HSOAC COVID-19 Patient Care Revenue DOB Update: Frequently Asked Questions (FAQs)

In December 2023, FEMA released the COVID-19 Patient Care Revenue Duplication of Benefits Recipient and Subrecipient Guide V 2.0 (Guide) which updated the initial earlier version[1]. Updates to the Guide do not change eligibility requirements regarding patient care reimbursement but generally reflect answers to common questions that FEMA has received over the past year regarding the Patient Care Revenue Duplications of Benefits Process and review memos. Upon release of the Guide, FEMA held webinars highlighting the updates and providing additional detail to on the existing process. This FAQ includes questions that were discussed and answered during the webinars.

A. Patient Care Revenue Process and Updates

For Applicants that have already completed a Patient Care Revenue Duplication of Benefits review, will the updated guidance (referring to version 2.0 of the Recipient and Subrecipient Guide) require additional review?

Applicants that have had a Patient Care Revenue Duplication of Benefits review completed and accepted based on current guidance are not required to redo any existing reviews. However, if an Applicant changes their existing claim, or submits additional Public Assistance (PA) claims, then a second review by FEMA may be necessary.

Which method of review is faster, the Alternate Method Review or the Standard Method Review?

Typically, the Standard Method Review is faster. For projects less than $25M, FEMA can conduct a Standard Method Review using already available public data without requiring any further information from the Applicant, or by using its financial data if it prefers. For projects over $25M, FEMA only needs limited financial data for a Standard Review. If an Applicant disagrees with the result of FEMA's standard review, it can submit an Alternate Applicant Methodology after initial review.

Can you give us an idea of the scope of the backlog for Patient Care Revenue reviews? When does FEMA anticipate the backlog to be cleared?

[1] The Guide outlines FEMA's risk-based approaches to potential duplication with patient care revenue (PCR). At Applicant level, FEMA assesses a high risk-applicant for duplication of benefits using either the Standard Method Review (SMR) or the Alternate Method. The Guide is available on FEMA.gov

FEMA

FEMA continues to work on improving the speed of its Patient Care Revenue Duplication of Benefits Reviews. At the current pace, FEMA expects to complete Patient Care Revenue Duplication of Benefits Reviews for 90% of Applicants in six to eight months. This number may vary depending on how many Applicants request an Alternate Method Review, which take longer, instead of using a Standard Method Review, and the number of late applications FEMA receives.

Is FEMA working to increase capacity for these reviews?

FEMA has doubled its capacity for Patient Care Duplication of Benefits reviews in 2023 and is in the process of increasing its capacity further by early 2024.

Are there other actions FEMA is taking to speed up reviews?

FEMA is also taking additional methods to increase its capacity for Patient Care Duplication of Benefits Reviews. At the end of 2023, FEMA worked with HSOAC/RAND to review publicly available data for all healthcare Applicants to pre-identify Applicants and projects that are unlikely to approach their Duplication of Benefits (DOB) ceilings. FEMA subsequently cleared 546 projects for 140 applicants through an abbreviated review based on those results.

Does all an Applicant's COVID projects need to be reviewed by FEMA? If not, what is the basis for project selection for review?

FEMA reviews are completed per Applicant, and FEMA typically reviews all an Applicant's projects together. As outlined in Section C. Risk Basked Approach pgs. 2-3 of the Guide, if an Applicant has projects which do not contain any patient care costs, FEMA typically excludes such projects from the review.

Does an Applicant need to wait until all their projects are complete to submit to FEMA for review?

It is optimal to review all projects together. However, if only a portion of costs are ready for review, the Applicant should coordinate with the regional Point of Contact (POC) to submit reviews. In cases where not all costs are ready for review, FEMA prefers that all costs for a given calendar year be submitted together (for example: all costs in 2020).

What happens if more information is needed? Will the reviewer contact the Applicant?

If additional information is needed, FEMA may create a Request For Information (RFI) in Grants Portal requesting additional information, or FEMA may contact the Applicant directly. During the time period when FEMA requests information and is awaiting a response from the Applicant, FEMA will place the review on hold until the information is received.

Does each Applicant receive an official Review Memo after its projects have been officially reviewed?

Yes, once a review is complete, FEMA will provide an official Review Memo documenting the results of the review. A copy of that memo will be available in the document section of the project in the Grants Portal. In addition, the Applicant may also receive a copy directly from its FEMA POC.

If an Applicant disagrees with the results of a Patient Care Revenue Duplication of Benefits review, can the review be reconsidered or appealed?

Yes. Following a Standard Method Review, if an Applicant disagrees with the proposed reduction, the Applicant can submit an Alternate Applicant Methodology for consideration. For Alternate Method Reviews, if an Alternate review has an unfavorable result, FEMA will provide specific feedback on the method and the Applicant will have an opportunity to update the alternate methodology for a second review. If an Applicant disagrees with the final Patient Care Duplication of Benefits determination, an Applicant can submit an appeal. More information on the appeal process is available here: https://www.fema.gov/assistance/public/audits-arbitration-appeals

FEMA established deadlines for project closeouts to be submitted by May 2024. What if an Applicant still has a pending Patient Care Revenue Duplication of Benefits review at that time?

FEMA Regional Administrators have the authority to extend individual project closeout deadlines for extenuating circumstances, and a pending patient care duplication of benefits review will be considered as valid reason to grant an extension.

However, adjustments are underway to streamline the process of requesting and reviewing extensions for COVID-19 projects, aiming to reduce administrative burdens while ensuring timely closeout. Targeted extensions are being considered, acknowledging the additional times they may require especially, including those projects pending Patient Care duplication of benefit reviews. Specific details on these measures will be provided soon.

How are Patient Care Revenue Duplication of Benefits reviews considered during a 2 CFR 200 Audit? Have auditors been given any instructions regarding these reviews?

Yes, The Office of Management and Budget (OMB) published a Compliance Supplement to 2 CFR Part 200, which provides instructions to auditors in Appendix XI, pg. 4-97.036-9[2]: "For COVID-19 projects where an applicant received revenue from patient care, including medical insurance, FEMA identifies the potential duplication by conducting a project and applicant review and reduces the project if necessary to avoid duplication in accordance with the COVID-19 Patient Care Revenue Duplication of Benefits Recipient and Subrecipient Guide. A reduction following the procedures in this guide meets the intent of this section."

How are Patient Care Revenue Duplication of Benefits reviews considered during Validate As You Go (VayGo[3]) review?

The Patient Care Revenue Duplication of Benefits review memos will be accepted as valid for VayGo purposes and no additional information would be required for patient care duplication of benefits reductions.

What is FEMA doing to provide technical assistance to health care providers with the ever-changing backup documentation requirements and reimbursement delays?

FEMA continues to work closely with Applicants and to provide them with necessary resources for reimbursement of eligible costs incurred during the COVID-19 pandemic. Applicants that need assistance may work with a program

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[2] Part 4 - Department of Homeland Security (DHS) (whitehouse.gov)

[3] Validate As You Go (VAYGo) is a FEMA Public Assistance grants payment review process that enables FEMA to validate grant recipients' funds usage throughout their projects' lifecycles. More information on VayGo can be found here: https://www.fema.gov/assistance/public/tools-resources/vaygo

delivery manager (PDMG) to facilitate the PA application process, help with information collection, and provide customer service to stakeholders in the process. An Applicant may request a PDMG at any time in the PA process.

For equipment purchases, is there an expectation there should be an additional DOB reduction for equipment purchases even in situations where a separate fair market value (FMV) disposition reduction has been applied to the equipment in accordance with FEMA rules?

The fair market value (FMV) calculations account for lost equipment value. If all of that lost value, or "depreciation," is claimed for FEMA PA reimbursement, that may not account for potential revenues generated from equipment use; so FMV is not always sufficient for addressing duplication of benefits.

B. Alternate Method Reviews

Could FEMA provide guidance that acknowledges that Applicants can compare clinical to clinical costs where they can demonstrate 2019 and 2020 clinical costs separate from all labor costs?

The Alternate Review Method allows significant flexibility for the Applicant to propose the methods and for FEMA to compare clinical labor costs from before and after the public health emergency (in conjunction with revenues). All Alternate Methods (including modifications of the Standard Method) require a detailed review, however.

Can FEMA accept a percentage-based approach for determining labor costs? E.g., if 10% of patients in the hospital were COVID-positive, can the Applicant claim 10% of contract labor costs in the relevant time period?

Where work was done for both eligible and ineligible activities, only eligible costs will be considered when reviewing for patient care duplication of benefits. An Applicant must demonstrate how its claim is tied to the performance of eligible activities. FEMA can consider a pro-ration of costs, to ensure a specific methodology will be acceptable. The Applicant should coordinate with your Regional and State Partner.

C. Standard Method Reviews

What is "publicly accessible data" and where we can specifically find the data?

Publicly accessible data includes financial statements submitted to the Electronic Municipal Market Access (EMMA) system and Centers for Medicare & Medicaid Services (CMS) cost reports from the Healthcare Cost Reporting Information System (HCRIS).

What if an Applicant doesn't have information in EMMA or HCRIS?

FEMA is aware that some Applicants may not have available information in EMMA or HCRIS. In those cases, an Applicant can provide similar data for a Standard Review. Appendix F of the updated Guide can assist with completing that information. Applicants can also submit an Alternate Methodology for review in those cases. FEMA has identified around 100 Applicants nationally without available information. Each FEMA Regional office is aware of the Applicants that are in these cases and are working to reach out to collect the appropriate information.

If an Applicant does have information in EMMA or HCRIS, can it still submit its own data for a standard review?

Yes, any Applicant can elect to submit their own financial information instead of using the public data, following the guidelines in Appendix F of the updated COVID-19 Patient Care Revenue Duplication of Benefits Recipient and Subrecipient Guide.

If the Applicant disagrees with the results of a Standard Method Review, does it have to wait until an Alternate Review is completed before the project is awarded?

If an Applicant submits an Alternate Applicant Methodology review after a Standard Review, FEMA can award the project based on the Standard Method Review, and the project will be adjusted in a Project Worksheet (PW) version or at closeout if the Alternate Applicant Methodology is found reasonable and results in a smaller reduction.

How does FEMA account for the extraordinary amount of staffing that was required to take care of a high acuity patient with COVID-19 or the extraordinary costs of PPE that were used in care for COVID-19 positive patients?

Increased staffing costs are accounted for when using the Standard Method Review, which determines whether labor expenses rose more than revenues during the public health emergency relative to 2019. PPE is considered to be at low likelihood for duplication and can be reimbursed solely using the Applicant's certification that there is no duplication with other funding sources.

If financial data can and often are updated multiple times, will there be an adjustment if updates significantly change the allowable reimbursement ceilings that determine repayment of obligated FEMA amounts in projects?

If public financial data is updated after a Patient Care Revenue Duplication of Benefits memo has already been delivered to FEMA or if an Applicant notes that the financial data used are inaccurate, the Applicant should inform FEMA and request that the Patient Care Revenue Duplication of Benefits memo be corrected using appropriate financial data. Each Standard Method review memo includes a detailed Appendix summary that explains precisely which public financial data was utilized. In the case where that data gets updated or changes or contains an error, FEMA will update the memo when requested to do so.

When reviewing audited financial statements for Health Care Systems, how do you align the analysis of financial statements that don't align to the entities in the approved projects in order to make appropriate comparisons and not "apples to oranges" comparisons?

FEMA uses audited, consolidated financial statements and needs to match the financial data to the Applicant's projects for an "apples-to-apples" comparison. This can sometimes be accomplished by using the data that corresponds to the specific hospital or hospitals that is/are applying for FEMA PA. FEMA can also use financial information that is specific to patient care services (not non-clinical services). By carefully matching the Applicant organization to the corresponding financial data, FEMA can calculate Applicant-specific "Allowable Ceilings" for each calendar year / cost category. Subrecipients (Applicants) should review Appendix B in detail to determine if labor and other costs were extracted appropriately. If Applicants identify problems with the data extraction, FEMA will review, and correct memos as needed. Applicants may also submit their own financial data for a Standard Method review or submitting an Alternate Method.

If the Applicant submits a project with only temporary or contract labor costs, will the allowable ceiling be calculated for all of labor being submitted or will a ceiling be calculated for temporary or contract labor?

When computing the Allowable Ceiling, the Standard Method considers all labor costs together (including benefits), and not just a portion (FAL, temp, OT, contract, etc.) of the costs.

Are disproportionate share hospital payments included in the standard method?

Disproportionate Share Hospital (DSH) payments are lump sum payments from states to qualified hospitals who serve low income and uninsured patients to reimburse for uncompensated patient care expenses. Yes, DSH payments[4] are included when calculating allowable ceilings for the Standard Method. FEMA also expects Applicants to account for DSH payments when submitting Alternate Methods.

Are 2023 claimed high risk costs assessed using the standard approach based on full year audited financial statements? When will those reviews start and expected to be completed?

If an applicant does not have full year audited financial statements for 2023, FEMA will use the first 131 days of 2023 to calculate 2023 ceilings, if such data are available. Otherwise, FEMA will use the first 5 months of 2023, the first 6 months of 2023, or the entire fiscal or calendar year (in that order of preference), then prorate that data to 131 days. Reviews using 2023 data have begun, and may be facilitated by Applicants providing such data, if they are not already publicly available.

How does the Standard Method address Applicants whose revenue is capped, so it was not possible to pass the additional costs to patients through billing during the Public Health Emergency (PHE), which eliminates duplication of benefits?

The Standard Method uses actual patient care revenue (PCR) and actual expense data, it fully accounts for scenarios in which hospital revenues are capped. The more expenses rise faster than PCR does, the higher the Allowable Ceiling for that calendar year/cost category.

Could FEMA expand on why force account labor and contract labor are considered as largely interchangeable? If only contract labor costs specific to COVID-19 Care was submitted for reimbursement, it seems most appropriate to compare those incurred costs to the exact same cost item?

During the Public Health Emergency (PHE), contract labor costs rose substantially in most hospitals. However, as seen in CMS cost reports,[5] force account labor costs often declined. Therefore, revenues that covered force account labor costs in pre-PHE period may have instead covered contract labor costs during the PHE. FEMA considers all labor costs as a whole. Considering all labor costs singularly would not account for all potential revenue sources and could result in duplication of benefits with patient care revenue. For example:

> In 2019, Hospital X spent $10M on labor and had $20M in revenue. Hospital X's labor expenses consisted entirely of its force account labor, as no Contract Labor was used pre-PHE. In 2020, and during the PHE, Hospital X's revenues remained the same ($20M) but several of its force account nurses quit to become traveling nurses. Hospital X replaced these nurses with contract nurses, such that the total number of employees remained the same, but its labor costs rose because contract nurses often cost more than force account labor. Since Hospital X's contract labor costs increased from $0 to $500k in 2020, but its force

[4] Medicaid Disproportionate Share Hospital (DSH) Payments | Medicaid

[5] Hospital 2552-2010 form | CMS

account labor decreased from $10M to $9.75M, the Standard Method would not treat all of the contract labor expenses ($500k) as unbudgeted and reimbursable. Instead, the Standard Method would determine that only a portion, (say $250k) was unsupported by any revenues, which illustrates why labor must be analyzed as a whole.