminating the tariffs may also harm domestic manufacturers of the same products and may make it more difficult to decrease the United States' dependence on other nations for critical medical supplies in the future.

The report's reliance on HTS 10-digit statistical reporting numbers is misleading:

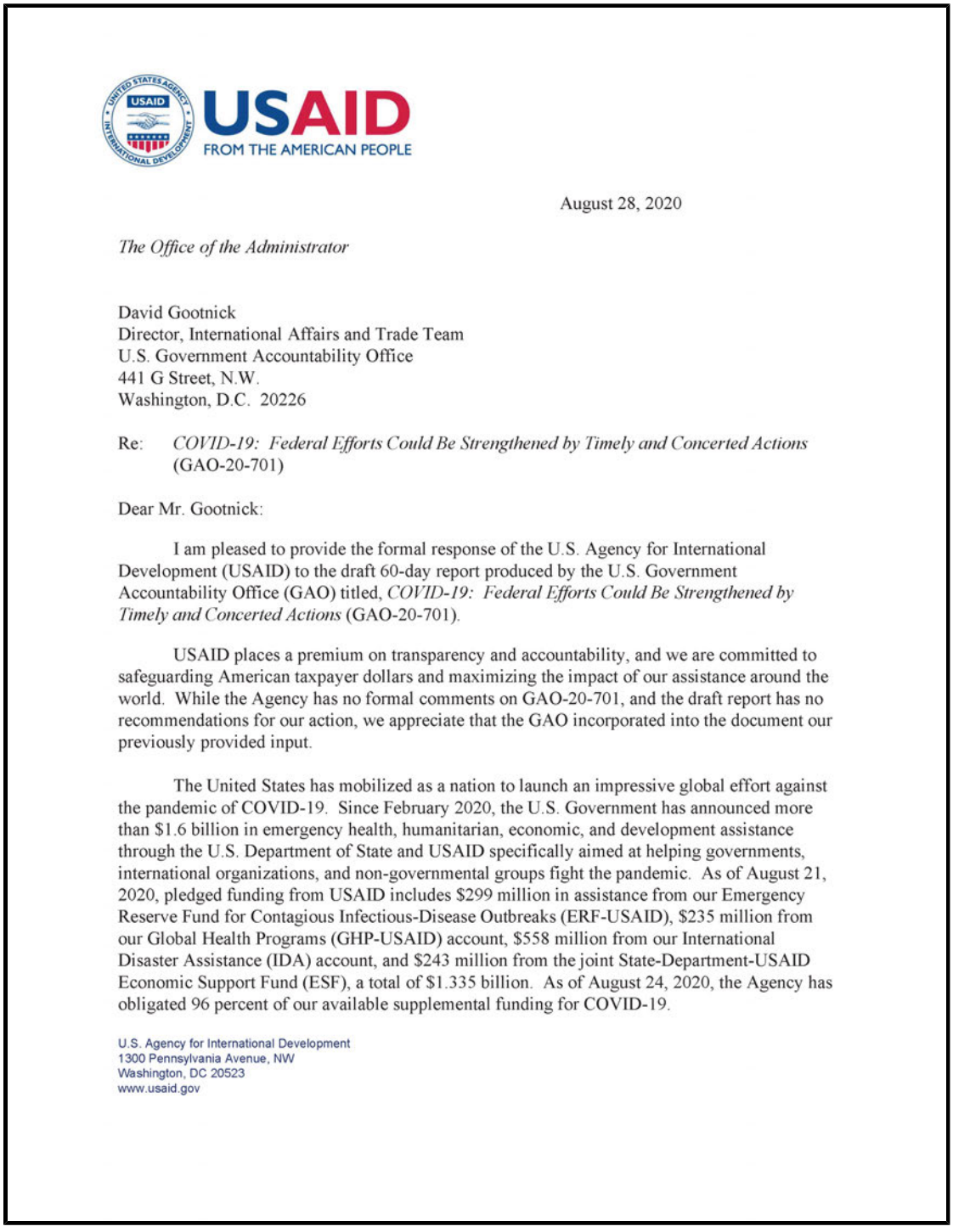
The report's characterization of the import trends concerning COVID-19 related products is misleading, as it relies on the use of HTS 10-digit statistical reporting numbers as a proxy for the import value totals for COVID-19 related products. We observe that the United States International Trade Commission (ITC) has advised against exactly this in its report *Covid-19 Related Goods: U.S. Imports and Tariffs*, USITC Pub. 5047 (April 2020):

> Due to the fact that many HTS 10-digit statistical reporting numbers are basket categories that cover more than one product, data at the HTS 10-digit statistical reporting number level may include a mix of COVID-19 related and non-COVID-19 related goods. For this reason, this report does not summarize import value totals as such totals would not solely reflect COVID-19 related goods.

Therefore, the GAO report does not and cannot accurately capture shifts in imports of COVID-19 related products solely by summarizing imports under HTS 10-digit statistical reporting numbers. By doing so, it risks overstating drastically the level of imports of COVID-19 related products.

For the same reason, the report's statements regarding the value of COVID-19 related products entering the United States from China, subject to additional tariffs, and from other countries, duty free, is grossly inaccurate and is likely to provide a significantly misleading impression to the public.

Appendix XIV: Comments from United States Agency for International Development



USAID
FROM THE AMERICAN PEOPLE

August 28, 2020

The Office of the Administrator

David Gootnick
Director, International Affairs and Trade Team
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20226

Re: *COVID-19: Federal Efforts Could Be Strengthened by Timely and Concerted Actions* (GAO-20-701)

Dear Mr. Gootnick:

I am pleased to provide the formal response of the U.S. Agency for International Development (USAID) to the draft 60-day report produced by the U.S. Government Accountability Office (GAO) titled, *COVID-19: Federal Efforts Could Be Strengthened by Timely and Concerted Actions* (GAO-20-701).

USAID places a premium on transparency and accountability, and we are committed to safeguarding American taxpayer dollars and maximizing the impact of our assistance around the world. While the Agency has no formal comments on GAO-20-701, and the draft report has no recommendations for our action, we appreciate that the GAO incorporated into the document our previously provided input.

The United States has mobilized as a nation to launch an impressive global effort against the pandemic of COVID-19. Since February 2020, the U.S. Government has announced more than $1.6 billion in emergency health, humanitarian, economic, and development assistance through the U.S. Department of State and USAID specifically aimed at helping governments, international organizations, and non-governmental groups fight the pandemic. As of August 21, 2020, pledged funding from USAID includes $299 million in assistance from our Emergency Reserve Fund for Contagious Infectious-Disease Outbreaks (ERF-USAID), $235 million from our Global Health Programs (GHP-USAID) account, $558 million from our International Disaster Assistance (IDA) account, and $243 million from the joint State-Department-USAID Economic Support Fund (ESF), a total of $1.335 billion. As of August 24, 2020, the Agency has obligated 96 percent of our available supplemental funding for COVID-19.

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523
www.usaid.gov

This funding appropriated by Congress will save lives in more than 120 countries through the prevention and control of infections in health facilities; the rapid identification, diagnosis, and treatment of cases of COVID-19; the follow-up of contacts of infected patients; awareness-raising through risk-communications and community-engagement; logistics and supply-chain management; global and regional coordination; country-level readiness and response; the strengthening of capacity in laboratory and disease-surveillance; and responses to the humanitarian impacts of the pandemic.

USAID remains committed to protecting the health and safety of our staff, implementing partners, and beneficiaries, while continuing the appropriate oversight of our programs to ensure the accountable and effective use of U.S. taxpayer funds. As part of our effort to maintain our continuity of operations during COVID-19, USAID has done the following:

- Activated a Task Force, a cross-Agency team to respond to the global pandemic and provide an integrated platform to facilitate a coordinated corporate response;
- Authorized and extended a number of administrative flexibilities for USAID's assistance in response to COVID-19;
- Issued guidance on innovative monitoring strategies and streamlined processes to support the effective monitoring of our programs;
- Coordinated with implementing partners through surveys and calls to provide information and determine how the pandemic affects their abilities to perform their missions, established a COVID-19 webpage and resource center for implementers, and issued guidance regarding personal protective equipment and covered materials (as defined by the Presidential Memorandum on Allocating Certain Scarce or Threatened Health and Medical Resources to Domestic Use, issued on April 3, 2020) for implementing partners;
- Made additional tools and authorities available to our overseas Missions that expand the telework, procurement, and supervisory capabilities of our Foreign Service National workforce; and
- Launched the Master COVID-19 Dataset and the COVID-19 Data Resource Hub to help our staff understand the most pressing challenges faced in our partner countries as a result of COVID-19.

The Agency's effort to care for our employees, mitigate risks, fulfill our monitoring responsibilities, maximize coordination with stakeholders, and improve controls in our core functions remains ongoing during our response to COVID-19. While we manage near-term challenges that arise from the pandemic, the Agency must prepare for lasting changes to the development and humanitarian landscape in the medium- to long-term caused by the disease and measures to contain it. In July, I commissioned an "Over-the-Horizon" Strategic Review to ensure the Agency is positioned to execute our mission in a way that is flexible and agile in a world changed by COVID-19.

I am transmitting this letter from USAID for inclusion in the final version of GAO-20-701. Thank you for the opportunity to review and respond to the draft report, and for the courtesies extended by your staff while conducting this engagement. We appreciate the opportunity to participate in the report.

Sincerely,

John Barsa

Contacts

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