Reporting for Provider Relief Fund (PRF)

Two important events happened this past Friday morning regarding the Provider Relief Fund:

- First, the reporting portal did not open as previously announced and providers do not yet need to begin reporting on the use of their funds.
- Second, additional reporting requirements and documents were released by HHS to incorporate the December 22, 2020 COVID Relief Bill updates with a focus on changes to the lost revenues calculation.

While providers can't yet report on the use of their PRF payments, they are encourage to go in and register in the portal. We recommend registering in the reporting portal with HRSA soon as there are over 400,000 entities that will need to register and later report and have already received reports of delays in the process.

Actual dates for providers to enter the portal and do their reporting have not yet been established and it appears that the decision will fall to the next HHS administration.

KEY TAKEAWAYS:

Join us this Thursday from noon to 1 p.m. EST for our first PRF Webinar.

HHS released additional information surrounding lost revenues.

Updated FAQs were released on January 12, 2021.

QUESTIONS? Contact us.

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Expanded definitions on lost revenues calculations were provided and offer three choices. We've also included the full reporting requirements from HHS in our email.

Option 1 – report on calendar year 2020 actual patient revenue vs 2019 actual patient revenue

Option 2 – report on calendar year 2020 actual patient revenue vs 2020 budgeted revenue. The budget must have been approved by March 27, 2020 and provided to HHS. Additionally, the CEO or CFO must sign an attestation "that the exact budget being submitted was established and approved prior to March 27, 2020."

Option 3 – an alternate methodology using "any reasonable method of estimating revenue" may be used. Detailed descriptions of the methodology used and why the methodology is reasonable are required. Additionally, an explanation of why the methodology is reasonable, and establish how the identified lost revenues were in fact a loss attributable to coronavirus, as opposed to another source.

Finally, in the reporting requirements, HHS mentions that any provider using option 3 will be under increased likelihood of an audit and they will review if the alternate method is reasonable. If your organization is considering using the "any reasonable method" for calculation lost revenues, we recommend you prepare all three calculations and be prepared for a detailed review by HHS.

Provider Relief Funds FAQ Updates 1.12.2021

OWNERSHIP STRUCTURES & FINANCIAL RELATIONSHIPS

Can a provider that purchased a TIN in 2019 or 2020 accept a Provider Relief Fund payment from a previous owner and complete the attestation for the Terms and Conditions? (Modified 1/12/2021)

No. The new TIN owner cannot accept the payment from another entity nor attest to the Terms and Conditions on behalf of the previous owner in order to retain the Provider Relief Fund payment, including payment under the Nursing Home Infection Control Quality Incentive Program. However, the new TIN owner may still receive funds in other distributions.

Can a provider that purchased a TIN in 2019 or 2020 accept a Provider Relief Fund payment from a previous owner and complete the attestation for the Terms and Conditions? (Modified 1/12/2021)

No. The new TIN owner cannot accept the payment from another entity nor attest to the Terms and Conditions on behalf of the previous owner in order to retain the Provider Relief Fund payment, including payment under the Nursing Home Infection Control Quality Incentive Program. However, the new TIN owner may still receive funds in other distributions.

AUDITING & REPORTING REQUIREMENTS

Can my organization get an extension to the submission due date for 2020 audit year reports for Single Audits conducted under 45 CFR Part 75? (Added 1/12/2021)

Yes. The Addendum to the 2020 Compliance Supplement, which is available here, permits recipients, which include non-federal entities and commercial organizations, that received COVID-19 funding with original due dates from October 1, 2020, through June 30, 2021, (which is applicable for fiscal year ends January 31, 2020 – September 30, 2020) an extension for up to three (3) months beyond the normal due date in the completion and submission of the Single Audit reporting package. No further action by awarding agencies is required to enact this extension. This extension does not require individual recipients and subrecipients to seek approval for the extension by the cognizant or oversight agency for audit; however, recipients and subrecipients should maintain documentation of the reason for the delayed filing.

Provider Relief Funds FAQ Updates 1.12.2021

AUDITING & REPORTING REQUIREMENTS

Can my organization get an extension to the submission due date for 2019 audit year reports for Single Audits conducted under 45 CFR Part 75? (Modified 1/12/2021)

Yes. The Office of Management and Budget (OMB) in OMB M-20-26, Extension of Administrative Relief for Recipients and Applicants of Federal Financial Assistance Directly Impacted by the Novel Coronavirus (COVID-19) due to Loss of Operations, dated June 18, 2020, provided recipients, which include non-federal entities and commercial organizations, extensions beyond the normal due date to submit 2019 audit year reports. Please see the OMB website for more details. Recipients with questions about this extension should email HRSA's Division of Financial Integrity.

Will HHS provide guidance to certified public accountants and those organizations that providers will rely on to perform audits? (Modified 1/12/2021)

Non-Federal Entities subject to Single Audit requirements can find guidance in the 2020 Compliance supplement addendum, which is available here. The applicable Catalog of Federal Domestic Assistance (CFDA) are as follows: CFDA 93.498 for the Provider Relief Fund (General and Targeted Distributions) and CFDA 93.461 COVID-19 Testing for the Uninsured.

For providers who received the General or Targeted Distributions (CFDA 93.498) with fiscal years ending on or after December 31, 2020 the auditor will need to test compliance of the Provider Relief Fund report. Providers who received $10,000 or more in aggregate Provider Relief Fund payments will need to submit a report on how they used the PRF payment, and for more information on how to accurately fill out these reports, please refer to HHS: Post Payment Notice of Reporting Requirements and HHS: Provider Relief Fund FAQs.

Provider Relief Funds FAQ Updates 1.12.2021

PHASE 3 OVERVIEW & ELIGIBILITY

What will be the methodology/formula used to calculate provider payment in Phase 3 General Distributions? (Modified 1/12/2021)

Providers will be paid up to 88 percent of their reported losses (both lost revenue and health care related-expenses attributable to coronavirus incurred during the first half of 2020). Some applicants will not receive an additional payment, either because they experienced no change in revenues or net expenses attributable to COVID-19, or because they have already received funds that equal or exceed reimbursement of 88 percent of reported losses. Providers that have not yet received and kept a payment that is approximately 2% of annual revenue from patient care as part of a prior General Distribution will receive at least that amount as part of their Phase 3 payment.

Certain applicants may not receive these full amounts because HHS determined the revenues and operating expenses from patient care reported on their applications included figures that were not exclusively from patient care (as defined in the instructions), reported figures were not reflected in submitted financial documentation, or reported figures were extreme outliers in comparison to other applicants of the same provider type; instead, HHS capped the amount paid to these provider types based on industry estimates of revenue and operating expenses from patient care.

What is the payment amount that an applicant should expect to receive from Phase 3 of the General Distribution? (Modified 1/12/2021)

If an applicant has not yet received and kept a payment that is approximately 2% of annual revenue from patient care as part of either Phase 1 or 2 of the General Distribution, then they will receive at least that amount in Phase 3 payment. In addition to this amount, providers will be paid up to 88 percent of their reported losses (both lost revenue and health care-related expenses attributable to coronavirus incurred during the first half of 2020). Some applicants may not receive this proportion of the losses reported on their applications, because HHS determined the reported revenues and operating expenses from patient care were not exclusively from patient care (as defined in the instructions) or because reported figures were not reflected in submitted financial documentation. Additionally, some applicants will not receive an additional payment either because they experienced no change in revenues or net expenses attributable to COVID19, or because they have already received funds that equal or exceed reimbursement of 88 percent of reported losses.

Provider Relief Funds FAQ Updates 1.12.2021

PHASE 3 OVERVIEW & ELIGIBILITY

When will Phase 3 payments be made? (Modified 1/12/2021)

HHS began issuing Phase 3 – General Distribution payments in mid-December, 2020, and will continue making payments through the first months of 2021 to those providers that experienced a change in revenues or net expenses attributable to COVID-19 and that have not already received funds that equal or exceed reimbursement of 88 percent of reported losses, as well as to those that have not yet received and kept a payment that is approximately 2% of annual revenue from patient care as part of either Phase 1 or 2 of the General Distribution. HHS is continuing to review and validate applications received and will disperse payments in batches as applications are adjudicated.

NURSING HOME INFECTION CONTROL DISTRIBUTION

If a provider purchases a facility that becomes eligible for a payment under the Quality Incentive Program for a given monthly reporting period, but the provider did not own the facility during the applicable reporting period, may the provider keep the payment? (Added 1/12/2021)

No. If a provider did not own the facility that qualified for a Quality Incentive Program payment during the applicable month on which the payment was based under the Quality Incentive Program and subsequently purchased the facility, the provider must return the payment to HHS. HHS makes payments based on the most current financial information available, which may not reflect the owner's information during the applicable reporting period, in the event of a sale. The current owner may still receive and retain funds for other reporting periods in which it did own the facility if it otherwise meets the eligibility criteria.

MISCELLANEOUS

What are the required timelines for reporting? (Modified 1/15/2021)

All recipients of aggregated Provider Relief Fund payments greater than $10,000 may register to report on use of funds as of December 31, 2020 starting January 15, 2021. The opening of the portal for reporting on use of funds is being delayed past January 15. In the near future, HRSA will announce the window for submitting the first report on a recipient's use of funds. Recipients with funds unexpended after December 31, 2020, have six more months from January 1 – June 30, 2021 to use remaining funds, and then must submit a second and final report no later than July 31, 2021.