August 9, 2022

Ana Montero
Division Director, Public Assistance
Federal Emergency Management Agency
500 C St., S.W.
Washington, D.C. 20472

Subject: Methodology for Preventing Duplication of FEMA Benefits

Dear Ms. Montero:

On behalf of our nearly 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates FEMA's work to provide COVID-19-related reimbursement to hospitals and health systems for eligible expenses. This is an issue of great importance to our members. As a result of the extraordinary measures taken to protect Californians from COVID-19 in 2020 and 2021[1], California's hospitals have lost more than $12 billion (even after including federal Provider Relief Funds). Because of these losses, over half of the state's hospitals had negative margins in 2021. These losses are unsustainable and threaten access to care for some Californians.

We write to you to request that FEMA extend the comment period related to the agency's methodology for reviewing hospital public assistance projects for duplication of benefits with patient care revenue and conduct broad outreach to gather stakeholder feedback on this highly technical topic.

California's not-for-profit and governmental hospitals are owed at least $532 million[2,3] by FEMA for eligible expenses, based on a recent survey of CHA members. Many of these expenses date to the early days of the pandemic, with 8% ($45 million) of the dollars included in applications submitted in 2020, 22% ($119 million) in 2021, and 70% ($376 million) in 2022. We understand that one of the reasons for the delay in processing these applications for public assistance is the need to ensure that none of the

[1] https://www.kaufmanhall.com/sites/default/files/2022-04/KH_CHA-2021-Financial-Analysis-Ebook.pdf
[2] CHA notes that the amount owed hospitals is likely much larger, as only 56% of members eligible for FEMA reimbursement responded to the survey.
[3] The FEMA-eligible hospitals that responded to the hospital have applied for $540.89 million in qualifying expenses but only received $9 million in reimbursement to date ($540.89m - $9.1m = $531.76m).

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expenses submitted have been paid for by other sources — including payments from commercial and governmental payers for services provided to enrollees.

FEMA public assistance has not addressed the complex area of hospital finance in response to previous disaster declarations, at least not to the extent it has during the COVID-19 public health emergency (PHE). As a result, the agency is developing a framework for reviewing hospital public assistance projects for duplication of benefits with patient care revenue. CHA recognizes that hospital finance is complex, and we support FEMA's efforts to prevent duplication of benefits. As it relates to governmental payers — Medicare and Medi-Cal — hospitals received de minimis additional revenue to offset the considerable, incremental costs (e.g., personal protective equipment, contract labor, facilities modification to improve infection control) associated with the COVID-19 PHE. **Included as attachments are overviews of the Medicare and Medi-Cal payment rate-setting processes. These documents also identify where additional payments may have been made that will need to be offset to prevent the duplication of benefits.**

We understand that the agency has shared its draft methodology with hospitals in some regions via webinar and has established a comment period, ending August 12. Unfortunately, FEMA did not widely publicize its draft methodology, these webinars, and the opportunity for hospitals to provide comments. Further, no such opportunity for discussion and feedback was offered to California's hospitals (Region IX). **Given the highly technical nature of hospital payments and the important implications this draft methodology has for California's hospitals' COVID-19 public assistance projects, we respectfully request that FEMA release its methodology publicly, extend its comment period for at least another 30 days, and hold stakeholder calls to gather feedback.**

We appreciate FEMA's efforts to support hospitals during the COVID-19 PHE. Further, we look forward to providing any assistance necessary to help the agency develop an equitable framework for identifying and offsetting payments for health care services that duplicate expenses submitted for FEMA public assistance. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy

Attachments (2)

California Hospital Association

Attachment I

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.

California Hospital Association

Attachment II

Overview of Medi-Cal Rate Setting

Background

California has an extensive history of using various mechanisms to fund Medi-Cal payments for hospital services. Originally, the main use of these various funding mechanisms was tied to specific programs authorized under time-limited federal waivers; however, over the past 15 years, the use of self-financing and/or provider taxes has grown into a critical element supporting the entire Medi-Cal program. The reliance on self-financing in the latest Medi-Cal estimate (state fiscal year 2021-22) now eclipses $11 billion dollars annually, or 10% of the state budget to support medical services. When matched with federal funding, the total impact exceeds $30 billion annually, which supports the 15 million beneficiaries enrolled in the Medi-Cal program.

These funding mechanisms and methodologies differ based on hospital type and delivery system. For instance, designated public hospitals (DPHs[1]) and non-designated public hospitals (NDPHs)/district hospitals may use certified public expenditures (CPEs) and intergovernmental transfers (IGTs) as additional funding mechanisms in both fee-for-service (FFS) and managed care delivery systems, while private not-for-profit and investor-owned hospitals cannot. To help understand these differences, it's best to examine the different Medi-Cal reimbursement as base payments and supplemental payments.

Base Payments — FFS base payment methodologies are highly prescribed pursuant to state law and federal state plan approvals, while managed care payments for inpatient services are subject to direct contract negotiations between managed care plans (MCPs) and hospital providers and can take many forms. More details are included later in this memo, but FFS inpatient reimbursement depends on the type of hospital:

- DPHs receive up to a portion of their actual audited costs.
- Private hospitals and NDPHs are reimbursed based on the All Patient Refined Diagnosis Related Groups (APR-DRG) methodology.

Supplemental Payments — In California, there are more than 30 supplemental payment programs that cover different hospital types and services (inpatient, outpatient, long-term care, etc.). These programs are approved by the Centers for Medicare & Medicaid Services (CMS) through various authorities: 1) 1115 Waivers, 2) state plan, 3) managed care directed payments, and 4) managed care rates. This document highlights only a few of the supplementals.

Benefit from the Public Health Emergency (PHE) — At the highest level, hospitals have received very little to no direct benefit by a change in Medi-Cal FFS reimbursement methodologies as a result of COVID-19. Any payment changes they received from Medi-Cal MCPs have been the result of contract

[1] "Designated Public Hospital" has the meaning given in subdivision (f) of Section 14184.10 of the Welfare and Institutions Code.

negotiations and discussions with health plans and not the result of Medi-Cal policy changes. The only benefit hospitals experienced through the PHE is due to an enhanced federal medical assistance percentage of 6.2%, which lowered the non-federal share needed to support their base and supplemental payments. However, not all of that benefit was actually observed by hospitals. For some programs, the enhanced federal funding was retained by the state; in other situations some of the funding hasn't been claimed yet; and in still other situations there is an expectation the state will recoup it in future reconciliations. Therefore, the incremental costs of COVID-19 have not been recognized through any meaningful changes in payment methodology in either Medi-Cal FFS payments or Medi-Cal MCP payments. As a result, the need to offset expenses submitted to the Federal Emergency Management Agency (FEMA) Public Assistance Program related to the COVID-19 PHE would be *de minimis* as it relates to Medi-Cal payments.

Based on this analysis, the only Medi-Cal payments received from the state that a hospital may need to offset expenses included in a FEMA public assistance application are for rate increases related to COVID-19 laboratory services, long-term care (LTC) services, certain durable medical equipment (DME), and COVID-19 vaccination administration. Medi-Cal payment methodologies for hospitals are briefly described below, including the limited circumstances in which payment has changed as a result of COVID-19.

Fee-for Service Delivery System

APR-DRG — Private and non-designated public/district hospitals receive base payments for FFS inpatient admissions using the APR-DRG methodology. APR-DRG is a bundled rate methodology that uses a patient's diagnosis/diagnoses and the severity of the patient's condition(s) further adjusted by a hospital-specific relative value and location to determine a bundled payment amount based on the type of admission and services performed. While a COVID-19 admission is reimbursable under the APR-DRG methodology, there was no premium/increase applied to COVID-19 admissions for Medi-Cal, unlike the 20% increase applied in Medicare Severity-Diagnosis Related Group (MS-DRG) for COVID-19 admissions. Furthermore, in California, the DRG methodology has been designed to be budget neutral based on 2012 payments such that annual updates to the DRG methodology are targeted to pay no more per weighted average admission than the weighted average admission in 2012. This budget-neutral methodology amounts to FFS payments frozen at 2012 levels. Therefore, not only did California hospitals not receive more for COVID-19-related admissions, they are being underpaid in their APR-DRG base rates for all admissions, including COVID-19, based on their actual cost as a result of the budget-neutral APR-DRG methodology administered in California. Due to systemic underfunding of the Medi-Cal program, hospitals that care for Medi-Cal patients are reimbursed only 74 cents on the dollar for the cost of care.

Outpatient/Professional Fee Schedule — All hospital types that deliver outpatient and professional services in the FFS system are reimbursed according to the Medi-Cal-established fee schedule. Upon delivering a service, hospitals and providers submit claims using procedure codes to identify the service provided and are paid according to the fee schedule for that procedure. The fee schedule does make some adjustments to the amount paid based on the provider type and the population served, and for some procedures (such as physician office visits) that provide a supplemental payment beyond the published fee schedule. However, aside from very specific instances that are further discussed below, the FFS fee schedule was not increased or modified to pay differently for services provided to treat COVID-19.

Public Hospital Cost-Based Reimbursement — California's DPH systems are paid up to their actual audited costs for FFS inpatient services provided to Medi-Cal members using a certified public expenditure (CPE) methodology. However, DPHs are responsible for funding most of the non-federal share of these payments. In other words, their CPE is what funds the non-federal share, and the state Medi-Cal program does not provide state dollars to fund the non-federal share of the DPH's costs. California has not altered this methodology or provided any direct state funding thus far as a direct result of COVID-19. Therefore, while DPHs are able to use their CPEs to claim federal funding for any increase in costs they have experienced for FFS Medi-Cal inpatient admissions as the result of the pandemic, they are still responsible for self financing the growth in the non-federal share of these costs.

Managed Care Delivery System

Managed Care Capitation Rates — Hospitals receive payments from Medi-Cal managed care plans for hospital services provided to health plan members. The level of base reimbursement is determined through contract negotiations with health plans, and these mechanisms can include a FFS structure, percentage of charges, per diem amounts, DRG-based system, risk-based sub-capitation and member assignment arrangement, and even pay for performance or shared savings incentive arrangements. Health plan capitation rates are based on principles of actuarial soundness and are developed by using historical health plan cost and utilization data and then applying various trends and program change adjustments to account for the costs associated with services to the populations they are contracted to cover during the time period in which they are covered. The data used to develop the most recent 2022 rates use actual experience from 2019 and, therefore, do not capture any of the impacts of COVID-19.

Lastly, the managed care plans receive additional funding to support public safety net providers within their capitations. Both DPHs and NDPHs are eligible for this additional funding and support these enhanced payments with IGTs. These payments mirror the base capitations for the plans and were also not adjusted due to the COVID-19 pandemic.

Supplemental Payments

1115 Waiver Programs (PATH and Global Payment Program) — Under the Providing Access and Transforming Health (PATH) initiative of California's recently approved 1115 Waiver[2], known as California Advancing and Innovating Medi-Cal (CalAIM), DPHs are eligible to receive funding to transition the previously approved 1115 Waiver program of Whole Person Care to the managed care delivery system, using a new enhanced care management (ECM) benefit and community supports (in lieu of services) benefits, and increase service capacity and infrastructure for ECM and community supports (CS). PATH funding and allocations to DPHs have no direct linkage to the COVID-19 pandemic, and COVID-19 is not an explicit condition that would qualify an individual for access to ECM or CS benefits.

CalAIM also extends the Global Payment Program (GPP) for a subset of DPHs. GPP is funded using most of California's federal disproportionate share hospital (DSH) allotment and additional funding authorized for uncompensated care under the safety-net care pool. The GPP allows eligible DPHs to repurpose DSH funding, which historically has only considered uncompensated costs for Medi-Cal and uninsured

[2] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf

inpatient services, to allow for spending on non-inpatient preventative care services for the uninsured. While services provided to uninsured individuals experiencing COVID-19 would be a part of the GPP framework, no increased funding or additional recognition of COVID-19 has been implemented in the GPP.

DSH and DSH-Replacement (DSH-R) — Given that eligible DPHs use the majority of California's federal DSH allotment through the GPP, what little federal DSH allotment is left is allocated for the subset of DPHs that are not in the GPP and the NDPHs. California still allows for private hospitals that would have been eligible to receive DSH funds through supplemental payments that equal what those hospitals would have otherwise received under DSH. These are supplemental payments that use state General Fund and non-DSH federal matching funds and are offset against the state's approved upper payment limit for FFS supplemental payments. In California, this is known as the DSH-Replacement (DSH-R) or Virtual DSH program. The funding methodology for DSH-R follows the historic DSH allocation methodology and, as such, there have been no adjustments or changes in the allocation methodology directly as a result of COVID-19. Uncompensated costs as a result of COVID-19 admissions would be captured as part of the DSH-R methodology, but COVID-19uncompensated costs are not being treated any differently than uncompensated costs for other conditions.

Regarding the remaining federal DSH allotment, eligible NDPHs and University of California hospitals receive DSH funds allocated using the historical DSH methodology; as such, no adjustments or changes to the allocation methodology have been implemented as a result of the pandemic. Uncompensated costs because of COVID-19 admissions would be captured as part of the DSH methodology, but COVID-19 uncompensated costs are not being treated any differently than uncompensated costs for other conditions.

Hospital Quality Assurance Fee (HQAF) Program — The HQAF program allows for improved hospital reimbursement of Medi-Cal services by assessing a fee on private hospitals based on their inpatient utilization, using that fee revenue to match with federal funding, and then paying supplemental payments to hospitals based on their Medi-Cal inpatient and outpatient utilization. All private general acute care hospitals must participate in the program except exempt facilities (e.g., public, small/rural, psychiatric, specialty, long-term care, and new hospitals). The FFS portion of HQAF payments and the fees assessed are fixed and based on historical utilization from a time prior to the pandemic (2018 utilization for the current program). Therefore, the impact of COVID-19 has not been captured under any FFS payments received by hospitals or fees paid by hospitals, and there have been no adjustments to the HQAF program directly because of COVID-19. In fact, the state has been in discussions since December 2021 and is still seeking approval from CMS for the HQAF program for 2022. The HQAF program uses the federal authority (upper payment limit) that allows hospitals to receive supplemental payments that would pay hospitals in aggregate up to what Medicare would pay for the same service. Despite the state's efforts at demonstrating actual experience related to the COVID-19 pandemic illustrating the higher Medicare payments for COVID-19 admissions, CMS has denied the proposed adjustments. Therefore, not only does the HQAF program not capture the impact of COVID-19 in the data, nor make any payment adjustments based on COVID-19, but CMS has also rejected the potential to recognize higher Medicare payments for COVID-19 in the upper payment limit calculations.

Managed Care Directed Payments — Directed payments are a financing mechanism used in managed care delivery systems that is in addition to the negotiation process between health plans and providers. They establish mandatory payment amounts for specified services.

DPH and district/municipal public hospital (DMPH) systems participate in a quality-based directed payment program known as the quality incentive program, which provides additional funding to DPH/DMPH systems for achieving certain quality benchmarks. While quality scores could capture the treatment of individuals with COVID-19, none of the quality measures are directly tied to COVID-19, and no increased funding was provided for the quality incentive program related to COVID-19. The non-federal share of these payments is financed through IGTs.

DPHs also participate in a directed payment program known as the enhanced payment program , which provides supplemental funding through managed care to DPHs based on their contracted inpatient and outpatient utilization. Like the other supplemental payment programs that are based on utilization, this program will pay additional funding for services provided to individuals with COVID-19. However, funding for the enhanced payment program was not increased as a result of COVID-19, and COVID-19 utilization does not pay any differently than other conditions.

The HQAF program described above also funds a private hospital directed payment (PHDP) program that provides eligible private hospitals additional funding for contracted inpatient and outpatient services provided to Medi-Cal managed care members. Like the other supplemental payment programs that are based on utilization, this program pays for services provided to individuals with COVID-19. However, funding in PHDP was not increased as a result of COVID-19, and COVID-19 utilization does not pay any differently than other conditions.

There are other directed payment programs that are not specific to hospitals, but hospitals or their contracted partners can receive them based on specific services (e.g., physician office visits, developmental and trauma screenings, or family planning services). None of these directed payments are for treating COVID-19, and while physician office visits to treat COVID-19 would qualify for a directed payment, the payment itself is not related to the COVID-19 condition and does not pay differentially based on it.

Other Supplemental Payments — There are also a variety of other Medi-Cal FFS supplemental payment programs authorized in California. Eligibility and funding levels for these supplemental payment programs vary. For instance, DPHs and DMPHs participate in a variety of CPE-based supplemental payments in order to receive federal reimbursement up to their audited costs for different categories of service (physician and non-physician services, distinct part-nursing facility services, and outpatient services). All DSH-eligible hospitals are eligible to receive outpatient DSH payments. Private hospitals are eligible for private hospital supplemental fund payments, and certain private hospitals are eligible for private trauma hospital payments. NDPHs also participate in the NDPH supplemental reimbursement program. All of these programs are authorized under the Medicaid state plan, which defines the eligibility, funding amounts available, and data to be used (if applicable). None of the data used thus far for these payments have captured COVID-19 experience, and there have been no adjustments in payment amounts or allocations of funds to attempt to pay a differential based on COVID-19 experience.

COVID-19-Related Payment Adjustments

As part of the COVID-19 PHE, CMS provided states the opportunity to seek federal approval for changes and flexibilities to their Medicaid programs that would be in effect through the PHE. This included flexibilities through section 1135 waivers and changes to their state plan, section 1115 Waivers, and Appendix K for home and community-based waiver programs. California received approval for a variety of program changes and flexibilities through these vehicles. As it relates to hospitals, the following approvals were granted during the PHE:

- **Rate Increase for COVID-19 Clinical Laboratory Services —** The Medi-Cal state plan limits reimbursement for clinical laboratory services to 80% of the Medicare fee schedule. The California Department of Health Care Services (DHCS) received Disaster State Plan approval to increase rates for COVID-19-related testing services and procedures to 100% of the Medicare fee schedule rates.
- **Rate Increase for LTC Services —** The Medi-Cal state plan establishes various methodologies for establishing FFS per diem rates for LTC facilities depending on the facility type, which includes skilled-nursing facilities that are a distinct part of a hospital . Under Disaster State Plan authority, DHCS received approval to increase LTC per diem rates, including for distinct-part nursing facilities, by 10% during the PHE.
- **Rate Increase for Certain DME —** The Medi-Cal state plan limits reimbursement for DME to 80% of the Medicare fee schedule for oxygen, oxygen equipment, and respiratory equipment. DHCS received Disaster State Plan approval to increase rates for these products and procedures to 100% of the Medicare fee schedule rates.
- **COVID-19 Vaccine Payment Rates —** Under the state plan, FFS reimbursement rates for vaccines are established according to the FFS fee schedule. Under Disaster State Plan authority, DHCS received approval to reimburse procedure codes related to the administration of the COVID-19 vaccine to 100% of the Medicare fee schedule rates.