# HHS OPENS PROVIDER RELIEF FUND REPORTING PORTAL WITH NEW GUIDANCE ON REPORTING REQUIREMENTS

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**Health Care and FDA Alert**

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On 1 July 2021, the Department of Health and Human Services (HHS) opened the Provider Relief Fund Reporting Portal for funding recipients to start submitting information in accordance with the Post-Payment Notice of Reporting Requirements released on 11 June 2021.[1] HHS also released a Reporting Portal User Guide,[2] which provides additional information regarding the steps for reporting and the required data elements, as well as new Frequently Asked Questions.[3] While the new guidance is largely in line with Provider Relief Fund guidance issued to date, key items of note include the following:

- **Lost Revenue Calculations.** HHS clarified that for entities calculating lost revenues using 2019 Actual Revenue (i.e., the difference between actual patient care revenues) and 2020 Budgeted Revenue (i.e., the difference between budgeted and actual patient care revenues), Reporting Entities will calculate losses by quarter, reporting US$0 for quarters in which there were no losses or the recipient made a profit and then aggregating only all quarters with losses for purposes of determining lost revenues.[4] HHS also contemplates this approach for Reporting Entities relying on an Alternate Reasonable Methodology of estimating revenues.[5] Effectively, this means Reporting Entities with losses early in the COVID-19 pandemic will not have to offset those losses with profits in quarters were revenues rebounded.
- **Extensions on Reporting and Use of Funds.** Notably, HHS announced that no extensions will be considered for either the period to use Provider Relief Funds or to report on the use of funds.[6]

## OVERVIEW

As described in our client alert here, on 11 June 2021, HHS released long-awaited updates to its reporting requirements for recipients of Provider Relief Fund payments.[7] According to HHS's updated Post-Payment Notice of Reporting Requirements, Reporting Entities are required to report on required data elements in each Payment Received Period in which they received payments exceeding US$10,000 in the aggregate. HHS notes that reporting must be completed by 11:59 p.m. Eastern Time on the last date of the Reporting Time Period.[8]

| Period | Payment Received Period | Deadline to Use Funds | Reporting Time Period |
|---|---|---|---|
| Period 1 | 10 April 2020 to 30 June 2020 | 30 June 2021 | 1 July 2021 to 30 September 2021 |

| | | | |
|---|---|---|---|
| Period 2 | 1 July 2020 to 31 December 2020 | 31 December 2021 | 1 January 2022 to 31 March 2022 |
| Period 3 | 1 January 2021 to 30 June 2021 | 30 June 2022 | 1 July 2022 to 30 September 2022 |
| Period 4 | 1 July 2021 to 31 December 2021 | 31 December 2022 | 1 January 2023 to 31 March 2023 |

## REQUIRED DATA ELEMENTS

### Entity Overview

Reporting Entities are required to report (i) the taxpayer identification number (TIN) associated with the eligible health care provider that is filing the report; (ii) the business name of the Reporting Entity as it appears on Internal Revenue Service (IRS) Form W-9; (iii) "Doing Business As" information, as applicable; (iv) the address as it appears on IRS Form W-9; (v) contact information of the person responsible for submitting the report on behalf of the Reporting Entity; and (vi) the applicable provider type or subtype.[9]

### Subsidiary Information

#### *Subsidiary Questionnaire*

Reporting Entities must complete a Subsidiary Questionnaire indicating whether the Reporting Entity has subsidiaries that are eligible health care providers and whether the Reporting Entity acquired or divested subsidiaries that are eligible health care providers and received payments during the period of availability of funds.[10] If the Reporting Entity is a subsidiary, it must indicate whether a parent entity will report on any of the Reporting Entity's General Distribution payments.[11] In addition, the Reporting Entity will need to report on whether any Targeted Distribution payments were transferred to or by a parent entity.[12]

#### *Acquired/Divested Subsidiaries*

Reporting Entities that acquired or divested related subsidiaries must indicate the change in ownership. Reporting Entities must report the (i) TIN of the acquired/divested subsidiary; (ii) whether the subsidiary was acquired or divested; (iii) the effective date of the acquisition or divestiture; (iv) if acquired, the TIN of a divesting entity; (v) if divested, the TIN of an acquiring entity; (vi) the total dollar amount received for TIN; (vii) the percentage of ownership; and (viii) whether the Reporting Entity holds a controlling interest. [13]

#### *Health Care Provider Subsidiaries*

Reporting Entities with subsidiaries must report the TINs of subsidiaries that are eligible health care providers and whether they are reporting on behalf of the subsidiary's General Distribution payments.[14] They must report all subsidiaries that meet the definition of eligible health care providers, even if there is no General Distribution payment and even if subsidiaries did not receive a Provider Relief Fund payment.

### Payments to Recipient

Reporting Entities must report all Provider Relief Fund payments made during the Payment Received Period, namely: (i) Total Nursing Home Infection Control Payments, (ii) Total Other Payments (i.e., all General

Distribution and Other Targeted Distribution Payments), and (iii) Total Rejected Payments.[15] HHS notes that, if the attestation was rejected, the recipient should have returned the payment within 15 days of the rejection in accordance with the payment Terms and Conditions.[16] HHS further notes that funding recipients that do not return payments in a timely manner will be sent to debt collection.[17]

### Interest Earned on Payment

Reporting Entities that held the payments being reported in an interest-bearing account must report the dollar value of interest earned on those payments. Interest should be calculated from the date the payment was received until the date of expenditure (or the date of return).[18] Interest must be broken down into two categories: (i) the total amount of interest earned on Nursing Home Infection Control payments (if applicable), and (ii) the total amount of interest earned on other Provider Relief Fund payments.[19]

### Tax Information and Fiscal Year

Reporting Entities must select from a drop-down list their federal tax classification. HHS notes that the Reporting Entity may refer to IRS Form W-9 for information regarding the federal tax classification, Exempt Payee Code (optional), and Exempt from Foreign Account Tax Compliance Act status (optional).[20] Reporting Entities must also select from a drop-down list the fiscal year-end date that matches the month in which the Reporting Entity reports its fiscal year financial results. If the fiscal year-end date has changed, the Reporting Entity should enter the fiscal year-end date applicable at the time of reporting.[21]

### Single Audit Information

Funding recipients that expend a total of US$750,000 or more in federal funds during their fiscal year are subject to Single Audit requirements. Reporting Entities must indicate for Fiscal Years 2019, 2020, and 2021 whether they were subject to audit and Provider Relief Fund payments were included in the audit.[22]

### Other Assistance Received

Reporting Entities must enter other assistance received by quarter during the period of availability, including Department of the Treasury and Small Business Administration assistance, Federal Emergency Management Agency assistance, HHS CARES Act Testing payments, insurance, and local, state, and tribal government assistance. The Reporting Entity must enter other assistance received by calendar year quarters in the period of availability of funds for the payments received in the Payment Received Period that corresponds to the current reporting period.[23] Calendar year quarters are defined as follows:

- Quarter 1 (Q1): 1 January–31 March
- Quarter 2 (Q2): 1 April–30 June
- Quarter 3 (Q3): 1 July– 30 September
- Quarter 4 (Q4): 1 October– 31 December

### Use of General and Other Targeted Distribution Payments

Reporting Entities that received between US$10,001 and US$499,999 in aggregated payments are required to report on the use of funds in two categories: (i) General and Administrative (G&A) Expenses, and (ii) Health Care-Related Expenses.[24] Reporting Entities that received US$500,000 or more must report on the use of funds in greater detail according to subcategories of expenses.[25] Expenses are reported by calendar year quarter. While

 

Reporting Entities are required to maintain documentation to demonstrate that costs were obligated or incurred during the period of availability, they are not required to submit the documentation.

### Net Unreimbursed Expenses Attributable to COVID-19

Reporting Entities must report unreimbursed health care expenses attributable to COVID-19, net of other reimbursed sources, in two categories: (i) G&A Expenses, and (ii) Health Care-Related Expenses.[26] Reporting Entities are required to report on the net unreimbursed expenses by indicating the calendar year quarterly expenses during the period of availability that correspond to the current reporting period.[27]

### Actual Patient Care Revenue

If the total payment equals total expenses, Reporting Entities must report actual patient care revenue. The Reporting Entity must provide total actual patient care revenue for completed calendar years within the period of availability for the payments received that correspond to the current reporting period.[28]

### Lost Revenue Information

If total payment is greater than total expenses, Reporting Entities may apply payments to lost revenue. The Reporting Entity must select the method they will use to calculate lost revenue, namely: (i) 2019 Actual Revenue (i.e., the difference between actual patient care revenues using 2019 calendar year quarters as the baseline), (ii) 2020 Budgeted Revenue (i.e., the difference between budgeted and actual patient care revenues), or (iii) an alternate reasonable methodology of estimating revenues.

As noted above, HHS also clarified that if a Reporting Entity experienced revenue losses during some, but not all, of the quarters, Provider Relief Fund payments may still be used to cover losses during quarters where losses occurred, and Reporting Entities utilizing Option 1 (2019 Actual Revenue) or Option 2 (2020 Budgeted Revenue) will not be required to offset lost revenues by quarters during which patient revenue increased because HHS instructs providers to enter US$0 in these quarters in lieu of showing the profits in such quarters.[29] HHS also instructs Option 3 (Alternate Reasonable Methodology) providers to enter US$0 for quarters with profits, suggesting a similar approach will be permitted for Option 3 reporters as well.[30]

If a Reporting Entity experienced revenue losses during some, but not all, of the quarters, payments may only be used to cover losses during quarters where losses occurred. However, HHS permits carrying forward excess expenses and losses from quarters with funds received less than expenses or losses.

#### *2019 Actual Revenue*

Reporting Entities must report actual quarterly revenue information for calendar years 2019 to the end of the period of availability (i.e., 2019 Actuals, 2020 Actuals, 2021 Actuals). Reporting Entities must submit revenues or net charges from patient care split by payer mix and calendar year quarter for each quarter during the period of availability.[31] If there is no revenue to report for a quarter, HHS is instructing Reporting Entities to enter “0.” Patient care is defined as health care, services, and supports, as provided in a medical setting, at home, telehealth, or in the community.[32] It does not include revenue such as insurance, retail, or real estate revenues; prescription sales; grants or tuition; contractual adjustments from third-party payers; charity care adjustments; bad debt; and gains or losses on investments.

### *2020 Budgeted Revenue*

Reporting Entities must report quarterly revenue information for calendar years 2020 through the end of the period of availability (i.e., 2020 Budgeted, 2020 Actuals, 2021 Budgeted, 2021 Actuals). Reporting Entities will submit (i) budgeted and (ii) actuals for their revenues or net charges from patient care split by payer mix and by calendar year quarter for each quarter during the period of availability.[33] As with actual revenue, if there is no revenue to report for a quarter, HHS is instructing Reporting Entities to enter "0."[34]

HHS notes that, if Reporting Entities choose this method, lost revenues that can be applied to Provider Relief Fund payments will be calculated by quarter for each quarter during the period of availability, as a stand-alone calculation, with 2019 quarters serving as a baseline. For each calendar year of reporting, the applicable quarters where lost revenues are demonstrated are totaled to determine an annual lost revenues amount.[35] The annual lost revenues are then added together to determine a total that can be applied to Provider Relief Fund payments.[36] Reporting Entities must also submit a copy of the 2020 budget approved prior to 27 March 2020, and an attestation by a chief executive officer, chief financial officer, or other similarly responsible individual representing the Reporting Entity on the accuracy of the budget.

### *Alternate Reasonable Methodology*

Reporting Entities are required to report quarterly lost revenues values using their alternate reasonable method calculation for calendar years 2020 through the end of the period of availability. If there is an increase in revenues during any quarter during the period of availability, the Reporting Entity must enter "0" to indicate no lost revenues.[37] Reporting Entities selecting this methodology are required to submit (i) a narrative document describing the methodology and an explanation of why it is reasonable, (ii) the calculation of lost revenues attributable to COVID-19, and (iii) any additional supporting documentation. HHS will notify Reporting Entities if their proposed methodologies are not reasonable.[38] If HHS determines that a Reporting Entity's proposed alternate methodology is not reasonable, the entity will be asked to resubmit its report within 30 days of notification using one of the other options to calculate lost revenue.

## Personnel Metrics

Reporting Entities must report personnel metrics. They must calculate a total number of people employed (across all TINs included in the reporting) by labor category for all clinical and nonclinical staff. All clinical and nonclinical personnel employed at any point and in any capacity during a calendar year quarter by the Reporting Entity (or its subsidiaries included in the report) must be categorized into one of the following labor categories.[39] If a hiring action occurred during the quarter, personnel should be considered nonclinical if less than 50 percent of their time does not involve direct patient care. The employee should be identified in the category that occurred closest to the end of the quarter. All full-time, part-time, or contractor personnel should be those that experienced no hiring action during the respective quarter.

- **Full Time**: Number of personnel employed for an average of 30 hours of service per week or 130 hours for a calendar month. However, health care practices may have exceptions to this, such as nursing shifts.
- **Part Time**: Number of personnel employed for between one and 34 hours per week, whom may or may not qualify for benefits.
- **Contractor**: Number of personnel employed as an individual or under organizational contracts and do not receive direct benefits or compensation from the employer or provider.

 

- **Furloughed**: Number of personnel on temporary involuntary and unpaid leave of absence.
- **Separated**: Number of personnel who (i) voluntarily submit a written or verbal notice of resignation, or (ii) the employer or provider decided to terminate its relationship with (includes layoffs and expired contracts).
- **Hired**: Number of personnel (i) not previously employed by the employer, or (ii) that left an employer due to voluntary or involuntary separation and are brought back to work by employer.

## Patient Metrics

Reporting Entities must report patient metrics, including inpatient admissions, outpatient visits (in-person or virtual), emergency department visits, and stays for long- and short-term residential facilities.[40]

- **Inpatient Admissions**: Number of hospital admissions on a clinician's order (i.e., direct admit) or formally admitted from the emergency department to the hospital (i.e., emergency admission).
- **Outpatient Visits (in-person and virtual)**: Number of in-person or virtual patient encounters with a clinician in an office-based clinic or hospital outpatient department setting that do not require an inpatient admission.
- **Emergency Visits**: Number of emergency department encounters for care or treatment. This may include patients on observation status who are cared for no longer than 72 hours and not formally admitted to a hospital.
- **Facility Stays (for long- and short-term residential facilities)**: Number of stays (defined as unique admissions) for patients residing in a long- or short-term care or treatment facility.

## Facility Metrics

Reporting Entities must report the number of staffed beds for medical or surgical use, critical care, and any other type of staffed bed that the facility has physically available and licensed to operate.[41]

## Impact of Payment Survey

### *Financial Effects of Payment*

Reporting Entities must answer certain questions regarding the financial impact of the payments, including whether they (i) had a significant impact on overall operations; (ii) affected the ability to retain personnel, pay fringe benefits, pay insurance, pay operational expenses, make lease payments, or pay utilities or operations; (iii) helped maintain solvency or prevent bankruptcy; (iv) helped retain staff that would have been furloughed or terminated; and (v) helped rehire or reactivate staff from furlough.[42]

### *Clinical Care Effects of Payments*

Reporting Entities must answer certain questions regarding the clinical care impact of the payments, including whether they (i) helped to make the changes needed to operate during the pandemic (e.g., by acquiring personal protective equipment, creating temporary facilities, providing for virtual visits); (ii) helped facility operations and patient care by allowing our facility to buy testing equipment, buy personal protective equipment, buy other equipment, buy supplies, enhance information technology, enhance or implement telemedicine services, improve facilities, increase testing capacity, and other healthcare related expenses; (iii) helped care for and treat patients

 

with COVID-19 (for applicable treatment facilities); and (iv) whether the payments had other impacts on business or patient services.[43]

### Use of Skilled Nursing Facility and Nursing Home Infection Control Distribution Payments (if applicable)

Reporting Entities that received between US$10,001 and US$499,999 in aggregated payments during each Payment Received Period are required to report on the use funds in two categories: (i) G&A Expenses, and (ii) Health Care-Related Expenses.[44] Reporting Entities that received US$500,000 or more in aggregated payments during each Payment Received Period are required to report on the use of these infection control payments in greater detail.[45] Expenses must be reported by calendar year quarter.

## CONCLUSION

Providers that received Provider Relief Funds between 10 April 2020 and 30 June 2020 will be the first tranche to begin reporting. They will have until 30 September 2021 to report on their use of funds. Recipients should review the reporting requirements and guidance as they begin the reporting process. K&L Gates' health care and FDA practice will continue to monitor further developments. K&L Gates provides guidance to health care providers regarding the Provider Relief Fund, including compliance with reporting and other requirements, as well as other funding programs available as a result of the pandemic.

## FOOTNOTES

[1] *See* Dep't of Health & Hum. Servs., Health Res. & Servs. Admin., Welcome to the Provider Relief Fund Reporting Portal, https://prfreporting.hrsa.gov/s/ (last visited July 7, 2021).

[2] *See* Dep't of Health & Hum. Servs., Health Res. & Servs. Admin., User Guide: Provider Relief Fund Reporting Portal - Reporting (June 30, 2021), https://hrsac19.my.salesforce.com/sfc/p/#t00000004XgP/a/t0000001mQd1/jTi7NwMvPg2yg.cahJMuyvHg9Maa4Uw0eKMLndi7Hss [hereinafter Provider Relief Fund Reporting Portal User Guide].

[3] *See* Dep't of Health & Hum. Servs., CARES Act Provider Relief Fund Frequently Asked Questions (last visited July 7, 2021), https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf [hereinafter Provider Relief Fund FAQs].

[4] Provider Relief Fund Reporting Portal User Guide at 43–45.

[5] *Id.* at 47.

[6] Provider Relief Fund FAQs at 34–35.

[7] *See* Dep't of Health & Hum. Servs., Provider Relief Fund General and Targeted Distribution Post-Payment Notice of Reporting Requirements (June 11, 2021), https://www.hhs.gov/sites/default/files/provider-post-payment-notice-of-reporting-requirements-june-2021.pdf.

[8] Provider Relief Fund Reporting Portal User Guide at 1.

[9] *Id.* at 13–14.

 

[10] *Id*. at 15–16.

[11] *Id*.

[12] *Id*.

[13] *Id*. at 17–18.

[14] *Id*. at 19.

[15] *Id*. at 20–21.

[16] *Id*.

[17] *Id*.

[18] *Id*. at 24–25.

[19] *Id*.

[20] *Id*. at 26.

[21] *Id*.

[22] *Id*. at 27.

[23] *Id*. at 30–31.

[24] *Id*. at 35–37.

[25] *Id*.

[26] *Id*. at 38–39.

[27] *Id*.

[28] *Id*. at 39–40.

[29] *Id*. at 43–45.

[30] *Id*. at 47.

[31] *Id*. at 42–43.

[32] *Id*. at 44–46.

[33] *Id*.

[34] *Id*.

[35] *Id*.

[36] *Id*.

[37] *Id*. at 46–48.

[38] *Id*.

[39] *Id*. at 57–59.

[40] *Id*. at 60.

[41] *Id*. at 61.

[42] *Id*. at 62–63.

[43] I*d*. at 63.

[44] *Id*. at 32–34.

[45] *Id.*

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