National Alliance of Safety-Net Hospitals

May 14, 2020

Alex M. Azar
Secretary
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Dear Secretary Azar and Administrator Verma:

The National Alliance of Safety-Net Hospitals appreciates everything you and your colleagues in the Department of Health and Human Services (HHS) are doing to help us help our communities and our patients through the greatest public health challenge any of us have seen in our lifetimes. You have listened and responded with much of the assistance and guidance we need and have done so in a very timely manner.

Yesterday, in an article titled "Distribution of CARES Act Funding Among Hospitals," the Kaiser Family Foundation shared the results of an analysis of the distribution of CARES Act funding under the net patient revenue methodology and concluded that "The formula used to allocate the $50 billion favored hospitals with the highest share of private insurance revenue as a percent of total net patient revenue." Kaiser's analysis also documented the extent of this disparity: "The hospitals in the top 10% based on share of private insurance revenue received $44,321 per hospital bed, more than double the $20,710 per hospital bed for those in the bottom 10% of private insurance revenue." In effect, the net patient revenue methodology was specifically disadvantageous to hospitals that care for the highest proportions of publicly insured patients: those covered by Medicare and Medicaid.

NASH is concerned about this distribution because many private safety-net hospitals were already in precarious financial condition even before the pandemic began, with their high proportions of low-income and low-income elderly patients covered by Medicare and Medicaid leading to low operating margins.

For this reason we ask you to develop a methodology for future disbursements that ensures a fairer distribution of these funds and does not disadvantage safety-net hospitals that care for especially high proportions of patients insured by public payers. We recognize that it will be difficult to develop such a methodology but the future of many private safety-net hospitals, and the communities they serve, may very well depend on making sure those funds are distributed to the hospitals that need them most. To do so, one approach might be to base eligibility for the distribution of the grant pool on one of two factors: hospitals eligible for the section 340B prescription drug discount program or those "deemed Medicaid disproportionate share." These two categories of hospitals, we believe, accurately capture providers that serve the highest proportions of publicly insured patients and most need these resources.

Private safety-net hospitals are on the front lines in the fight against COVID-19. Like others, we have invested heavily in equipment and resources to ensure our ability to serve our communities during these challenging times and like others we have needed to do so at a time when our flow of revenue has

fundamentally disappeared. Despite this we continue to serve our communities, which generally consist of especially large proportions of low-income, elderly, and low-income elderly patients who are dependent on Medicaid and Medicare.

We are most grateful for everything you are doing to help us fight this fight and look forward to continuing to work with you.

Sincerely,

Ellen J. Kugler
Executive Director

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