Updated HHS FAQs – June 11, 2021

Provider Relief Fund General Information (FAQs)

Terms and Conditions

Is there a set period of time in which providers must use the funds to cover allowable expense or lost revenues attributable to COVID-19? *(Modified 6/11/2021))*

Yes. Provider Relief Fund recipients must only use payments for eligible expenses, including services rendered, and lost revenues attributable to coronavirus before the deadline that corresponds to the Payment Received Period, which is based on the date the payment is received. Funds will be available for at least 12 months and a maximum of 18 months. The payment is considered received on the deposit date for automated clearing house (ACH) payments or the check cashed date.

	Payment Received Period	**Deadline to Use Funds**
Period 1	April 10, 2020 to June 30, 2020	June 30, 2021
Period 2	July 1, 2020 to December 31, 2020	December 31, 2021
Period 3	January 1, 2021 to June 30, 2021	June 30, 2022
Period 4	July 1, 2021 to December 31, 2021	December 31, 2022

Providers must follow their basis of accounting (e.g., cash, accrual, or modified accrual) to determine expenses.

Recipients may use payments for eligible expenses incurred prior to receipt of those payments (i.e., pre-award costs) so long as they are to prevent, prepare for, and respond to coronavirus. However, HHS expects that it would be highly unusual for providers to have incurred eligible expenses prior to January 1, 2020. All recipients are subject to audit.

HHS reserves the right to audit Provider Relief Fund recipients now or in the future, and is authorized to collect any Provider Relief Fund amounts that have not been supported by documented expenses or losses attributable to coronavirus or not used in a manner consistent with program requirements or applicable law. All payment recipients must attest to the Terms and Conditions, which require the submission of documentation to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus.

In order to accept a payment, must the provider have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received? ***(Modified 6/11/2021)***

No. Providers do not need to be able to prove that prior and/or future lost revenues and expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment at the time they accept such a payment. Providers must report on the use of Provider Relief Fund payments in accordance with legal and program requirements in the relevant Reporting Time Period. Recipients may use payments for eligible expenses incurred prior to receipt of those payments (i.e., pre-award costs) so long as they are to prevent, prepare for, and respond to coronavirus. Providers must follow their basis of accounting to determine expenses. Duplication of expenses and lost revenues is not permitted. All recipients are subject to audit.

What should providers do if they have remaining Provider Relief Fund money that they cannot expend on permissible expenses or losses by the relevant deadline? ***(Added 6/11/2021)***

Providers that have remaining Provider Relief Fund money that they cannot expend on permissible expenses or losses by the relevant deadline will return this money to HHS. Deadlines to use funds correspond to the date they received payment, as outlined in the Post-Payment Notice of Reporting Requirements. The Provider Relief Fund Terms and Conditions and legal requirements authorize HHS to audit Provider Relief Fund recipients now or in the future to ensure that program requirements are met. HHS is authorized to recoup any Provider Relief Fund amounts that were made in error or exceed lost revenue or expenses due to COVID-19, or in cases of noncompliance with the Terms and Conditions.

Auditing and Reporting Requirements

Will HHS release separate requirements for recipients of the Skilled Nursing Facility (SNF) and Nursing Home Infection Control Distribution payments? ***(Added 6/11/2021)***

No. HHS included requirements on how recipients of the SNF and Nursing Home Infection Control Distribution payments will report on these funds in the June 2021 Post-Payment Notice of Reporting Requirements. Recipients of this funding will be able to submit a consolidated report that distinguishes use of SNF and Nursing Home Infection Control Distribution funds from use of other General and Targeted Distribution payments.

How does a Reporting Entity determine whether an expense is eligible for reimbursement through the Provider Relief Fund? ***(Added 6/11/2021)***

To be considered an allowable expense under the Provider Relief Fund, the expense must be used to prevent, prepare for, and respond to coronavirus. Provider Relief Fund payments may also be used for lost revenues attributable to the coronavirus. Reporting Entities are required to maintain adequate documentation to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources and other sources were not obligated to reimburse them.

The burden of proof is on the Reporting Entity to ensure that adequate documentation is maintained.

Will HHS provide guidance to certified public accountants and those organizations that providers will rely on to perform audits? *(Modified 6/11/2021)*

The only guidance HHS provides to auditors is through the Office of Management and Budget Compliance Supplement. Non-Federal Entities subject to Single Audit requirements can find guidance in the 2020 Compliance Supplement Addendum, which is available at https://www.whitehouse.gov/wp-content/uploads/2020/12/2020-Compliance-Supplement-Addendum_Final.pdf - PDF and in the forthcoming 2021 Compliance Supplement. The applicable Assistance Listings numbers include 93.498 [Provider Relief Fund] and 93.461 [HRSA COVID-19 Uninsured Program].

Are Provider Relief Fund payments to commercial (for-profit) organizations subject to Single Audit in conformance with the requirements under 45 CFR 75 Subpart F? *(Modified 6/11/2021)*

Commercial organizations that expend $750,000 or more in annual awards have two options under 45 CFR 75.216(d) and 75.501(i): 1) a financial related audit of the award or awards conducted in accordance with Generally Accepted Government Auditing Standards; or 2) an audit in conformance with the requirements of 45 CFR 75.514 (Single Audit). Provider Relief Fund General and Targeted Distribution payments (93.498) and Uninsured Testing, Treatment, and Vaccine Administration reimbursement payments (93.461) must be included in determining whether an audit in accordance with 45 CFR Subpart F is required (i.e., annual *total awards expended* are $750,000 or more). Audit reports of commercial organizations must be submitted via email to HRSA's Division of Financial Integrity at PRFaudits@hrsa.gov.

Use of Funds

How do I determine if expenses should be considered "expenses attributable to coronavirus not reimbursed by other sources?" *(Added 6/11/2021)*

Expenses attributable to coronavirus may include items such as supplies, equipment, information technology, facilities, personnel, and other health care-related costs/expenses for the period of availability. The classification of items into categories should align with how Provider Relief Fund payment recipients maintain their records. Providers can identify their expenses attributable to coronavirus, and then offset any amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/Children's Health Insurance Program (CHIP); other funds received from the federal government, including the Federal Emergency Management Agency (FEMA); the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured (Uninsured Program);the COVID-19 Coverage Assistance Fund (CAF); and the Small Business Administration (SBA) and Department of the Treasury's Paycheck Protection Program (PPP). Provider Relief Fund payments may be applied to the remaining expenses or costs, after netting the other funds received or obligated to be received which offset those expenses. The

Provider Relief Fund permits reimbursement of marginal increased expenses related to coronavirus provided those expenses have not been reimbursed from other sources or that other sources are not obligated to reimburse.

Supporting Data

What documentation is required for reporting? *(Modified 6/11/2021)*

Supporting worksheets will be available to assist Reporting Entities with completion of reports. In addition, Reporting Entities who are using a portion of their funds for lost revenues may be required to upload supporting documentation when reporting on their calculation of lost revenues. The documentation required is dependent upon which method of calculating lost revenues providers select. Please review the most recently published Post-Payment Notice of Reporting Requirements for additional details.

Change of Ownership

Who is responsible for reporting use-of-funds in the event of a change of ownership after receipt of a Provider Relief Fund payment? *(Modified 6/11/2021)*

In the case of a change in ownership after receipt of a Provider Relief Fund payment, the responsibility for reporting in the Provider Relief Fund Reporting Portal is dependent on whether funds were from the General or Targeted Distribution.

For General Distribution payments: A parent entity may report on its subsidiaries' General Distribution payments regardless of whether the subsidiary TINs received the General Distribution payments directly or whether General Distribution payments were transferred to them by the parent entity. The parent entity may report on these General Distribution payments regardless of whether the parent or the subsidiary attested to the Terms and Conditions.

For Targeted Distribution payments: The original recipient of a Targeted Distribution payment is always the Reporting Entity. A parent entity may not report on its subsidiaries' Targeted Distribution payments as part of its consolidated report. The original recipient of a Targeted Distribution must report on the use of funds in accordance with the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act. This is required regardless of whether the parent or subsidiary received the payment or whether that original recipient subsequently transferred the payment. A Reporting Entity that is a subsidiary must indicate the payment amount of any of the Targeted Distributions it received that were transferred to/by the parent entity, if applicable.

Non-Financial Data

What are the categories for classifying personnel? *(Modified 6/11/2021)*

Personnel will be classified as either "clinical" or "non-clinical" staff using the following categories: a) full-time; b) part-time; c) contractor; d) furloughed; e) separated; and f) hired.

a. Full-time: number of personnel employed on average 30 hours of service per week, or 130 hours for a calendar month.
b. Part-time: number of personnel employed any time between 1 and 34 hours per week, whom may or may not qualify for benefits.
c. Contractor: number of personnel employed as an individual or under organizational contracts and do not receive direct benefits or compensation from the Reporting Entity.
d. Furloughed: number of personnel on involuntary and unpaid leave of absence.
e. Separated: number of personnel who 1) voluntarily submitted a written or verbal notice of resignation or 2) the Reporting Entity decided to terminate its relationship with the employee(s) (includes lay-offs and expired contracts).
f. Hired: number of personnel 1) not previously employed by the Reporting Entity or 2) that left a company due to voluntary or involuntary separation and are brought back to work by employer

What are the categories for patient admission? ***(Modified 6/11/2021)***

Patient metric categories include a) inpatient admissions; b) outpatient admissions visits (in-person and virtual); c) emergency department visits; and d) facility stays (for long-term and short-term residential facilities). The definitions are included below.

a. 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).
b. Outpatient Visits: 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.
c. Emergency Visit: 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 but not formally admitted to a hospital.
d. Facility Stays: number of stays (defined as unique admissions) for patients residing in a long-term or short-term care or treatment facility.

A comprehensive user guide with definitions will be made available when the first reporting period begins.

What is considered a "staffed bed" for reporting facility metrics? ***(Modified 6/11/2021)***

A staffed bed is licensed and physically available with staff on hand to attend to patients; includes both occupied and available beds.

Miscellaneous

Who is required to report when the portal opens? *(Added 6/11/2021))*

A Reporting Entity must report only when they have retained over $10,000 in aggregated Provider Relief Fund payments received during a single Payment Received Period.

What are the required timelines for reporting? *(Modified 6/11/2021)*

Provider Relief Fund recipients are required to report in each Payment Received Period in which they received one or more payments exceeding, in the aggregate, $10,000, as indicated in the table below. Reporting must be completed and submitted to HRSA by the last date of the relevant Reporting Time Period. Provider Relief Fund recipients that do not report within the respective Reporting Time Period are out of compliance with payment Terms and Conditions and funds may be subject to recoupment.

	Payment Received Period (Payments Exceeding $10,000 in Aggregate Received)	**Reporting Time Period**
Period 1	April 10, 2020 to June 30, 2020	July 1, 2021 to September 30, 2021
Period 2	July 1, 2020 to December 31, 2020	January 1, 2022 to March 31, 2022
Period 3	January 1, 2021 to June 30, 2021	July 1, 2022 to September 30, 2022
Period 4	July 1, 2021 to December 31, 2021	January 1, 2023 to March 31, 2023

If an entity received payments totaling over $10,000, but returned some, do they still have to report? *(Modified 6/11/2021)*

A Reporting Entity must report only when they have retained over $10,000 in aggregated Provider Relief Fund payments received during a single calendar year.

What is the process to return unused funds? *(Modified 6/11/2021)*

When the first reporting period begins, providers will be able to return unused funds through the Reporting Portal.

General Distribution FAQs

Phase 3

Overview and Eligibility

Are providers that received payments under Phase 3 of the General Distribution limited to using these funds to cover coronavirus-related losses or expenses experienced during the first two quarters of calendar year 2020? ***(Modified 6/11/2021)***

No. The Terms and Conditions require payment recipients to certify that funds will only be used to prevent, prepare for, and respond to coronavirus, and will only reimburse the recipient for health care-related expenses or lost revenues that are attributable to coronavirus. While HHS collected information on the losses and expenses associated with the first two quarters of 2020 for the purposes of making additional General Distribution payments to those providers with demonstrated financial need, the Terms and Conditions do not place limits on which quarters these funds must be applied to cover eligible losses or expenses.