COVID-19 Patient Care Revenue Duplication of Benefits

Recipient and Subrecipient Guide

A. Introduction

The COVID-19 pandemic has required FEMA to coordinate response and recovery activities in every state, territory, and Tribal Nation. The availability of funding from numerous sources has complicated the delivery of assistance and the processes by which FEMA, Recipients, and Applicants (Subrecipients once projects are obligated) ensure that benefits are not duplicated. Subrecipients are claiming eligible costs for medical care that may also be covered by patient care revenue, including insurance proceeds. This is primarily an issue for Subrecipients who have a billing process in place to receive revenue for patient care. Obstacles to identifying duplication and taking project reductions include:

- Medical billing and patient care revenue, which are comprised of varying rates for services and providers, are different from insurance proceeds that FEMA typically assesses.
- Typically patient billing for medical services are not broken down into the same operational components that are being submitted to FEMA, but both contribute to the same services.

Recipients and subrecipients are required to comply with applicable provisions of laws and authorities, including but not limited to:

- Section 312 of the Robert T. Stafford Act states that FEMA must ensure that no entity will receive financial assistance for any loss for which financial assistance has already been received from any other program, from insurance, or from any other source.
- The Public Assistance Program and Policy Guide (PAPPG), Version 3.1,[1] Chapter 2:V.P states that FEMA is legally prohibited from duplicating benefits from other sources. If the Applicant receives funding from another source for the same work that FEMA funded, FEMA reduces the eligible cost or de-obligates funding to prevent a duplication of benefits (DOB).
- Coronavirus (COVID-19) Pandemic: Public Assistance Programmatic Deadlines, FEMA Policy # 104-22-0002, says that if an Applicant receives funding from another source for the same exact cost item that FEMA funded, FEMA will reduce the eligible amount to prevent a duplication of benefits. For example, if FEMA provides Public Assistance (PA) funding for eligible COVID-19 medical care costs and the Applicant also receives funding from another source for COVID-19 medical care, FEMA will only

[1] *Version 3.1 of the PAPPG is applicable to all COVID-19 declarations.*

consider it a duplication of benefits if the Applicant uses the other sources funding for the same exact cost items that were eligible and claimed to FEMA for PA funding.

- *FEMA Coronavirus (COVID-19) Pandemic: Medical Care Eligible for Public Assistance (Interim) (Version 2).* For eligible work and costs for medical care activities and associated costs in primary medical care facilities, temporary medical care facilities and expanded medical care facilities
- For other COVID-19 related eligible work and costs, please see: Public Assistance Disaster-Specific Guidance - COVID-19 Declarations | FEMA.gov

B. Risk-Based Approach

In line with standard project review practices, FEMA uses a risk-based approach to review PA projects for potential DOB involving patient care revenue. This approach considers factors such as project size, work claimed, and work that is billable to patients. As part of the review, FEMA classifies each PA project as having low or high risk of DOB.

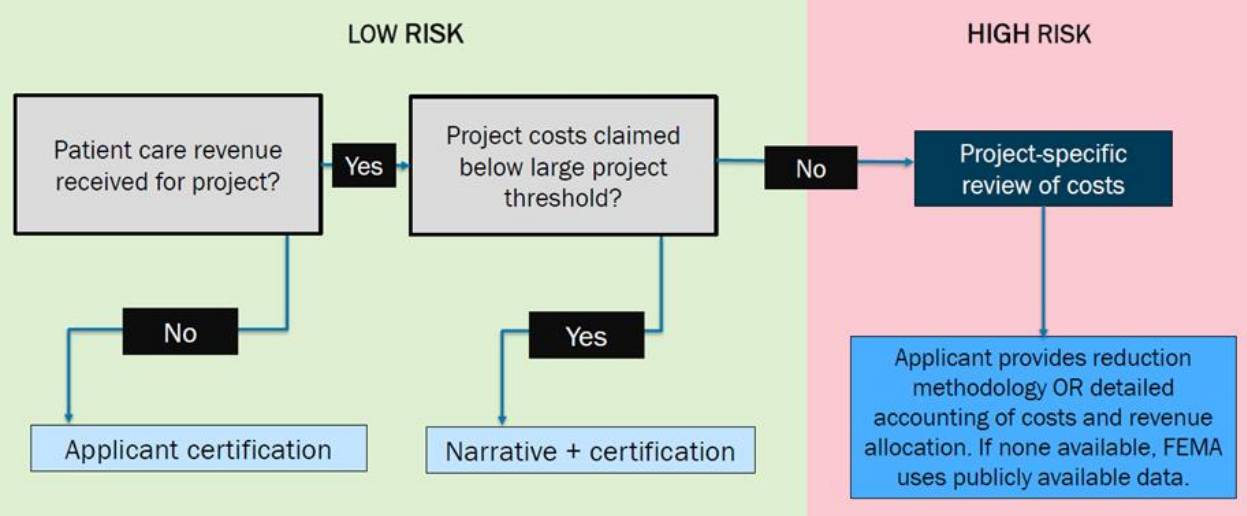

Figure 1: Risk-based Assessment

FEMA considers projects low risk if they fall below the large-project threshold[2] for COVID-19 disasters and the Applicant has not received patient care revenue for work claimed in the project. If an Applicant received patient care revenue for work claimed in their project, their request to FEMA must be appropriately reduced to avoid DOB. For these projects, Applicants

[2] The large project threshold for COVID-19 events is $131,100 for projects obligated prior to August 3, 2022, and $1 million for projects obligated on or after August 3, 2022.

certify that they have reduced their project to avoid duplication and provide a brief narrative description of their project reduction approach.

Large projects where the Applicant has received patient care revenue for work claimed in the project are high risk projects. FEMA reviews these projects to either (a) confirm that there is no duplication, (b) confirm the Applicant resolved any duplication, or (c) calculate how much the project needs to be reduced to avoid duplicative payment. Applicants are strongly encouraged to use their own method for identifying and addressing duplication. Applicants who have at least one high-risk project, or who have multiple small projects in a calendar year, will have all of their small projects reviewed as part of the high-risk process.

C. High-Risk Project Review

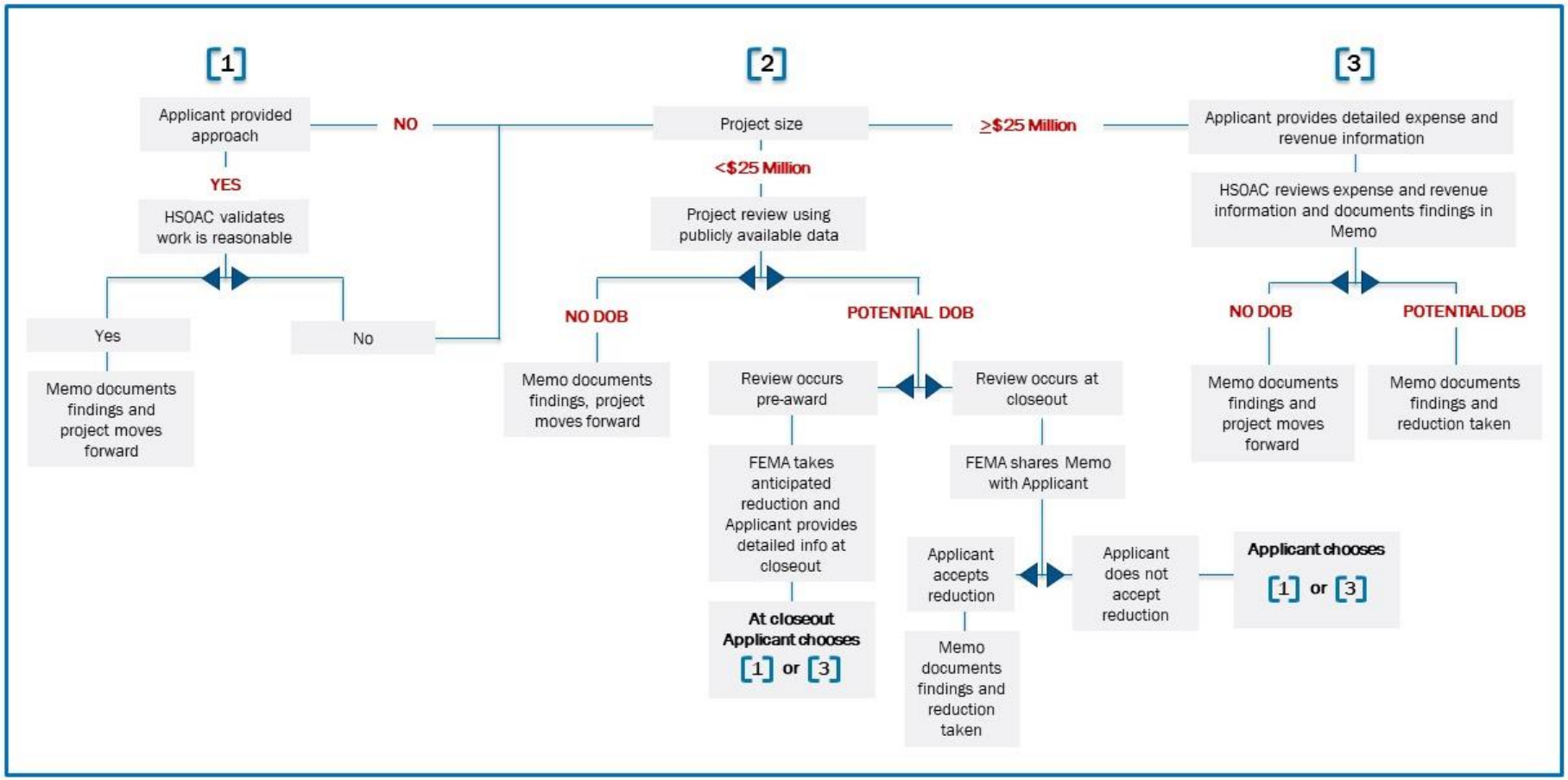

Figure 2: Process Flow Chart for Reviewing High-Risk Projects

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High-Risk Project Review Approach 1 - Applicant-provided methodology: Applicants are strongly encouraged to provide their own data and description of the methods used to assess duplication; to take reductions where needed; and to demonstrate compliance with applicable law, statute, regulation, and policy. When an Applicant provides its own methodology for patient care revenue reductions, FEMA assesses its reasonableness on a case-by-case basis. Table 1 shows some characteristics of reasonable methods as well as those that raise concern:

Characteristics of a Reasonable Method	Characteristics that Raise Concern
• A reduction is calculated using data that include actual (or expected) revenues. • A reduction is calculated using data that include actual costs (or costs that are calculated using chargemaster rates AND a cost-to-charge ratio). • The method differentiates between high-risk activities (e.g., labor for clinical care) and low-risk activities (e.g., facility modifications). • The method uses pre-pandemic norms as a baseline and estimates the above-and-beyond costs associated with COVID-19.	• The method uses chargemaster rates without an appropriate adjustment using a cost-to-charge ratio. • The method excludes a significant portion of costs that are expected to be fully or partially reimbursed by medical insurance. • The method allocates an excessive share of COVID-care revenue to ineligible activities. • The method uses post-pandemic activities as a baseline, so FEMA is unable to adequately evaluate pandemic increase.

Table 1: Characteristics of Applicant Methodologies

High-Risk Project Review Approach 2 - Reviews with public data: If an Applicant does not provide their own method and data for addressing DOB, or if the Applicant's method is determined to not be reasonable, and the project is less than $25 million, FEMA will use

public data sources[3] to assess duplication with patient care revenue using FEMA's DOB method. To complete the analysis, FEMA will follow these steps:

1. Identify which claimed costs are likely to generate patient care revenues ("high likelihood"), and which are not ("low likelihood").
2. Exclude costs that have a low likelihood of generating revenue.
3. Calculate ceilings for the Applicant for each cost category for each calendar year using publicly available data.
    - Ceilings are maximum amounts FEMA could pay without causing duplication with patient care revenue.
4. Apply ceilings to any claimed costs in a category with high likelihood of generating revenues.
5. Take reductions if that category's ceilings are surpassed that year.

FEMA will consider the following cost categories.

Cost Category	Examples of Items by Category
Labor	Salaries, benefits, and other payments for force-account labor and contract labor
Non-PPE supplies	Test kits, disinfection and cleaning supplies, thermometers, linens, etc.
Equipment	Oxygen tanks, hospital beds, ventilators, refrigerator trucks, coolers, freezers, temperature monitoring devices, etc.

Table 2: Cost Categories

During a project review, FEMA focuses on how likely specific item costs are to have DOB with patient care revenue. Costs with low likelihood of duplication in a category are allowed and not limited by ceilings. High-likelihood items are limited by allowable ceilings. The high-likelihood designation does not mean that FEMA is unlikely to reimburse the cost item. It only means that an Applicant's overall expenditures related to that cost item are highly likely to be partially funded by patient care revenues, so FEMA will review to ensure there is no duplication. Examples of key items and how likely they are to have DOB include:

[3] Nearly all healthcare systems provide financial statements to the Electronic Municipal Market Access (EMMA) system. CMS cost reports are accessed through the Healthcare Cost Reporting Information System (HCRIS).

Cost Category*	Likelihood of Duplication with Patient Care Revenue
PPE	Low
Non-medical supplies and equipment for facility modifications	Low
Setup of temporary and expanded facilities	Low
Temporary isolation areas	Low
Air disinfection	Low
COVID-19 testing - employees	Low
Temporary physical barriers	Low
Force account clinical labor for direct patient care	High
Contract clinical labor for direct patient care	High
Medical equipment	High
Medical supplies	High
Therapeutics (medications/prescriptions)	High
Medical transport	High
COVID-19 testing - patients	High
Medical waste disposal	High
* All activities must support COVID-19 patient care in primary care facilities	

Table 3: Duplication of Benefits Likelihood

High-Risk Project Review Approach 3 - Reviews with Applicant data: If an Applicant does not provide their own reasonable method and supporting information for addressing DOB, and the project is greater than than $25 million, the Applicant must submit its operating expense and patient care revenue data which FEMA will use to assess duplication using FEMA's DOB method. FEMA will follow the same steps outlined in Approach 2, but will use the Applicant provided information.

D. Review and Reduction Process

For the purpose of determining any potential DOB, the Allowable Ceilings for each cost category are compared to the project costs by category. The possible results and courses of action are shown in Table 4:

Costs claimed are lower than or equal to the Allowable Ceiling	Costs claimed are higher than the Allowable Ceiling	Allowable Ceiling is zero or negative in the cost category

No duplication with patient-care revenue and no reduction is needed	One or more projects should be reduced to not exceed the Allowable Ceiling and avoid DOB	Expenditures were fully covered by patient-care revenue; there is likely duplication, project costs in the category are not eligible.

Table 4: Allowable Ceiling Results and Courses of Action

When FEMA has completed the assessment of the project(s), FEMA will provide an analysis of the project(s) to the Recipient and Applicant. If a reduction is not needed, the project will move forward to obligation or closeout depending on project status when the assessment occurs.

FEMA will work with each applicant to achieve a position outcome. However, if the Applicant disagrees with FEMA's determination, they may appeal the determination at final reconciliation, consistent with 44 CFR 206.206.

E. Definitions of Key Items

Patient Care Revenue: FEMA considers the following revenues to be included in patient care revenue: Net patient service revenue, appropriations from state and local governments, capitation or premium revenue for patient care (excluding insurance premium revenue).

Net Patient Service Revenue: Operating revenue for performing patient care, specifically excluding provision for bad debts, contractual adjustments, charity discounts, teaching allowances, policy discounts, administrative adjustments, and other deductions from revenue.

Appropriations from State and Local Governments: Funds that Applicants receive from state, local, territorial, or tribal, governments to support operations or carry out designated programs.

Capitation Revenue for Patient Care: Agreements with Insurance Providers, Managed Care Organizations, Self-Funded employer plans and other payers to receive set amounts of revenue for providing patient care for a cohort of people covered by the payer regardless of how much patient care is provided each month.

Insurance Premium Revenue: Revenue received by an affiliate or separate business line of the hospital or health system in return for providing health insurance. FEMA does not include Insurance Premium Revenue as part of Patient Care Revenue, defined above.

Operating Revenue: Revenue received to perform, directly and indirectly, all of an organization's operations, including patient care and other operating activities such as parking, non-patient food services, and lab services to other hospitals.

F. Other Helpful Resources

- Public Assistance Disaster-Specific Guidance - COVID-19 Declarations
- COVID-19 Resources for State, Local, Tribal & Territorial Governments
- COVID-19 Recovery Resource Roadmaps
- COVID-19 Fact Sheets and Guidance