2020 Coronavirus Aid, Relief, and Economic Security Act Analysis

-Version 1, April 2020-

Analysis Description

On March 27, 2020, Congress responded to the COVID-19 emergency by adopting the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). The act provides financial relief and resources to hospitals impacted by the public health emergency.

This analysis indicates how existing Medicare provider payments will be affected by the CARES Act legislation. Each impact shown in this analysis is described below.

Please Be Aware – several payment changes adopted in the CARES Act are not included due to lack of data and/or full detail on implementation.

This analysis evaluates Medicare FFS payments only, it does NOT reflect any estimated payment changes for Medicare Advantage patients, nor does it show potential changes in payments from non-Medicare payers. All components related to facility operations are held constant (e.g. volume, case-mix, etc.) in order to measure the impact of policy changes only.

Dollar impacts shown in this analysis may differ from those provided by other organizations due to differences in source data and analytic methods. Dollar impacts have been rounded to the nearest hundred dollars; hence, totals may not foot due to rounding; sum and dollar amounts less than $50 will appear as zeros due to rounding.

Data Sources and Methodology:

The following describes the data sources and calculation methodology for each of the impacts in the analysis:

PAMA CLFS Adjustment: Under the Clinical Laboratory Fee Schedule (CLFS), Medicare payments are set to the weighted median of private payor rates collected for those services by CMS as a result of the "Protecting Access to Medicare Act of 2014" (PAMA). Currently, reductions are to be phased in over a six-year period, and are capped at a cumulative 10% per year for each of CYs 2018-2020, and 15% per year for CYs 2021-2023. For hospital laboratory services, these reductions will only apply to those services paid separately, and will have no effect on those that are part of a bundled payment (including packaged APC payments). This analysis uses a CY 2020 baseline and reflects the CARES Act impact of removing the incremental CY 2021 reduction to Medicare payment rates for CLFS services and extending the 15% cap to CY 2024.

Data Source(s)/Method(s): (source: Protecting Access to Medicare Act of 2014). Laboratory service volumes are based on CY 2016 outpatient claims provided at acute care hospitals from the 2016 Medicare Standard Analytic File (SAF), with status indicator (SI) assignments determined based on the CY 2018 OPPS Final Rule Appendix B. Packaged services as well as those for which hospitals are not paid are excluded. Services that are conditionally packaged are also excluded when provided on the same claim as a service with which they are typically packaged.

Payment rates and impacts are based primarily on CMS' final payment rates released November 2017. For those codes for which the 2017 baseline national limitation amount (NLA) were set to zero or left blank in CMS file, this analysis uses median payment rates calculated based on the 2016 Medicare SAF. Payment rates are then multiplied by the volume of each service in order to determine estimated revenues and impacts.

State Medicaid DSH Reductions: The ACA authorized predetermined reductions to the federal Medicaid DSH pool for FFYs 2014-2019, with more recent legislation pushing these cuts back to FFYs 2020-2025. The impacts in this analysis reflect the CARES Act elimination of the $4 billion in Medicaid DSH cuts for FFY 2020 and reduces the cut for FFY 2021 to $4 billion from $8 billion. Implementation of the FFY 2021 cuts are also delayed until December 1, 2020.

This analysis distributes the reductions to states based on each individual state's estimated reduction provided by CMS with the proposed DSH reduction methodology found in the July 28, 2017 *Federal Register* (this used the same methodology as adopted in final rule found in the September 25, 2019 *Federal Register*, however CMS has yet to release updated allotment reductions). The estimated impact shown is the aggregated total for FFYs 2020-2025. Whether or not hospitals in a specific state are affected is dependent on if that state reaches its reduced cap on federal Medicaid DSH, and if that state intends to pass the cuts on to hospitals or not.

LTCH BiBa 50% Rule: Beginning in FFY 2021, the Bipartisan Budget Act (BiBa) mandates an IPPS equivalent payment rate for ALL discharges for LTCHs when less than 50% of cases in the previous year (FFY 2020 for the first year) are paid at standard LTCH PPS payment. This impact reflects the CARES Act waiver of the LTCH 50% rule during the emergency period. This analysis also assumes the waiver will begin October 1, 2020 and remain until December 31, 2020 and only provides impacts for LTCHs with less than 50% of cases paid at standard LTCH PPS payment from the FFY 2020 LTCH Final Rule Impact File.

Data Source(s)/Method(s): The IPPS equivalent payment component of the analysis was calculated using the CMS FFY 2018 LTCH MedPAR and calculating the adjusted IPPS comparable per diem payment multiplied by the LTCH length of stay for ALL cases, regardless of if the case was flagged in the file as LTCH or not. The impact of the IPPS equivalent amount being applied to all cases was calculated by taking the difference between estimated FFY 2020 LTCH payments and the calculated IPPS equivalent. Percent of cases paid at the LTCH PPS payment rate as well as estimated FFY 2020 LTCH payments were calculated using the FFY 2020 LTCH Final Rule Impact File.

The adjusted IPPS comparable per diem amount includes: the FFY 2020 IPPS standard amount, IPPS MS-DRG weight, IPPS labor-share and wage index, Disproportionate Share Hospital (DSH) adjustment, Indirect Medical Education (IME) adjustment, 2020 IPPS capital standard amount, geographic adjustment factor (GAF), and COLA. The standard LTCH payment was calculated by adjusting the LTCH standard amount by the 2020 LTCH labor-share and wage index, COLA, and MS-LTC-DRG weight. This value is multiplied by the length of stay of each case as well as the average geometric length of stay for that cases DRG. The full comparable amount to what would otherwise be paid under IPPS does not include this multiplier.

Sequestration Cuts (all provider settings): The impact shown reflects the elimination of the 2.0% sequester reduction on total Medicare payments from May 1, 2020 through December 31, 2020. Sequestration was originally authorized in the Budget Control Act (BCA) of 2011 for 2013 through 2020, and was then extended by further legislation through 2029. The impact also includes the one-year adopted extension of the sequester through 2030.

Data Source(s)/Method(s): Inpatient, Outpatient, IRF, and LTCH impacts are based on Medicare payment data provided by CMS in the FFY 2020 payment rule Impact Files. IPF, SNF, HH, Critical Access Hospitals (CAH), cancer hospital, and children's hospital impacts are based on Medicare payments reported on the Medicare cost report (latest of 2016, 2017, or 2018). The impact is calculated by applying a 2.0% reduction to estimated revenues in each applicable care setting. The reduction is applied to all Medicare lines of payment, including those outside of the PPS rate and not shown in this analysis, i.e., Direct Graduate Medical Education. Payments to Medicare Advantage plans will also be reduced, but the potential effect on providers will depend on the terms of each individual contract.