COVID-19 Patient Care Revenue Duplication of Benefits 2.0

Recipient and Subrecipient Guide

A. Updates to Recipient and Subrecipient Guide 2.0

- Updates to Figure 1 and Figure 2
- Methodology name updates to Standard Method Review and Alternate Method Review
- Clarification on large projects with low likelihood costs does not need a RAND review only certification
- Updates to encourage the utilization of Standard Method then Alternate Method
- Additions of Appendix's A-F

B. 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 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

C. 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.

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

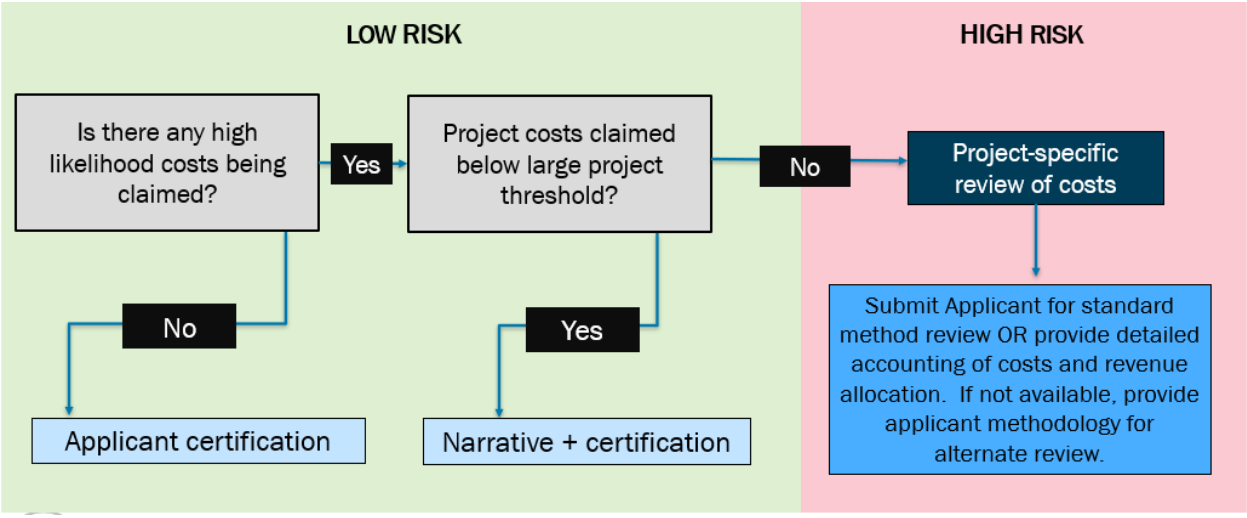

Figure 1: Risk-based Assessment

Low-Risk Projects

FEMA considers all projects to be low risk that fall below the large-project threshold[2] for COVID-19 disasters or have a project of any size with only low likelihood costs claimed. If the Applicant has not received patient care revenue for work claimed in the project an Applicant certification is required as the Streamlined Project Application (SPA) is certified. 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 certify that they have reduced their project to avoid duplication and provide a brief narrative description of their project reduction approach.

[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.

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 for a faster review to use the standard method utilizing public data or if an Applicant has a project over $25Million to provide their calendar year of detailed cost and revenue information. Applicants who have at least one high-risk project, or who have multiple small projects with high-risk costs in a calendar year, will have all of their small projects reviewed as part of the high-risk process.

D. High-Risk Project Review

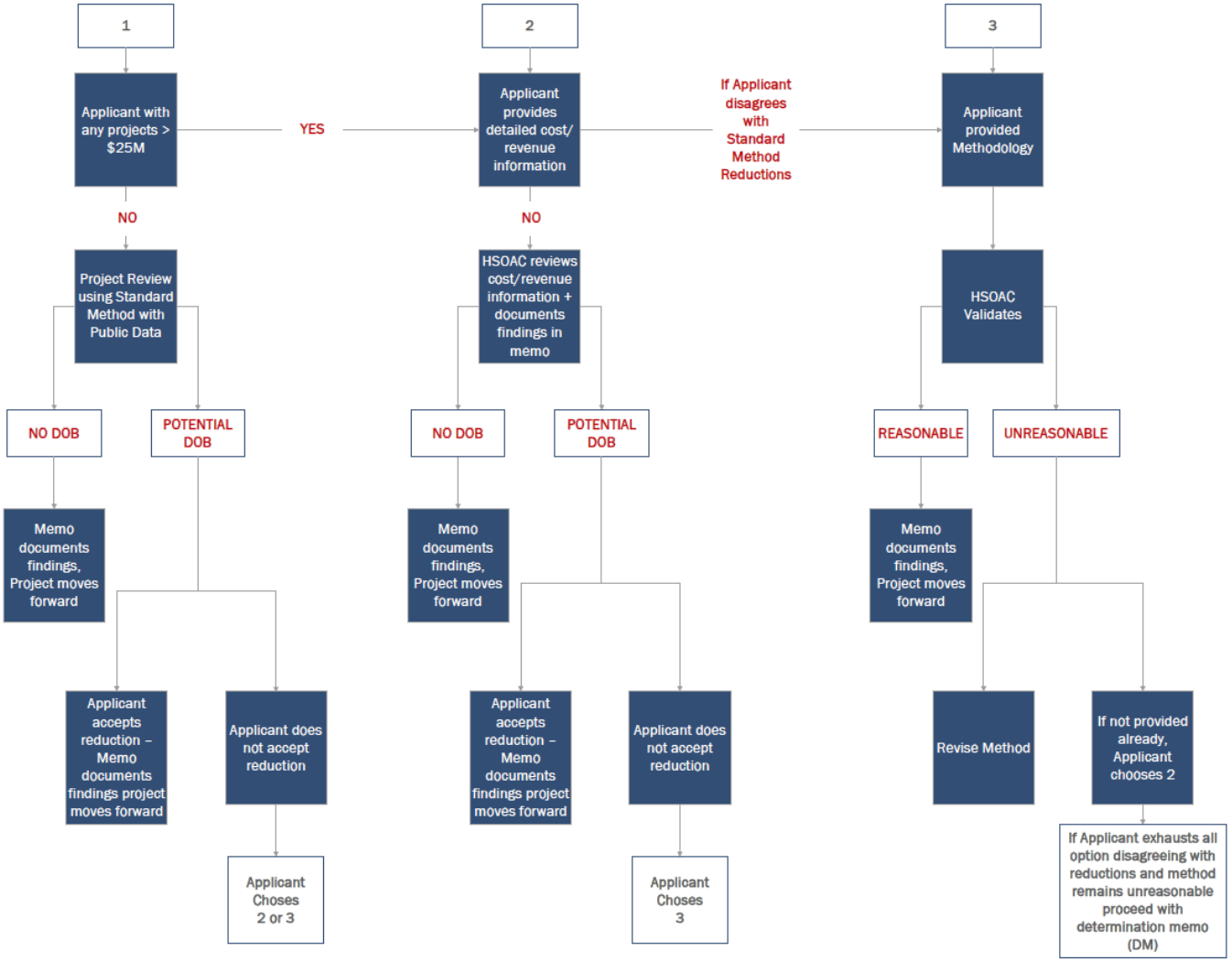

Figure 2: Process Flow Chart for Reviewing High-Risk Projects

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Recipient and Subrecipient Guide

Standard Method and Alternate Method Reviews

Applicants are encouraged to utilize the Standard Method Review (SMR) as their first submission. FEMA will perform an independent review of all high-risk Applicant projects using public data or Applicant provided financial data review methods as described in Appendixes A, C and F.

High-Risk Project Review Approach 1 - Reviews with public data: This option is available and applied to high-risk Applicants as long as each project is under $25M. FEMA identifies publicly available, Applicant-specific expense and revenue information for pre-pandemic (2019) and pandemic years (2020, 2021, 2022, and 2023). FEMA uses this information to calculate a maximum amount, referred to as the allowable ceiling, for each eligible cost category by comparing the year-to-year change in operating expenses with the change in operating revenue. When full calendar year data is not publicly available Applicants should provide their own financial data.

An applicant's allowable ceilings are calculated for each eligible cost category (labor, medical supplies/services, and medical equipment) and for each calendar year. Ceilings limit the allowable costs, by cost category, summed across all project work performed in a given year. If project costs in a cost category exceed the allowable ceiling, HSOAC will recommend reducing projects in sequence based on the project submission date. This process is further explained in Appendix A.

For projects that span calendar years, project costs are apportioned to each year based on project documentation, when feasible. When timing is not clear, FEMA will assume equal spending per month.

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 are shown in Appendix B.

High-Risk Project Review Approach 2 - Reviews with Applicant provided financial data to include opearating expenses and revenue information: This option is for Applicants that have a high-risk project with any single project over $25 million. The Applicant must submit their operating expenses and patient care revenue data for pre-pandemic and pandemic calendar years. FEMA will conduct the same review described above but with detailed Applicant-provided operating expense and revenue information as opposed to publicly available information. Additional detail on information that applicants must provide is in Appendix F.

High-Risk Project Review Approach 3 - Applicant-provided methodology:

If an Applicant disagrees with recommended Standard Method reductions, the Applicant may submit an Alternate Method Review to support why a different reduction should be taken on projects reviewed by FEMA with a recommended reduction. FEMA will validate the reasonableness of the Applicant's Alternate Method based on the description of the methodology and supporting data with associated project(s). An overview of FEMA's review process is included in Appendix D; an outline of the resulting memo types and transmission pathways is in Appendix E.

If the Applicant's method is determined to be unreasonable FEMA will provide recommended revisions to the Alternate Method to address or the Applicant may provide financial data including detailed cost and revenue information for FEMA to perform standard method, specified in Appendix A.

E. 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.

F. 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.

G. 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

Appendix A: Standard Method Cost Categories

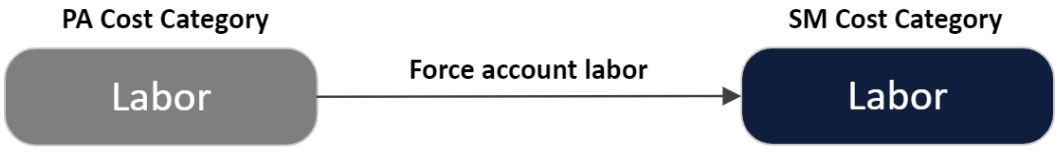
This document describes the process that HSOAC analysts use to prepare PA cost claims for analysis using the Standard Method. The Standard Method uses public financial data that is typically published in three broad cost categories: Labor, Supplies and Services, and Equipment. These standard financial reporting categories allow HSOAC to calculate Allowable Ceilings for reimbursement for each of three corresponding Cost Categories. However, in Grants Manager, Applicant costs are recorded in five Public Assistance (PA) cost categories: Labor, Contract, Material, Equipment, and Rental Equipment. For proper alignment to allowable reimbursement ceilings, HSOAC analysts reclassify Applicant costs into Standard Method cost categories.

Rules for Reassignment

General rules for how PA cost categories are translated into Standard Method cost categories are outlined below. Individual cases may necessitate recategorization that deviates from the standard presented here. Overall, analysts attempt to match PA claimed costs to the same aggregated cost category that accountants assigned them to in the Applicant's public financial reports.

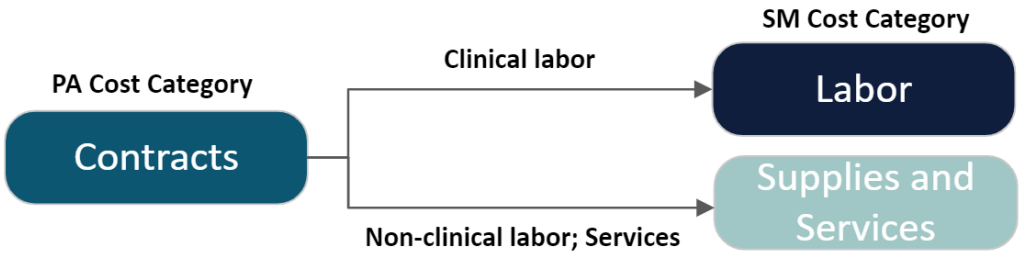
Labor

Labor generally translates directly from the PA to Standard Method cost category. The Standard Labor category includes force account labor (people on the Applicant's payroll) and their benefits.



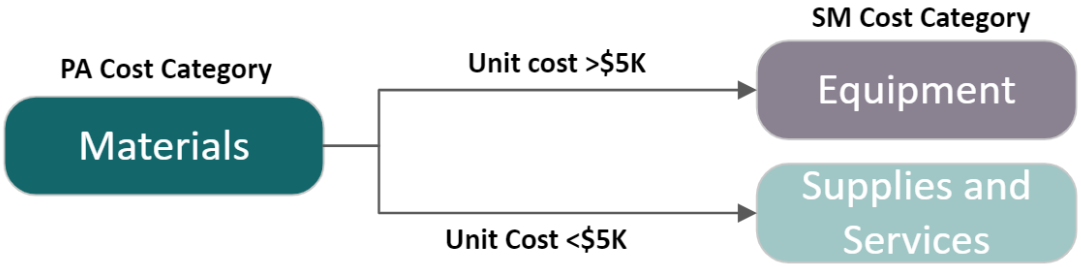
Contracts

Contracts for clinical labor are considered a Standard Method Labor cost; however, contracts containing non-clinical labor are assigned to Supplies and Services rather than Labor. For example, if there is a contract to install a new air conditioning system, and some of that contract is for labor to install that system, the entire contract would be assigned to the Supplies and Services Standard Method cost category. There may also be rare instances in which COVID-19–related contracts contain itemized non-clinical labor that is assigned to Labor.



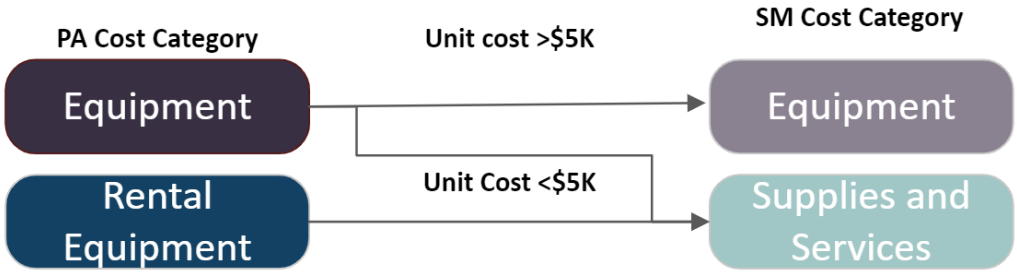
Materials

Materials costs generally correspond to Supplies and Services. However, some items described as "materials" are reusable for more than one year and have unit costs greater than $5,000; these items are categorized as Equipment.



Equipment and Rental Equipment

Purchased equipment with a unit cost of less than $5,000 and *all* rental equipment are categorized as Supplies and Services. Purchased equipment items that are used for more than one year and have a unit cost greater than $5,000 are categorized as Equipment.



Appendix B: Summary of Approach to Assigning Likelihood Ratings to PA Cost Claims

Starting in December 2021, a group of experts with backgrounds in clinical medicine, health care delivery, economics, and accounting used a consensus-based process to characterize the likelihood of duplication of benefits (DoB) with patient care revenue for common Public Assistance (PA) request items. Costs that are typically associated with standard patient care activity were assessed as having a *high likelihood* of DoB with patient care revenue. For example, nursing labor, medications, intravenous catheters, cardiac monitors, medical waste removal, and surface cleaning and disinfection supplies are not directly billed to patients but were a standard part of medical care prior to the public health emergency (PHE) and therefore are paid for using patient care revenue. Therefore, based on this assessment, cleaning and disinfection and other *high likelihood* costs claims are evaluated for DoB using the Standard Method and can be reimbursed only when an Applicant's costs have been shown to have increased faster than associated revenues. On the other hand, costs that are typically unrelated to patient care were assessed as having a *low likelihood* of DoB. Some additional items that were infrequently used prior to the PHE but experienced extreme increases in prices and quantity needed were also deemed to be *low likelihood*; these include personal protective equipment (PPE); labor, supplies, services, and equipment related to disposal of human remains; and setup of temporary facilities for COVID-19 treatment. These and other *low likelihood* cost claims are always recommended for reimbursement.

This guidance has been summarized into the tables of categorized items provided in this document. HSOAC analysts reference these tables when rating the likelihood (low or high) of DoB with patient care revenue when conducting Standard Method reviews and when evaluating Applicant methods for DoB. Cost items have been grouped below by Standard Method cost category (Equipment, and Supplies and Services, and Labor). The DoB tables are updated regularly to facilitate consistent assessment. For costs that are not explicitly listed in the tables below, HSOAC analysts use information provided by the Applicant and assessments by health care accounting experts to assess likelihood of DoB.

Equipment

Materials and equipment that can be used for more than one year and have a unit cost greater than $5,000 are categorized as "Equipment."

Likelihood Rating	Item Category	Examples
Low	Building modification and retrofitting	Non-clinical equipment purchased for retrofitting patient care areas; heating, ventilation and cooling (HVAC) system purchase; high efficiency particulate air (HEPA) system; air filtration/scrubber systems
Low	Cleaning/disinfection	Portable handwashing station (used in temporary facilities)
	PPE	3D Printer; fit-testing equipment; PPE decontamination system
	Screening of visitors/staff	Infrared scanner
	Transportation/storage of remains	Purchase of mobile morgue; mortuary rollers
	Testing and vaccination site operations, non-clinical	Vaccine freezer
High	Cleaning/disinfection	Surface decontamination systems (UV-based)*
High	Direct patient care	Depreciation expenses; ventilator; patient airway and intubation equipment; bronchoscopy equipment; ambulance and response vehicles; bladder scanner; chest compression device; crash cart for patient resuscitation; defibrillator; electrocardiogram (ECG) machine; extracorporeal membrane oxygenation (ECMO) equipment; hospital beds; medication refrigerator; mobile X-ray; cardiac monitors; ultrasound devices; power supply for clinical equipment
High	Patient COVID-19 testing	COVID-19 test equipment (e.g., PCR machine)

Note: *Although purchases of UV-based surface decontamination systems increased during the PHE, such systems are assessed as *high likelihood* of DoB because they were in use before the PHE and can be used for other surface decontamination needs.

Supplies and Services

Materials, rental equipment, and equipment with a unit cost less than $5,000 are categorized as "Supplies and Services." Contracts for the activities described below also fall under Supplies and Services.

Likelihood Rating	Item Category	Examples
Low	Building modification and retrofitting	Retrofitting services or facilities modifications; construction of negative pressure room; installation of air filtration system; barricades to facilitate social distancing; materials for facilities modifications; air filtration/scrubber systems; rentals for retrofitting facilities (except for clinical equipment); generators; fuel; heaters; plumbing, electrical work, computer networking
	Food	Food for clinical staff at COVID-19 testing/vaccination sites; food provided to patients outside of regular hospital nutrition services due to COVID
	Indirect support of patient care, supplies	Truck usage charges (force account)
	Patient communication	iPad or tablet (used to communicate between patient & family); two-way radio
	PPE	Gloves; gowns; coveralls; shoe covers; bouffant caps; face shields and safety goggles; 3D Printer (<$5000); face masks/respirators, powered air-purifying respirators (PAPRs), controlled air-purifying respirators (CAPRs), PPE storage (e.g, paper bags); costs related to warehousing PPE*
	Public health communication	COVID-19 data collection and reporting; public health campaigns; ads and media advertising; signage (banners, posters, decals) within hospitals
	Setup/operations hospital emergency command	Contract for setup or operations of emergency command center; supplies for emergency command center; desks; telephones; computer/network equipment
	Staff COVID testing	COVID-19 testing contract for staff: lab processing; testing supplies: buffer/reagents; plates; pipettes; test transport; testing kits
	Screening of visitors/staff	Thermometer tips; Infrared thermometers/scanners; temporary facility rentals (e.g., tents)
	Training for COVID preparedness	Training in COVID-19 protocols (non-itemized labor)
	Transportation/ storage of remains	Contract to transport/store remains; truck lease to transport remains; cadaver cover/bag; fuel for mobile morgue; mortuary rollers
	Testing/ vaccination site operations, non-clinical	Facility supplies and rented equipment (e.g., temporary facility rentals); medical and non-medical supplies for mass vaccination clinics or testing sites

*Note: HSOAC definition of PPE excludes hand sanitizer, soap, and cleaning agents, which are considered *high likelihood* for DoB. HSOAC also assesses medical waste disposal to be *high likelihood* for DoB. Both cleaning supplies and medical waste disposal were standard components of medical care prior to the PHE and are therefore expected to be paid for using patient care revenue.

Supplies and Services (continued)

Likelihood Rating	Item Category	Examples
High	Cleaning & disinfection	Surface decontamination supplies and services, cleaning/disinfection contract or supplies, hand sanitizer, reusable cleaning supplies
	Direct patient care	All patient care supplies (e.g., glucometer, pumps, scanners, catheters, intravenous catheter tubing, nebulizer, pulse oximeter, thermometers, stethoscope, airway/ventilator equipment, oxygen supplies, continuous renal replacement therapy (CRRT) and hemodialysis supplies; emergency response vehicle contracts; power, cables, and batteries for clinical equipment; laboratory supplies; therapeutics; medications; equipment purchases <$5,000 (e.g., portable x-ray machines, defibrillators, monitors, hospital beds); medical equipment rentals
	Indirect support of patient care, services	Non-clinical service contracts (e.g., security services, business operations, scheduling, legal services, administrative support)
	Indirect support of patient care, supplies	Barcode scanners; computers/laptops; laundry/linen services; office supplies; patient clothing/hygiene materials, service contract for clinical equipment, shipping and freight charges for high-likelihood supplies, software licenses, storage rentals for COVID supplies (excluding PPE), government fees associated with high likelihood items (e.g., sales taxes, import duties, and taxes)
	Medical waste disposal	Contract to pick up, transport, store, or dispose of medical waste; medical waste containers; hazardous waste bags
	Patient COVID testing	COVID-19 testing contract for patients; lab processing; testing supplies: buffer/reagents; plates; pipettes; test transport; testing kits

Labor

Labor generally refers to force account labor or contract labor for clinical positions.

Likelihood Rating	Item Category	Examples
Low	Building modification and retrofitting	Force account trade labor (e.g., electrician, plumber, carpenter, network engineer)
	PPE	Performing fit testing and training for PPE usage; staff labor for warehousing PPE
	Quarantine and on-call	Pay for quarantine time and/or on-call labor
	Setup and/or operations of hospital emergency command center	Operations and/or setup labor (e.g., RNs, chief nursing officer, CEO, building trades for setup and maintenance of emergency command center operations)
	Staff COVID-19 testing	Registered nurses, nurse assistants, and other clinical labor involved in testing staff for COVID-19
	Screening of visitors/staff	Contract to conduct temperature screenings; Force account labor directed to screening tasks
	Training for COVID-19 preparedness	Training in COVID-19 protocols
	Transportation/storage of remains	Force account labor performing transportation and storage of remains
	Testing/vaccination site operations, non-clinical	Clinical and non-clinical labor for setup;* labor for directing traffic at mass vaccination or testing sites ("valets")
High	Direct patient care	All force account clinical labor or contracts providing clinical labor, including ancillary expenses such as per diem payments, lodging, travel reimbursement, airfare, and malpractice insurance.
	Indirect support of patient care	Non-clinical labor (e.g., information technology [IT] support, housekeeping, billing specialist, security guard, secretary, unit clerk; translator, call center for business operations)
	Patient COVID testing	Registered nurses, nursing assistants, medical assistants, and other clinical labor involved in testing patients for COVID-19

*Note: Clinical labor administering tests would be considered high likelihood for DoB. In some cases, clinical labor performed non-clinical duties such as site setup, which is deemed low likelihood for DoB

Appendix C: Approach for Debiting PA Project Costs from Allowable Ceilings

The Standard Method requires that Allowable Ceilings be calculated from an Applicant's financial data. These ceilings define the maximum amount FEMA can reimburse for eligible expenses in a particular cost category in a given calendar year without causing duplication of benefits with the Applicant's patient care revenue (PCR). Public data is used to calculate allowable ceilings for Applicants with projects that are all less than $25 million, while Applicant-provided data is used for Applicants with at least one project with $25 million or greater costs. Ceilings are calculated for each calendar year and for each of three cost categories: Labor, Supplies and Services, and Equipment.

During a Standard Method review, HSOAC analysts examine all claimed costs for an Applicant across all fully scoped, costed, and eligible projects to assess which cost items are potentially already covered by PCR. Using standardized guidance,[3] analysts assess each cost item (e.g., nurse hours) within each Standard Method cost category (e.g., Labor) and consider whether PCR would likely cover at least some of the cost for those items. Costs are then assigned to have either a high likelihood of being at least partially covered by patient care revenue or a low likelihood of duplication with PCR—these are referred to as likelihood ratings.

High-likelihood costs are debited from the corresponding cost category's Allowable Ceiling for that calendar year, while low-likelihood costs are always recommended for reimbursement, if eligible. Once the Allowable Ceiling is exhausted, any remaining high-likelihood costs are considered duplicative with PCR, resulting in a recommended reduction.

Table 2 from a sample Applicant Review Memo (ARM) illustrates where reductions are applied across calendar years and cost categories.

[3] The Guide to Assigning Likelihood Ratings to PA Cost Claims provides additional information on how likelihood ratings are assigned.

Table 2. Total Claimed Costs and Allowable Ceilings by Cost Category-Calendar Year (in thousands of $)

Cost Category	Total Claimed Costs	Allowable Ceiling for High Likelihood Costs	Claimed Costs Exceed Allowable Ceiling
2021			
Labor	2,008	927	Yes
Supplies and Services	14,181	20,220	No
Equipment	45	4,379	No
2022			
Labor	0	0	No
Supplies and Services	7,308	6,029	Yes
Equipment	0	0	No
Total	**25,497**	**N/A**	**N/A**

NOTE: Columns may not sum due to rounding. If a project includes costs in multiple years, then the costs were apportioned based on the project's period of performance. Allowable Ceilings were calculated for each cost category-calendar year with financial data available, regardless of whether costs were claimed by the Applicant. HSOAC did not calculate Allowable Ceilings for 2023 due to a lack of calendar year 2023 public financial data.

Reduction Method Across Projects

If an Applicant Review Memo (ARM) includes only one project, then the recommended reduction applies to that project. If there are multiple projects that contain high-likelihood costs in a calendar year / cost category and those costs have exceeded the ceiling, recommended reductions are applied to projects in chronological order based on the project creation date in Grants Manager. The earlier projects are debited from the ceiling first until the Allowable Ceiling has been exhausted. After the Allowable Ceiling has been exhausted, all remaining high-likelihood costs are recommended for reduction to avoid duplication with PCR. Table 4 from an ARM illustrates sequential reductions by project in two calendar year / cost categories.

Table 4. Estimated Duplication by Project for Cost Category-Calendar Years in Which Claimed Costs Exceed Allowable Ceiling (in thousands of $)

Project #	Available Ceiling	-	High Likelihood Costs	=	Remaining Ceiling	Estimated Duplication
Labor 2021						**1,081**
100001	927		216		711	0
100002	711		411		300	0
100003	300		527		0	227
100004	0		854		0	854
Supplies and Services 2022						**1,279**
100010	6,029		677		5,352	0
100011	5,352		2,587		2,765	0
100012	2,765		1,012		1,753	0
100013	1,753		2,047		0	294
100014	0		985		0	985
Total Estimated Duplication						**2,360***

NOTE: Columns and rows may not sum due to rounding. Only projects with costs claimed for the specified cost category-calendar years are included. Any low likelihood costs claimed are excluded from the table. Any negative calculated remaining ceiling is reported as zero. HSOAC did not estimate duplication for 2023 due to a lack of calendar year 2023 public financial data. Values marked with an asterisk may change after 2023 project costs are assessed.

Appendix D: Detail on Evaluation of Alternate Method

Approach for Assessing Reasonableness of Alternate Method Reductions

When an Alternate Method is referred for review, HSOAC assesses Applicant-provided methods based on analysis of the provided materials and the professional judgment of experts in the fields of health finance, cost analysis, medical insurance, medical billing, health economics, health policy, healthcare accounting, and related fields. HSOAC carries out the steps outlined below to assess the reasonableness of the Applicant's proposed reductions to account for PCR:

1) Review Applicant's patient care revenue reduction documentation to determine whether the methods embody a sound concept that, if applied correctly, could measure DoB with PCR.
2) Determine whether the financial data are comprehensive and correct (i.e., include all relevant sources of PCR and all relevant expenses).
3) Review whether the calculations provided by the Applicant are accurate.

Step 1: Review Applicant's Patient Care Revenue Reduction Documentation

HSOAC first reviews the Applicant's methodology to determine whether the methods embody a sound concept that, if applied correctly, could measure DoB with PCR. Table 3 highlights characteristics that HSOAC would expect to see as part of a reasonable methodology as well as characteristics that would raise concern about the methodology. As HSOAC works to validate Applicant methodologies, it may identify more characteristics of reasonable approaches and characteristics that raise concern. The Alternate Method needs to identify the project(s) that are applicable to this method. The method should address all cost categories within the applicable projects. The Applicant should identify all projects that are addressed by each method, and, if applicable, document the reason projects lacking a method do not need one.

Table 1: Characteristics of Reasonable Methods versus Methods that Raise Concern

Characteristics of a Reasonable Method	Characteristics that Raise Concern
• A reduction is calculated using data that include actual (or expected) patient care revenue • A reduction is calculated using data that include actual costs (or costs that	• 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

are calculated using chargemaster rates AND a cost-to-charge ratio) • The method differentiates between activities with a high likelihood for reimbursement with patient care revenue (e.g., labor for clinical care) and low-likelihood activities (e.g., facility modifications) • The method uses pre-pandemic operating expenses and revenue as a baseline and estimates the above-and-beyond costs associated with COVID-19	• The method allocates an excessive share of COVID-care revenue to ineligible activities • The Applicant uses different methods for similar costs (e.g., a project with 2021 clinical labor costs uses a different method than another project with 2020 clinical labor costs) • The Applicant uses methods similar to the Standard Method but create ceilings for interchangeable costs (i.e., force account and contract labor) such as creating an allowable ceiling for contract labor alone rather than for all labor. • The Applicant uses methods to compare pre-pandemic wage rates to 2020-2022 rates but does not include all wage components in both (base wage, benefits, etc.) or does not account for inflation.

Step 2: Review How the Applicant Identified Costs that Generate Patient Revenue

Next, HSOAC will review the reasonableness of cost categorizations provided by the Applicant. Some costs are unlikely to generate patient care revenue (e.g., facility modifications), while others are certain to generate patient care revenue (e.g., nurse labor for patient care). HSOAC has used a panel of experts to sort costs into those that are at low likelihood for revenue generation versus high likelihood (see Appendix F for items by cost category and likelihood rating). HSOAC will evaluate how the Applicant categorized costs. If there are cost categories that have been miscategorized as not generating patient care revenue, HSOAC will note that in the review memo and recommend that the Applicant account for duplication with patient care revenue.

Step 3: Review Applicant-Provided Sources of Revenue and Attribution of Revenue

Revenue sources — Patient care revenue sources typically include Medicare, Medicaid, commercial insurance providers and patient out-of-pocket payments. Additionally, HSOAC expects Applicants to report patient care revenues that are not dependent on the number of patients, including Disproportionate Share Hospital payments, capitation payments, and state and local subsidies that are given to support patient care.

Revenue attribution — When calculating reductions to account for patient care revenue, Applicants need to make decisions about how patient care revenue is applied across costs. HSOAC will review how the Applicant attributes patient care revenue. Reasonable options for patient care revenue attribution include:

1. Attributing revenue evenly across all eligible cost categories

2. Attributing revenue according to pre-pandemic norms (e.g., if costs for medical supplies accounted for 10% of patient care revenue prior to the pandemic, then 10% of patient care revenue is attributed to the costs for medical supplies during the pandemic)

There may be other reasonable methodologies for revenue attribution that HSOAC has not yet encountered. HSOAC will review any Applicant-provided methodologies to determine whether they represent a reasonable method to attribute patient care revenue to cost categories that are consistent with best practices in accounting in the healthcare market.

Results from the HSOAC analysis will be documented in an Alternate Method Review Memo (AMRM) that contains: (1) a summary of the findings from steps #1 - #3 and (2) overall findings indicating whether the methodology and resulting reductions (if applicable) are reasonable.

Step 4: Review Calculations

HSOAC considers the calculations correct if they are free of mathematical errors. This step typically involves HSOAC analysts manually checking that the Applicant's arithmetic is correct. HSOAC also determines if all formulas used are executed correctly by checking for consistency between any formulas stated in the methods documentation narrative to all calculations that incorporate the Applicant's financial data (e.g., formulas embedded in an Excel workbook).

Appendix E: Content of Standard and Alternative Method Review Memos

The Standard Method **Applicant Review Memo** (ARM) summarizes estimate(s) of potential duplication of benefits (DoB) with Patient Care Revenue (PCR) across the project(s) evaluated at time of review. The ARM will contain the following information:

- Header information summarizing the Applicant and scope of review, including the number of projects evaluated and the date on which project cost data were pulled from Grants Manager;
- Summary of the claimed costs across all projects evaluated for potential DoB with PCR, a brief overview of the Standard Method Review process and options available to the Applicant, and the total amount of the recommended reduction, if any;
- Applicant's project summary statistics, including the Applicant's total costs by calendar year, and a tabular summary of claimed costs by Standard Method cost category in each project;
- Approach, Findings, and Recommendations:
    - Summary of the Standard Method approach, including links to Appendices that provide further details on the method and calculation of Allowable Ceilings, and a narrative explaining the steps and findings of the review, which are summarized in corresponding tables;
    - A table showing the allowable ceilings compared to the total costs across all projects, by cost category-calendar year;
    - And, if total claimed costs in at least one cost category-calendar year exceed the Allowable Ceiling;
        - A table providing the project-specific breakdown of costs into low and high likelihood of DoB with PCR for each cost category-calendar year in which claimed costs exceeded the Allowable Ceiling
        - A table providing project-specific estimated duplication for each cost category-calendar year in which claimed costs exceeded the Allowable Ceiling
    - A table showing the total recommended reduction for each project reviewed, regardless of whether or not the project exceeded an Allowable Ceiling;
- Notes about sufficiency of project documentation, and anything else deemed noteworthy to explain the approach taken to evaluate potential DoB with PCR;
- Appendix explaining the Standard Method used to estimate duplication and
- Appendix detailing the source of operating expenses and patient care revenue data and how they were applied to determine allowable ceilings for this Applicant.

Project Review Memo

The Standard Method **Project Review Memo** (PRM) accompanies an ARM. The PRM summarizes the findings specific to one project, and will contain the following information:

- Header information summarizing the project;
- Summary of the project claimed costs evaluated for potential DoB with PCR, and the amount of the recommended reduction, if any;
- A table of summary statistics, including the project's claimed costs and any recommended reductions, by cost category-calendar year;
- Notes about sufficiency of project documentation, specific file names, and anything else deemed noteworthy to explain the approach taken to evaluate potential DoB with PCR;

Alternate Method Review Memo

The **Alternate Method Review Memo** will contain the following information in several sections:

Header

- Header information including the number of projects reviewed in the memo and total claimed costs for all projects reviewed in the memo.
    - If an Applicant referred for an AMRM includes several distinct methods, each method may be reviewed in a separate memo.

Summary

Statement on total PA request, cost categories the Applicant's method covers whether the request includes a reduction to account for duplication with patient care revenue, whether HSOAC finds the method to be reasonable.

- Summary statistics in a table showing costs by category claimed in each project.
- Summary description of the Applicant's method for addressing duplication with patient care revenue, and its total proposed reduction across all project amounts
- Analysis to assess whether the Applicant's method is reasonable for addressing duplication with patient care revenue across three dimensions:
    - Conceptual soundness
    - Data support
    - Correct calculation
- Determination of whether the method is considered reasonable or not reasonable for addressing duplication with patient care revenue

Recommended Revisions

- If not reasonable, the memo recommends revisions to correct deficiencies identified in the review
- Sometimes an unreasonable method produces a result, which when compared to the expected result by the standard method, may be an acceptable PA request. In this case, the memo notes this.

Notes

Brief statements on limits and assumptions of HSOAC's review, notable discrepancies in review materials

Appendices

- Appendix that describes project information for those included in review (e.g., title, PA process step, claimed costs)
- Appendix that lists documentation considered in the analysis

Appendix F: Financial data requirements to support Standard Method Reviews

Standard method reviews are based on allowable ceilings that are calculated using revenue and expenses for a calendar year (January 1 – December 31). CY2019 is required for all Applicants because it represents the pre-pandemic baseline. The other years are required only if the Applicant claimed costs during that calendar year.

All Revenues and Expenses must correspond to the parts of the Applicant organization for which Applicants claimed costs. If the cost claims involve the entire health system, then HSOAC will use financial data for the entire health system. If the costs claims involve one or more medical centers, then the financial data provided should reflect just those medical centers. Financial data can also be provided by location.

Applicant-provided data should match the following date ranges:

1/1/2019 - 12/31/2019

1/1/2020 - 12/31/2020

1/1/2021 – 12/31/2022

1/1/2023 - 5/11/2023

The following table describes the necessary data to conduct a Standard Method review.

Category	Requirements
Patient Care Revenue (PCR)	Includes all revenues for performing patient care including net patient service revenue, appropriations from state and local governments, and capitation revenue for patient care (excluding insurance premium revenue if the Applicant administers a health insurance plan). PCR includes but is not limited to: • Contracted amounts from third-party payers such as Commercial Insurance, Employer Self-Funded Health Plans, Workers Compensation Plans, Capitation or Premium Revenues (excluding health insurance premiums), Accountable Care Organization (ACO) Agreements, and Health Maintenance Organization (HMO) arrangements; • Contracted amounts from government health programs such as Medicaid, Medicare, TRICARE, Federal Employees Health Benefits Program (FEHP), Department of Veterans Affairs; HRSA COVID-19 Uninsured Program; Medicaid Disproportionate Share Hospital (DSH); and • Amounts determined collectable from self-pay, uninsured, and charity care patients Excludes: provision for bad debts, contractual adjustments, charity discounts, teaching allowances, policy discounts, administrative adjustments, and other deductions from revenue.
Labor	Salaries, wages, and benefits for force account labor; overtime force account labor; premium pay; contract clinical labor (inclusive of all payments, including per diem compensation for living expenses)
Supplies & Purchased Services	All supplies, including laboratory supplies, test kits, PPE, disinfection and cleaning supplies, thermometers, linens, medications, oxygen equipment, etc. All purchased services, except for clinical contract labor.
Equipment Depreciation	Moveable equipment depreciation or depreciation of all equipment within calendar year. Equipment generally defined as good with unit cost > $5,000, such as hospital beds, refrigerator trucks, coolers, freezers, ventilators, X-ray machines, some patient monitoring equipment, extracorporeal membrane oxygenation [ECMO] and other life support equipment
Calendar Year (CY)	January 1 - December 31