



September 13, 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 with feedback on the agency's voluntary methodology for reviewing hospital public assistance projects for duplication of benefits with patient care revenue from third-party payers and to request that FEMA conduct duplication of benefits reviews on an expedited basis.

Hospital-Developed Methodologies

Given that FEMA has previously instructed hospitals to develop their own methodology for offsetting expenses that were covered by patient care revenue, we strongly support the agency allowing hospitals to submit their own methodologies to mitigate duplication of benefits. Additionally, we respectfully request an accelerated review by FEMA of hospital-developed methodologies given the considerable delay in obligating necessary funds that has already occurred. The review would provide recommendations for strengthening the methodology but not alter hospitals' established method for avoiding duplication. To achieve accelerated reviews, we ask the agency to ensure that it has the appropriate staffing resources (e.g., FTEs with sufficient health care finance acumen) available in all

¹ https://www.kaufmanhall.com/sites/default/files/2022-04/KH_CHA-2021-Financial-Analysis-Ebook.pdf

regions. This will allow for funds for expenses that hospitals have incurred responding to the public health emergency (PHE) to be obligated in an expeditious manner.

Regarding the voluntary methodology FEMA is developing, we are concerned the agency may favor its methodology over hospital-developed methodologies. If this occurs, it will result in significant, unnecessary re-work for hospitals and lead to further delays in processing applications for hospitals that develop their own methodologies. Therefore, we strongly discourage the agency from favoring the voluntary methodology it is developing.

If using a hospital-specific revenue offsetting methodology will delay application processing more than using the FEMA voluntary methodology, we ask that FEMA clearly state this now. If that is the course that FEMA is taking, we ask the agency to provide a reliable estimate of the additional time required for using a hospital-specific duplication of benefits methodology. CHA also asks that FEMA provide criteria the agency requires in a methodology and let the hospitals determine the best way to use the data they have collected to provide this information vs. mandating a specific methodology or template.

Finally, CHA respectfully asks that FEMA make available to hospitals examples of hospital-developed methodologies the agency has approved. We encourage the agency to create an expedited review process for any application that uses a model the agency has already accepted. Not only will this accelerate the obligation of much-needed funds to reimburse hospitals for expenses they incurred responding to the COVID-19 PHE, but it will reduce the staffing resources necessary to review hospital-developed models.

FEMA-Developed Voluntary Methodology

CHA greatly appreciates FEMA's efforts to develop a voluntary methodology for offsetting any FEMA-eligible expenses for which incremental patient care revenue was received to prevent duplication of benefits. We believe this will be of great benefit for hospitals that elect not to develop their own methodology and choose to use FEMA's.

Technical Feedback

CHA asks that FEMA publicly post a document that details how the actual cost ceilings for each category (e.g., labor, medical equipment, personal protective equipment (PPE)) will be calculated before it finalizes the voluntary model. Unfortunately, there isn't sufficient information for hospitals to provide detailed feedback based on what FEMA staff presented during the webinars on August 30 or September 8. Additionally, it would be helpful if FEMA provided more examples of how the methodology will be applied and the documentation required in certain situations.

Once FEMA finalizes the voluntary model, we encourage the agency to make an Excel template available that hospitals can use to calculate the various ceilings and any required expense offsets necessary to avoid duplication of benefits. This Excel template should include specific references to the Medicare cost report worksheets and line numbers used in the offset calculation. Additionally, CHA respectfully asks FEMA to hold frequent "office hours" sessions to answer questions about the methodology. This will educate hospitals as to how the methodology will be applied, allowing hospitals to make an informed decision about using it or developing their own methodology to offset any revenue necessary to prevent duplication of benefits. As part of the office hours process, we ask that FEMA establish clear guidelines and FAQs related to its methodology. Finally, CHA requests that FEMA provide an appeal process that involves a second-level review conducted by individuals who were not involved in the initial review. We

believe it is important to provide an avenue for discussing differences in outcomes (based on modeling and/or use of cost report information).

Reimbursement for Purchases of Equipment

Hospitals have purchased a significant amount of unbudgeted equipment (e.g., ventilators) to ensure they had the necessary capacity and capabilities to respond to surges of COVID-19 patients. Unfortunately, FEMA staff on recent webinars asserted the agency will only reimburse providers for the depreciation cost of the equipment realized during the PHE. In most instances, the unbudgeted equipment purchased specifically in response to the COVID-19 pandemic will not be used by hospitals after the pandemic. If FEMA only covers the depreciation expense realized during the PHE, the agency will short-change hospitals that have taken extraordinary measures — by purchasing equipment that is unnecessary after the PHE — to provide lifesaving care to individuals afflicted with COVID-19. CHA respectfully asks the agency to fully reimburse hospitals for the total expense of unbudgeted equipment purchased in response to the COVID-19 PHE. Further, should the individual states wish to store the equipment that will no longer be utilized due to the PHE discontinuance, a process for this storage would be appreciated. Otherwise, hospitals will incur significant costs to store the equipment as a precaution against a future pandemic, given that much of the unbudgeted equipment purchased during the pandemic is unnecessary as caseloads (both volume of patients and types of disease) revert to normal.

Apply Standards that Are Relevant for When Expense Was Incurred

Given the ongoing and unique nature of the COVID-19 PHE, FEMA's requirements and guidance related to expenses eligible for public assistance reimbursement have evolved over time. CHA notes that it is particularly challenging for hospitals to obtain additional information or evidence necessary to meet a new documentation standard to support the eligibility of an expense for public assistance for an item or service that was provided more than a year ago. CHA respectfully asks that FEMA process applications for public assistance based on the documentation standards that were in effect when the item or service was provided. We are deeply concerned that when the agency retroactively applies updated standards, it may result in eligible expenses being disallowed, as hospitals may not be able to meet the updated requirements. In these instances, hospital staff were unaware (and could not have known) of the need to capture certain information necessary to support the expense. Further, we note that given the novelty of COVID-19, many items or services used to test for or treat the virus were not covered by third-party payers when they initially became available. We encourage FEMA to clarify that expenses for any item or service that was not initially covered is a "low-risk" item during the period when third-party payers did not provide payment for new items and services.

Low-Risk Items

CHA strongly supports FEMA's bifurcation of projects between "low-risk" and "high-risk" projects based on whether patient care revenue was received for the project and/or the project is below the "large project" dollar threshold. Low-risk projects will require only an applicant certification (if no patient care revenue was received) or an applicant certification and a narrative describing efforts to prevent duplication of benefits (if patient care revenue was received and the project was below the "large project threshold"). In instances where a project application includes both low-risk and high-risk items, we ask the agency to allow for the expedited processing and payment of the low-risk items included in the application. If that is not possible, CHA respectfully asks FEMA to provide a simplified approach to splitting the project into two (e.g., project 1a and 1b) without requiring duplicate information to be submitted for each project.

Additionally, FEMA has indicated that there are certain items it considers “low risk.” For example, during webinars on September 8, FEMA staff remarked that PPE is considered a low-risk item. CHA strongly encourages the agency to publish a comprehensive list of “low-risk” items for hospitals to use, which will not be revised, except to add items, as they prepare their applications.

Timing of Reviews

California’s not-for-profit and governmental hospitals are owed at least \$532 million^{2,3} by FEMA for public assistance-eligible expenses. 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 expenses submitted have been paid for by other sources — including payments from commercial and governmental payers for services provided to enrollees.

While CHA appreciates that health care billing is a complex topic, we are concerned that FEMA is now almost 30 months into the pandemic and has not provided sufficient, consistent guidance on reviewing applications for duplication of benefits to the various regional offices to allow for efficient processing. Additionally, FEMA has changed efforts around expedited review mid-stream with new requirements for documentation and processing. First, we ask that the agency allocate additional consistent resources to the regions to allow them to expedite the review of applications for duplication of benefits. Region 9 has stated that it is unlikely that the backlog of existing applications will be cleared by the end of the year — and this does not include additional applications that will be filed in response to upcoming deadlines. Given that some of these applications are over 500 days old, this is unacceptable.

Additionally, we respectfully ask that the agency add interest to public assistance amounts reimbursed to hospitals for eligible expenses incurred as a result of the COVID-19 PHE. Other federal government agencies, including CMS and the Internal Revenue Service, add interest to late payments, just as they charge interest for hospitals making late payments. It is only fair for FEMA to do the same, given that many of the outstanding applications date back to late 2020 and early 2021.

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

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 survey have applied for \$540.89 million in qualifying expenses but received only \$9 million in reimbursement to date (\$540.89m - \$9.1m = \$531.76m).