

October 22, 2020

HHS Revises Provider Relief Fund Reporting Requirements

Department also expands eligibility for its forthcoming 'General Distribution' of funds

The Department of Health and Human Services (HHS) Oct. 22 issued a revision to its reporting requirements for providers that received Provider Relief Fund (PRF) payments. The [notice](#) includes revised data elements that recipients must submit for calendar years 2019 and 2020. Specifically, recipients will report their use of PRF payments by submitting the following information:

1. Health care-related expenses attributable to COVID-19 that another source has not reimbursed and is not obligated to reimburse, which may include General and Administrative (G&A) or health care-related operating expenses (*note: this definition is unchanged from the previous, September guidance*); and
2. PRF payment amounts not fully expended on health care-related expenses attributable to COVID-19 are then applied to patient care lost revenues, net of the health-care related expenses attributable to COVID-19 calculated under step one. **Recipients may apply PRF payments toward lost revenue, up to the amount of the difference between their 2019 and 2020 actual patient care revenue.**

HHS also states that if recipients do not expend PRF funds in full by the end of calendar year 2020, they will have an additional six months in which to use remaining amounts toward expenses attributable to COVID-19 but not reimbursed by other sources, or to apply toward lost revenues in an amount not to exceed the difference between 2019 and 2021 actual revenue. For example, the reporting period January-June 2021 will be compared to the same period in 2019, or January-March 2021 will be compared to the same quarter in 2019.

The administration, also in this notice, provides helpful clarifications to allow health systems to move general PRF payments to subsidiary hospitals, even if a subsidiary hospital originally attested to the receipts of the funds. Specifically, the notice expands the definition of “reporting entity” to include, for example, “the parent of one or more subsidiary billing TINs that received General Distribution payments,” among other criteria.

On Sept. 19, HHS had issued new reporting requirements that were deeply problematic for hospitals and would have forced many to unjustifiably return funding. The AHA and our member hospitals and health systems [advocated aggressively](#) against the September guidance. The department alludes to feedback it received in a [notice](#)

explaining why it revised its September requirements and instead issued those described above.

Expansion of Phase 3 “General Distribution” Eligibility. HHS also [announced](#) that it is expanding eligibility for its forthcoming Phase 3 “general distribution” of \$20 billion to include additional providers (regardless of whether they accept Medicaid or Medicare) that may not have received PRF payments. Among those it cites are hospital units; behavioral health providers; hospice providers; laboratories; and ambulatory health care facilities. For more information on how to apply for funds under Phase 3, see our [summary](#).

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and Paycheck Protection Program and Health Care Enhancement Act included \$175 billion in the Public Health and Social Services Emergency Fund to reimburse health care providers for health care-related expenses or lost revenues not otherwise reimbursed that are attributable to COVID-19. In order to accept these funds, recipients agreed to Terms & Conditions, which require compliance with reporting requirements as specified by HHS.

Further Questions

If you have questions, please contact AHA at 800-424-4301.