

The Provider Relief Fund: Frequently Asked Questions

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SUMMARY

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The Provider Relief Fund: Frequently Asked Questions

The Provider Relief Fund (PRF) was established in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) to reimburse, through grants or other mechanisms, eligible health care providers for increased expenses or lost revenue attributable to Coronavirus Disease 2019 (COVID-19). The CARES Act provided $100 billion to prevent, prepare for and respond to coronavirus, domestically and internationally. The amounts were subsequently increased by $78 billion, with $75 billion added in the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA, P.L. 116-139) and $3 billion in the Consolidated Appropriations Act, 2021 (P.L. 116-260). The latter was the first time the Provider Relief Fund was referred to in statute and required changes to the fund's reporting requirements and requirements for future fund allocations.

The answers to the frequently asked questions (FAQs) in this report provide overview information on the PRF, how funds have been allocated, and the fund's requirements for provider reporting. In addition, this report describes the use of the PRF to pay providers for providing coronavirus testing, treatment, and vaccines to uninsured individuals and the use of the fund to pay providers for costs associated with vaccinating individuals who are underinsured (e.g., who do not have insurance that covers vaccine administration).

Contents

Fund Overview Questions 1
What Is the Provider Relief Fund? 1
Do Providers Have to Repay Their PRF Funds? 1
What Type of Health Providers Are Eligible for the Fund? 2
How Much Was Appropriated to the Fund? 2
What Agency Administers the Fund? 2
What Data Are Available on the Fund? 2
Fund Allocation Questions 3
How Has Funding Been Allocated? 3
General Distributions 3
Targeted Distributions 4
What Is the Difference Between General and Targeted Distributions? 5
What Are Some Potential Drawbacks of the Methodology that HHS Used to Distribute Funds? 5
How Are Allocations Determined? 5
What Is the Relationship Between the Provider Relief Fund, the Uninsured Fund, and the Coverage Assistance Fund? 6
What Is the Relationship Between the PRF and the American Rescue Plan Funding for Rural Providers? 7
What Other Purposes Have the PRF Funds Been Used For? 7
Provider Requirements 7
What Must Providers Do to Receive Funds? 7
What Requirements Apply to Providers Receiving PRF Funds? 8
What Must Providers Report After Receiving Funds? 8
Who Is Responsible for Reporting on PRF Funds? 9
Can Providers Refuse or Return Funds? 10
Agency Requirements 10
What Are HHS Reporting Requirements for the Fund? 10

Contacts

Author Information 10

The Provider Relief Fund (PRF) was established in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136), which provided $100 billion to reimburse health care providers for increased expenses or lost revenue attributable to Coronavirus Disease 2019 (COVID-19). The amounts were subsequently increased by $78 billion, with $75 billion appropriated in the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA, P.L. 116-139) and $3 billion appropriated in the Consolidated Appropriations Act, 2021 (P.L. 116-260). The latter law was the first time the Provider Relief Fund was referred to in statute and required changes to the fund's reporting requirements and requirements for future fund allocations.

The answers to the frequently asked questions (FAQs) below provide overview information on the fund, how funds have been allocated, and the fund's requirements for provider reporting. Data on the fund are publicly available and updated regularly as new funds are released or as entities return funds.[1] Due to ongoing data updates, this report does not include information on amounts allocated or remaining; however, data are available for download and can be used to examine the amounts that remain in the fund and the amount that a particular entity or state received, among other things.

Fund Overview Questions

What Is the Provider Relief Fund?

The CARES Act appropriated $100 billion to "to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus."[2] These funds were appropriated to the Public Health and Social Services Emergency Fund (PHSSEF), a flexible funding source within the Department of Health and Human Services (HHS). The fund was later termed the "Provider Relief Fund." The language did not specify an administering entity for the fund. HHS elected to have the fund administered by the Health Resources and Services Administration (HRSA). HRSA is also administering the Uninsured Fund and the Coverage Assistance Fund, both of which are using an unspecified amount of the PRF to pay providers (see "What Is the Relationship Between the Provider Relief Fund, the Uninsured Fund, and the Coverage Assistance Fund?").

Do Providers Have to Repay Their PRF Funds?

PRF funds are grants and do not have to be repaid.[3] Providers must attest to receiving these funds and comply with the applicable terms and conditions of the PRF (see "What Requirements Apply to Providers Receiving PRF Funds?").

[1] U.S. Department of Health and Human Services (HHS), "CARES Act Provider Relief Fund: Data," https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/data/index.html#fifty-billion-targeted-allocations. Note that these data include amounts appropriated to the Provider Relief Fund (PRF) in the three laws. To download these data, go to https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6.

[2] P.L. 116-136, 134 STAT. 563.

[3] This contrasts with the Medicare Accelerated and Advance Payment Program, in which providers received Medicare payments in advance of providing and billing for these services to Medicare beneficiaries. For more information, see CRS Report R46698, *Medicare Accelerated and Advance Payments and COVID-19: Frequently Asked Questions*.

What Type of Health Providers Are Eligible for the Fund?

The CARES Act provided funds for lost revenue and defined eligible providers as follows: "public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit entities and not-for-profit entities not otherwise described in this proviso as the Secretary may specify, within the United States (including territories), that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19."[4] In these provisions, "the Secretary" refers to the HHS Secretary. Allocations from the fund have included both specific types of providers (e.g., nursing homes) and providers that bill specific programs (e.g., Medicare Fee-for-Service).[5]

How Much Was Appropriated to the Fund?

A total of $178 billion was appropriated to the fund across three laws, as follows:

- $100 billion in the CARES Act,
- $75 billion in the Paycheck Protection Program and Health Care Enhancement Act, and
- $3 billion in the Consolidated Appropriations Act, 2021.

What Agency Administers the Fund?

The CARES Act did not specify an administering entity within HHS. HHS elected to have the fund administered by HRSA. HRSA is also administering two companion funds: (1) the Uninsured Program,[6] which includes an unspecified amount allocated from the CARES appropriation to the PRF (see "What Is the Relationship Between the Provider Relief Fund, the Uninsured Fund, and the Coverage Assistance Fund?"), and (2) the COVID-19 Coverage Assistance Fund, which covers the administrative costs for patients who have insurance, but whose insurance does not cover vaccine administrative cost fees or has cost sharing for these fees.[7]

What Data Are Available on the Fund?

HHS makes data on the fund publicly available and updates the data regularly as new funds are distributed or as entities return funds.[8] Data are available for download and can be used to examine the amounts that remain in the fund and the amount that a particular entity or state received, among other things. The data that HHS provide on payments are limited to provider name, state, city, and payment amount. This tends to limit the ability to analyze data by provider type (e.g., evaluate how much money hospitals received). Analysts may find that such data cannot

[4] P.L. 116-136, 134 STAT. 563.

[5] See information about targeted distributions and general distributions at HHS, "CARES Act Provider Relief Fund: General Information," https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html.

[6] Formally, this is termed the "COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured," HHS, Health Resources and Services Administration (HRSA), "COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured," https://www.hrsa.gov/coviduninsuredclaim.

[7] HHS, HRSA, "COVID-19 Coverage Assistance Fund," https://www.hrsa.gov/covid19-coverage-assistance.

[8] To download these data, go to https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6. As of the date of this report's publication, new funds have not been distributed since the third general distribution in December 2020.

be reliably merged with other data sets (e.g., Medicare provider data) because the variation in entity names (e.g., capitalization) makes it difficult to accurately merge data.

Fund Allocation Questions

How Has Funding Been Allocated?

In statute, the HHS Secretary had broad authority to determine how the PRF would be allocated. HHS has chosen to allocate funds in two ways: (1) general, which are available to a broad group of providers, and (2) targeted distributions, which have more restrictive eligibility general aimed at providing funds to a facility type with high needs (e.g., nursing homes). The two types are described in more detail below. Readers may also be interested in a time line of fund allocations, available at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html#phase1.

General Distributions

HHS has made three general distributions. The first, Phase One, was a general allocation of $50 billion distributed to health providers that billed Medicare Fee-for-Service.[9] This distribution occurred because the federal government paid those providers directly and therefore had the ability to provide funds quickly to those entities. The CARES Act, enacted on March 27, 2020, established the PRF; Phase One funding began on April 10, 2020. A provider's Medicare Fee-for-Service patient revenues in 2018 determined the amounts allocated; as such, some safety-net and other provider types that serve Medicaid and uninsured populations were either ineligible for this allocation or received lower amounts because of the methodology used.

Phase 2 targeted Medicaid, CHIP, and dental providers and included assisted living facilities.[10] It provided $18 billion to providers that were not included in Phase 1 of the general distribution. These providers received an amount equal to 2% of the provider's total patient care revenue. Phase 2 funds began in June and required that providers applying for funding include in their applications certain financial information related to documenting revenue necessary to determine the amount that a facility would receive.[11]

Phase 3 targeted providers that had not received funding in prior distributions (i.e., because they were new or because they were behavioral health providers not included in a prior allocation). Providers that had previously received funding but had not received the full 2% of patient revenue in PRF assistance were invited to apply for additional funds. A total of $24.5 billion was available in this distribution, and HHS began distributing these funds in December 2020.

[9] For more information about the various components of the Medicare program, see CRS Report R40425, *Medicare Primer*.

[10] Medicare Fee-for-Service does not include dental benefits. As such, dentists generally do not bill the Medicare program. Some Medicare Advantage plans (i.e., managed care plans) may include these benefits as an optional service. Some assisted living facilities provide personal care and other types of services not covered by Medicare. These facilities, like other types of residential facilities, may have incurred additional expenses related to COVID-19 (e.g., for enhanced cleaning and personal protective equipment for staff).

[11] See HHS, https://www.hhs.gov/sites/default/files/provider-distribution-instructions-phase-2.pdf.

Congress has enacted legislation providing for PRF funding beyond Phase 3. As of the date of this report's publication, HHS has not made subsequent distributions. Specifically, the Consolidated Appropriations Act required that

> not less than 85% of (i) the unobligated balances available as the date of enactment of this Act, and (ii) any funds recovered from health care providers after the date of enactment of this Act, shall be for any successor to the Phase 3 General Distribution allocation to make payments to eligible health care providers based on applications that consider financial losses and changes in operating expenses occurring in the third or fourth quarter of calendar year 2020, or the first quarter of calendar year 2021, that are attributable to coronavirus.[12]

Targeted Distributions

HHS also allocated PRF funds to certain types of providers in 2020 that had high needs due to COVID-19. These included the following:

- *Hospitals with large numbers of COVID-19 admissions.* The PRF provided $12 billion in May to 395 hospitals that had more than 100 COVID-19-related admissions and $10 billion in July to 161 hospitals with one COVID-19 admission per day or a disproportionate intensity of COVID admissions.
- *Skilled nursing facilities and nursing homes.* The fund provided funds to nursing homes at various points in 2020. It provided $4.9 billion in May to more than 13,000 facilities. It provided an additional $2.5 billion in August for increased testing, staffing, and personal protective equipment (PPE) needs. These facilities were eligible to receive $2 billion in incentive payments in October and December of 2020.
- *Facilities funded by the Indian Health Service (IHS, including those operated by Indian Tribes, Tribal Organizations, and Urban Indian Organizations).* The PRF provided $500 million in May to approximately 300 IHS-funded health facilities.
- *Safety Net Hospitals.* The fund provided $10 billion in June to hospitals that met certain criteria based on their patient mix, the amount of uncompensated care they provided, or their profit margin.
- *Hospitals with thin margins*. The fund provided $3 billion in July to hospitals with less than 3% profitability threshold.
- *Rural hospitals, urban hospitals with certain rural Medicare designations, and hospitals in small metropolitan areas*. The fund provided $1 billion in July to urban hospitals that were more than 40 miles away from another hospital and to certain Medicare designated rural hospitals (e.g., sole community hospitals and Medicare dependent hospitals).[13]
- *Children's hospitals.* The fund provided $1.4 billion in August to free-standing children hospitals as defined by Medicare or hospitals that were eligible for HRSA's Children's Hospital GME program.[14] These hospitals generally have

[12] H.R. 133, see pp. 740 at https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf. P.L. 116-260 was enacted on December 27, 2020.

[13] For information on these designations, see CRS Infographic IG10023, *Medicare Payment for Rural or Geographically Isolated Hospitals*.

[14] For information on this program, see CRS Report R45067, *Children's Hospitals Graduate Medical Education (CHGME)*.

low Medicare FFS payments, so they may not have received funding as part of the first general distribution.

What Is the Difference Between General and Targeted Distributions?

All providers who meet the criteria (e.g., bill Medicare) are eligible for a general distribution. To be eligible for targeted distribution, providers have to meet additional criteria (e.g., have a high number of COVID-19 inpatients). HHS awarded funds in general allocations to all types of health providers, with the total amount intended to equal 2% of an entity's patient revenues. HHS also made awards to certain types of health providers that had high needs. Providers are eligible under both types of allocations.

What Are Some Potential Drawbacks of the Methodology that HHS Used to Distribute Funds?

HHS awarded PRF funds to providers in amounts that were equal to 2% of a provider's patient revenue. This amount was cumulative and could have been received through multiple distributions. The use of patient revenue as a metric has been critiqued by some because it may favor providers with a higher percentage of their revenue coming from privately insured patients—a result of private insurers paying providers higher rates than those paid by Medicare and Medicaid.[15] For example, the Medicaid and CHIP Payment Access Commission (MACPAC) found that Medicaid and CHIP providers tend to receive less from the fund because Medicaid providers generally had lower revenue. The commission also found that some providers that were not Medicare providers did not receive payments from the PRF.[16] In addition to these findings, news articles have indicated that access to PRF grants has contributed to surpluses for some large hospital systems.[17]

How Are Allocations Determined?

HHS determined the amount that it would allocate to both targeted and general distributions. The initial statute that created the PRF (the CARES Act) and the subsequent statute that increased funding (PPPHCEA) did not require funds to be allocated in a specific manner. The Consolidated Appropriations Act, 2021, enacted in December of 2020, required that not less than 85% of the unobligated balance of the PRF (including amounts that are returned to the PRF) be used for an allocation that follows the Phase 3 general allocation. It also specified that for that allocation, revenue must be calculated considering financial losses in the last quarter of 2020 or the first quarter of 2021 that are attributable to the coronavirus. As of the date of this report's publication, no new allocations had been announced.

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[15] Karyn Schwartz and Tricia Neuman, *Funding for Health Care Providers During the Pandemic: An Update*, Kaiser Family Foundation, Washington, DC, April 20, 2021, https://www.kff.org/policy-watch/funding-for-health-care-providers-during-the-pandemic-an-update/.

[16] MACPAC, *COVID Relief Funding for Medicaid Providers*, Washington, DC, January 2021, https://www.macpac.gov/wp-content/uploads/2021/02/COVID-Relief-Funding-for-Medicaid-Providers.pdf.

[17] Alexandra Ellerbeck, "The Health 202: Pandemic Relief Funds Boosted Surpluses for Some Large Hospitals," June 21, 2021, https://www.washingtonpost.com/politics/2021/06/21/health-202-pandemic-relief-funds-boosted-surpluses-some-large-hospitals/.

What Is the Relationship Between the Provider Relief Fund, the Uninsured Fund, and the Coverage Assistance Fund?

HHS is using a portion of the PRF appropriation to pay providers for treatment provided to uninsured individuals because no other funding was appropriated for this purpose. The Uninsured Fund has two components: (1) a total of $2 billion appropriated in the Families First Coronavirus Response Act (P.L. 116-127)[18] and PPPHCEA for uninsured testing and (2) an allocation from the CARES allocation to the PRF for uninsured treatment and coverage assistance for vaccines. PRF funds were not specifically appropriated for either purpose. Instead, in April 2020, the Trump Administration announced that it would use an unspecified portion of the CARES allocation to the PRF to reimburse providers for COVID-19 treatment provided to uninsured patients.[19] Subsequently, both the Trump Administration and the Biden Administration have clarified that this reimbursement will include administrative costs incurred by providers when vaccinating uninsured individuals. In addition, the Biden Administration is using the PRF for costs associated with vaccinating underinsured individuals through the newly created Coverage Assistance Fund.[20] Though the COVID-19 vaccine is free, providers can charge a third party for administrative costs related to provider time, storage, and record keeping, among others.[21] Some individuals may not have insurance coverage that includes vaccines or may face large out-of-pocket costs associated with their insurance plan's cost sharing for vaccines. The fund reimburses providers for the administrative costs associated with vaccinating these individuals.

HHS has not specified amounts for the uninsured fund or for underinsured vaccine costs. The Government Accountability Office (GAO) estimated that HHS allocated $10 billion for this purpose in March 2021.[22] GAO's estimate was prior to the announcement of the Coverage Assistance Fund, so the estimate did not include funds reserved for this purpose.[23] Reimbursements are provided on a rolling basis, with eligible claims being paid to providers as long as funds remain available. As such, should provider payments exceed $10 billion, HHS may choose to increase the amount allocated for uninsured treatment and vaccines and the Coverage Assistance Fund. As stated above, $2 billion was explicitly appropriated for uninsured testing, and this amount has been expended.[24] On May 25, 2021, the Biden Administration announced that it was allocating $4.8 billion from the American Rescue Plan Act (ARPA, P.L. 117-2) for uninsured testing.[25] These amounts are separate from the PRF; as such, PRF funds are not currently being used for uninsured testing.

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[18] CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*.

[19] CRS Insight IN11526, *COVID-19 and the Uninsured: Federal Funding Options to Pay Providers for Testing and Treatment*.

[20] HHS, HRSA, "COVID-19 Coverage Assistance Fund," https://www.hrsa.gov/covid19-coverage-assistance.

[21] CRS Insight IN11609, *COVID-19 Vaccine: Financing for Its Administration*.

[22] U.S. Government Accountability Office, *COVID-19 Sustained Federal Action is Crucial as Pandemic Enters Its Second Year*, 31-387, March 2021, p. 60, https://www.gao.gov/assets/gao-21-387.pdf.

[23] GAO released a subsequent report that examined the obligations of the PRF, but this report did not include estimates of amounts allocated for specific PRF purposes. See U.S. Government Accountability Office, *Continued Attention Needed to Enhance Federal Preparedness, Response, Service Delivery, and Program Integrity*, 21-551, July 2021, p. 87 and p. 93.

[24] HHS, "HHS COVID-19 Funding: Treatment & Testing of the Uninsured," https://taggs.hhs.gov/Coronavirus/Uninsured, and CRS Insight IN11526, *COVID-19 and the Uninsured: Federal Funding Options to Pay Providers for Testing and Treatment*.

[25] HHS, "HHS to Dedicate $4.8 Billion from the American Rescue Plan to COVID19 Testing for the Uninsured," press release, May 25, 2021, https://www.hhs.gov/about/news/2021/05/25/hhs-to-dedicate-billions-from-the-american-

HHS is providing regularly updated information on amounts reimbursed from the Uninsured Fund at https://taggs.hhs.gov/Coronavirus/Uninsured. Data are also available about the providers that receive reimbursements from this fund at https://data.cdc.gov/Administrative/Claims-Reimbursement-to-Health-Care-Providers-and-/rksx-33p3.

What Is the Relationship Between the PRF and the American Rescue Plan Funding for Rural Providers?

Section 9911 of the American Rescue Plan appropriated $8.5 billion for rural providers that bill Medicare and Medicaid.[26] This funding stream is to be administered in a number of ways that are similar to the PRF (e.g., reporting requirements) but is separate from the $178 billion appropriated for the PRF. As of the date of this report's publication, these funds have not been released, nor have there been announcements about application processes for providers to seek these funds.

What Other Purposes Have the PRF Funds Been Used For?

GAO examined PRF allocations as of March 1, 2021, and found that $0.980 billion was being used to administer the fund and that $9.970 billion was allocated for "vaccine and therapeutic development and procurement activities."[27] As such, approximately $11 billion of the $178 billion cannot be allocated to provider payments. As discussed above (see "How Has Funding Been Allocated?"), the majority of funds have been allocated to providers through either general or targeted distributions. In addition to these distributions, an unspecified amount of the PRF is being used to pay providers that provided uninsured testing, treatment, and vaccines and to pay providers for vaccine administration costs for uninsured individuals who do not have vaccine coverage or who have cost sharing for vaccine administration costs (see "What Is the Relationship Between the Provider Relief Fund, the Uninsured Fund, and the Coverage Assistance Fund?").

Provider Requirements

What Must Providers Do to Receive Funds?

Requirements to receive funds varied by distribution. The first general distribution (i.e., Phase One) for Medicare Fee-for-Service Providers was automatic, as HHS had payment and revenue information for these providers. Subsequent allocations required that entities submit documentation to HHS to receive funds. For example, for targeted distributions related to having provided care to a large number of COVID-19 patients, hospitals were required to submit documentation of their COVID-19 patient caseloads. As another example, the Phase 3 general

rescue-plan-for-the-uninsured.html.

[26] For information about this funding source, see the "Health Care Infrastructure and Provider Support" section of CRS Report R46834, *American Rescue Plan Act of 2021 (P.L. 117-2): Public Health, Medical Supply Chain, Health Services, and Related Provisions*.

[27] U.S. Government Accountability Office, *COVID-19 Sustained Federal Action is Crucial as Pandemic Enters Its Second Year*, 31-387, March 2021, p. p. 60, https://www.gao.gov/assets/gao-21-387.pdf. For a discussion of the allocation of PRF funds for vaccines, see Rachel Cohrs, "The Trump Administration Quietly Spent Billion in Hospital Funds on Operation Warp Speed," *STAT*, March 2, 2021.

distribution permitted entities that had previously received funds to receive up to 2% of their patient revenue, which required submitting financial information to document patient revenue.

What Requirements Apply to Providers Receiving PRF Funds?

Providers were required to attest to certain terms and conditions to accept PRF funds. Each distribution of funds had specific terms and conditions associated with the distribution—for example, that the provider met the specific conditions of that distribution (e.g., was a Medicaid provider for the second general distribution).[28] There are, however, some terms and conditions that apply across all of the allocations. These include certification that

- the entity provides or provided testing and care for actual or possible cases of COVID-19;
- the entity is not terminated or excluded from participating in the Medicare program or precluded from receiving payment from another federal health care program;
- that payment will be used only to prevent, prepare for, or respond to the coronavirus and will be used only for health care expenses or lost revenue attributable to the virus;
- that payment will not be used to reimburse expenses or losses that have been reimbursed by another source;
- the entity will comply, in the required timeframe, with HHS reporting requirements associated with the fund and report truthfully, accurately, and completely;
- the entity will maintain appropriate records and cost documentation; and
- for all presumptive or actual cases of COVID-19, the entity will not seek to collect from the patient out-of-pocket expenses that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider for patients who have insurance plans with a specific provider network.[29]

Entities are also required to comply with certain general provisions included in FY2020 appropriations, such as those related to executive pay, lobbying, gun control advocacy, and abortion, among others.[30]

What Must Providers Report After Receiving Funds?

Entities that receive more than $10,000 (either one time or in the aggregate) are required to report the uses of their funds and to have expended all received funds within a year of receiving them, and to report all their expenditures within three months after the end of the expenditure period. For example, funds awarded between April 10 and June 30, 2020, must be expended by June 30, 2021, and reported by September 30, 2021. In general, the usage deadline is a year from the end

[28] For links to the terms and conditions associated with each distribution, see HHS, "CARES Act Provider Relief Fund: For Providers."

[29] For more information on "in-network" and "out-of-network" coverage, see CRS Report R46116, *Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations*.

[30] HHS, "Acceptance of Terms and Conditions," https://www.hhs.gov/sites/default/files/terms-and-conditions-provider-relief-30-b.pdf, pp. 2-11.

of the awarding period, and the reporting period commences the day after and continues for three months.[31] This CRS report discusses the requirements that were issued on June 11, 2021, which supersede prior reporting requirements and apply to all past and future PRF allocations.[32] Entities are generally required to report using their normal basis of accounting. They are also required to report on

- interest earned on PRF payments;
- other assistance received (e.g., Paycheck Protection Program);[33]
- use of Nursing Home Infection control payments, if applicable;
- use of general or targeted distribution payments, which may be used only for expenses that have not or will not be reimbursed by another source;
- net unreimbursed expenses attributable to coronavirus (requirements specify that this is to be calculated quarterly, net after PRF and other assistance payments are applied and must be broken out quarterly by whether such expenses are general, administrative, and/or health care related); and
- lost revenue reimbursement. Specifically, lost revenue reimbursements may be applied to remaining amounts that were not expended on health care-related expenses due to the coronavirus. HHS requires that entities submit documents to support their claims of lost revenue, which may be calculated by either of three options: (1) the difference between actual patient care revenue in 2019 and 2020, (2) the difference between the budgeted amount (prior to March 27, 2020) and actual patient care revenue, or (3) any reasonable method of estimating revenue.[34]

Who Is Responsible for Reporting on PRF Funds?

To receive funds from the PRF, an entity must have a Tax Identification Number (TIN). The entity then registers with that TIN and must report on all payments that meet the $10,000 reporting threshold for the TIN. Under the PRF reporting requirements, the entity that registered its TIN has the responsibility to report to HHS, regardless of whether payments were transferred to a subsidiary. However, if an entity received payments directly (under its own TIN), but also received funds transferred from a parent entity, it must also report the transferred payments. HHS says that transferred targeted distributions payments (i.e., payments for high COVID-19 inpatient cases) are more likely to be audited by HRSA.[35]

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[31] See Tables 1 and 2 on page 2 in HHS, "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.

[32] HHS, "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.

[33] For more information on this program, see CRS Insight IN11324, *CARES Act Assistance for Employers and Employees—The Paycheck Protection Program, Employee Retention Tax Credit, and Unemployment Insurance Benefits: Overview (Part 1)*, and CRS Insight IN11329, *CARES Act Assistance for Employers and Employees—The Paycheck Protection Program, Employee Retention Tax Credit, and Unemployment Insurance Benefits: Assessment of Alternatives (Part 2)*.

[34] For methodology to calculate lost revenue, see pages 10-11 of HHS, "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.

[35] HHS notes some entities may be subject to additional auditing to ensure payment accuracy. See HHS, "Reporting

Can Providers Refuse or Return Funds?

Providers must attest to certain terms and conditions after receiving funds. Providers may choose to return funds if they choose not to abide by the terms and conditions of the attestation. In addition, providers must expend funds by a certain date, which varies based on when providers received funding.[36] For example, the earliest deadline is June 30, 2021, which applies to providers that received funds in Phase 1 (between April 10, 2020 and June 30, 2020). Providers that did not use their funds by the June 30, 2021, deadline associated with that distribution are required to return unexpended funds within 30 days after the end of the applicable reporting period.[37]

Agency Requirements

What Are HHS Reporting Requirements for the Fund?

The Consolidated Appropriations Act, 2021, required the HHS Office of Inspector General (OIG) to submit a final report on its audit findings for the PRF not later than three years after the fund's final payments are made. The report is to be submitted to the House and Senate appropriations committees. The law also specified that the OIG may conduct audits of interim payments prior to the final report. Finally, the law required a report not later than 60 days after enactment of the Consolidated Appropriations Act, 2021 (i.e., February 25, 2021), that included the obligations made from the fund, summarized by state. It also required that these reports be updated every 60 days until the funds are expended.

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Requirements and Auditing," https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/reporting-auditing/index.html.

[36] For a time line, see HHS, HHS, "HHS Issues Revised Notice of Reporting Requirements and Reporting Timeline for Recipients of Provider Relief Fund Payments," press release, June 11, 2021, https://www.hhs.gov/about/news/2021/06/11/hhs-issues-revised-reporting-requirements-timeline-for-provider-relief-fund-recipients.html.

[37] HHS, HRSA, "Provider Relief Fund General Information," see "Terms and Conditions," at https://www.hrsa.gov/provider-relief/faq/general.

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