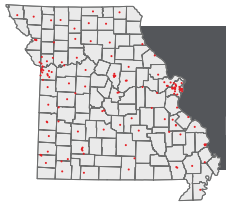
MHA PROFILE OF MISSOURI HOSPITALS



141 MHA MEMBER HOSPITALS

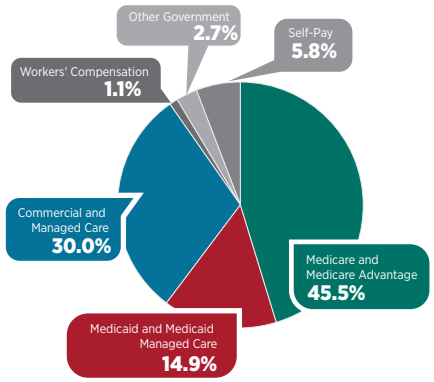
65	Medicare acute inpatient prospective payment system hospitals
35	critical access hospitals
5	federal military or veterans hospitals
5	general or specialty pediatric hospitals
16	psychiatric hospitals
6	long-term, acute care hospitals
6	rehabilitation hospitals
31	for-profit organizations
109	tax-exempt organizations
69	private, not-for-profit organizations
30	state or local government acute care hospitals
6	psychiatric hospitals owned by DMH

ALL HOSPITALS

BUSINESS MIX
(Ratio of Outpatient to Inpatient Visits)

34.3 : 1 — **24,701,519** outpatient visits, **720,267** admissions

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **68.9%**

OPERATING MARGIN
Percent of hospitals operating at a loss/gain.

Average Operating Margin	3.1%
Average Operating Margin W/O Provider Relief Funds	-3.0%

Percent w/ negative margins and Percent w/ Positive margins

40.3% ▼ | 59.7% ▲

ECONOMIC VALUE TO COMMUNITIES

GROSS PRODUCT **$23,408,336,516**

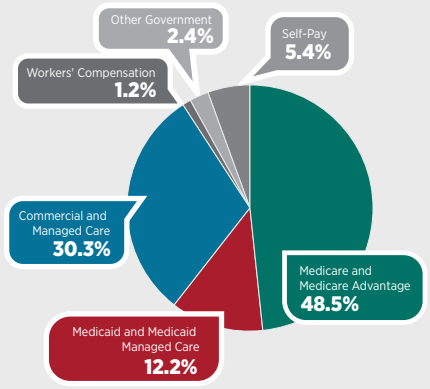
PAYROLL AND BENEFITS **$10,072,032,827**

URBAN

BUSINESS MIX
(Ratio of Outpatient to Inpatient Visits)

28.2 : 1 — **17,520,363** outpatient visits, **620,954** admissions

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **68.5%**

OPERATING MARGIN
Percent of hospitals operating at a loss/gain.

Average Operating Margin	5.5%
Average Operating Margin W/O Provider Relief Funds	0.4%

Percent w/ negative margins and Percent w/ Positive margins

27.9% ▼ | 72.1% ▲

ECONOMIC VALUE TO COMMUNITIES

GROSS PRODUCT **$19,591,113,373**

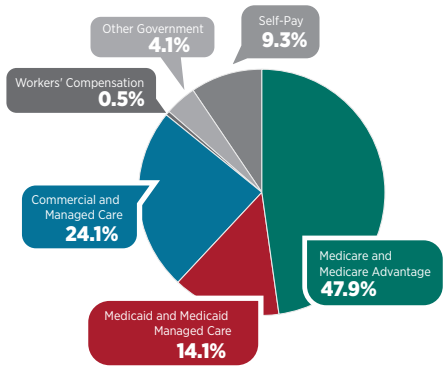
PAYROLL AND BENEFITS **$8,115,708,948**

RURAL

BUSINESS MIX
(Ratio of Outpatient to Inpatient Visits)

72.3 : 1 — **7,181,156** outpatient visits, **99,313** admissions

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **75.4%**

OPERATING MARGIN
Percent of hospitals operating at a loss/gain.

Average Operating Margin	0.4%
Average Operating Margin W/O Provider Relief Funds	-3.7%

Percent w/ negative margins and Percent w/ Positive margins

53.1% ▼ | 46.9% ▲

ECONOMIC VALUE TO COMMUNITIES

GROSS PRODUCT **$3,817,223,143**

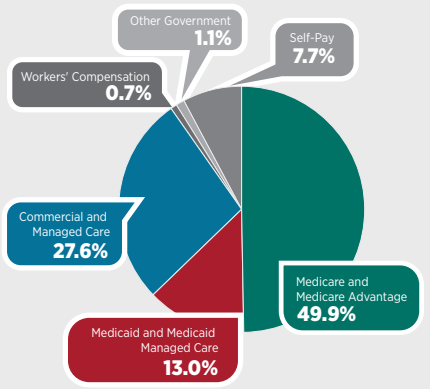
PAYROLL AND BENEFITS **$1,956,323,879**

CAH

BUSINESS MIX
(Ratio of Outpatient to Inpatient Visits)

107.9 : 1 — **1,857,702** outpatient visits, **17,217** admissions

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **71.7%**

OPERATING MARGIN
Percent of hospitals operating at a loss/gain.

Average Operating Margin	-0.8%
Average Operating Margin W/O Provider Relief Funds	-3.0%

Percent w/ negative margins and Percent w/ Positive margins

50.0% ▼ | 50.0% ▲

ECONOMIC VALUE TO COMMUNITIES

GROSS PRODUCT **$946,565,705**

PAYROLL AND BENEFITS **$488,698,617**


MHA
INFLATION
IS HARMING HOSPITALS.
Expenses are significantly higher — on an adjusted admission basis — than in 2019.
2019
WAGES AND BENEFITS
SUPPLY EXPENSES
PHARMACEUTICAL EXPENSES
OTHER OPERATING
17%
INFLATIONARY INCREASE
TOTAL HOSPITAL EXPENSES
2021
WAGES AND BENEFITS
SUPPLY EXPENSES
PHARMACEUTICAL EXPENSES
OTHER OPERATING
16%
20%
37%
13%

HOSPITAL FINANCE

Hospitals throughout the country are facing severe economic pressures, the most prevalent being historically high inflation rates. According to the AHA's 2022 environmental scan, overall hospital expenses have increased 17% on a per adjusted discharge basis between 2019 and 2021. Expenses have soared even higher in 2022. Inflationary pressures are not unique to health care; however, providers are uniquely challenged because much of their revenue is generated from predetermined, nonnegotiable payment rates. In Missouri, 63% of total revenues are predetermined and payments are received from a government entity. Hospitals are struggling to obtain reimbursement rate increases that keep pace with inflation.

Medicare Market Basket

Issue: Inflation is far exceeding the 2023 Medicare Prospective Payment System rate increases.

Action Taken: Because of significant feedback from hospitals, and House and Senate 'Dear Colleague' letters, CMS increased the final FY 2023 payment rates. While this action has improved the financial outlook, inflationary pressures continue to outpace Medicare payment rate updates.

MEDICARE'S ECONOMIC IMPACT ANALYSIS FOR 2023

	PROPOSED	FINALIZED
Inpatient PPS operating	1.4%	2.6%
Inpatient PPS capital	-0.4%	+0.6%
Long-Term Care Hospital PPS	0.7%	2.3%
Inpatient Psychiatric Facility PPS	1.5%	2.5%
Inpatient Rehabilitation Facility PPS	2.0%	3.2%
Skilled Nursing Facility PPS	-0.9%	2.7%
Outpatient PPS	2.7%	4.5%

Thank You: MHA thanks Reps. Sam Graves, Vicky Hartzler, Blaine Luetkemeyer, Jason Smith and Ann Wagner for signing the 'Dear Colleague' letter.

Medicare-Dependent Hospital Program

Issue: Unless Congress acts, the MDH program will end Friday, Sept. 30.

Implications: As much as a 13% reduction in Medicare IPPS payments for MDH hospitals.

Request for Action: MHA urges Congress to enact legislation to extend the MDH program. Several proposals have been introduced to extend the program, including the Rural Hospital Extensions for Low-Volume Programs Act (HELP Act, H.R. 8565) introduced by Rep. Sam Graves (R-MO), the Assistance for Rural Community Hospital Act (ARCH Act, H.R. 8747) introduced by Rep. Carol Miller (R-WV) and the Rural Hospital Support Act (S. 4009) introduced by Sen. Robert Casey (D-PA).

Thank You: MHA thanks Rep. Sam Graves for introducing H.R. 8565 that would permanently extend the MDH program.

Medicare Low-Volume Payment Adjustment

Issue: Unless Congress acts, expanded access to the Medicare Low-Volume Payments will end Friday, Sept. 30.

Implications: Within Missouri, 18 hospitals are projected to receive $13.3 million in Medicare IPPS payment reductions.

Request for Action: MHA urges Congress to enact legislation to extend the MLV program. Several proposals have been introduced to extend the program, including the Rural Hospital Extensions for Low-Volume Programs Act (HELP Act, H.R. 8565) introduced by Rep. Sam Graves (R-MO), the Assistance for Rural Community Hospital Act (ARCH Act, H.R. 8747) introduced by Rep. Carol Miller (R-WV) and the Rural Hospital Support Act (S. 4009) introduced by Sen. Robert Casey (D-PA).

Thank You: MHA thanks Rep. Sam Graves for introducing H.R. 8565 that would permanently extend the MLV program.

Unlawful Medicare 340B Payment Reductions

Issue: CMS unilaterally reduced Medicare outpatient payments for certain drugs purchased under the 340B Program from average sales price plus 6% to ASP minus 22.5%. The payment reductions applied to 340B drugs are reimbursed through the Medicare OPPS. Rural sole community hospitals, CAHs, children's hospitals and certain cancer hospitals were granted exceptions to the payment reduction.

Implications: In Missouri, Medicare 340B payment reductions are projected to be $55.9 million in 2022.

Action Taken: The U.S. Supreme Court recently ruled that the 340B Medicare payment cuts to hospitals were unlawful. Although CMS initially proposed that the payment rate for 2023 would include the reductions, CMS stated that the final rule would reverse the policy for 2023. CMS currently is requesting information about how to pay back prior year 340B payment reductions.

Request for Action: The unlawful payment reductions began in 2018. Since that time, the OPPS base rate was increased to ensure the 340B payment reductions would be budget neutral. MHA urges Congress to compel CMS to repay the unlawful payment reductions without penalizing hospitals receiving Medicare OPPS payments.

340B Drug Discount Restrictions

Issue: Several pharmaceutical manufacturers have instigated diverse but well-choreographed efforts to upend long-standing 340B practices by arbitrarily declaring that drug discounts no longer will be provided through contract pharmacies. Although the Health Resources and Services Administration has written strong letters reiterating its opposition to the pharmaceutical manufacturers' attacks, the agency has limits on its regulatory authority over 340B.

Action Taken: Congress sent 'Dear Colleague' letters that urge the U.S. Department of Health and Human Services to begin assessing civil monetary penalties, require manufacturers to refund covered entities the discounts they have unlawfully withheld, stop any attempt to unilaterally change 340B upfront discounts and immediately seat the Administrative Dispute Resolution Panel to begin processing disputes within the program.

Thank You: MHA thanks Reps. Emanuel Cleaver, Vicki Hartzler, Sam Graves, Blaine Luetkemeyer, Jason Smith and Ann Wagner for signing the 'Dear Colleague' letter.

Sequestration

Issue: Congress enacted legislation that ends the 2% Medicare sequestration moratorium during 2022. Hospitals received a reinstatement of the sequester in phases — 1% in April and 1% in July. The reinstatement of the Medicare sequestration, coupled with the low Medicare market basket updates for 2022 and 2023, is causing fiscal harm to hospitals.

Implications: Hospitals in Missouri are expected to experience $62.5 million in sequestration payment reductions in 2022. The projected amount of Medicare payment reductions for 2023 is $100 million.

Request for Action: MHA urges Congress to reinstate the Medicare sequestration moratorium.

Statutory Pay-As-You-Go

Issue: The Statutory Pay-As-You-Go Act of 2010 requires mandatory spending reductions if the cost of legislation would increase the federal budget deficit over a five- or 10-year period. Should such legislation be enacted without offsets, the Office of Management and Budget is required to implement "across-the-board" reductions in certain types of federal spending. Medicare payments would be cut by as much as 4%.

Implications: If SPAYGO were to reduce Medicare payments, providers in Missouri would sustain an estimated $181.1 million in additional Medicare payment reductions.

Request for Action: Although Congress enacted legislation that would trigger SPAYGO, it always has acted to waive the reductions. If SPAYGO is triggered for CY 2023, MHA urges Congress to waive Medicare payment reductions.

WORKFORCE

A hospital's ability to care for its patients depends on the quality of staff, especially those on the front lines of care. The stress of the ongoing COVID-19 pandemic has stretched the capacity of Missouri's health care system, and undermined both the supply and resiliency of health care practitioners necessary to meet care demands. Along with the effects of the pandemic, hospitals and health care workers also contend with workforce safety issues when caring for agitated and oftentimes violent patients with regulatory safety standards that are misaligned. These situations largely have contributed to the most predominant operational challenge for hospitals — maintaining its health care workforce.

Nursing Workforce Shortage

VACANCY RATE
14.5% OR **5,295** FTEs

TURNOVER RATE
34.5% OR **12,580** FTEs

Increasing the Health Care Workforce Pipeline

Issue: According to the U.S. Bureau of Labor Statistics, 2.6 million more workers will be needed within the next eight years to meet anticipated demands for health care. Many of these workers will need to be nurses who serve as front-line caregivers. The current vacancy and turnover rates, coupled with an increasing need for new nurses, are contributing to a significant nurse shortage crisis in Missouri.

Action Taken: Hospitals in Missouri have been proactively increasing the number of newly trained nurses by working with schools of nursing, providing grants to increase the number of nurse educators and offering continuing education. Nursing trade organizations also have endorsed the use of a Unique Nurse Identifier that, among other things, may be used to track education and ensure nurse licensure remains current.

Request for Action: Legislation is needed to ensure a steady pipeline of new nurses now and throughout the next few years. MHA is supportive of flexible grant opportunities to procure nursing educators, such as the Future Advancement of Academic Nursing Act (S. 246/H.R. 851) introduced by Sen. Jeff Merkley (D-OR) and Rep. Lauren Underwood (D-IL). MHA also supports bills that would expedite the visa authorization process for qualified international nurses, such as the Healthcare Workforce Resilience Act (S. 1024/H.R. 2255) introduced by Sen. Richard Durbin (D-IL) and Rep. Bradley Schneider (D-IL).

Thank You: MHA thanks Rep. Emanuel Cleaver for co-sponsoring H.R. 851; Reps. Emanuel Cleaver, Sam Graves and Billy Long for co-sponsoring H.R. 2255; and Sen. Roy Blunt for co-sponsoring S. 1024.

Traveling Nurse Agencies

Issue: The use of traveling nurse agencies significantly increased throughout the pandemic. Because of the increase in demand, the pricing to secure agency contracts significantly increased. MHA is concerned that nurse staffing agencies are taking advantage of the pandemic to increase profits.

Request for Action: MHA urges members of Congress to enact the Travel Nursing Agency Transparency Study Act. (H.R. 8576) introduced by Rep. Gregory Murphy (R-NC) that would compel the U.S. Comptroller General to study the effects of travel nurse agencies on the health care industry during the COVID-19 pandemic. The report would include studies about business and payment practices of the agencies, including any potential price gouging or excessive profiteering, the difference between how much agencies charged health care institutions versus how much they paid contracted nurses, the extent to which the agencies could provide more transparency, and specific ways in which rural areas were affected by the rise of travel nursing across the country — including rural workforce shortages.

Thank You: MHA thanks Reps. Emanuel Cleaver, Sam Graves, Billy Long, Blaine Luetkemeyer and Ann Wagner for signing a 'Dear Colleague' letter that encouraged the Biden administration to enlist federal agencies to investigate anticompetitive activities.

Conflicting Regulatory Requirements

Issue: By design, federal agencies have different perspectives on and approaches to overseeing issues within the agency's jurisdiction. At times, the differences can create conflicting standards. Such conflicts currently exist in addressing workplace violence. CMS focuses on programs and standards that promote the safety of patients. The U.S. Department of Labor's Occupational Safety and Health Administration focuses on programs and standards that promote the safety of employees. These differences can and have produced conflict and contradiction in regulatory expectations of hospitals. CMS can and has punished hospitals for incidents in which workers have needed to protect themselves from patient assaults. OSHA penalizes facilities for failing to ensure adequate protection of staff when assaults occur.

Request for Action: MHA urges Congress to compel the agencies to work together in a way that eliminates conflicting and contradictory regulations.

Thank You: MHA thanks Sen. Roy Blunt for his leadership in requesting that CMS and OSHA work together to address the discrepancies.

Workplace Violence

Issue: According to the U.S. Department of Labor, the health care and social services field experiences the highest rates of injuries caused by workplace violence. Hospitals and health system teams experience violence from bullying, threats and incivility to physical altercations, and active shooters. Hospital staff need to be protected from workplace violence so the focus can remain on patient care.

Request for Action: MHA supports proposed legislation that addresses workplace safety, such as the Safety From Violence for Healthcare Employees Act (SAVE Act, H.R. 7961) introduced by Rep. Madeleine Dean (D-PA), which would increase the penalties for individuals who interfere with the performance of duties and pose a threat to hospital personnel. MHA urges Congress to enact legislation that would address workplace violence.

Mandated Nurse Staffing Ratios

Issue: Due to the COVID-19 PHE, CMS voices a continued concern about long-term care nurse staffing ratios and the effect on quality. Hospitals in Missouri have long supported the need for affordable, high-quality care and patient safety, which is a top priority for all health care providers. The number of patients for whom a nurse can provide safe, competent and quality care is dependent upon the specific needs and condition of each patient. These factors include acuity, location, institutional resources, nurse training and experience, caregiver support, and environmental factors. Clinicians and hospitals are in a better position to determine appropriate staffing levels based on the needs of each patient, not regulators who utilize a "cookie cutter" approach to establish arbitrary minimum staffing requirements.

Request for Action: MHA encourages Congress to oppose any attempt to impose minimum staffing levels. Minimum staffing requirements will have unintended consequences, especially in rural provider settings, including less access to inpatient beds, higher cost to treat patients, additional nurse staffing pressures and stifled innovation. The consequences will not result in improved quality, improved safety or reduced cost.

CRITICAL ACCESS HOSPITAL 96-HOUR RULE

Congress created the critical access hospital designation through the Balanced Budget Act of 1997 in direct response to increasing numbers of rural hospital closures. CAHs receive certain benefits, such as reimbursement based on Medicare's share of allowable cost, to ensure their financial viability, which in turn assures health care access and essential services to rural citizens. CAHs are vital to their communities as they provide health care services located close to home.

The 96-Hour Rule

Issue: The legislation that created the CAH designation requires a physician certify that an inpatient admission is not expected to exceed 96 hours. The 96-hour rule essentially limits inpatient services for individuals receiving care in a CAH. Historically, the Centers for Medicare & Medicaid Services considered the 96-hour certification as a low enforcement priority and waived the requirement during the COVID-19 public health emergency.

Implications: Absent the waiver, CAHs would have been unable to care for many COVID-19 patients, substantially increasing the impacts of patient surge on acute care facilities. According to the American Hospital Association's Rural Report, CAHs have a "challenging patient mix," serving rural populations who "are notably older, have higher rates of chronic diseases and have higher prevalence of multiple chronic conditions." Some patients whose care can be well managed by a CAH may require a length of stay exceeding 96 hours. A separate federal regulation requires that the aggregate average lengths of stay for a CAH cannot exceed 96 hours.

Action Taken: Within a recent House 'Dear Colleague' letter, members asserted that the 96-hour rule is problematic for both patients and the hospital, "resulting in CAHs either refusing care, forgoing payment, or being forced into an unnecessary and expensive transfer of a patient to a larger facility," often located long distances from home. Although Congress has proposed legislation in the past that would withdraw the 96-hour rule, the rule remains and will once again have the potential to cause unnecessary transfers once the PHE has ended.

Request for Action: MHA urges Congress to enact legislation that would permanently withdraw the 96-hour rule requirement.

Thank You: MHA thanks Rep. Sam Graves for his leadership by introducing, and Rep. Blaine Luetkemeyer for co-sponsoring, the Save America's Rural Hospitals Act (H.R. 6400). Among other things, the bill would permanently remove the 96-hour rule. MHA also thanks Rep. Adrian Smith (R-NE) for introducing the Critical Access Hospital Relief Act of 2022 (H.R. 6700) that also would repeal the 96-hour rule.

RURAL EMERGENCY HOSPITAL DESIGNATION

On Dec. 21, 2020, Congress enacted the Consolidated Appropriations Act of 2021, which established a new hospital designation known as a rural emergency hospital. Hospitals currently designated as a CAH, or that are a small rural hospitals with no more than 50 beds, will have the option to become an REH as early as January 2023. REHs would provide 24-hour emergency room access and other outpatient services. CMS has proposed Conditions of Participation policies, enrollment processes, and other payment and policy regulations. CMS is expected to finalize those rules sometime this fall.

Demographics of Missouri Hospitals Eligible to Become an REH

46 HOSPITALS ARE ESTIMATED TO BE ELIGIBLE TO BECOME AN REH

11 ARE INPATIENT PPS HOSPITALS
35 ARE CAHs

CONGRESSIONAL BREAKDOWN OF HOSPITALS ELIGIBLE TO BECOME AN REH

Cleaver	3
Graves	14
Hartzler	10
Long	5
Luetkemeyer	2
Smith	12

34 HOSPITALS
received CAH status by being a necessary provider

41 CURRENTLY PARTICIPATE
in the 340B Program

Eligible hospitals admitted
34,303 INPATIENTS
in 2020

Medicare REH Payment Methodology

- Reimbursement will be 105% of the Medicare OPPS rate.
- REHs would receive a fixed monthly payment of $268,294.
- Patients are responsible for deductibles and coinsurance based on 100% of the OPPS coinsurance liability, not 105%.
- The REH may establish a separate provider, designate space as a skilled nursing facility and be paid based on the Medicare SNF PPS system. Traditional swing bed practices will not be allowed.

Operational and Cost Considerations

- CAHs should heavily scrutinize allowable cost allocations to determine the amount of cost an REH can absorb (i.e., home office allocations).
- Staffing composition and ratios would need to be assessed and possibly revised.
- Need for a full assessment of current and future capital expenditures.
- Need to negotiate new or renegotiation commercial contracts.
- Assess SNF service viability.
- CMS has not clearly defined whether off-campus provider-based departments, provider-based rural health clinics or provider-based clinics would remain provider-based, or how each would be reimbursed. Hospitals would need to carefully assess once guidance is clear.
- CAHs should assess the requirements of the REH CoPs.

Potential Barriers

- Missouri statute currently would not allow for an REH designation.
- Of hospitals that are eligible to become an REH in Missouri, 89% are designated as 340B. Under current law, REHs would not be allowed to participate in the 340B Program. Congress would need to enact legislation to allow REH-designated hospitals to become a 340B entity.
- There is limited flexibility in transitioning from an REH back to a CAH (necessary provider limitation considerations).