California Hospital Association

September 23, 2021

Sent Electronically

The Honorable Diana Espinosa
Acting Administrator
Health Resources & Services Administration
5600 Fishers Lane
Rockville, MD 20857

Subject: Information Collection Request Title: COVID–19 Provider Relief Fund Reporting Activities, OMB No. 0906– XXXX New, Federal Register (Vol. 86, No. 140), July 26, 2021

Dear Acting Administrator Espinosa:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) greatly appreciates the support the Department of Health and Human Services (HHS) and other federal agencies have provided during the COVID-19 pandemic. The Provider Relief Fund (PRF) has allowed hospitals to continue providing urgently needed care to Californians suffering from COVID-19 while maintaining access for all who need care.

California hospitals' losses related to COVID-19 are estimated to exceed $15 billion for 2020 and 2021. However, total PRF support only covered 56% ($8.4 billion) of the increased expenses and lost revenue associated with COVID-19 in 2020[1]. With case counts rising again[2,3], California's hospitals still desperately need additional resources to respond to the ongoing pandemic. Similar to other hospitals across the country, CHA's members are struggling with nursing shortages[4]. We have heard from members that rates for traveling ICU nurses can exceed $300 per hour, which is unaffordable. To ensure that California's hospitals can continue their mission as the backbone of the state's medical response to the ongoing COVID-19 pandemic, continued support is crucial. Therefore, we greatly appreciate the announcement[5] of the release of an additional $25.5 billion in additional relief funds. We look forward to additional details about the application process for these funds and encourage the administration to provide a roadmap for the distribution of remaining funds.

[1] https://www.kaufmanhall.com/sites/default/files/2021-04/kh-cha-financial-forecast-ebook_final.pdf
[2] https://www.latimes.com/california/story/2021-09-08/californias-central-valley-overwhelmed-by-covid-19-delta-surge
[3] https://calmatters.org/health/coronavirus/2021/08/california-covid/
[4] https://calmatters.org/health/coronavirus/2021/08/california-nurses-shortage/
[5] https://www.hrsa.gov/provider-relief/future-payments

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The terms and conditions associated with the various PRF distributions require that recipients "shall submit reports as the Secretary determines are needed to ensure compliance with conditions that are imposed on this Payment, and such reports shall be in such form, with such content, as specified by the Secretary in future program instructions directed to all Recipients." HRSA has promulgated and revised reporting requirements and related FAQs multiple times since the inception of the PRF.

These requirements and the associated guidance are essential to ensuring that PRF recipients report on their use of funds accurately. Further, CHA strongly believes that clear, concise guidance is essential to ensuring that all PRF recipients report on their use of funds in a consistent manner and that the reporting process is not more administratively burdensome than necessary.

CHA appreciates the opportunity to provide feedback to HRSA on the agency's estimated administrative burden per reporting period and provide suggestions to reduce the administrative burden on both the agency and PRF recipients while increasing the utility of the data collected. In general, CHA believes that HRSA has substantially underestimated the burden created by the reporting requirements. Further, we believe there are significant opportunities to reduce the reporting burden and improve the utility of the data collected by clarifying reporting guidance, reducing the number of reports required, and limiting the data requested to only that which is necessary to ensure appropriate use of funds. Below, please see CHA's specific comments in each area.

Average Burden Per Response

Based on HRSA data included in the proposed rule, the agency estimates that the average reporting burden across all four reporting periods for all providers required to report is five hours[6] per report as illustrated in the table below from the information collection request (ICR).

Total Estimated Annualized Burden Effort

Reporting Period	Number of Respondents	Number of Responses Per Respondent	Total Responses	Average Burden Per Response (Hours)	Total Burden Hours
Period 1	126,831	1	126,831	5.6	710,254
Period 2	120,536	1	120,536	4.2	506,251
Period 3	19,962	1	19,962	5.6	111,787
Period 4	19,962	1	19,962	5.6	111,787
Total	287,291	.....	287,291	5.0	1,440,079

CHA respectfully asks HRSA to provide more detail as to how it developed its estimate average reporting burden per response. As discussed below, the average estimate provided appears to be greatly understated. The ICR does not disclose any details as to how it arrived at its estimate other than to provide a definition of the items included in the reporting burden. The lack of details makes it difficult to fully comment on the estimate.

Further, CHA respectfully questions whether it is appropriate for HRSA to develop a single reporting burden estimate for all respondents. The reporting requirements instruct PRF recipients who received between $10,001 and $499,999 in aggregated PRF payments during each Payment Received Period to

[6] 5.01 = 1,440,079 hours / 287,291 total responses

report expenses in two summarized categories (General and Administrative Expenses and Health Care-Related Expenses). PRF recipients who received $500,000 or more in aggregated PRF payments during each Payment Received Period must report expenses based on 12 detailed subcategories. Given that reporting expenses in the two summarized categories will be far less burdensome than reporting using 12 detailed subcategories, CHA believes that presenting a single burden estimate is misleading. This is particularly true given that approximately 200,000 providers received PRF between $10,001 and $499,999, while only 23,500 received $500,000 or more[7]. Therefore, we believe a single estimate is skewed lower by the majority of PRF recipients who will report a reduced dataset. And this single estimate significantly underrepresents the reporting burden experienced by hospitals and health systems, given they are subject to far more detailed reporting requirements.

The ICR defines reporting burden as:

> *… the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information."*

Based on this definition, CHA believes HRSA has significantly understated the reporting burden. Configuring IT systems and acquiring the data necessary to meet the reporting requirements exceeds HRSA's estimate by itself. Anecdotal conversations with CHA members suggest that it requires at least 50 hours per hospital for the IT programming necessary to establish the specific cost centers required to track COVID-19-related expenses[8]. Members also report spending between eight and 16 hours per hospital to summarize lost revenue by payer and quarter as requested by HRSA. And, it is estimated that aggregating the personnel data, which is for informational purposes and not necessary to substantiate the use of PRF payments as required by Congress, is estimated to require 40 hours per hospital. However, the single most time-consuming activity related to reporting is simply understanding the ever-evolving instructions.

HRSA released the first FAQs related to the PRF in May 2020. They were updated — with items added, modified, or deleted — almost weekly for most of 2020. Their evolution during 2021 has not slowed, as HRSA has issued at least 12 revisions so far this year[9]. Similarly, HRSA issued six different Post-Payment Notices of Reporting Requirements since July 2020.

CHA greatly appreciates that HRSA has modified its guidance — in certain instances — in response to feedback from key stakeholders. However, keeping track of these changes has required significant effort on the part of PRF recipients. Conversations with CHA members suggest that each organization has at least one person who is tasked with monitoring guidance and summarizing how changes will impact PRF reporting. This typically requires approximately 50% of a full-time employee's time. Over the last 15

[7] https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6t, accessed September 7, 2021
[8] This does not include the time required to summarize the expense and determine which are eligible to be claimed against PRFs received.
[9] As of September 23, 2021

months, that translates into approximately 1,300 hours[10]. This estimate does not include the time and cost associated with obtaining additional guidance from external legal counsel, accounting auditors, or management consultants as to how the reporting instructions or related FAQs could be interpreted.

And, despite all the changes to the various guidance documents, many reporting areas remain unclear. In response to this ambiguity, CHA members report convening cross-functional teams to interpret the guidance and translate that understanding into data collection and validation strategies. These cross-functional teams typically include between six and 10 individuals representing the finance, reimbursement, compliance, revenue cycle, clinical, and IT functions of the organization. The teams typically meet for an hour weekly. Not including any pre-or post-meeting work, this adds an additional 360 to 570[11] hours to each organization's reporting burden. Given that tracking changes in the reporting guidance has thus far required between 1,660 and 1,870 hours per organization, HRSA could reduce recipients' administrative burden significantly if it clarified key outstanding issues related to PRF reporting. Taking this necessary step would also improve the quality of the data collected during the reporting process.

Clarifying Reporting Guidance

CHA recognizes the difficulty facing HRSA in creating reporting guidelines for PRF recipients, and we greatly appreciate the agency's ongoing efforts to provide detail and clarify key reporting requirements. However, there are many outstanding items where the guidance remains ambiguous despite questions being raised by CHA[12] and other stakeholders. Further, while we greatly appreciate responses to queries from the HRSA PRF Case Management Team, in many instances those responses are cut and pasted from the same FAQs that require clarification. Therefore, these answers are not as instructive as they should be.

Beyond adding to the administrative burden of reporting, ambiguity in the reporting requirements will result in variability in how organizations report expenses and lost revenue related to COVID-19. This will negatively impact the utility of the data collected by HRSA.

CHA believes that much of the ambiguity would be resolved if HRSA addressed the following issues:

- *Targeted Distributions*: HRSA is requiring targeted distributions to be reported by the entity that received them, even if they were reallocated to other entities under the same corporate umbrella. PRF recipients would benefit from guidance as to how they are to reclassify and report the expenses and lost revenue related to COVID-19 from the parent entity (or entity to which the targeted distribution was reallocated) to the entity that received the targeted distribution. Alternatively, HRSA could simplify reporting and allow targeted distributions to be reported by the entity to which they were reallocated.

- *Examples of Revenue That Must Be Offset Against COVID-19-Related Expenses*: CHA respectfully asks HRSA to provide examples of the revenue types (both patient care and other sources) that must be offset against COVID-19-related expenses. It would also be helpful, given that there may be unique circumstances around certain types of increased patient care payments, if HRSA

[10] 1,300 = (2080 (1 FTE)/12) x .5 x 15
[11] Assumes 6 to 10 participants meeting for an hour per week for 60 weeks.
[12] https://calhospital.org/wp-content/uploads/2021/04/cha_provider_relief_fund_asks_3.10.2021_final.pdf

provided a framework for determining when patient care revenue needs to be offset. As examples[13], should the following payments be used to offset COVID-19-related expenses?

- 20% add-on payment for Medicare inpatient discharges
- 2% increase in Medicare payments as a result of the suspension of the sequester
- Medicaid disproportionate share hospital (DSH) payments that have not increased as a result of COVID-19

- *Treatment of Revenue Used to Offset COVID-19 Expenses*: The PRF FAQs instruct recipients to, "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)[14]."

  CHA respectfully asks HRSA to confirm any patient care revenue (direct patient billing, commercial insurance, Medicare/Medicaid/CHIP) must not be offset against expenses related to COVID-19, provided this same revenue is used to determine whether a provider has quarterly revenue loss to report against PRF. Without this clarification, we are concerned HRSA is using the same dollar of a provider's patient care revenue to reduce the PRF funds that can be claimed in both the calculation of expenses and lost revenue attributed to COVID-19.

- *FEMA Expenses*: CHA appreciates that HRSA has clarified that PRF recipients do not need to offset their expenses related to COVID-19 by amounts they have applied for but not received from FEMA[15]. However, we respectfully ask HRSA to clarify if PRF recipients can exclude COVID-19 expenses from their report if they are eligible for FEMA reimbursement, but the provider has not as yet received funds from FEMA for the expenses. This will allow the recipient to apply its PRF to lost revenue, while allowing FEMA to cover eligible expenses.

- *Reporting Lost Revenue Using Option iii*: CHA greatly appreciates the example related to lost revenue reporting using Option iii and the associated "best practices" for reporting under this method in the Lost Revenues Guide[16]. CHA respectfully asks the agency to provide additional examples of how Option iii might be used to address other circumstances when both Option i and Option ii reporting options do not allow for "apples-to-apples" comparisons of revenue from before and during the COVID-19 public health emergency (PHE).

[13] This list is by no means comprehensive.
[14] https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/provider-relief-fund-faq-complete.pdf, pg. 19, last updated 8/30/21
[15] https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/provider-relief-fund-faq-complete.pdf, pg. 18, last updated 8/30/21
[16] https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/prf-lost-revenues-guide.pdf

Reducing Data Collection Periods

HRSA is currently requiring PRF recipients to submit four reports covering different time periods to substantiate their retention of PRF. The table below summarizes the reporting periods and the time frames covered.

PRF Reporting Dates

	Payment Received Period (Payments Exceeding $10,000 in Aggregate Received)	Deadline to Use Funds	Reporting Time Period
Period 1	From April 10, 2020 to June 30, 2020	30-Jun-21	July 1 to September 30, 2021
Period 2	From July 1, 2020 to December 31, 2020	31-Dec-21	January 1 to March 31, 2022
Period 3	From January 1, 2021 to June 30, 2021	30-Jun-22	July 1 to September 30, 2022
Period 4	From July 1, 2021 to December 31, 2021	31-Dec-22	January 1 to March 31, 2023

CHA notes that these dates are arbitrary and not anchored in statute. The Coronavirus Aid, Relief, and Economic Security (CARES) Act and subsequent legislation[17] appropriating additional amounts to the PRF give the Secretary wide latitude in determining when recipients must report on their usage of funds as illustrated by language from the statute below:

> *Provided further, That recipients of payments under this paragraph shall submit reports and maintain documentation as the Secretary determines are needed to ensure compliance with conditions that are imposed by this paragraph for such payments, and such reports and documentation shall be in such form, with such content, and in such time as the Secretary may prescribe for such purpose.*

The legislative language does not require reporting on a specific schedule, much less the current reporting schedule promogulated by HRSA. Given that the Secretary has discretion in setting the reporting schedule, CHA respectfully asks that the Secretary require PRF recipients to report only once on their use of funds. Further, we ask that the single reporting deadline be set to the later of March 31, 2023, or 12 months after the termination of the PHE. This will allow PRF recipients sufficient time to use the funds to fully respond to the pandemic. We believe taking this step will have the following beneficial impacts for all stakeholders:

- *Allow HHS Time to Update Its Systems:* CHA is aware that a number of hospitals are currently unable to complete the reporting process for Reporting Period 1 due to a HRSA administrative issue. For example, one CHA member returned funds for one of the distributions last fall via paper check. Despite having cashed the check over a year ago, HRSA still has not updated its payment database to reflect the return of this payment. As a result, these funds are still appearing in the provider's PRF reporting portal as a payment it needs to report on. Delaying reporting will provide HRSA additional time to resolve its internal data management and administrative issues.

- *Reduced Administrative Burden*: Reporting only once will reduce administrative burden for both PRF recipients and HRSA. For PRF recipients, it will reduce the number of times they are required to pull data and prepare for PRF audits to the minimum necessary to meet statutory

[17] Paycheck Protection Program and Health Care Enhancement and Consolidated Appropriations Acts of 2020

requirements. For the agency, it will reduce the number of times it must collect data and its contractors will audit submissions.

- *Clarify Unanswered Reporting Requirement Questions:* HHS should use the additional time provided by delaying reporting to clarify key unanswered questions about reporting on spent PRF funds, which to date have been left unresolved by the agency. Unambiguous instructions will not only reduce the administrative burden for PRF recipients and the agency[18] but will result in recipients reporting data in a consistent manner, which will make it more usable for the agency.

  The ambiguity in the PRF Notice of Reporting Requirements has resulted in multiple, reasonable interpretations of the same guidance items. These disparate interpretations will inevitably result in variations in how providers will report their expenses and lost revenue attributed to COVID-19.

  CHA strongly encourages HRSA to use the time afforded by delaying the reporting deadline to convene a workgroup of agency staff, PRF recipients, and health care accounting, finance, and compliance experts to identify and resolve outstanding issues that must be clarified. Further, once a complete and final set of guidance documents has been created, the agency should work with stakeholders to provide additional educational sessions similar to the technical assistance sessions provided when the PRF reporting portal opened[19] to respond to questions from the field and provide additional collateral, such as the Lost Revenues Guide[20], to provide examples of how recipients should report on their use of funds.

- *Allow More Time to Use Funds*: Provider Relief Funds received from April 10 through June 30, 2020, account for approximately 70% of the total payments received by California hospitals. The timing of these payments and artificial spending deadline means that some hospitals would have to spend this bolus of funds unnecessarily fast or they may be required to return needed funds, despite continuing to incur significant expenses caring for patients with COVID-19 and partnering with local communities to deliver the vaccinations necessary to end the PHE. Delaying reporting will allow the agency to consider the totality of a PRF recipient's expenses and lost revenue related to COVID-19 in one report. It will also prevent a recipient from being required to return funds from one period, only to have need for them in a later period.

CHA greatly appreciates the recently announced a "60-day grace period" for the September 30, 2021, Reporting Period 1 deadline[21]. If HRSA does not consolidate PRF reporting into one period that occurs after the end of the PHE, we ask the agency to provide an ongoing process for recipients to request a deadline extension due to extreme uncontrollable circumstances (EUC). This policy would be available for hospitals that have experienced a recent natural disaster — like having to evacuate the facility due to wildfire[22] or experiencing loss of key utilities, like internet service due to a hurricane — and provide them with sufficient time to report on their use of funds. Further, we believe an EUC exemption should also be

[18] HRSA's administrative burden will be reduced during the audit process. The agency's audit contractors will likely also arrive at different interpretations of the ambiguous reporting guidance and related FAQs. This will result in some recipients being subject to clawbacks of PRF funds while others who took a similar interpretation will not. This will increase the number of legal challenges the agency faces in response to its contractors' audit determinations.
[19] https://webex.webcasts.com/viewer/event.jsp?ei=1480779&tp_key=059854c38e
[20] https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/prf-lost-revenues-guide.pdf
[21] https://www.hrsa.gov/provider-relief/reporting-auditing
[22] https://www.sacbee.com/news/california/fires/article253848753.html

available to any PRF recipient who experiences challenges reporting due to documented HRSA administrative errors that prevent a recipient from accurately reporting on their use of funds for a given reporting period.

Requesting Only Necessary Data

HRSA is collecting personnel, patient, and facility metrics "to quantify the impact of COVID-19 on the Reporting Entity's personnel, patient, and facility metrics." None of this data is necessary to ascertain if the recipient appropriately used PRFs. And much of it is already reported as part of the Medicare cost report for hospitals, skilled-nursing facilities, home health agencies, rural health clinics, and federally qualified health clinics. Therefore, CHA respectfully asks HRSA to not require PRF recipients to report these metrics, given that none are necessary to calculate expenses and lost revenues related to COVID-19, most are (or will be) available on the Medicare cost report, and some are administratively burdensome to collect.

The personnel data request is particularly burdensome. Starting with data from 2019, it requires recipients to report the number of individuals who are full-time, part-time, contractors, furloughed, separated, and hired by clinical and non-clinical category. As discussed above, it is estimated that this will take at least 40 hours for each hospital to collect. Data for the number of full-time equivalent employees — which is a better metric to determine staffing levels than raw headcounts, for clinical, non-clinical, and contracted staff — is available on the Medicare cost report.

The burden of this request is exacerbated by two factors. First, few if any hospitals integrate their contract labor data by category into their human resources and payroll systems. So, in many instances, collecting these data will require hospitals to manually review their invoices from contract labor providers to determine how many individuals were hired as contractors during the periods in question. Second, the PRF FAQs defining the categories for classifying personnel define "hired" as the "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." It is uncommon for organizations to flag in payroll systems when an employee is rehired. As a result, PRF recipients will need to take extra steps to identify new employees who previously worked for the organization. Further, it is not clear from the reporting instructions how far PRF recipients must "look back" to determine if someone previously worked for the organization. If HRSA continues to require PRF recipients to report rehired employees, we respectfully ask the agency to confirm that the "look-back" window extends only to 2019.

CHA appreciates the opportunity to offer comments on necessary clarifications to the PRF reporting instructions. If you have any questions, please contact me at (202) 270-2143 or cmulvany@calhospital.org.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy