

# Congress of the United States

## Washington, DC 20515

May 5, 2020

The Honorable Alex M. Azar II  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue S.W.  
Washington D.C., 20201

Dear Secretary Azar:

The Department of Health and Human Services (HHS) recently announced additional allocations from the initial \$100 billion dedicated for health care providers in the Public Health and Social Services Emergency Fund (PHSSEF) provided by Congress under the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136).<sup>1</sup> In light of this latest distribution, we write to you today regarding our serious concerns about HHS's continued disregard for the ongoing needs of Medicaid providers.

HHS is ignoring clear Congressional intent by distributing the fund through methodologies that discriminate against Medicaid providers, impairing their ability to meet the needs of their communities and threatening their financial stability during and after the crisis. Medicaid providers are at the frontlines of the COVID-19 pandemic. Whether it is hospitals fighting to meet the needs of communities in crisis, nursing facilities and home-based providers working to keep patients safe, maternal health providers and pediatricians stepping up to ensure patients can receive essential prenatal care and vaccinations, or behavioral health providers striving to serve those in need of mental health and substance use disorder treatment, Medicaid providers play a critical role in confronting this pandemic. It is also vitally important that these providers alongside other essential providers such as school-based providers, primary care providers, health centers, dental providers, and others continue to exist when the country reaches the other side of this crisis. It is for these reasons that when creating the PHSSEF, Congress specified that "eligible health care providers" included "Medicare *or Medicaid* enrolled suppliers and providers."<sup>2</sup> Unfortunately, with roughly \$70 billion of the original \$100 billion already spoken for, HHS has yet to determine how Medicaid-dependent providers, operating at some of the thinnest margins, will receive necessary financial support.

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<sup>1</sup> The PHSSEF was further enhanced by the Paycheck Protection Program Health Care Enhancement Act. (P.L. 116-139).

<sup>2</sup> Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) (emphasis added).

As part of the CARES Act, Congress provided \$100 billion in funding for the PHSSEF to help support hospitals and other health care providers across the country. This funding was further enhanced under the Paycheck Protection Program Health Care Enhancement Act (P.L. 116-139), which provided an additional \$75 billion in funding. Earlier last month, HHS announced it would release the first \$30 billion from the PHSSEF. As part of this release, HHS limited funding solely to Medicare providers and relied on their Medicare fee-for-service claims to determine payment amounts. Unfortunately, as noted in a follow up letter to the Administration from the independent Medicaid and CHIP Payment and Access Commission (MACPAC), this method failed to “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.”<sup>3</sup>

HHS made matters worse by developing a second formula with an additional \$20 billion in allocations that effectively discriminates against those providers with a robust, or solely, Medicaid patient population. By choosing net patient revenue as the metric to determine how the funds would be distributed, providers with high levels of privately-insured individuals are being rewarded while those providers supporting the safety net are once again left waiting. In a four page fact sheet about the distributions, HHS devoted only one sentence to Medicaid providers, stating that some providers such as those that solely take Medicaid will receive further funding while at the same time failing to make any commitment as to when, how much, or whether Medicaid-dependent providers will receive equitable treatment.<sup>4</sup> In a response, the bipartisan National Association of Medicaid Directors publicly highlighted the failure of HHS to facilitate the expeditious distribution of Congressionally-appropriated funds to critical Medicaid providers serving the nation’s most vulnerable populations, noting the broad universe of impacted providers and the fiscal fragility of such providers.<sup>5</sup> MACPAC also again weighed in for a second time regarding their ongoing concern that “so little relief” has been offered to providers that are solely or predominately focused on serving the nation’s most vulnerable residents.<sup>6</sup>

Furthermore, HHS also recently announced that it would allocate additional funds to providers in “high impact areas,” but has been unclear as to how Medicaid providers will be treated. In its initial release, HHS noted that it would take into consideration the challenges of hospitals serving low-income patients reflected by Medicare Disproportionate Share Hospital (DSH)

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<sup>3</sup> MEDICAID & CHIP PAYMENT & ACCESS COMM’N., LETTER TO CMS ADMINISTRATOR ON CARES ACT FUND DISTRIBUTION (Apr. 10, 2020), *available at* <https://www.macpac.gov/wp-content/uploads/2020/04/Letter-to-the-CMS-Administrator-on-CARES-Act-Fund-Distribution.pdf>.

<sup>4</sup> HHS.GOV, HHS ANNOUNCES ADDITIONAL ALLOCATIONS OF CARES ACT PROVIDER RELIEF FUND (Apr. 22, 2020), <https://www.hhs.gov/about/news/2020/04/22/hhs-announces-additional-allocations-of-cares-act-provider-relief-fund.html>.

<sup>5</sup> NAT’L ASS’N OF MEDICAID DIRS., LETTER TO HHS ON CARES ACT PROVIDER RELIEF FUNDS (JAN. 29, 2020), *available at* <https://medicaidirectors.org/wp-content/uploads/2020/04/NAMD-Requests-to-HHS-on-CARES-Act-Provider-Funds.pdf> (noting the universe of impacted providers includes behavioral health providers, substance use disorder treatment providers, home-and community-based service providers, Federally Qualified Health Centers and Rural Health Centers, children’s hospitals, nursing homes and other long-term care facilities, non-emergency medical transportation providers, school-based health service providers, pediatricians, and maternal health providers).

<sup>6</sup> MEDICAID & CHIP PAYMENT & ACCESS COMM’N., LETTER TO HHS SECRETARY FOLLOWING UP ON CARES ACT FUND DISTRIBUTION (Apr. 30, 2020), *available at* <https://www.macpac.gov/wp-content/uploads/2020/04/Letter-to-the-HHS-Secretary-Following-Up-on-CARES-Act-Distribution.pdf>.

adjustments, but was silent on how Medicaid DSH or deemed DSH status would be taken into consideration.<sup>7</sup> In a follow-up announcement, HHS made vague reference to Medicaid DSH but provided no details including how deemed DSH providers would be treated. Deemed DSH providers operate on some of the thinnest margins of all providers. Even after receiving Medicaid DSH payments, deemed DSH hospitals had an average operating margin of -1.7 percent.<sup>8</sup> In recognition of the significant costs these providers incur from treating so many low-income individuals, Congress has long required that state Medicaid programs make payments to deemed DSH providers. Unfortunately, HHS continues to provide little clarity as to how these essential providers will be treated under the allocations or whether their unique needs will be taken into consideration. While some of these providers may see some funds as a result of a Medicare DSH-based formula, we strongly feel that HHS must consider targeting funds according to a measure that specifically reflects a Medicaid and low-income patient case-mix.

HHS's continued neglect for the needs of Medicaid-dependent providers struggling to deal with the COVID-19 crisis is unacceptable. The country is in the middle of a pandemic. The Medicaid program is a first responder, and the providers it relies on must be treated with equity. At a bare minimum that should include expeditious access to the PHSSEF as intended by Congress.

Accordingly, we call on HHS to take immediate steps to ensure that both Medicaid-only and Medicaid-dependent providers have sufficient and equitable access to PHSSEF funding and that any future allocations focus on the needs of these essential providers to ensure fair distribution of the PHSSEF pool. In addition to taking immediate action to address these gaps, we call on HHS to ensure all current and future distributions are fully transparent to Congress and the public.

In order for us to properly oversee your agency's administration of the PHSSEF, please provide responses to the following questions no later than May 18, 2020.

1. What level of funding does HHS plan to allocate to Medicaid providers, how will HHS ensure that both Medicaid-only and Medicaid-dependent providers receive equitable access to the PHSSEF, and how will HHS determine the amount each Medicaid provider should receive?
2. Please provide a detailed explanation of the methodology for the "high impact" distribution, including whether any of the funds will be allocated according to a provider's Medicare DSH status, Medicaid deemed DSH status, or a combination of both.
3. Please describe the steps you have taken to consult with state Medicaid directors, governors, stakeholders, and providers to determine which Medicaid providers have the greatest financial needs.
4. Please provide relevant data on the level of PHSSEF funding provided to Medicaid-dependent providers, including deemed Medicaid DSH hospitals. Please provide this data at the provider level.

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<sup>7</sup> See *supra* note 4.

<sup>8</sup> MEDICAID & CHIP PAYMENT & ACCESS COMM'N., REPORT TO CONGRESS (Mar. 2019), *available at* <https://www.macpac.gov/wp-content/uploads/2019/03/March-2019-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.

Sincerely,

*Ron Wyden*

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Ron Wyden  
Ranking Member  
Senate Committee on Finance

*Frank Pallone, Jr.*

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Frank Pallone, Jr.  
Chairman  
House Committee on Energy and Commerce