Which providers are required to complete the report?

The following provider types are required to complete the report:

- Ambulatory Surgical Centers;
- Assisted Living Facilities licensed under Chapter 247, Health and Safety Code;
- Emergency Medical Services Providers;
- Health Services Districts created under Chapter 287, Health and Safety Code;
- Home and Community Support Services Agencies;
- Hospice Providers;
- Hospitals;
- Hospital Systems;
- Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID);
- Community Living Assistance and Support Services (CLASS) or Case Management Agency (CMA) Providers;
- Deaf-blind with Multiple Disabilities (DBMD) Providers;
- Home and Community-based Services (HCS) Providers;
- Texas Home Living (TxHmL) Providers;
- Nursing Facilities; and
- End-Stage Renal Disease Facilities licensed under Section 251.011, Health and Safety Code

Does a provider need to complete the report if they do not have a Medicaid contract or did not receive any Federal Provider Relief Funds?

If the provider is licensed as one of the provider types, they are a required to submit a report regardless of whether they have a Medicaid contractor received no Provider Relief Funds. If the provider did not receive any Federal Provider Relief Funds, they should enter $0 in all the questions regarding the funding. Please note that questions related to COVID-19 expenditures have been updated on November 8, 2021. There are separate questions on COVID-19 expenditures that are reimbursed by Federal Funds and those expenditures that are not reimbursed by Federal Funds.

Does a provider need to complete the report if they had a change of ownership (CHOW)?

If the CHOW was effective prior to January 1, 2020, then the prior owner does not need to complete the report. If the CHOW happened after January 1, 2020, then the previous owner will have to complete a report for the time period between January 1, 2020, and the CHOW date; the new owner will have to complete a report for the time period beginning with the CHOW date.

Can a provider get a copy of the questions before they begin the report?

A .pdf version of the report is available on the HHSC website.

Are providers required to answer all the questions in the report in order to complete the report?

Certain questions are only applicable to certain provider types. The .pdf version of the report indicates which provider types are required to complete each question. When completing the report, the report will only display the questions applicable to the provider type selected in Question 26.

How does a provider report loans received through the Paycheck Protection Program (PPP)?

If the provider is not a hospital, hospital system or nursing facility, do not report any loans under the PPP whether or not they are forgiven.

If the provider is a hospital, hospital system or nursing facility, report in Question 28 only the funds (or goods & services received in lieu of funds) that were forgiven through the Paycheck Protection Program (PPP).

How do nursing facilities answer Question 27 and Questions 29 – 42?

Nursing facilities are to report all costs to implement the additional COVID-19 licensure requirements in Question 27, regardless of whether or not they are paid for using Federal funds. Questions 29 – 42 are used to identify how the nursing facility uses the funds received from Federal COVID-19 sources. For example:

The nursing facility makes the following expenditures:

- In order to meet the additional regulatory requirements due to COVID-19, the nursing facility spent $10,000 on increased staff hours to screen employees and residents for COVID-19 symptoms.
- In order to maintain their staffing requirements, the nursing facility spent $20,000 on increased wages and offered sign-on bonuses to recruit and retain staff (not related to new regulatory requirements.)
- Due to the necessity to change the way they operate their HVAC system the nursing facility's utility costs increased.
- The nursing facility received $15,000 in COVID-19 Federal funds and chose to spend:
    - $5,000 of the $15,000 on increased staff time for screening employees and residents
    - $7,000 of the $15,000 on staff wages
    - $3,000 of the $15,000 on increased utility costs

The nursing facility would report the costs as follows:

In Question 27: $10,000 (total amount spent on increased staff hours d/t increased regulatory requirements - regardless of whether or not the costs are covered by any funding source)

In Question 29: $12,000 (amount of COVID-19 Federal funds spent on additional staff hours and wages, i.e., staffing costs regardless of the reason for the expenditure)

In Question 30: $8,000 (amount of staffing costs that was NOT reimbursed from Federal funds)

In Question 35: $3,000 (amount of COVID-19 Federal funds spent on increased utilities regardless of the reason for the expenditure)

What happens if a provider does not submit a report?

If a provider fails to complete and/or submit the required monthly report(s) on-time may result in one or more of the following:

- A report to the Department of State Health Services or HHSC Regulatory Services
- Potential adverse actions on your licensure
- A payment hold

HHSC is granting a "grace period" to help providers come into compliance if they fail to meet any deadlines between October 1, 2021, and November 30, 2021. While the deadlines to report will not change, HHSC will not any of the actions listed above against a provider as long as the provider submits all the required reports due between October 1, 2021, and November 31, 2021. The grace period ends December 1, 2021.

How does a provider with multiple National Provider Identifier (NPI), Texas Provider Identifier (TPI), HHSC contract, etc., under a single Taxpayer Identification Number (TIN) report their Provider Relief Funds?

If a provider has multiple NPIs, TPIs, HHSC contracts, etc., under a single TIN the provider may choose to report all their Provider Relief Funds in the aggregate and identify all of the NPIs, TPIs, HHSC contracts, etc., associated with that TIN on an offline form. Contact the Provider Finance Department at HHSC_RAD_Survey@hhs.texas.gov to obtain a copy of the form.

Does a provider have to include all the provider identifiers in Questions 16 – 22?

Providers are only required to provide the Taxpayer Identification Number (TIN) and National Provider Identifier (NPI). A provider may not have an HHSC Facility ID, HHSC License Number, HHSC Contract Number or HHSC Component Code as these identifiers are not applicable to all provider types. If a provider does not have one of these provider identifiers they should leave that question blank.

How does a hospital, hospital system or nursing facility report the use of Provider Relief Funds to offset lost revenue?

If a hospital, hospital system or nursing facility uses any of the Provider Relief Funds to offset lost revenue the amount should be reported as "other costs" in Question 39 and use the description "lost revenue" in Question 40.

Where can a provider find their Texas Provider Identifier (TPI)?

A provider can find their TPI one of three ways:

- On a TMHP claim
- By logging into their TMHP account

- By contacting TMHP. The TMHP contact page website has phone numbers for different provider types and an email form for contacting them

Please contact the HHSC Provider Finance Department at HHSC_RAD_Survey@hhs.texas.gov if you have questions that are not included on this FAQ.