United States Government Accountability Office

Report to Congressional Addressees

January 2023

COVID-19

HHS Funds Allocated to Support Disproportionately Affected Communities

GAO-23-105500

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GAO Highlights

Highlights of GAO-23-105500, a report to congressional addressees

Why GAO Did This Study

Between March 2020 and March 2021, six pandemic relief laws appropriated billions of dollars to HHS's Public Health and Social Services Emergency Fund. This fund is used for HHS emergency preparedness and response activities, including addressing the health effects felt disproportionately among certain communities.

The CARES Act includes a provision for GAO to report on its ongoing COVID-19 monitoring and oversight efforts. GAO was also asked to review how HHS allocated pandemic relief funds to support communities disproportionately affected by COVID-19. This report describes (1) how much four HHS agencies allocated to support communities disproportionately affected by COVID-19; and (2) how a sample of states allocated selected funding from CDC to support disproportionately affected communities.

GAO reviewed agency data and documentation, and interviewed agency officials from the four HHS agencies. GAO also reviewed documentation and interviewed health department officials from five states. The states—Arizona, Louisiana, Michigan, New Hampshire, and Washington—were selected to reflect variation in geography and racial and ethnic populations, among other characteristics.

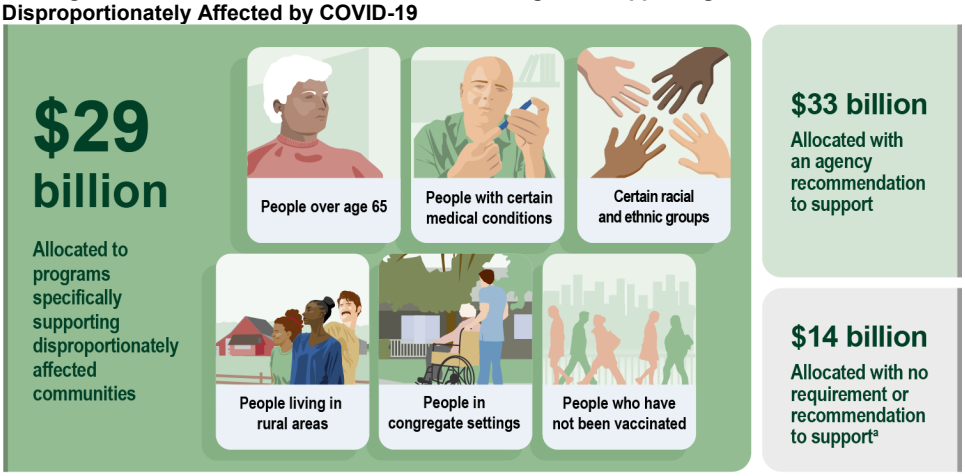
HHS provided technical comments on a draft of this report, which were incorporated as appropriate.

View GAO-23-105500. For more information, contact Carolyn L. Yocom at (202) 512-7114 or YocomC@gao.gov.

What GAO Found

The Department of Health and Human Services (HHS) provided $75 billion in pandemic relief funding from its Public Health and Social Services Emergency Fund to four agencies: the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration, Indian Health Service, and Office of Minority Health. CDC received more than half of the funding. GAO found that these agencies directed $29 billion (over 35 percent) of this funding to programs specifically supporting communities disproportionately affected by COVID-19. In addition, the agencies allocated $33 billion to programs with a recommendation that awardees—often state health departments—support such communities with the funds.

HHS Agencies' Allocations of Selected Funds to Programs Supporting Communities Disproportionately Affected by COVID-19



Source: GAO analysis of Department of Health and Human Services (HHS) information. | GAO-23-105500

Note: Amounts do not sum to $75 billion in pandemic relief funding due to rounding.

[a]HHS officials told GAO that many recipients opted to support disproportionately affected communities with these funds.

States had discretion in targeting the allocation and use of federal relief funds provided through various CDC programs. Five selected states GAO reviewed allocated selected CDC funds to support a range of COVID-19 testing, vaccination, and other response efforts in disproportionately affected communities. However, state officials reported challenges in doing so—challenges that CDC officials said many other states faced:

- **Delays in state acceptance of federal funds.** The health departments in three selected states waited between 3 and 9 months for the state to accept certain funds awarded by CDC.
- **Capacity challenges.** Consistent with findings in other GAO work, all five selected states reported hiring and workload issues, as well as challenges due to the limited capacity of local partners, which constrained their efforts to allocate and use the CDC funds.

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Abbreviations

CDC	Centers for Disease Control and Prevention
HRSA	Health Resources and Services Administration
HHS	Department of Health and Human Services
IHS	Indian Health Service
OMH	Office of Minority Health

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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January 24, 2023

Congressional Addressees

The COVID-19 pandemic has had widespread effects on the health of the nation, including more than one million deaths attributed to the disease. These effects, however, have been uneven, with certain communities experiencing disproportionate health outcomes related to COVID-19, such as hospitalizations and deaths. For example, available Centers for Disease Control and Prevention (CDC) data indicate that Hispanic or Latino individuals, as well as non-Hispanic Black or African American and American Indian or Alaska Native individuals have been hospitalized with COVID-19 at a rate two or more times that of non-Hispanic White individuals.[1] According to CDC, individuals over age 65, individuals living in rural communities, and others have also seen worse outcomes due to the pandemic.

From March 2020 through March 2021, six pandemic relief laws appropriated funds to support the Department of Health and Human Services' (HHS) COVID-19 response efforts.[2] HHS reported that together, these laws appropriated about $349 billion to HHS's Public Health and Social Services Emergency Fund, a budget account used to fund HHS emergency preparedness and response activities. The majority of the

[1]Hospitalization rates are adjusted by age and reflect data as of September 2022. Rates are based on COVID-NET, a CDC surveillance system that collects data on COVID-19-associated hospitalizations confirmed by laboratory testing, in select counties in 13 states representing about 10 percent of the U.S. population. See Centers for Disease Control and Prevention, "Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity," accessed November 1, 2022, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

[2]For the purposes of our review, these pandemic relief laws consist of the six laws providing comprehensive relief across federal agencies and programs that the Department of the Treasury uses to report COVID-19 spending. These six laws are the American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4; Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020); Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020); CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020); and the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, 134 Stat. 146.

$349 billion was for providing relief to health care providers and activities such as developing and procuring COVID-19 tests and vaccines.[3]

According to HHS, about $75 billion of the $349 billion went to CDC, the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), and HHS's Office of Minority Health (OMH) for their COVID-19 response efforts; CDC received more than half of these funds. In this report, we refer to the $75 billion provided to these four agencies as selected pandemic relief funds.[4] The four agencies, which we refer to collectively as HHS agencies, allocated these funds to a range of federal programs, including programs that awarded relief funds to states.[5] States, in turn, had some discretion within federal guidelines in allocating and using those funds.

The CARES Act includes a provision for GAO to report on its ongoing monitoring and oversight efforts related to the COVID-19 pandemic.[6] In addition, you asked us to examine HHS's allocation of pandemic relief funds to support communities disproportionately affected by COVID-19. In this report, we describe

1. how much of the selected pandemic relief funding CDC, HRSA, IHS, and OMH allocated to support communities disproportionately affected by COVID-19; and

2. how a sample of states allocated selected pandemic relief funding from CDC to support disproportionately affected communities.

To describe how much of the selected pandemic relief funding CDC, HRSA, IHS, and OMH allocated to support communities disproportionately affected by COVID-19, we reviewed data from these four agencies on their allocation of the funds by activity and program. We also reviewed agency documentation and interviewed officials to identify

[3]For GAO work on the use of these funds, see GAO, *COVID-19: Current and Future Federal Preparedness Requires Fixes to Improve Health Data and Address Improper Payments,* GAO-22-105397 (Washington, D.C.: Apr. 27, 2022).

[4]In addition to funds appropriated to CDC, HRSA, and IHS through the Public Health and Social Services Emergency Fund, the six pandemic relief laws also appropriated funds to these agencies outside of this fund.

[5]States also received other federal funding to support their COVID-19 response efforts through other programs and agencies.

[6]Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020). All of GAO's reports related to the COVID-19 pandemic are available on GAO's website at https://www.gao.gov/coronavirus.

the purposes and communities supported by the funds, how funds were allocated, and whether the programs were established since the COVID-19 pandemic began.[7] We compared agency information on communities supported with the funds with the communities identified by the Presidential COVID-19 Health Equity Task Force as having been disproportionately affected by COVID-19.[8] We determined the amount of funds allocated to programs (1) with a stated purpose of supporting disproportionately affected communities; (2) with a recommendation that awardees use funds to support these communities; and (3) without a requirement or recommendation that the funds directly support these communities. Amounts include costs associated with the administration of these programs. To assess the reliability of the agencies' data, we discussed them with agency officials and reviewed them for completeness and consistency with agency documentation; we found the data to be sufficiently reliable for our purposes.

To describe how a sample of states allocated selected pandemic relief funds from CDC to support disproportionately affected communities, we reviewed documents and interviewed health department officials from five states: Arizona, Louisiana, Michigan, New Hampshire, and Washington. We selected these states to provide variation in geographic location, the degree to which state public health infrastructures were centralized or decentralized, and racial and ethnic population distribution. We focused on states' allocation of funds from five CDC programs, each of which accounted for at least $1 billion in pandemic relief funds and provided funds directly to states to allocate within federal guidelines.[9] We reviewed

[7]For the purposes of our analysis, we considered new activities (such as COVID-19 testing) that were funded through programs that existed prior to the pandemic as existing programs.

[8]Specifically, we assessed whether the communities supported by agency programs funded by selected pandemic relief funds matched communities listed in the Presidential COVID-19 Health Equity Task Force Final Report. Department of Health and Human Services, Office of the Assistant Secretary for Health, *Presidential COVID-19 Health Equity Task Force Final Report and Recommendations* (Washington, D.C.: October 2021).

[9]These five CDC programs are the National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Communities, Including Racial and Ethnic Minority Populations and Rural Communities (National Initiative to Address COVID-19 Health Disparities) program; two programs focusing on COVID-19 testing, surveillance, and related activities—the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (Epidemiology and Laboratory Capacity) Enhancing Detection and Reopening Schools programs; and two focusing on the public health workforce (the COVID-19 Crisis Response program, and Disease Intervention Specialists Workforce Development program).

documents states submitted to CDC, such as work plans and progress reports that described funding allocations and any challenges states faced allocating funds. In addition, we interviewed state health department officials about how, if at all, they allocated funds to support disproportionately affected communities; we also asked them open-ended questions about challenges they faced allocating and using funds to support those communities. We also asked CDC officials whether other states had reported experiencing the same challenges our selected states identified.

We conducted this performance audit from October 2021 through January 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Communities Disproportionately Affected by COVID-19

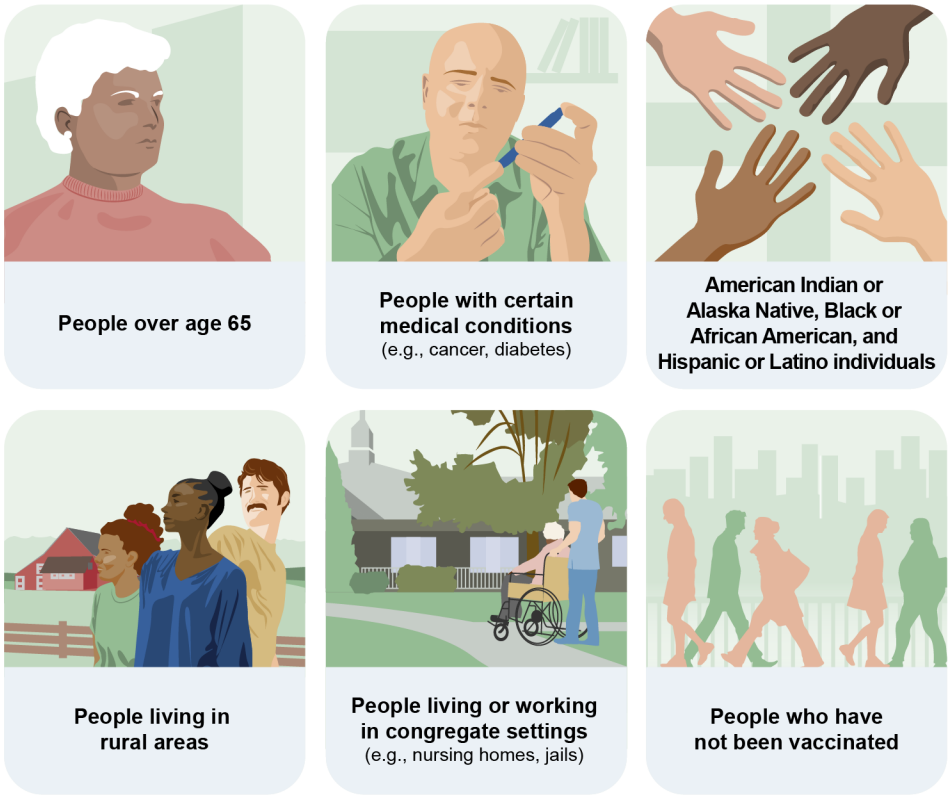
COVID-19 has had a disproportionate effect on the health of a range of communities in the United States. Certain groups of people, for example, have been at increased risk of COVID-19 exposure based on where they live or work. In addition, certain groups have been at increased risk of severe illness, hospitalization, or death.[10] (See fig. 1.) For some people, their characteristics or circumstances include them in more than one of the communities disproportionately affected by COVID-19. In addition, the pandemic's effect on communities has changed over time, including as a result of the introduction of vaccines and new COVID-19 variants.[11] For example, during the initial months of the pandemic, urban counties had higher rates of COVID-19 deaths than rural counties. Later, rural counties

[10]For example, people who are older, have certain underlying medical conditions, or are pregnant are at increased risk for severe illness, hospitalization, and death due to COVID-19. See Centers for Disease Control and Prevention, "Understanding Risk," accessed October 26, 2022, https://www.cdc.gov/coronavirus/2019-ncov/your-health/understanding-risk.html.

[11]COVID-19 variants have led to changing effects on communities. The Omicron variant led to a surge in COVID-19 cases in December 2021 and January 2022, according to CDC estimates. Death rates during this surge were relatively higher among people over age 65, Black or African American and Hispanic or Latino individuals, and other communities. See Centers for Disease Control and Prevention, "COVID Data Tracker: COVID-19 Weekly Cases and Deaths per 100,000 Population by Age, Race/Ethnicity, and Sex," accessed September 6, 2022, https://covid.cdc.gov/covid-data-tracker/#demographicsovertime.

had increasing COVID-19 death rates, including rates that at times surpassed urban counties' rates.[12]

Figure 1: Examples of Communities Disproportionately Affected by COVID-19



Source: GAO analysis of Centers for Disease Control and Prevention (CDC) information. | GAO-23-105500

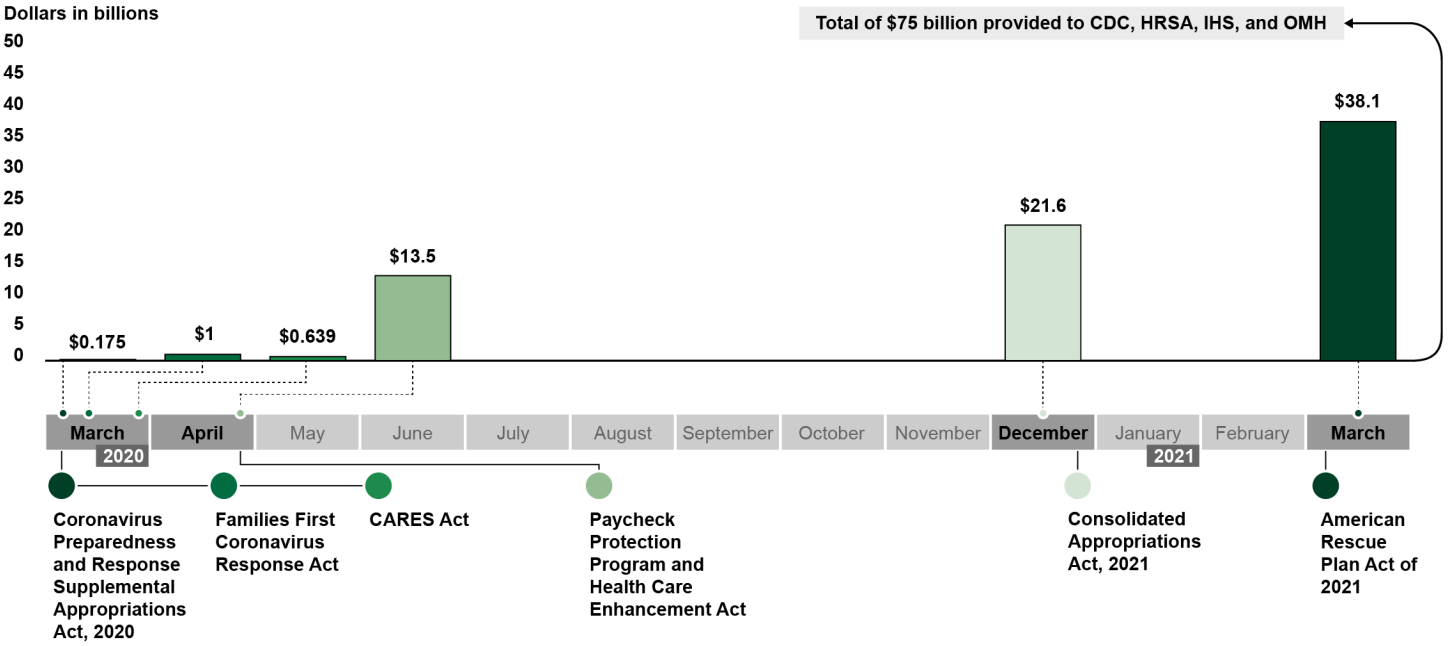
Federal Funding for HHS COVID-19 Response

From March 2020 through March 2021, six pandemic relief laws appropriated about $484 billion for HHS and its agencies to support COVID-19 response efforts. According to HHS, most of these funds—$349 billion—were appropriated to its Public Health and Social Services

[12]See Centers for Disease Control and Prevention, "COVID Data Tracker: Trends in COVID-19 Cases and Deaths in the United States, by County-level Population Factors," accessed September 6, 2022, https://covid.cdc.gov/covid-data-tracker/#pop-factors_7daynewdeaths.

Emergency Fund. Of this $349 billion, $75 billion was provided to CDC, HRSA, IHS, and OMH.[13] (See fig. 2.)

Figure 2: Timeline of Appropriation of Selected Pandemic Relief Funds Provided to Four HHS Agencies



Source: GAO analysis of Department of Health and Human Services (HHS) information. | GAO-23-105500

Notes: Amounts include appropriations to HHS's Public Health and Social Services Emergency Fund that were provided to the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), and HHS's Office of Minority Health (OMH). Amounts do not include other funds CDC, HRSA, and IHS received for COVID-19 response, outside of the Public Health and Social Services Emergency Fund. Amounts also do not include funds appropriated to the Public Health and Social Services Emergency Fund for the Provider Relief Fund administered by HRSA, which reimburses eligible health care providers for health care-related expenses or lost revenues attributable to COVID-19.

In addition to the $75 billion provided to CDC, HRSA, IHS, and OMH through HHS's Public Health and Social Services Emergency Fund, the six pandemic relief laws also appropriated funds to CDC, HRSA, and IHS outside of this fund. Some of these other funds could be used for programs and activities similar to those funded through HHS's Public Health and Social Services Emergency Fund. For example, CDC

[13]Also included in the $349 billion was $178 billion for the Provider Relief Fund, which is administered by HRSA, and about $96 billion for other HHS agencies and offices, such as the Office of the Assistant Secretary for Preparedness and Response, the Office of the Assistant Secretary for Health, the Food and Drug Administration, and the National Institutes of Health, which we did not include in our scope.

received funds from multiple sources to support COVID-19 vaccination efforts.

HHS Agencies' Roles in Supporting Public Health

The four HHS agencies—CDC, HRSA, IHS, and OMH—all play a role in supporting public health and have existing programs that support a range of organizations and communities, which can be leveraged in times of emergencies. (See table 1.) For example, CDC provides funding and technical assistance to support state, local, tribal, and territorial health department efforts to manage public health and fight infectious diseases.

Table 1: Four HHS Agencies' Roles in Supporting Public Health

Agency	Role
Centers for Disease Control and Prevention	Protects the public health of the nation by providing leadership and direction in the prevention and control of diseases and other preventable conditions, and responding to public health emergencies.
Health Resources and Services Administration	Supports health care for people who are geographically isolated, or economically or medically vulnerable.
Indian Health Service	Provides American Indians and Alaska Natives with comprehensive health services by developing and managing programs to meet their health needs[a]
Office of Minority Health	Dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate disparities.

Source: GAO summary of Department of Health and Human Services (HHS) information. | GAO-23-105500

[a]Federally recognized tribes and individuals who meet the applicable statutory and regulatory definitions of "Indian" have a unique political status and are eligible for certain federal programs, benefits, and services because of that status, including health care. Racial self-identification as American Indian or Alaska Native is distinct from political status.

HHS Agencies Allocated Over 35 Percent of $75 Billion in Relief Funds to Specifically Support Communities Disproportionately Affected by COVID-19

HHS Allocated $29 Billion to Programs Specifically Supporting Disproportionately Affected Communities and Recommended that Awardees of Another $33 Billion Also Do So

Selected Pandemic Relief Funds

The $75 billion that was appropriated in six COVID-19 relief laws to the Public Health and Social Services Emergency Fund and provided to four Department of Health and Human Services agencies:

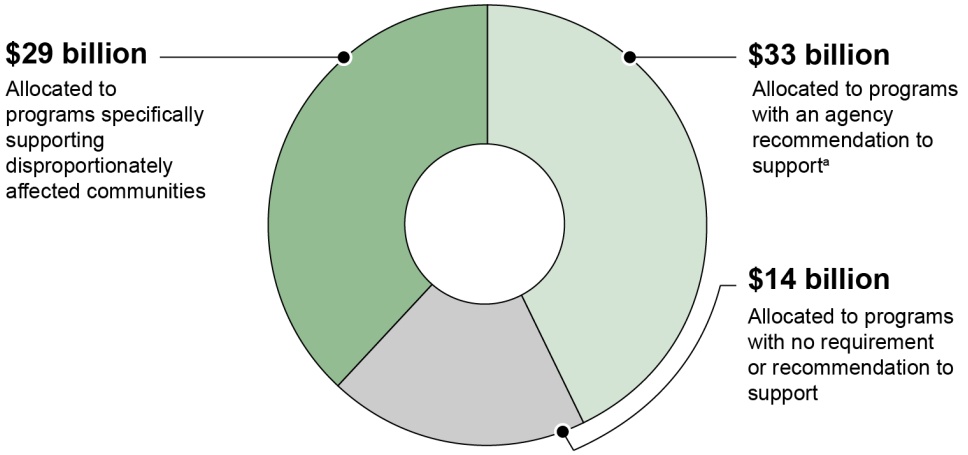
- Centers for Disease Control and Prevention
- Health Resources and Services Administration
- Indian Health Service
- Office of Minority Health

Source: GAO. | GAO-23-105500

Of the $75 billion in selected pandemic relief funding that we reviewed, HHS agencies—CDC, HRSA, IHS, and OMH—allocated more than 35 percent of the funds, or $29 billion, to programs specifically supporting communities disproportionately affected by the pandemic; and recommended that awardees of an additional $33 billion use the funds to support such communities.[14] The HHS agencies allocated the remaining $14 billion without requiring or recommending that the funds support disproportionately affected communities. (See fig. 3.)

[14]The $29 billion includes funding HHS agencies allocated to federal programs that directly serve disproportionately affected communities, as well as funding HHS agencies awarded with a requirement that the funds support disproportionately affected communities.

Figure 3: HHS Agencies' Allocations of Selected Pandemic Relief Funds to Programs Supporting Communities Disproportionately Affected by COVID-19



Source: GAO analysis of Department of Health and Human Services (HHS) data. | GAO-23-105500

Notes: Selected pandemic relief funds refers to $75 billion that was appropriated in six COVID-19 relief laws to the Public Health and Social Services Emergency Fund and provided to four agencies (Centers for Disease Control and Prevention; Health Resources and Services Administration (HRSA); Indian Health Service; and Office of Minority Health). It does not include funds for the Provider Relief Fund administered by HRSA, which reimburses eligible health care providers for health care-related expenses or lost revenues attributable to COVID-19.

Communities disproportionately affected by COVID-19 include, for example, people who are older, have certain underlying medical conditions, or are from certain ethnic and racial groups.

Amounts do not sum to $75 billion total due to rounding.

[a]Programs with an agency recommendation to support refers to HHS programs with guidance recommending that awardees—often state health departments—use funds to support communities disproportionately affected by COVID-19.

For the $29 billion allocated to programs specifically supporting disproportionately affected communities, the funds went to programs serving the types of organizations and communities that the agencies have historically supported. (See app. I for a list of the programs specifically supporting communities disproportionately affected by COVID-19.) For example, HRSA allocated funds to providers and programs serving vulnerable and medically underserved populations. CDC allocated funds to state, local, and territorial health departments nationwide, with a requirement that the departments use the funds to serve disproportionately affected communities within their jurisdictions. (See table 2.)

Table 2: Allocation of $29 Billion in Selected Pandemic Relief Funds Specifically Supporting Communities Disproportionately Affected by COVID-19, by HHS Agency

Agency	Amount allocated	Types of organizations funded and communities served
Health Resources and Services Administration	$18 billion	Providers serving underserved and vulnerable populations, including in rural areas; and programs supporting health infrastructure, including the training of health professionals and the advancement of telehealth.
Centers for Disease Control and Prevention	$9.2 billion	State, local, and territorial health departments serving disproportionately affected communities nationwide and other organizations serving communities disproportionately affected by COVID-19.
Indian Health Service	$1.1 billion	Federally and tribally operated health care facilities and urban Indian organizations serving American Indians and Alaska Natives.
Office of Minority Health	$315 million	Community-based organizations serving racial and ethnic minority populations.

Source: GAO analysis of Department of Health and Human Services (HHS) information. | GAO-23-105500

Notes: Selected pandemic relief funds refers to the $75 billion that was appropriated in six COVID-19 relief laws to the Public Health and Social Services Emergency Fund and provided to four HHS agencies (Centers for Disease Control and Prevention; Health Resources and Services Administration (HRSA); Indian Health Service; and Office of Minority Health). It does not include funds for the Provider Relief Fund administered by HRSA, which reimburses eligible health care providers for health care-related expenses or lost revenues attributable to COVID-19.

Communities disproportionately affected by COVID-19 include, for example, those who are older, have certain underlying medical conditions, or are from certain ethnic and racial groups.

Amounts do not sum to $29 billion due to rounding.

In addition to the $29 billion, HHS agencies—specifically, CDC—allocated another $33 billion to programs in which the agency recommended funds be used to support disproportionately affected communities, and provided program-specific guidance for doing so. For example, CDC issued guidance recommending that awardees—often state health departments—include disproportionately affected communities in their planning, or use certain data or tools that identify vulnerable communities—such as CDC's Social Vulnerability Index—to inform their pandemic planning, response, or strategies. CDC's Social Vulnerability Index ranks the vulnerability of each Census tract based on factors such as poverty, vehicle access, and housing, and can be used to identify communities that will need extra support before, during, or after an emergency event. (See table 3.) CDC officials told us they did not require awardees to use the relief funding to support these communities, because they wanted to allow some flexibility for awardees who may have other sources of funding to support disproportionately affected communities.

Table 3: CDC Programs Funded with Selected Pandemic Relief Funds with Guidance Recommending Support for Communities Disproportionately Affected by COVID-19

Program	Amount awarded and purpose of funds	CDC guidance
Epidemiology and Laboratory Capacity Enhancing Detection	$29.4 billion to support awardees in conducting a broad range of COVID-19 testing and epidemiologic surveillance related activities.[a]	Guidance recommends that awardees include plans for testing populations at increased risk of becoming infected by COVID-19.
COVID-19 Crisis Response	$2 billion to support awardees with public health workforce enhancements.	Guidance recommends that awardees use CDC's Social Vulnerability Index data to inform their COVID-19 planning, response, and hiring strategy.[b]
Disease Intervention Specialists Workforce Development	$1.1 billion to support awardees with mitigating the spread of COVID-19 and other infections.	Guidance recommends that awardees use CDC's Social Vulnerability Index data or U.S. Census Bureau's Community Resilience Estimates to inform their planning, response, and hiring strategy.[b]

Source: GAO analysis of Centers for Disease Control and Prevention (CDC) information. | GAO-23-105500

Notes: Selected pandemic relief funds refers to $75 billion that was appropriated in six COVID-19 relief laws to the Public Health and Social Services Emergency Fund and provided to four Department of Health and Human Services agencies (CDC, Health Resources and Services Administration (HRSA), Indian Health Service, and Office of Minority Health). It does not include funds for the Provider Relief Fund administered by HRSA, which reimburses eligible health care providers for health care-related expenses or lost revenues attributable to COVID-19.

Amounts do not sum to $33 billion total due to rounding.

[a]Includes an initial allocation of $10.3 billion and a subsequent amount of $19.1 billion that CDC described as expansion funding.

[b]CDC's Social Vulnerability Index ranks the vulnerability of each Census tract based on factors such as poverty, vehicle access, and housing, and can be used to identify communities that will need extra support before, during, or after an emergency event.

[c]U.S. Census Bureau's Community Resilience Estimates summarize how at-risk every neighborhood in the United States is to the impacts of disasters, including COVID-19.

HHS agencies allocated the remaining $14 billion to support broad COVID-19 response and other efforts without a requirement or recommendation that the funds support disproportionately affected communities. For example, CDC allocated $10 billion to state, local, and territorial health departments to fund COVID-19 testing efforts to support the reopening of schools for the 2021-2022 school year, and did not require or recommend that awardees support specific communities with the funds. CDC officials told us they allocated funds in this manner in order to give awardees flexibility to identify how to best support their local public health needs. CDC officials also told us that they worked with recipients to ensure they were able to address the needs of their local populations, and many awardees told the agency that they had used CDC's Social Vulnerability Index and other data to assist them in supporting vulnerable populations with this funding.

HHS Agencies Largely Allocated Funds Specifically Supporting Disproportionately Affected Communities to Programs Established during the Pandemic

For the $29 billion in relief funds specifically supporting disproportionately affected communities, HHS agencies allocated most of the funds (about $24 billion) to an array of new programs established during the pandemic. Most of these new programs were established to implement directives included in the six COVID-19 relief laws. (See table 4.)

Table 4: Examples of New HHS Programs Supporting Communities Disproportionately Affected by COVID-19 with Selected Pandemic Relief Funding

Agency	Program	Amount allocated	Description
Centers for Disease Control and Prevention	National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Communities	$2.3 billion	Funded 108 selected state, local, territorial, and freely associated state health departments to expand their capacity to prevent and control COVID-19 infection or transmission among populations at higher risk and who are medically underserved.
	Increasing Community Access to Testing	$875 million	Funded the provision of no-cost COVID-19 testing for persons who were symptomatic, exposed, or at high-risk of severe outcomes in vulnerable communities, including those experiencing a surge in COVID-19 cases.
Health Resources and Services Administration	Rural Payments	$8.5 billion	Supported health care providers serving rural beneficiaries covered by Medicare, Medicaid, or the Children's Health Insurance Program.
	Uninsured Program Fund	$6.8 billion	Reimbursed health care providers for costs associated with COVID-19 testing for uninsured individuals.
	Community-Based Workforce for COVID-19 Vaccine Outreach	$330 million	Funded community organizations' efforts to enhance vaccine confidence and bolster COVID-19 vaccinations in underserved communities.
	Rural Tribal COVID-19 Response	$16 million	Awarded 57 selected tribes, tribal organizations, and others with funding to aid COVID-19 response activities in rural communities.
Office of Minority Health	Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19	$250 million	Funded 73 local health departments (representing urban and rural areas) to enhance both health literacy and COVID-19 testing and other mitigation measures in racial and ethnic minority and other socially vulnerable populations.

Source: GAO analysis of Department of Health and Human Services (HHS) information. | GAO-23-105500

Notes: Selected pandemic relief funds refers to $75 billion that was appropriated in six COVID-19 relief laws to the Public Health and Social Services Emergency Fund and provided to four HHS agencies (Centers for Disease Control and Prevention, Health Resources and Services Administration (HRSA), Indian Health Service, and Office of Minority Health). It does not include funds for the Provider Relief Fund administered by HRSA, which reimburses eligible health care providers for health care-related expenses or lost revenues attributable to COVID-19.

HHS agencies allocated about $5 billion—the remainder of the $29 billion—to existing programs, including many programs that were already serving disproportionately affected communities. The funding directed to programs already serving disproportionately affected communities expanded their scope to include COVID-19 response activities. In contrast, some of the funding directed to broader public health programs narrowed their focus to serving disproportionately affected communities in certain settings, such as prisons, homeless service sites, and health care settings. (See table 5.)

Table 5: Examples of Existing HHS Programs That Received Selected Pandemic Relief Funds to Support COVID-19 Response Activities for Disproportionately Affected Communities

Program	Amount	Funding awardees
Health Centers	$700 million	Over 1,300 HRSA-funded health centers and 78 other health centers serving underserved and vulnerable populations
Rural Health Clinics	$689 million	Over 4,000 Rural Health Clinics serving underserved rural areas[a]
Small Rural Hospital Improvement Program	$547 million	46 states supported over 1,500 small hospitals with 49 or fewer beds serving rural communities

Source: GAO analysis of Department of Health and Human Services (HHS) information. | GAO-23-105500

Notes: Selected pandemic relief funds refers to $75 billion that was appropriated in six COVID-19 relief laws through the Public Health and Social Services Emergency Fund and provided to four HHS agencies (Centers for Disease Control and Prevention, Health Resources and Services Administration (HRSA), Indian Health Service, and Office of Minority Health). It does not include funds for the Provider Relief Fund administered by HRSA, which reimburses eligible health care providers for health care-related expenses or lost revenues attributable to COVID-19.

[a]Under Medicare, there is an existing Rural Health Clinic designation and payment methodology that is administered by the Centers for Medicare & Medicaid Services. These designations were used to distribute the COVID-19 funding reflected in this table.

Both the newly established and existing programs used the relief funds to support disproportionately affected communities in a variety of ways, including by

- funding the provision of COVID-19 testing and mitigation efforts in disproportionately affected communities;
- funding federal programs and other health care providers serving disproportionately affected communities; and
- enhancing recruiting and retention for the health care and public health workforce serving disproportionately affected communities.

As the four HHS agencies determined how to allocate the selected pandemic relief funds, agency officials told us they first considered congressional direction and intent. In some cases, the pandemic relief laws appropriated the funds for COVID-19 relief purposes through particular programs or for certain communities. In other cases, the

pandemic relief laws provided HHS with discretion on how to allocate the funds to support a broader purpose, such as serving high risk and underserved communities.

Agency officials also told us they considered HHS leadership priorities, assessed public health needs, and worked with agency leaders to determine the most appropriate and effective programs to fund. In addition, HHS agencies took a variety of approaches in awarding funds within particular programs. In some cases, HHS agencies awarded funding equally among a set of awardees, whereas in other cases the agencies considered the size of an awardee's population, the number of uninsured patients served, or the number of COVID-19 cases.

Selected States Allocated CDC Funds for a Range of Activities to Support Disproportionately Affected Communities; All Reported Challenges

States Allocated Selected CDC Funds for a Wide Range of Testing, Vaccination, and Other Pandemic Response Efforts

Our five selected states—Arizona, Louisiana, Michigan, New Hampshire, and Washington—allocated funds from five CDC programs for a range of activities to support COVID-19 response efforts in disproportionately affected communities. Specifically, these states allocated funds from the following CDC programs we focused on: the newly established COVID-19 health disparities program, which required states to focus on

disproportionately affected communities, and four other CDC programs that had no such requirement.[15]

CDC's National Initiative to Address COVID-19 Health Disparities Program

This program was established to address COVID-19-related health disparities and advance health equity by expanding awardees' capacity to prevent and control COVID-19 infection or transmission among populations at higher risk and who are medically underserved.

Source: GAO based on Centers for Disease Control and Prevention (CDC) documentation. | GAO-23-105500

Selected States' Allocations of COVID-19 Health Disparities Program Funds

Our selected states allocated the COVID-19 health disparities program funds for a wide range of activities to support rural communities, certain racial and ethnic groups, and other disproportionately affected communities.[16] All five states, for example, allocated funds for testing and vaccination efforts targeting disproportionately affected communities. States also allocated the program funds for other efforts, such as transportation and behavioral health services. (See fig. 4.)

[15]We focused on five CDC programs, each of which accounted for at least $1 billion in pandemic relief funds and provided funds directly to states to allocate within federal guidelines. These programs were the National Initiative to Address COVID-19 Health Disparities program, Epidemiology and Laboratory Capacity Enhancing Detection program, Epidemiology and Laboratory Capacity Reopening Schools program, COVID-19 Crisis Response program, and Disease Intervention Specialists Workforce Development program. States also received funds from other federal programs for their pandemic response. For example, states received funds from other CDC programs, as well as funds from other federal agencies such as the Federal Emergency Management Agency and the Department of the Treasury. For information about other federal programs that provided states with funding supporting the pandemic response, see GAO-22-105397.

[16]The five selected states each received from about $25 million to $37 million in CDC funds under this program.

Figure 4: Examples of Selected States' Allocations of COVID-19 Health Disparities Program Funds to Support Disproportionately Affected Communities

Rural communities

Expansion of COVID-19 testing, contact tracing, and vaccine support in rural areas

Arizona allocated funds for efforts such as in-home and mobile testing; outreach on testing; and training for public health providers to help with vaccination. Partners included selected local health departments, tribal organizations, and other organizations.

Rural advisory teams

Washington allocated funds to address COVID-19 disparities in 15 rural counties by establishing rural community advisory teams. These teams were to include community members and leaders, and to identify and inform community-led approaches to COVID-19 education, testing, and other activities.

Rural transportation services

New Hampshire allocated funds for efforts to improve transportation services for rural residents, to make it easier for them to obtain COVID-19 and other services. Transportation services included volunteer drivers, free bus fare, and other assistance.

Certain racial and ethnic groups

Refugee community outreach

Washington allocated funds to place community health outreach workers or vaccine ambassadors in refugee health screening clinics and other clinics seeing large numbers of arriving refugees.

Testing and vaccination in tribal communities

Louisiana allocated funds for a project to increase testing and vaccinations and provide training on updated pandemic quarantine protocols in tribal communities.

Community health worker services for Hispanic or Latino residents

Arizona allocated funds for a project to reduce COVID-19 impacts among one county's socially vulnerable Hispanic or Latino residents by hiring community health workers to improve health literacy and provide other support.

Other high-risk or underserved communities

Behavioral health services

Michigan allocated funds to support people experiencing behavioral health impacts due to the pandemic, focusing on urban areas identified as being particularly vulnerable to the effects of COVID-19.

Support for families with young children

New Hampshire allocated funds for programs to support families with young children by helping them access COVID-19 testing and vaccines, health care services, food, and other support.

Detecting COVID-19 in correctional facilities

Louisiana allocated funds to implement wastewater testing to help detect COVID-19 in correctional facilities and thus identify the need for further testing, isolation, and quarantine practices.

Source: GAO analysis of information from Arizona, Louisiana, Michigan, New Hampshire, and Washington. | GAO-23-105500

In addition to supporting specific communities, CDC allowed states to allocate the COVID-19 health disparities program funds for broader efforts, such as improving state data or expanding state health equity efforts; all five selected states did so. Louisiana, for example, allocated funds to improve the COVID-19 contact tracing and case tracking data system so data could be analyzed by demographic group. In Arizona, funds were allocated to expand the health department's Office of Health Equity; develop a health equity community of practice including tribal groups, local health departments, and others; and support other health equity initiatives. New Hampshire allocated funds to expand the state's health care workforce, such as by hiring community health workers to support disproportionately affected communities and investing in efforts to address workforce shortages.

When deciding how to allocate the COVID-19 health disparities program funds, state officials considered data and stakeholder input. For example:

- Michigan allocated funds to establish health equity councils in a number of state regions that were highly affected by COVID-19, state documentation indicated. To select those regions, officials used data on regions' racial and ethnic composition, CDC's Social Vulnerability Index, and other information.
- In Washington, officials said they sought input from over 100 community partners on their proposed funding priorities and revised their plans as a result. For example, they allocated funds for COVID-19 related outreach and care for people with substance use disorders—a population they had not initially prioritized.
- Arizona officials said they allocated funds to seven local health departments and collaborated with local health officials on how to target those funds to address health disparities.

Selected States' Allocation of Other CDC Program Funds

For the four other CDC programs we reviewed, all five selected states allocated at least some of the funds to support COVID-19 response efforts in disproportionately affected communities.[17] CDC did not require

[17]The four CDC programs we reviewed provided different funding amounts to the five selected states. For the Epidemiology and Laboratory Capacity Enhancing Detection program, the five states each received funding ranging from about $139 million to $890 million; this included an initial amount and a later amount states received for expansion funding. For the Epidemiology and Laboratory Capacity Reopening Schools program, these states received funding ranging from about $41 million to $301 million. For the COVID-19 Crisis Response program, the five states received funding ranging from about $9 million to $59 million. Finally, for the Disease Intervention Specialists Workforce Development program, these states received funding ranging from $5 million to about $28 million.

states to allocate funds from these programs to support disproportionately affected communities, though for three of the four programs it recommended that states do so. (See table 6.)

Table 6: Examples of How Selected States Allocated CDC Program Funds to Support Disproportionately Affected Communities

Program	How states allocated funds to support disproportionately affected communities
	COVID-19 testing, surveillance, and related activities
Epidemiology and Laboratory Capacity Enhancing Detection	• **Testing in high-risk regions.** Michigan officials said they used CDC's Social Vulnerability Index to identify high-risk regions and then worked with community members to identify neighborhood locations that would best meet local needs. • **Call center staff for vulnerable populations.** New Hampshire funded a COVID-19 call center with staff dedicated to helping vulnerable populations obtain access to services such as COVID-19 testing and home-based care, officials said.
Epidemiology and Laboratory Capacity Reopening Schools	• **Support for schools with at-risk populations.** In Washington, officials said all schools could access COVID-19 testing, but they prioritized outreach to schools serving at-risk populations. Schools were identified based on how many students received free and reduced price lunch and other measures. Officials also allocated additional funds for schools in areas with COVID-19 testing and vaccination access problems.
	Public health workforce
COVID-19 Crisis Response	• **Staff for schools in at-risk regions.** Louisiana allocated funds for new school nurses and other health staff in schools in the state's most at-risk regions according to CDC's Social Vulnerability Index, officials said. • **Local health department workforce.** Arizona officials said they allocated funds to local health departments using CDC's Social Vulnerability Index as a measure of local risk. They also allocated funds to tribal groups to address workforce gaps.
Disease Intervention Specialists Workforce Development	• **Targeted funds for disease investigation.** Washington officials said they allocated funds using the Census Bureau's Community Resilience Estimates, race and ethnicity data, and other data, as well as input from community partners. Officials funded regional investigative support for local health departments, and extra support for five departments in areas with COVID-19 outbreaks or high disease burden.

Source: GAO analysis of information from Arizona, Louisiana, Michigan, New Hampshire, and Washington. | GAO-23-105500

Notes: The Centers for Disease Control and Prevention (CDC) recommended recipients of funds from the Epidemiology and Laboratory Capacity Enhancing Detection, COVID-19 Crisis Response, and Disease Intervention Specialists Workforce Development programs to use funds to support communities disproportionately affected by COVID-19. CDC did not require or recommend recipients of funds from the Epidemiology and Laboratory Capacity Reopening Schools program to do so.

Louisiana Officials' Observations on Allocating Funds from CDC's Epidemiology and Laboratory Capacity Reopening Schools Program

CDC's Epidemiology and Laboratory Capacity Reopening Schools program provided funds for COVID-19 testing and other efforts to support school reopening. Louisiana officials said they did not allocate these funds to particular schools serving disproportionately affected communities. Officials noted that many Louisiana schools are in rural or underserved areas. They had the resources to support every school that wanted to participate in testing, so they encouraged all schools to do so.

Source: GAO summary of information from state officials and the Centers for Disease Control and Prevention (CDC). | GAO-23-105500

State officials said they sometimes chose to allocate funds more broadly rather than target funds to support disproportionately affected communities. For example, Arizona and Louisiana officials said they made Epidemiology and Laboratory Capacity Reopening Schools funds available statewide in order to give all schools the opportunity to take part in their voluntary school-based COVID-19 testing programs. Michigan officials said they decided to allocate an equal amount of COVID-19 Crisis Response funds to each of the state's 45 local health departments; this decision was informed by input from and coordination with local health department officials.

State-Reported Challenges Allocating and Using CDC Funding Included Delays in Accepting Funds and Capacity Issues

Our five selected states reported a variety of challenges allocating and using funds from the five CDC programs we reviewed. First, some states reported being unable to readily allocate CDC funding due to delays in their state's required acceptance or approval of the funds, which required action by different entities, such as the legislature, depending on the state.[18] Specifically, officials from three state health departments—Louisiana, Michigan, and New Hampshire—reported that their state governments had not accepted certain CDC funds until between 3 and 9 months after CDC awarded the funding (see text box). Officials from New Hampshire explained that certain CDC funds were awarded after the state's emergency declaration had expired and normal processes for approving funds were required.

[18]State governments have established a variety of processes to accept federal funding awarded to them. In some cases, the state legislature or an executive government entity must accept or approve federal funding before state officials may begin working on such programs. CDC officials told us that, with the significant influx of COVID-19 relief funding, many states implemented new processes requiring additional approvals prior to health departments being able to access the funds.

Example of Michigan's Delayed Acceptance of CDC Program Funds

March 11, 2021: The American Rescue Plan Act of 2021 was enacted.

April 8, 2021: The Centers for Disease Control and Prevention (CDC) awarded about $301 million in funding from the American Rescue Plan Act of 2021 to Michigan through its Epidemiology and Laboratory Capacity Reopening Schools program. This program was to support school-based COVID-19 testing for the 2021-2022 school year. Funds were initially set to expire in July 2022, but were later extended for one year.

December 21, 2021: Michigan's state legislature accepted the funding 8 months after it was awarded by CDC.

State funding allocation: Officials from Michigan's health department told us in May 2022 they had not yet allocated funding for this program, because they received the funding too late in the school year to take action on it. Instead, they planned to use the funding to support school-based COVID-19 testing for the 2022-2023 school year. In November 2022, officials said they had allocated funds for several efforts, such as providing testing support for schools experiencing outbreaks and purchasing tests to send home with students.

Source: GAO analysis of state and CDC documents and interviews. I GAO-23-105500

CDC officials told us that many other states were also affected by their states' delayed acceptance or approval of certain CDC funds. For example, CDC officials told us that over half of the recipients of funding from the two Epidemiology and Laboratory Capacity programs we reviewed, which include all 50 states, faced delays obtaining required state approvals to spend the funding.[19] CDC officials also told us that three states opted not to accept certain CDC funds and another state opted to accept only partial CDC funding.

Health department officials from the five selected states also reported capacity issues that affected their ability to allocate and use the CDC funds, according to our interviews with state officials and review of state documents. Specifically, the capacity issues included the following:

- **Heavy workloads.** Officials from two states (Arizona and Louisiana) told us it was challenging to allocate and use funds

[19]CDC awarded $29.4 billion through its Epidemiology and Laboratory Capacity Enhancing Detection program and $10 billion through its Epidemiology and Laboratory Capacity Reopening Schools program to 64 recipients, including state, local, and territorial health departments.

from multiple, large programs while simultaneously addressing the emergent and dynamic health needs of the pandemic.[20]

- **Hiring challenges.** Although the CDC funding awarded to states provided additional resources—including funding they could use to hire staff—officials from all five selected states told us they experienced challenges finding qualified personnel to fill these positions. Officials from three states said this was due to increased competition in hiring from a limited workforce and the time-limited nature of positions supported by these funds.[21] Two states also reported facing delays recruiting for new positions due to the length of time it took to obtain state approval to create new positions, according to our interviews with state officials and review of state documents.
- **Difficulties in executing contracts.** Officials from all five selected states described challenges preparing and executing contracts with other organizations to implement programs supported by the CDC funding. These officials cited factors such as the amount of time required for state contracting processes, and the need to ensure that organizations meet contract requirements.
- **Limited capacity of local organizations.** Officials from two states (Michigan and Washington) told us that in some cases the limited capacity of local community based organizations directly serving those disproportionately affected by COVID-19 made it difficult to obtain their participation. This constrained state and local health departments' ability to award the CDC funds. For example, Washington state officials planned to partner with seven health clinics serving certain disproportionately affected communities, but found that several of these clinics did not have the capacity to take on the workload related to managing or implementing the CDC funds during the program's 2-year grant period.
- **Supply challenges.** Three states (Arizona, Louisiana, and Washington) reported experiencing challenges related to the lack of availability of COVID-19 testing supplies, according to our review of state documents. Reports from one state noted that this

[20]Officials from these two states also noted that some local health departments faced similar challenges allocating or using CDC funding, which in one state was exacerbated by having been understaffed prior to the pandemic.

[21]Because certain CDC funds were available for a 2-year period, officials from three states told us that their hiring efforts were similarly time-limited.

challenge related to a surge in the demand for testing while the Delta and Omicron variants were spreading. This challenge affected the ability of two of these states to use the CDC funds.

CDC officials told us that many state and local health departments faced significant capacity challenges during the pandemic that affected their ability to allocate or use CDC funds. These capacity challenges are not unique to the CDC funding; our prior work has noted similar challenges among states as they have worked on other COVID-19 response efforts.[22]

In some cases, our selected states reported taking action to mitigate the impact of these challenges. For example, to address hiring challenges, Arizona officials reported that they were working to streamline some of their state's hiring processes and modify employment requirements, including by opening up certain public health career opportunities to those living outside the state, according to a state document. To address issues related to the limited capacity of local organizations, Washington officials told us they worked with CDC to obtain approval to redirect funds that the state was unable to allocate as planned, and instead, partner with other local organizations to support community-based outreach and related activities. CDC officials also told us that they took steps to help mitigate challenges that states were experiencing, including by offering training and technical assistance, facilitating information-sharing among states, and for the COVID-19 health disparities program, offering an extension to the period of performance to allow states more time to complete their work.

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS provided technical comments from CDC and HRSA, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

[22]For more information on these and other related challenges, see for example, GAO-22-105397, 116 and 249; and GAO, *COVID-19: Efforts to Increase Vaccine Availability and Perspectives on Initial Implementation,* GAO-21-443 (Washington, D.C.: Apr. 14, 2021), 33.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Carolyn L. Yocom
Director, Health Care

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Committee on Appropriations
United States Senate

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Committee on Finance
United States Senate

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The Honorable Ayanna Pressley
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Appendix I: Programs Specifically Supporting Communities Disproportionately Affected by COVID-19 with Selected Pandemic Relief Funds

The Department of Health and Human Services (HHS) reported that its Public Health and Social Services Emergency Fund received $349 billion in appropriations from the six COVID-19 relief laws. According to HHS, $75 billion of this amount went to the Centers for Disease Control and Prevention, Health Resources and Services Administration, Indian Health Service, and Office of Minority Health to support their COVID-19 relief efforts. These agencies allocated $29 billion, or over 35 percent, of these selected pandemic relief funds to programs specifically supporting communities disproportionately affected by COVID-19. Table 7 lists the programs supported by these funds.

Table 7: HHS Agencies' Allocations of Selected Pandemic Relief Funds to Programs Specifically Supporting Communities Disproportionately Affected by COVID-19

Agency	Program Name	Amount
Centers for Disease Control and Prevention (CDC)	Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems	$3,107,000,000
	National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved Communities	2,250,000,000
	Long Term Care Facility Infection Prevention and Control	1,620,000,000
	Increasing Community Access to Testing	875,200,000
	Epidemiology and Laboratory Capacity: Detection and Mitigation of COVID-19 in Confinement Facilities, Homeless Service Sites, and Other Congregate Living Facilities	808,500,000
	Public Health Americorps	400,000,000
	Community Health Workers for COVID Response and Resilient Communities	49,000,000
	High Risk and Underserved Partner Awards	45,000,000
	Undergraduate Public Health Scholars Program	35,000,000
	Subtotal	**9,189,700,000**
Health Resources and Services Administration (HRSA)	Rural Payments	8,500,000,000
	Uninsured Program Fund	6,800,000,000
	Health Centers	700,015,150
	Rural Health Clinics	688,800,000
	Small Rural Hospital Improvement Program	546,780,531
	Community-Based Workforce for COVID-19 Vaccine Outreach Program	330,000,000
	Community Health Worker Program	239,500,000
	Ryan White/HIV AIDS Program	90,000,000
	Rural Public Health Workforce Training Network Program	51,995,000
	Telehealth Programs	42,667,137
	Rural Tribal COVID-19 Response Program	16,305,246
	Telehealth Broadband Pilot Program	8,284,571
	Subtotal	**18,014,347,635**

Agency	Program Name	Amount
Indian Health Service (IHS)	COVID-19 testing and federally operated and tribally operated health care facilities and urban Indian organizations, including the purchase and provision of test kits and related supplies	763,000,000
	Public health workforce activities	210,000,000
	COVID-19 testing and federally operated and tribally operated health care facilities and urban Indian organizations, including the purchase and provision of personal protective equipment	70,000,000
	Vaccine distribution	20,100,000
	Subtotal	**1,063,100,000**
Office of Minority Health (OMH)	Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19	250,000,000
	National Infrastructure for Mitigating the Impact of COVID-19 within Racial and Ethnic Minority Communities	39,990,337
	National Hypertension Control Initiative: Addressing Disparities among Racial and Ethnic Minority Populations	25,009,662
	Subtotal	**315,000,000**
Total		**$28,582,147,635**

Source: GAO analysis of information from Department of Health and Human Services (HHS) agencies. | GAO-23-105500

Notes: Selected pandemic relief funds refers to $75 billion that was appropriated in six COVID-19 relief laws through the Public Health and Social Services Emergency Fund and provided to four HHS agencies (CDC, HRSA, IHS, and OMH). It does not include funds for the Provider Relief Fund administered by HRSA, which reimburses eligible health care providers for health care-related expenses or lost revenues attributable to COVID-19. Amounts include funds allocated for program administration.

Appendix II: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contact named above, Susan Barnidge (Assistant Director), Patricia Roy (Analyst-in-Charge), Robin Burke, Carmen Rivera-Lowitt, and Martha Elbaum Williamson made key contributions to this report. Also contributing were Drew Long, Ethiene Salgado-Rodriguez, and Emily Wilson Schwark.

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