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April 10, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Verma:

I am writing today to express the concern of the Medicaid and CHIP Payment and Access Commission (MACPAC) about the decision to distribute the first wave of funding to health care providers under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) based on institutions' Medicare fee-for-service revenues as announced at the White House coronavirus task force briefing on April 7 and described in more detail on April 10.

While we appreciate the decision to move the initial $30 billion in federal funding quickly in response to the COVID-19 pandemic, using the expedited Medicare fee-for-service electronic funds transfer pathway does not account for the real and pressing concerns of safety-net providers that are on the frontlines of serving the nation's poorest and most vulnerable people, but may not have high Medicare revenue. Given that the purpose of the relief fund is to reimburse providers for health care expenses related to COVID-19 not covered by other revenue sources, these providers should be prioritized when distributing the remaining $70 billion in federal funds. We ask that you ensure that safety-net providers, including hospitals considered deemed disproportionate share hospitals (DSH) for the purposes of Medicaid payment, physician practices, health centers, children's hospitals, and other providers serving Medicaid and other low-income patients have access to federal funds made available through the CARES Act without delay.

As you know, MACPAC is statutorily charged with reviewing and assessing hospital payment policies as they relate to access and quality of care for program beneficiaries and how they affect providers that serve a disproportionate share of low-income and other vulnerable populations. To carry out this responsibility, the Commission has conducted extensive analyses regarding hospital payment under Medicaid with significant attention

to payment policies affecting base payments, upper payment limit supplemental payments, and DSH payments.

Our ongoing work on DSH payments in particular has documented the precarious financial situation of many hospitals that receive Medicaid DSH payments. Deemed DSH hospitals (which serve a high share of Medicaid and low-income patients) have higher uncompensated care and lower financial margins than other hospitals. In the aggregate, uncompensated care accounted for 6.5 percent of hospital operating expenses for deemed DSH hospitals, about twice the amount for other hospitals (3.7 percent) according to fiscal year 2017 Medicare cost report data. In addition, aggregate operating margins for deemed DSH hospitals were -1.8 percent, much lower than the operating margins for all hospitals (0.2 percent) (MACPAC 2020).

Moreover, it is important to note that these hospitals play a critical role in the health care system and the ongoing pandemic response. Deemed DSH hospitals account for about 14 percent of U.S. hospitals nationally, but they provide a larger share of hospital beds (20 percent) and serve a larger share of Medicaid patients (34 percent of Medicaid inpatient days) than other hospitals (MACPAC 2020). Most importantly, many of these facilities have low Medicare revenue and thus would be disadvantaged by a decision to allocate funds based on this measure.

While we have less information on revenue for physician practices, data from the National Ambulatory Medical Care Survey indicate that over one-quarter of primary care physicians rely on Medicaid and CHIP for more than one quarter of their revenues, and 8.8 percent of these doctors rely on Medicaid for more than 50 percent of their practice revenues (MACPAC 2014). These practices would likely be disadvantaged by the decision to allocate the first wave of funding based on Medicare revenues.

We urge you to prioritize the needs of providers serving Medicaid and other low-income populations when determining how the remainder of federal funding to providers will be distributed. Thank you for your attention to this matter.

Sincerely,

Melanie Bella, MBA
Chair

cc: The Honorable Charles Grassley, Chair, Senate Finance Committee
The Honorable Ron Wyden, Ranking Member, Senate Finance Committee
The Honorable Frank Pallone, Chair, House Energy and Commerce Committee
The Honorable Greg Walden, Ranking Member, House Energy and Commerce Committee
Ms. Kimberly Brandt, Principal Deputy Administrator for Policy and Operations, Centers for Medicare & Medicaid Services
Mr. Calder Lynch, Deputy Administrator and Director, Center for Medicaid and CHIP Services

References

Medicaid and CHIP Payment and Access Commission (MACPAC). 2014. Table 23. Provider Availability Measures of Access to Care for Medicaid/CHIP Beneficiaries, 2012. In *Report to Congress on Medicaid and CHIP*. March 2014. Washington, DC: MACPAC.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. Chapter 1: Annual analysis of disproportionate share hospital allotments to states. In *Report to Congress on Medicaid and CHIP*. March 2020. Washington, DC: MACPAC.