California Hospital Association

Overview of Medicare Rate Setting

Background: Medicare payment for hospital services is based on a complex set of regulatory formulas. For services provided in most instances and settings, these formulas use historical data. These data do not include the incremental costs associated with COVID-19 in the calculation of payment rates. This extends to payment for Medicare Advantage (MA) plans — whose rates are based on the cost to provide care to Medicare "fee-for-service" (FFS) beneficiaries. Therefore, the incremental costs of COVID-19 are not included in most Medicare FFS payments made directly to hospitals via the inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS) or through capitated payments made to MA plans. As a result, the need to offset expenses submitted to the Federal Emergency Management Agency (FEMA) Public Assistance Program related to the COVID-19 public health emergency (PHE) only requires offsetting for Medicare payment in a limited number of circumstances. This includes cost-based payments (e.g., critical access hospitals), New COVID-19 Treatment Add-On Payments, and the 20% COVID-19 Medicare discharge add-on payment. The circumstances when an offset is required and an offset is not required are described in detail below.

Prospective Payment System (PPS) Hospitals: Hospitals in urban areas and rural hospitals that do not qualify as critical access hospitals are paid under the IPPS and OPPS. The average margin on services provided to Medicare patients by PPS hospitals was -8.5% in 2020 after accounting for federal relief funds[1].

Payment rates for PPS hospitals for discharges/services are set prior to the start of the federal fiscal year (FFY) for the IPPS or calendar year (CY) for the OPPS. Both the IPPS and OPPS have mechanisms to account for high cost (outlier cases) in their payment formulas, which serve as a stop-loss mechanism.

The formulas used to set payment rates in the IPPS and OPPS use historical claims and cost data from periods prior to the COVID-19 PHE. Given that the data used to set rates do not include COVID-19 cases, the payments do not reflect the additional resources necessary to provide care to COVID-19 patients. Therefore, with the exception of specific Medicare COVID-19-related add-on payments described below, payments (or a portion of Medicare payments) do not need to be offset from hospital claims to the FEMA Public Assistance Program.

IPPS*:* The IPPS primarily pays prospectively determined payments per inpatient stay for hospitals' operating and capital costs. Under the IPPS, hospitals receive one payment for all services provided to a patient from admission to discharge as well as all pre-admission diagnostic services and related non-diagnostic services provided by the hospital in the three calendar days prior to admission[2]. IPPS payments are calculated[3] using base operating and capital rates adjusted for

[1] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch3_SEC.pdf
[2] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Three_Day_Payment_Window
[3] https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf

geographic input price variance, patient severity, and hospital-specific factors[4]. The base operating rate includes the cost of personal protective equipment and overhead costs like security staff for the facility and the capital rate includes the depreciation cost of equipment used to deliver care (e.g., ventilators). Hospitals do not bill for these items separately (e.g., there is no separate ICD-10 code on the claim for PPE, overhead costs, or specific equipment used), therefore there is not a separate payment from Medicare associated with these items. Further, as discussed below, Medicare did not increase the base operating or capital rate to account for the increased costs for these or other items associated with the COVID-19 PHE.
Market Basket Update: The operating and capital base rates are adjusted annually for forecasted inflation using a proxy market basket of goods and services needed to provide hospital care. The market basket was created and is maintained by the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary. Each individual item in the market basket has a weight for how much that item contributes proportionally to the overall index. For FFYs 2020 and 2021, the market basket weights were determined using 2014 data. For 2022, the weights were determined using 2018 data. Further, the price proxy that measures labor cost growth — the employment cost index — only includes hospital-employed staff and not contract labor such as staffing agency nurses. Increased reliance on contract staff, especially contract nurses, due to persistent clinical labor shortages has been a key driver of hospital cost growth during the PHE. In 2019, hospitals spent a median of 4.7% of their total nurse labor expenses on contract travel nurses. This skyrocketed to a median of 38.6% in January 2022[5].

The price proxies (generally from the Bureau of Labor Statistics) used to measure inflation in each of the individual items come from more recent data. CHA notes that while these market baskets of goods and services were used to calculate the annual inflation update for Medicare claims paid during FFYs 2020, 2021, and 2022, the time periods used to set these weights did not include any COVID-19 cases.

The incremental cost of caring for COVID-19 patients is not reflected in the basket of goods and services used to calculate the annual Medicare inflation update for claims paid from FFYs 2020 through 2022. Given this, offsetting expenses submitted to the FEMA Public Assistance Program for Medicare payments is inappropriate. Further, as illustrated below, the market basket update has not kept pace with the actual inflation experienced by hospitals for the care they have provided to patients since the start of the COVID-19 PHE.

[4] Teaching status (indirect medical education) and percentage of care provided to indigent patients (disproportionate share).
[5] https://www.aha.org/system/files/media/file/2022/04/2022-Hospital-Expenses-Increase-Report-Final-Final.pdf

Medicare IPPS Market Basket Update Compared to Growth in Hospital Expenses Per Adjusted Discharge

Federal Fiscal Year	IPPS Market Basket Update[6]	Hospital Total Expense Per Adj. Discharge	Inflationary Shortfall
2020	2.6%[7]	10.8%[8]	-8.2%
2021	2.4%[9]	12.9%[10]	-10.5%
2022[11]	2.0%[12]	10.1%[13]	-8.1%

IPPS Patient Severity Adjustment Recalibration: The Medicare base rate is adjusted for individual patient severity using the Medicare Severity Diagnosis Related Group (MS-DRG) system. The MS-DRG system is a relative weighting system that organizes discharges into similar resource consumption groups based on the diagnosis and procedure codes submitted on the claim. Each MS-DRG is assigned a relative cost-based weight. An inpatient discharge for an MS-DRG with a weight of 10.00 (e.g., MS-DRG 216 – Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with Major Complications: 10.0393) consumes approximately 10 times the resources of an inpatient stay for an MS-DRG of 1.00 (e.g., MS-DRG 117 – Intraocular Procedures without complication: 1.041)[14].

CMS rebases MS-DRG weights annually. Typically, the agency uses claims data from two FFYs years prior and Medicare cost report data from three FFYs years prior to the FFY in which the weights will apply. CMS did this for FFYs 2020 and 2021. However, the agency continued using the data it used for FFY 2021 to rebase the weights in FFY 2022. This was done due to concerns that claims data from FFY 2020 (two-years prior to FFY 2022) was abnormal and would result in inaccurate MS-DRG weights.

The table below illustrates the data sources used to set the MS-DRG relative weights for the years impacted by the COVID-19 PHE.

[6] Does not include increase for prior reductions related to documentation and coding adjustments.
[7] Federal Register Vol. 84, No. 159, pg. 42344
[8] https://www.kaufmanhall.com/sites/default/files/documents/2020-12/National%20Hospital%20Flash%20Report_Oct2020_KaufmanHall.pdf
[9] Federal Register Vol. 85, No. 182, pg. 58797
[10] https://www.kaufmanhall.com/sites/default/files/2021-10/national-hospital-flash-report_oct.-2021_final.pdf
[11] Hospital total expense per adjusted data is based on data comparing May 2021 to May 2022.
[12] Federal Register Vol. 86, No. 154, pg. 45215
[13] https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-05-2022-May.pdf
[14] FFY 2022 IPPS Final Rule, Table 5

Data Used to Set MS-DRG Relative Weights for FFYs 2020, 2021, and 2022

Federal Fiscal Year	Claims Data	Medicare Cost Report Data	Was COVID-19 Present During Year Used to Set Weights?
2020[15]	FFY 2018	FFY 2017	NO
2021[16]	FFY 2019	FFY 2018	NO
2022[17]	FFY 2019	FFY 2018	NO

CHA notes the data used to calculate the weights used to pay Medicare claims during FFY 2020, 2021, and 2022 did not include any COVID-19 cases. Therefore, the weights and Medicare payments associated with those weights do not include the incremental costs incurred by hospitals when they care for COVID-19 patients. Given this, offsetting expenses submitted to the FEMA Public Assistance Program for Medicare payments is inappropriate.

IPPS Outlier Payments: Medicare makes an additional "stop-loss" payment for cases that are extraordinarily costly. High-cost outlier cases are identified by comparing the cost of that case to a threshold that is the sum of the hospital's:

- Base rate adjusted for geographic variation, patient severity, and any facility-specific factors
- Fixed-loss amount

For each case that exceeds the threshold, Medicare makes an outlier payment equal to 80% of the hospital's costs above the threshold (or 90% for burn cases). Therefore, even with this additional payment, hospitals are still paid less than their cost of providing care for high-cost Medicare discharges. Further, outlier payments are made in a budget-neutral manner. CMS targets outlier payments to be a certain percentage of IPPS payments (e.g., 5.1% in 2020[18]) and then adjusts the market basket update in a given year (e.g., multiplies it by .0949 in 2020[19], thereby reducing it) so that the outlier payments do not cause the total dollar value of IPPS payments made in a certain year to exceed the amount that would have been made in the absence of an outlier payment.

When CMS sets the fixed-loss outlier for a FFY, it typically uses claims data from the FFY two years prior (similar to how it sets MS-DRG weights). The table below illustrates the data sources used to set the fixed-loss outlier threshold for FFY 2020 through 2022.

[15] Federal Register, Vol. 84, No. 159, pg. 42165
[16] Federal Register, Vol. 85, No. 182, pg. 58596
[17] Federal Register, Vol. 86, No. 154, pg. 44961
[18] Federal Register, Vol. 85, No. 182, pg. 59057
[19] ibid

Data Used to Set the Inpatient Fixed-Loss Outlier Threshold for FFYs 2020, 2021, and 2022

Federal Fiscal Year	MedPAR Claims Data	Was COVID-19 Present During Year Used to Set Outlier Threshold?
2020[20]	FFY 2018	NO
2021[21]	FFY 2019	NO
2022[22]	FFY 2019	NO

As illustrated in the table above, CMS deviated from its normal practice in FFY 2022. Instead of using claims data from FFY 2020 to calculate the fixed-loss outlier threshold, the agency again used FFY 2019 claims data. This was done out of concern that data from 2020 would not be reflective of anticipated inpatient utilization in FFY 2022. CHA notes the data used to calculate the outlier thresholds (and therefore Medicare payment) for FFYs 2020, 2021, and 2022 was from periods that did not contain COVID-19 cases. The outlier thresholds and Medicare payments associated with those thresholds do not include the incremental costs incurred by hospitals when they care for COVID-19 patients. Therefore, any outlier payments should not be offset from amounts claimed for FEMA Public Assistance Program reimbursement.

20% Add-On Payment for COVID-19 Discharges[23]: Section 3710 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act directs the Secretary of Health and Human Services to increase the weighting factor of the assigned MS-DRG by 20% for an individual diagnosed with COVID-19 discharged during the COVID-19 PHE. Discharges of an individual diagnosed with COVID-19 will be identified by the presence of the following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes:

- B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020[24]
- U07.1 (COVID-19) for discharges occurring on or after April 1, 2020[25], through the duration of the COVID-19 PHE

This incremental payment is specifically for the additional costs associated with caring for COVID-19 patients incurred by hospitals that are not factored into IPPS payments. As such, it could be appropriate for hospitals to offset this payment from requests for FEMA reimbursement if it has not been used to offset other COVID-19 impacts that are not being submitted to FEMA.

New COVID-19 Treatments Add-On Payment (NCTAP)[26]: The NCTAP is designed to mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments. It is effective

[20] Federal Register, Vol. 84, No. 159, pg. 42626
[21] Federal Register /Vol. 85, No. 182, pg. 59037
[22] Federal Register, Vol. 86, No. 154, pg. 45537
[23] https://www.cms.gov/files/document/se20015.pdf
[24] For discharges prior to April 1, 2020, the ICD-10-CM Official Coding Guideline – Supplement is at https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-CodingGudance-Interim-Advice-coronavirus-feb-20-2020.pdf
[25] For discharges on or after April 1, 2020, the ICD-10-CM Official Coding and Reporting Guidelines are at https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf
[26] https://www.cms.gov/medicare/covid-19/new-covid-19-treatments-add-payment-nctap#:~:text=NCTAP%20claims%20are%20those%20that,%2C%20or%20baricitinib%20(Olumiant).

from November 2, 2020, until the end of the fiscal year that follows the end of the COVID-19 PHE.[27]

Through the NCTAP, the Medicare program provides an enhanced payment for eligible inpatient cases that use certain new products with current Food and Drug Administration (FDA) approval or emergency use authorization (EUA) to treat COVID-19, including the following:

- On August 23, 2020, the FDA issued (reissued on November 30, 2020, and revised on March 9, 2021) an EUA for the use of COVID-19 convalescent plasma for treating COVID-19 in hospitalized patients.
- On October 22, 2020, the FDA approved remdesivir (Veklury) for the treatment of COVID-19 for adults and certain pediatric patients requiring hospitalization.
- On November 19, 2020, the FDA issued (and amended on December 20, 2021) an EUA for the use of baricitinib (Olumiant) for the treatment of suspected or laboratory-confirmed COVID-19 in certain hospitalized patients.
- On December 22, 2021, the FDA issued an EUA for molnupiravir for the treatment of mild-to-moderate COVID-19 in certain adults who are at high-risk for progression to severe COVID-19, including hospitalization or death.
- On December 23, 2021, the FDA issued an EUA for nirmatrelvir (Paxlovid) for the treatment of mild-to-moderate COVID-19 in certain adults and pediatric patients at high risk for progression to severe COVID-19, including hospitalization or death.

For eligible cases, the NCTAP is equal to the lesser of these:

- 65% of the operating outlier threshold for the claim
- 65% of the amount by which the costs of the case exceed the standard DRG payment (including the adjustment to the relative weight under Section 3710 of the CARES Act)

To the extent that a hospital is requesting FEMA reimbursement for a product that it received an NCTAP payment for, the hospital should offset the incremental NCTAP payment from the amount requested for reimbursement.

OPPS: Medicare payments under the OPPS are intended to cover services provided in hospital outpatient departments, including nursing services, medical supplies, equipment, and rooms. CMS classifies services into ambulatory payment classifications (APCs) on the basis of clinical and cost similarity. All services within an APC have the same payment rate[28]. While Medicare makes a single payment to hospitals for all inpatient services provided from admission to discharge, a hospital may receive multiple APC payments for outpatient services provided on the same date of service.

CMS determines the payment rate for each service by multiplying the relative weight for the service's APC by a wage-adjusted conversion factor. The relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The costs associated with professional services, such as physician services, are not included.

[27] Federal Register, Vol. 87, No. 90, pg. 28209
[28] https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_opd_final_sec.pdf

OPPS Conversion Factor: The OPPS conversion factor, first calculated in 2000[29], is adjusted for inflation annually using the IPPS market basket update[30]. The conversion factor includes the cost of personal protective equipment and overhead costs like security staff for the facility and the capital rate includes the depreciation cost of equipment used to deliver care. Hospitals do not bill for these items separately (e.g., there is no separate ICD-10 code on the claim for PPE, overhead costs, or specific equipment used); therefore, there is not a separate payment from Medicare associated with these items. Further, as discussed below, Medicare did not increase the conversion factor to account for the increased costs for these or other items associated with the COVID-19 PHE.

This market basket update for OPPS is the same value that is used in the IPPS. Like the IPPS base rate, the OPPS conversion factors used for FFYs 2020, 2021, and 2022 are not based on data that include costs associated with COVID-19 cases. Therefore, OPPS payments calculated using the conversion factor do not compensate hospitals for the incremental costs associated with treating COVID-19 patients. Given this, offsetting expenses submitted to the FEMA Public Assistance Program for Medicare payments is inappropriate.

APC Relative Weight Rebasing: The inflation-adjusted Medicare OPPS conversion factor is adjusted for service intensity using the APC system. The APC system is a relative weighting system that organizes outpatient services into similar groups based on the procedure codes submitted on a claim to Medicare and the national average cost of an outpatient clinic visit to Medicare beneficiaries. Each APC is assigned a relative cost-based weight. A service described by an APC with a weight of 15.00 (e.g., APC 5625 – Level 5 Radiation Therapy: 15.6946) requires approximately 15 times the resources to deliver than a service described by an APC with a weight of 1.00 (e.g., APC 5012 – Clinic Visits and Related Services: 1.4416)[31].

CMS rebases APC weights annually. Typically, the agency uses claims data from two years prior and Medicare cost report data from three years prior to the year in which the weights will apply — which CMS did for 2020 and 2021. However, the agency continued using the data it used for 2021 to rebase the weights in 2022. This was done due to concerns that claims data from 2020 (two years prior to 2022) was abnormal and would result in inaccurate APC weights.

The table below illustrates the data sources used to set the APC relative weights for the years impacted by the COVID-19 PHE.

Data Used to Set APC Relative Weights for CYs 2020, 2021, and 2022

Calendar Year	Claims Data	Medicare Cost Report Data	Was COVID-19 Present During Year Used to Set Weights?
2020[32]	2018	2017	NO

[29] https://www.govinfo.gov/content/pkg/FR-2000-04-07/pdf/00-8215.pdf
[30] Federal Register Vol. 85, No. 249, pg. 85903
[31] https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-opps-addenda.zip
[32] Federal Register, Vol. 84, No. 218, pg. 61149

2021[33]	2019	2018	NO
2022[34]	2019	2018	NO

OPPS Outlier Payments: CMS makes outlier payments for individual services that cost hospitals significantly more than the payment rates for the service's APC group. CMS defines an outlier as a service with costs that exceed 1.75 times the APC payment rate and exceeds the APC payment rate by an outlier threshold. When a service meets both tests, CMS will reimburse the hospital for 50% of the difference between the cost of furnishing the service and 1.75 times the APC rate. Further, outlier payments are made in a budget-neutral manner. CMS targets outlier payments to be a certain percentage of OPPS payments (e.g., **1.0%** in 2020[35]) and then adjusts the market basket update in a given year[36] so that the outlier payments do not cause the total dollar value of OPPS payments made in a certain year to exceed the amount that would have been made in the absence of an outlier payment.

Data Used to the Outpatient Fixed-Loss Outlier Threshold for 2020, 2021, and 2022

Calendar Year	Claims Data	Was COVID-19 Present During Year Used to Set Outlier Threshold?
2020[37]	2018	NO
2021[38]	2019	NO
2022[39]	2019	NO

As illustrated in the table above, CMS deviated from its normal practice in FFY 2022. Instead of using claims data from FFY 2020 to calculate the fixed-loss outlier threshold, the agency again used FFY 2019 claims data. This was done out of concern that data from 2020 would not be reflective of anticipated outpatient utilization in FFY 2022. CHA notes the data used to calculate the outlier thresholds (and therefore Medicare payment) for CYs 2020, 2021, and 2022 were from periods that did not contain any COVID-19 cases. The outlier thresholds and Medicare payments associated with those thresholds do not include the incremental costs incurred by hospitals when they care for COVID-19 patients. Therefore, any outlier payments should not be offset from amounts claimed for FEMA Public Assistance Program reimbursement.

Critical Access Hospitals (CAHs)[40]: CAHs are limited to 25 inpatient beds and primarily operate in rural areas. They must meet certain distance requirements or be declared a necessary hospital by the state in which they operate to qualify for CAH status. CAHs are limited to taking cases that are expected to require 96 hours or less of inpatient hospital care. There are no restrictions on CAH outpatient services.

[33] Federal Register, Vol. 85, No. 249, pg. 85873
[34] Federal Register, Vol. 86, No. 218, pg. 63751
[35] Federal Register, Vol. 84, No. 218, pg. 61192
[36] Because actual outlier payments in the prior year were equaled the estimated amount, no adjustment was necessary in CY 2020.
[37] Federal Register, Vol. 84, No. 218, pg. 61193
[38] Federal Register, Vol. 85, No. 249, pg. 85916
[39] Federal Register, Vol. 86, No. 218, pg. 63510
[40] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/payment-basics/medpac_payment_basics_20_cah_final_sec.pdf

Medicare pays for the same services from CAHs as from other acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests, and post-acute skilled nursing days). However, CAHs' payments are not based on the type of service provided or the number of services provided. Payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients.

Each CAH receives 101% of its allowable costs for outpatient, inpatient, laboratory, and therapy services, as well as post-acute care in the hospital's swing beds. The cost of treating Medicare patients is estimated using cost accounting data from Medicare cost reports. CMS' cost accounting methodology allocates costs among patients based on a combination of factors such as the number of days a patient stays in the hospital and the dollar value of charges the patient incurs for ancillary services. Given that CAHs are paid based on their cost, it is appropriate to offset a portion of Medicare payment related to the amount of FEMA Public Assistance Program reimbursement requested.

Medicare Advantage (MA): Under the MA program, the Medicare beneficiary buys insurance coverage from private plans using their Part B premium. The coverage must include all Medicare Part A and Part B benefits except hospice[41].

MA plan bids partially determine the Medicare payments they receive. Plans bid to offer Parts A and B coverage to Medicare beneficiaries. The bid is presented as the amount to cover an average, or standard, beneficiary. The bid includes plan administrative cost and profit. CMS bases its monthly payment to each private plan for an enrolled beneficiary on the relationship between the plan's bid and its benchmark.

The benchmark is a bidding target. The local MA benchmarks are determined under statutory formulas whereby county-level rates vary depending on average Medicare FFS[42] spending per Medicare beneficiary. The county-level benchmark is based on a five-year rolling average of Medicare FFS spending weighted for enrollment and average risk scores, to yield the per capita FFS Medicare spending amount for each county[43]. The table below provides the years included in the five-year rolling average FFS spending data used to calculate the county-level benchmarks for 2020, 2021, and 2022.

Data Used to the MA County-Level Benchmark for 2020, 2021, and 2022

Calendar Year	Years Included in MA Benchmark	Was COVID-19 Present During Years Used to Set Weights?
2020[44]	2013 - 2017	NO
2021[45]	2014 - 2018	NO
2022[46]	2015 - 2019	NO

[41] https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_ma_final_sec.pdf
[42] Medicare fee-for-service is "traditional" unmanaged Medicare Parts A and B.
[43] https://bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_WhitePaper_MA_Bidding_and_Payment_2018_09_19-1.pdf
[44] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2020Part2.pdf
[45] https://www.cms.gov/files/document/2021-announcement.pdf
[46] https://www.cms.gov/files/document/2022-announcement.pdf

CHA notes the data used to calculate the MA county-level benchmarks (and therefore Medicare payment) for CYs 2020, 2021, and 2022 were from periods that did not contain any COVID-19 cases. The capitated Medicare payments to health plans associated with those benchmarks do not include the incremental costs of COVID-19 incurred by hospitals that provide care to MA beneficiaries. Therefore, any MA payments should not be automatically offset from amounts claimed for FEMA Public Assistance Program reimbursement.