



May 1, 2020

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

Dear Secretary Azar,

The Partnership for Medicaid – a nonpartisan, nationwide coalition made up of organizations representing clinicians, health care providers, safety net health plans, counties, and labor – recognizes and appreciates Congress and the Department of Health and Human Services (HHS) for taking strong steps to address the nation’s health care needs during the COVID-19 pandemic. Through a series of legislation, Congress has authorized critical dollars for health care providers struggling under the impact of the crisis. As the Department works to distribute this vital fiscal support, we urgently call on HHS to prioritize the wide array of providers and health professionals committed to serving Medicaid enrollees as you continue your critical work.

The *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) created a Public Health and Social Services Emergency Fund (PHSSEF) to provide up to \$100 billion in funding for health care providers, including Medicaid providers. Between April 10 and 17, HHS disbursed \$30 billion of this funding based on Medicare fee-for-service payments. On April 22, HHS announced another \$20 billion for general allocation available to these same providers based on net patient revenue to augment the first disbursement. Through this approach, HHS is reconciling payments to distribute the total \$50 billion general allocation proportional to providers’ share of 2018 net patient revenue. In addition, the Department allocated \$20 billion for certain hospitals in areas with severe COVID-19 outbreaks and rural health clinics and hospitals.

While the methodology for distributing the second wave of funding is intended to accommodate providers and health professionals who serve substantial Medicaid, Medicare Advantage, or commercial patient populations, we are concerned that this approach does not provide equitable relief to those in need. Medicaid providers who do not bill Medicare and independent practitioners are effectively excluded from these initial disbursements and currently have no guarantee of receiving relief funds. As you know, the providers and health professionals that serve Medicaid have wholeheartedly joined in the national response to COVID-19 and yet are faced with tremendous financial challenges due to lost revenues and increased costs.

We now urge HHS to ensure that a proportional amount of the remaining PHSSEF funding, and any additional relief funding appropriated by Congress, is provided quickly to ALL Medicaid providers and health professionals impacted by the COVID-19 pandemic. We further ask HHS



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to work closely with states to identify and approve innovative approaches for distributing financial relief to providers and health professionals.

Medicaid is the safety net for individuals with low incomes and urgently requires relief to maintain its critical role during this public health crisis and beyond. As a source of coverage for one in five Americans - over 70 million lives – Medicaid will continue to play a key role in connecting individuals to testing and treatment for COVID-19 for the duration of the pandemic. Medicaid providers, health professionals, and health plans are the backbone of this key form of coverage, and we must urge the federal government to do everything possible to protect our capacity to provide care and coverage to the tens of millions of people we serve.

Additionally, the Partnership for Medicaid further requests that HHS take the following steps to strengthen the Medicaid program and ensure the strongest possible safety net to protect our nation's most vulnerable during the pandemic.

In a formal [comment letter](#) sent to the Centers for Medicare & Medicaid Services (CMS) in February 2020, the Partnership requested: that the Medicaid Fiscal Accountability Regulation (MFAR) be withdrawn. Implementation of the MFAR as proposed would only introduce more uncertainty into an already-fragile health care system. Given the added challenges facing hospitals, providers and health professionals, states, and the entire health care system due to COVID-19, the Partnership for Medicaid urges that a moratorium must be placed on MFAR immediately.

Concerns and confusion over enforcement of the public charge regulation encourages disenrollment from Medicaid during a time when access to testing, treatment, and care is critical and in the best interests of public health. The Partnership previously [requested](#) that the public charge rule be withdrawn; at a minimum, we encourage HHS to pause the Medicaid-related provisions of the public charge regulation, for at least the duration of the COVID-19 public health emergency.

We strongly encourage HHS to adopt the above proposals and we thank you for your consideration. The Partnership for Medicaid looks forward to ongoing collaboration with HHS to preserve and strengthen the Medicaid program and support its crucial role as a strong safety net for vulnerable Americans. If you have questions on any of the priorities discussed in this letter, please contact Shelby Higgins at the American Academy of Family Physicians, First Co-Chair of the Partnership for Medicaid at shiggins@aaafp.org or partnershipformedicaid@gmail.com.

Sincerely,

American Academy of Family Physicians
American College of Obstetricians and Gynecologists
American Dental Education Association
America's Essential Hospitals



Association for Community Affiliated Plans
Catholic Health Association of the United States
Easterseals
The Jewish Federations of North America
Medicaid Health Plans of America
National Association of Community Health Centers
National Association of Counties
National Association of Rural Health Clinics
National Association of Pediatric Nurse Practitioners
National Council for Behavioral Health
National Health Care for the Homeless Council
National Hispanic Medical Association
National Rural Health Association

Cc: Seema Verma, Administrator, Centers for Medicare and Medicaid Services
Thomas J. Engels, Administrator, HRSA
Calder Lynch, Deputy Administrator and Director, Center for Medicaid and CHIP Services
Lee Stevens, Senior Policy Advisory, Office of the Secretary, IEA
Gary Beck, Advisor for External Affairs, Office of the Secretary, IEA
Erin Reilly, External Affairs Specialist, Office of the Secretary, IEA
Michael Baker, Policy Advisor, Office of the Secretary, IEA
Caryn Marks, Office of the Secretary, IEA

Appendix

The Partnership for Medicaid's member organizations have independently urged Congress and HHS to provide relief to providers and health professionals serving Medicaid enrollees. The following examples demonstrate the diversity of providers and health professionals in need of emergency support.

Federally Qualified Health Centers (FQHCs). With over 1,400 organizations and more than 11,000 sites nationwide, FQHCs or "community health centers" are nonprofit, community-directed providers that serve as the primary medical home for over 29 million patients, including 1 in 5 Medicaid beneficiaries. Health centers serve as the largest primary care network in the country, providing comprehensive services in all 50 states and U.S. Territories. By mission and statute, FQHCs cannot, and do not, restrict the patients they care for if payment is too low. The current crisis has been devastating to health centers across the country. Due to the pandemic and its effects, including stay at home orders and concerns about transmission, patient volumes have dropped precipitously; a 50 percent drop is common and, in the hardest hit areas, the drop is over 70 percent. In some practices like dental, patient volume is almost nonexistent. Health Centers have had to lay off staff, close clinic sites in some cases, close service lines in others and, in almost every case, cut back hours of operation. Cash reserves are being rapidly depleted and the situation for some FQHCs is reaching a critical stage. All of this is happening at the same time as health centers are ramping up to provide testing and treatment for communities who are underserved and most vulnerable to the effects of COVID-19, including those with chronic illnesses, people living in poverty including those experiencing homelessness, older adults, and communities of color. Although Congress, the HHS, and many state Medicaid agencies have taken action to facilitate payment for telehealth and other virtual services in the Medicare and Medicaid programs, and to authorize and implement emergency grant and loan programs, these measures alone cannot fully address health centers' financial concerns resulting from the drop in Medicaid revenues. Should this situation continue, FQHCs may not be able to keep their doors open in order to respond to any patient and community health needs during this public health emergency.

Independent Physicians. As of now, independent physicians and practices have to a large degree not benefitted from other funds that have been made available to larger providers. These practices are typically small businesses and have already reported decreased reimbursement as a result of cancellation of routine non-urgent visits, visits shifting from in-person to virtual, and declining patient volumes.¹ Recent analysis conducted by HealthLandscape and the American Academy of Family Physicians estimates that 60,000 family

¹ Los Angeles Times, "Widening Coronavirus Crisis Threatens to Shutter Doctors' Offices Nationwide," March 24, 2020. Available at <https://www.latimes.com/politics/story/2020-03-24/coronavirus-outbreak-primary-care-doctors>



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practices will close or significantly scale back by June.² One practice that saw between 25 and 28 patients per day prior to the pandemic now reports seeing between four and eight patients, forcing the physician owner to cease taking a salary and to drop employees to part-time status.³ After being in business for 50 years, a practice in Arkansas was forced to lay off 12 employees, and a practice in North Carolina reported having insufficient funds to keep in business beyond the next two weeks.⁴

Pediatric Practices. Pediatric practice managers are reporting seeing only 20 to 30 percent of normal caseloads due to the pandemic. As a result, these practices are reducing staff hours, halting vaccine orders, and cutting their own salaries to cover fixed costs. More than 95 percent of office-based pediatricians practice in small businesses with very small staffs; these practices are operating with very narrow margins and less than two weeks of cash flow on hand at any given time.

Children’s Hospitals. Children’s hospitals have similarly reported their initial experience and projected results over the coming few months. For the most part, these hospitals are the leading providers of the most complex pediatric cancer, cardiovascular, trauma and lifelong chronic care in their regions. All are academic teaching and research hospitals, governed as charitable, community benefit organizations. Patient care revenues have immediately declined in the range of 20 to 40 percent, with some institutions reporting even higher losses of volume. Data now show that children’s hospitals are collectively losing roughly \$1 billion per month due to lost revenue and increased costs due to the COVID-19 crisis. Much of these losses are incurred without access to relief provided through the Medicare program, and without support through membership in larger health care systems with full access to all levels of federal support.

Pediatric-Focused Advanced Practice Nurses. Pediatric-focused Advanced Practice Nurses have also struggled to balance patient safety priorities with the financial impact on their practices and related problems with obtaining personal protective equipment, testing materials, staff furloughs and changes in office procedures. Some have experienced declines of at least 50 percent in their primary care practices, forcing cuts to staffing hours and requiring staff to adjust office facilities and hours to reassure families that sick children won’t be examined at the same times as well-child visits. Other practices have shifted to telehealth screening of sick children and limiting well-child visits to only children who have not completed their initial vaccinations.

Obstetrician-Gynecologists. Providers of obstetrical and gynecological services are also suffering significant financial hardship in the face of the pandemic, and were largely left out of the

² USA Today, “Thousands of US Medical Workers Furloughed, Laid Off As Routine Patient Visits Drop During Coronavirus Pandemic,” April 2, 2020. Available at <https://www.usatoday.com/story/news/health/2020/04/02/coronavirus-pandemic-jobs-us-health-care-workers-furloughed-laid-off/5102320002/>

³ <https://twitter.com/rshawnm/status/1243543147541671937>

⁴ https://twitter.com/Farzad_MD/status/1242053463737094144

Medicare-based methodology used for disbursement of the initial tranche of the PHSSEF. Many obstetrician-gynecologists in private practice are small business owners, operating small and medium-sized clinical practices. Due to the impacts of COVID-19, including recommendations of social distancing, postponing outpatient visits and delaying elective surgeries and procedures, many of these practices are furloughing staff, reducing or completely foregoing their own salary, and even bearing the operating costs of their practices with their own private funds in an effort to continue serving their patients. The National Center for Health Statistics reports that 43 percent of births were covered by Medicaid in 2018, while an additional 49 percent were covered by private insurers.⁵ Medicaid is also a primary payer for older women; of the approximately 25 million women Medicaid beneficiaries, 32 percent are over 50 years old.⁶ As such, obstetrician-gynecologists, who care for women across their lifespan, have been largely unable to benefit from the federal support provided to date, as most of their patients are enrolled in Medicaid or have private insurance coverage.

Mental Health and Addiction Treatment Providers and Health Professionals. Medicaid is the single largest payer of mental health and addiction services in the country. COVID-19 has increased anxiety, fear, isolation, and grief, leading to declining mental health and an increase in substance use in our communities that will only continue to get worse. In a [poll](#) by the Kaiser Family Foundation, 45 percent of adults say their mental health has been affected by the pandemic and 19 percent say it has had a major impact. Behavioral health organizations do not have the funds they need to ride out this crisis. According to a survey of 880 behavioral health organizations across the country, 62 percent believe they can only survive financially for three months or less under current conditions. Organizations have cancelled, rescheduled, or turned away 31 percent of patients and 92 percent have reduced their operations.⁷ The CARES Act provider fund relied on making payments directly to providers, and HHS at least initially prioritized paying hospitals through Medicare. However, behavioral health organizations rely primarily on Medicaid, not Medicare, and have been largely left out of critical emergency funding.

Hospitals Serving High Medicaid and Low-Income Patient Populations. While portions of the provider relief fund are allocated to hospitals, the initial allocation methodology focuses on hospitals with large shares of Medicare and net patient revenues and hospitals located in areas with severe COVID-19 outbreak. This approach clearly disadvantaged hospitals with disproportionately high Medicaid and low-income volumes and are not seeing a large influx of COVID-19 patients. The preparation and response efforts associated with COVID-19 has significantly increased costs for these

⁵ Martin JA, Hamilton BE, Osterman MJK, Driscoll AK. Births: Final data for 2018. National Vital Statistics Reports; vol 68, no 13. Hyattsville, MD: National Center for Health Statistics. 2019.

⁶ Kaiser Family Foundation. Medicaid's Role for Women. Available at <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>.

⁷ COVID-19 Economic Impact on Behavioral Health Organizations, (April 15, 2020). Survey conducted jointly by ndp | analytics and the National Council for Behavioral Health from April 6 to April 12, 2020. Results obtained pre-publication from the National Council for Behavioral Health.



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hospitals and, at the same time, they are facing an abrupt drop in revenue from halting planned and elective services. They have yet to receive meaningful relief relative to their need. Given their precarious financial situations to begin with, hospitals serving Medicaid and low-income patient populations are struggling even to make payroll. These hospitals need rapid fiscal relief and support and we urge HHS to distribute emergency funds in a way that prioritizes hospitals serving vulnerable communities and complex patients.

Medicaid Health Plans. Medicaid health plans are highly concerned that the providers and health professionals comprising their networks remain viable and able to serve Medicaid enrollees both during the pandemic and after the crisis wanes, and serve as a key source of support for Medicaid providers and health professionals. Many have provided relief to providers and other health professionals by way of providing accelerated and retainer payments, suspending prior authorization, and other methods, and seek to provide value to states and HHS as they distribute PHSSEF going forward. Because of the potentially dire impact of the pandemic on Medicaid-focused providers, Medicaid plans strongly support provision of immediate federal relief to these providers.