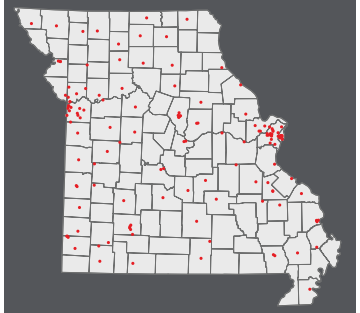
MHA PROFILE OF MISSOURI HOSPITALS



140

MHA MEMBER HOSPITALS

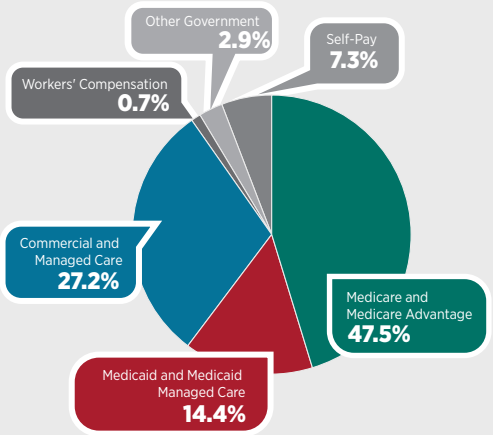
65 ~~66~~	Medicare acute inpatient prospective payment system hospitals	16	psychiatric hospitals	109	tax-exempt organizations
35	critical access hospitals	6	long-term, acute care hospitals	69	private, not-for-profit organizations
5	federal military or veterans hospitals	6	rehabilitation hospitals	30	state or local government acute care hospitals
5	general or specialty pediatric hospitals	28 ~~30~~	for-profit organizations	6 ~~5~~	psychiatric hospitals owned by DMH

RURAL

BUSINESS MIX
(Ratio of Outpatient to Inpatient Visits)

84.7 : 1 | **7,617,857** outpatient visits, **89,922** admissions

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **72.1%**

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

Average Operating Margin **-1.6%**

Percent w/ negative margins and Percent w/ Positive margins

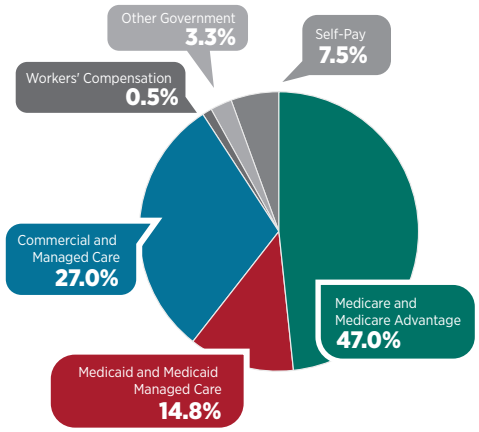
41.7% ▼ | 58.3% ▲

RURAL PPS

BUSINESS MIX
(Ratio of Outpatient to Inpatient Visits)

77.8 : 1 | **5,567,671** outpatient visits, **71,549** admissions

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **72.6%**

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

Average Operating Margin **-3.9%**

Percent w/ negative margins and Percent w/ Positive margins

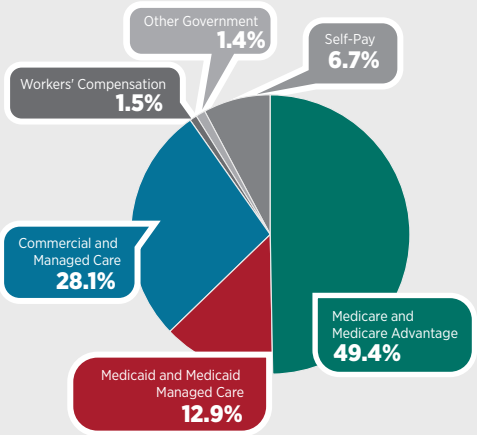
46.2% ▼ | 53.8% ▲

CAH

BUSINESS MIX
(Ratio of Outpatient to Inpatient Visits)

111.6 : 1 | **2,050,186** outpatient visits, **18,373** admissions

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **70.4%**

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

Average Operating Margin **0.3%**

Percent w/ negative margins and Percent w/ Positive margins

38.2% ▼ | 62.8% ▲

HEALTHY HOSPITALS CREATE RESILIANT COMMUNITIES

Hospitals and health systems strive to provide first-class care, so that Missourians have access to needed diagnostics and treatments, regardless of location and ability to pay. They are unique in that they must maintain clinical staff and equipment necessary to provide care 24/7/365. They are held to a multitude of stringent and comprehensive regulatory requirements through CMS and other accreditation and survey agencies. That state of quality and readiness comes at a price, yet consumers, payers and policy makers often assail hospitals for the cost of care.

Attempts to reign in health care costs come in the form of incremental reductions in hospital reimbursement, pressures from commercial insurers, skepticism of hospitals' tax-exempt status and attacks on the 340B program. These efforts collectively undermine the stability of hospitals and their ability to serve as the cornerstone of their communities.

Reimbursement

Hospitals should be remunerated appropriately for services provided. Unreimbursed costs associated with governmental payers continue to increase, shifting significant burden onto commercial insurers and patients to make up the difference. As Congress considers legislative proposals that would reduce certain payments to align with cost, it must also consider increases for under-reimbursed services.

Medicare

Laws and regulations have cut Medicare reimbursement to a point where hospitals are paid less than it costs to treat beneficiaries. According to MedPAC, the average Medicare margin for hospitals in 2021 was -8.3% once provider relief payments were removed. The following are examples of these reductions:

- Sequestration
- Affordable Care Act productivity adjustments
- Medicare disproportionate share uncompensated care
- ATRA/MACRA IPPS coding adjustment
- Bad debt reimbursement reduction
- Outpatient PPS site-neutrality (Section 603)
- Hospital readmission reduction policy
- Hospital-acquired condition program
- Low market basket updates

Medicare Advantage

Approximately 50% of Missouri Medicare beneficiaries obtain coverage through a Medicare Advantage plan. Bad actions from MA plans create further payment reductions through routine denials, overly burdensome appeals processes, site-of-service limitations, unreasonable reimbursement rates and patient transfer restrictions. Medicare Advantage plans have left hospitals with a choice of continuing to treat MA patients at losses or cancel contracts. Neither solution is sustainable.

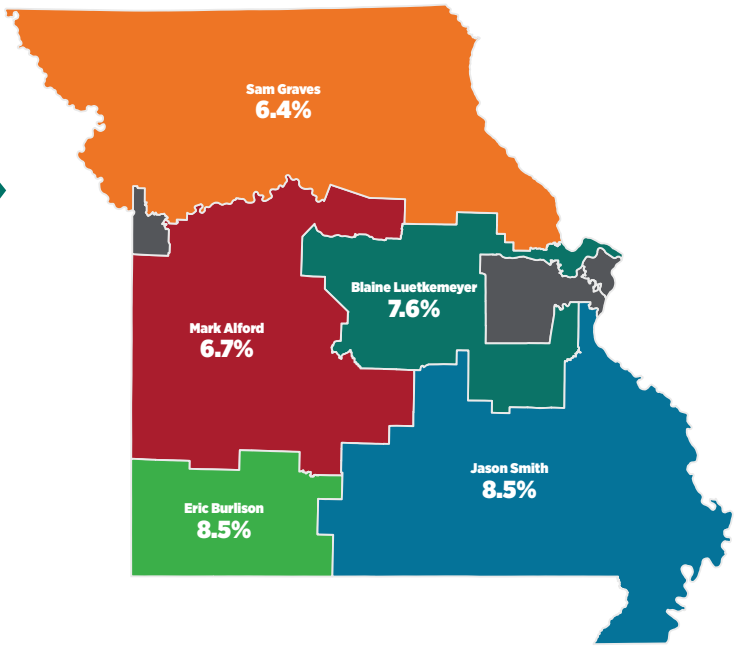
Tax Exempt Status

Tax-exempt hospitals have a responsibility to provide benefits to the patients and communities they serve. These savings allow hospitals to offer under-reimbursed but critical services such as labor and delivery, programs to improve the health of the community and reinvest in staff, equipment and facilities so every patient receives the best care possible.

Hospitals use various mechanisms to disclose how tax-exempted dollars are used to care for their communities, including the Medicare cost report, IRS 990 filings and community benefit reporting. Using these datasets, Ernst & Young estimates that for every dollar of unrealized tax revenue, hospitals provided $9 of benefit to the community.

MHA annually shares community benefit data on www.FocusOnHospitals.com. This source contains information about how hospitals promote health and provide direct patient care to the most vulnerable. As reported within the 2023 MHA Community Investment Report, hospitals provided more than $1.3 billion in uncompensated care over a 12-month period while absorbing additional unpaid costs from governmental payment sources. In total, more than $3.1 billion in community benefits were provided. The percentage of uncompensated care provided by rural hospitals averaged 7.1% of total operating revenues.

Uncompensated Care as Percent of Operating Revenue by Rural Hospitals



Hospitals often are among the first to step up and serve their patients and communities, and data show that hospitals receiving tax-exempt status in Missouri are responsible stewards of this status by reinvesting in their communities.

340B Attacks

The 340B drug discount program has been a successful and valuable program to eligible hospitals in Missouri. These hospitals use 340B proceeds as envisioned by Congress to provide numerous benefits to patients and their communities. The following testimonials are a few examples of how hospitals use 340B drug discount program proceeds to provide care they otherwise would be unable to and why the 340B program needs to be preserved.

Golden Valley Memorial Healthcare, Clinton, Missouri

"Missouri's maternal mortality rate outpaces the national average — but even more concerning is that 75% of maternal deaths in Missouri are considered preventable. Unfortunately, a lack of access to safe, high-quality care contributes to this crisis. However, thanks to the 340B program, Golden Valley Memorial Healthcare is able to provide high-quality maternity care, accounting for roughly 350 births each year. This is particularly important for the rural population it serves. Without Golden Valley Memorial Healthcare and its 340B savings, many patients would have to drive more than 90 minutes to reach the nearest birthing center."

Harrison County Community Hospital, Bethany, Missouri

"We cannot overemphasize the importance of the 340B program to our patients, community and organization. We have patients that tell us they would need to go without medication if this program did not exist. Our hospital, without the program, likely would not be able to keep the doors open and be operating today."

Freeman Health System, Joplin, Missouri

"Many working people with insurance coverage can still find themselves unable to pay their copays or coinsurance for expensive drug therapies for diseases like cancer and diabetes. The ability of hospitals to use patient assistance programs to reduce out-of-pocket expenses based on ability to pay is the only way many patients are able to receive medications needed. The 340B program also allows hospitals to maintain service offerings that are under reimbursed. For many rural providers, 340B is the difference between the town having a hospital or not."

BJC HealthCare – Parkland Health Center-Farmington, Missouri

"Without the 340B program, a patient would have been required to undergo a less effective therapy with much harsher and caustic side effects. With 340B, the savings on more appropriate medications allowed us to provide funding assistance to cover the cost of the more effective treatment with less residual effects."

BLOCK MEDICAID DISPROPORTIONATE SHARE HOSPITAL FUNDING REDUCTIONS

Medicaid Disproportionate Share Hospital payments are critical for rural hospitals — allowing them to capture the uncompensated costs of care provided to Medicaid beneficiaries and the uninsured. Medicaid DSH allotment calculations are state-specific and capped by statute.

The Patient Protection and Affordable Care Act of 2010 called for significant cuts to Medicaid DSH payments beginning in 2014. Reductions were premised on the rationale that the coverage provisions of the ACA would reduce the number of uninsured individuals. In theory, as the uninsured population becomes insured, Medicaid DSH payments will decrease. In practice, however, many of the uninsured would become Medicaid beneficiaries. Because Medicaid programs often pay significantly less than cost, Medicaid DSH payments still will be necessary to offset this increase in unreimbursed Medicaid cost. The need for delaying these cuts will remain until such time that all patients are insured and hospitals are remunerated for cost incurred to treat Medicaid beneficiaries. The Consolidated Appropriations Act of 2021 delayed them through federal fiscal year 2023. Currently, they are slated to take effect Oct. 1, 2023. If Congress does not act, the total reduction in federally funded Medicaid DSH allotments is projected to be **$8 billion per year** for FFYs 2024 – 2027.

Issue

The Medicaid and Children's Health Insurance Program Payment and Access Commission is required to provide an annual report to Congress on the efficacy of the Medicaid DSH program. The report analyzes uncompensated care costs and the number of hospitals providing high levels of uncompensated care. MACPAC estimates Missouri's share of the payment reductions to be $398.4 million in federal funds for 2024.

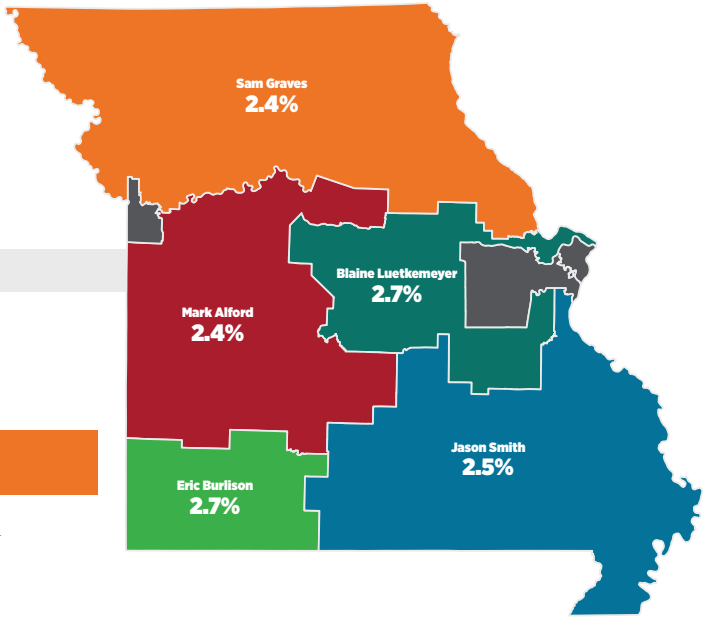
Hospitals located in rural areas are among the most financially stressed, especially those with high levels of uncompensated care. Those facilities rely on Medicaid DSH payments to maintain financial viability, even with an average -3.1 percent operating margin. Substantial reductions in Missouri's Medicaid DSH allotment to rural hospitals could result in hospital closures, impeding access to care for many Missourians. If Medicaid DSH payment cuts are implemented, the 94 Missouri hospitals receiving these payments would incur an estimated 1.9% average reduction to total operating revenue. Unless Congress acts, the estimated average Medicaid DSH reduction will reduce operating payments to rural hospitals by 2.4%.

PROJECTED REDUCTION TO TOTAL OPERATING REVENUE

Rural 2.4%

Urban 1.1%

Total 1.9%



Request for Action:

The Missouri Hospital Association urges the Missouri congressional delegation to enact legislation, such as the Supporting Safety Net Hospitals Act (H.R. 2665) that would block implementation of the Medicaid DSH cuts slated to take effect Oct. 1, 2023.

Thank you:

MHA appreciates the support from Senator Hawley and representatives Alford, Bush, Cleaver, Luetkemeyer, and Wagner for cosigning Dear Colleague letters of support to prevent the Medicaid DSH payment reductions for federal fiscal years 2024 and 2025. MHA thanks Representative Cleaver for cosponsoring the Supporting Safety Net Hospitals Act (H.R. 2665).

STABILIZE MEDICAID FUNDING AND PAYMENTS

Issue

For decades, federal law has authorized states and local governments to impose provider taxes to generate the state share of Medicaid funding. The law also prohibits the unit of government imposing the tax from administering a hold harmless arrangement to reimburse providers for all or a portion of the tax. CMS has impermissibly tried, on several occasions, to extend that prohibition to similar arrangements among private parties, despite a finding by the OIG that such arrangements are lawful. In its latest attempt, CMS has issued an Informational Bulletin and a proposed rule, CMS-2439-P, which would extend the definition of an unallowable health care provider tax beyond the statutory text and invalidate mitigation arrangements that include redistributions among private providers. If finalized, CMS would be misinterpreting the law, exceeding its statutory authority and jeopardizing the stability of the Medicaid program in Missouri by undermining support for the tax, which is critical to funding services for those who serve the most vulnerable populations.

Request for Action

The Missouri Hospital Association urges the Missouri Congressional Delegation to compel CMS to withdraw the Informational Bulletin and proposed rule.

BLOCK SITE-NEUTRALITY PAYMENT LEGISLATION

CMS requires providers to charge and bill based on the costs incurred to treat Medicare beneficiaries. These costs include professional and facility expenses. Professional costs compensate the practitioner for the time needed to serve a patient while facility expenses include non-physician employees, supplies, facility, utilities, information technology and other supporting expenditures. Physicians who care for patients within their own practices bill and receive payment to cover both the professional and facility expenses. However, when patients receive care within a hospital, the attending physician bills and receives a lower payment rate to cover the professional cost while the hospital bills and receives payment for the facility expenses. Hospitals who provide services in locations that are not on the main campus are required to bill for the facility expenses incurred as a off-campus provider-based department, also known as an hospital outpatient department (HOPD).

The facility expenses incurred for services provided in an independent physician clinic are often less than if the same service is provided in a hospital-based setting. Unlike standalone physician clinics, hospitals include emergency services, are subject to EMTALA, serve all patients regardless of their ability to pay, maintain backup strategies for complications that may arise, fulfill equipment redundancy requirements, maintain stringent ventilation requirements, disaster preparedness and response plans, infection control programs, life safety codes (NFPA 101), and abide by risk-adjusted safety standards to minimize the hazards of fire, explosion and electricity (NFPA 99). As a result of the abundant regulatory standards imposed on hospitals, their costs are higher, warranting a differential in the Medicare payment rate when services are provided in a hospital outpatient department.

Issue

Congress began enacting site-neutrality policies within Section 603 of the Bipartisan Budget Act of 2015, which reduced Medicare outpatient PPS payments for services provided in certain off-campus provider-based departments. Recently, Congress has renewed interest in furthering additional site-neutrality payments that would reduce Medicare outpatient PPS to a physician fee schedule payment rate. Site-neutral payment policies fail to account for the fundamental differences between HOPDs and other sites of care. Section 603 and other Medicare imposed site-neutral payment policies already have had negative impacts on the financial stability of hospitals. Medicare outpatient margins averaged -23.8% in 2021. Due to the already poor Medicare outpatient margins, additional cuts to HOPD payments will jeopardize access to care.

Request for Action

Legislative proposals that would reduce HOPD drug administration services to a site-neutral payment rate would reduce payments by $3.0 to $3.8 billion over the next 10 years. If these proposals are enacted, hospitals in Missouri are estimated to encounter $49 million in Medicare payment reductions.

> The House Committee on Energy and Commerce marked-up and unanimously passed out of committee the PATIENT Act (H.R. 3561). If enacted, section 302 would cut Medicare payments for drug administration services provided at off-campus HOPDs. MHA urges members of Congress to block the advancement of section 302 of the PATIENT Act.
>
> The House Committee on Ways and Means marked-up and passed out of committee the Health Care Price Transparency Act (H.R. 4822). If enacted, section 203 of the legislation would cut Medicare payments for drug administration services provided at off-campus HOPDs. The proposal would delay the implementation for rural and cancer hospitals for one year. MHA urges members of Congress to block the advancement of section 203 of the Act.

Legislation that would reduce all non-evaluation and management services provided by a grandfathered HOPD would reduce Medicare payments by $31.2 billion over the next 10 years, of which $800.8 million in reductions would occur in Missouri hospitals.

> Senator Sanders (I-Vt.) has released the Primary Care and Health Workforce Expansion Act discussion draft that would prohibit hospitals from charging facility fees in the commercial market for all services in off-campus HOPDs and many services in on-campus HOPDs. Of the current site-neutrality proposals, this legislation contains the largest amount of potential payment reductions and would create significant operations issues for both hospitals and clinicians. MHA urges members of the Senate Health, Education, Labor and Pensions Committee and members of Congress to block the advancement of the legislation.

PRESERVE AND PROTECT THE 340B PROGRAM

The 340B Drug Discount Program was enacted in 1992 and last expanded in 2019 to allow safety net providers to obtain discounts for certain drugs. It also requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to those providers. The law enables eligible hospitals (rural and urban) that serve large numbers of low-income patients to stretch scarce federal resources and provide more comprehensive care to their patients and communities. Sixty-nine Missouri hospitals currently are participating in the 340B program.

Issue

The 340B program long has been under attack by pharmaceutical manufacturers that implement unilateral policies to restrict the number of eligible entity contract pharmacies. Eligible hospital entities in Missouri currently utilize approximately 846 contract and child site pharmacies. Actions taken by drug manufacturers to restrict the use of contract pharmacies not only are problematic for eligible entities, but also for patients. Patients who live in rural communities often need to travel for hospital care. Once the patient returns home, access to outpatient drugs often is obtained from local pharmacies. When the manufacturer restricts the use of contract pharmacies, rural patients are required to travel a significant distance to obtain outpatient drugs from a contract pharmacy permitted by a manufacturer. Without Congressional direction, contract pharmacy policy will be left to the whims of manufacturers, resulting in a patchwork network of participating local pharmacies with some being permitted to dispense the 340B drugs of one manufacturer, but not the drugs of another. This only will create hardship and confusion for the patients cared for by 340B providers.

Implications

The 340B program does not cost the federal government anything while providing hospitals relief from high pharmaceutical and unreimbursed governmental payer costs. Even with the benefits of the 340B program, eligible Missouri hospitals located in rural areas realize very thin margins, averaging 0.4% in 2021. It is not uncommon for drug manufacturers to enjoy margins exceeding 20%, with some recently exceeding 30%. If pharmaceutical manufacturers succeed in reducing or eliminating 340B benefits, hospitals will be forced to make up the difference through cost-shifting onto commercial business and reducing services that benefit the community, all while pharmaceutical manufacturers realize even higher margins. The savings accrued to eligible hospitals are used to serve the communities and ensure patients have access to high quality care. When manufacturers are allowed to restrict those benefits, those dollars leave local communities and accrue to out-of-state drug companies.

Previous Actions

Although the Health Resources and Services Administration wrote strong letters reiterating its opposition to the pharmaceutical manufacturers' attacks, the agency has limits on its regulatory authority over 340B. The 117th Congress sent 'Dear Colleague' letters that urged 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.

Recent Actions

Despite these unambiguous pronouncements regarding Congressional intent, the U.S. Court of Appeals for the Third Circuit recently issued a decision that upheld the lower court's finding that 340B drug manufacturers are not required to supply discounted medications to an unlimited number of contract pharmacies, adding that HHS incorrectly interpreted the law. While two other similar cases are pending decisions, Congressional action is needed to clarify the intent of the law so that 340B-eligible entities and contract pharmacies are protected.

Request for Action

Representative Matthew Rosendale (R-Mont.) introduced the Drug Pricing Transparency and Accountability Act (H.R. 198). If enacted, the bill would place a two-year moratorium on eligible providers from adding contract pharmacies. The bill also would include restrictions to reduce the number of current contract pharmacies. MHA opposes the proposed legislation and urges members of Congress to enact legislation that will preserve the savings intended for 340B-eligible entities by allowing eligible entities to utilize multiple contract pharmacies.

MHA supports the PROTECT 340B Act (H.R. 2534), introduced by Representative Abigail Davis Spanberger (D-Va.), that ensures the equitable treatment of covered entities and pharmacies participating in the 340B Drug Discount Program. MHA appreciates actions taken by Congressman Graves who recently signed on as a cosponsor to the PROTECT 340B act.

PRICE TRANSPARENCY REFORM IS NEEDED

Congress has enacted various laws that compel hospitals to become more transparent about charging practices and payment rates, most prominently the Patient Protection and Affordable Care Act and the Consolidated Appropriations Act of 2021. Based on these laws, various agencies have finalized numerous regulations that hospitals must follow which include IRS Section 501(R), CMS-1607-F, CMS-1694-F, CMS-1717-F2, CMS-1786-P, CMS-9909-IFC, CMS-9908-IFC and CMS-9900-NC. See the attached "Addendum — Transparency Requirements for Hospitals" that illustrates the complexity and volume of transparency laws and regulations hospitals must follow.

Issue

Congress and patients have desired health care price transparency for some time. MHA also has long supported price and quality transparency to the benefit of patients. Unfortunately, the majority of current laws and regulations do not provide the information that patients need, namely the amount of out-of-pocket expenses for which they will be responsible. The current laws and finalized regulations are more useful for academic studies, health care finance professionals and insurance companies, which use them to compare rates among peers. They also are extremely costly to administer and create unnecessary administrative burden due to the ever-changing and misaligned federal policies. More importantly, current laws rely heavily on data from hospitals, while insurers, pharmacy benefits managers, pharmaceutical manufacturers and other industry providers play a large role in the cost of care.

Request for Action:

MHA urges members of Congress to enact legislation that creates a single set of price transparency requirements for all health care services. Congress also is urged to enact legislation that would compel PBMs, insurers, pharmaceutical manufacturers, pharmacy aggregators and other medical supply chain stakeholders to be transparent in their costs and charges.

MHA acknowledges and appreciates Chairman Smith for introducing Sections 101, 102, 103, 104 and 105 within the Health Care Price Transparency Act (H.R. 4822). If enacted, these sections would codify hospital price transparency requirements, require the Government Accountability Office to report on the harmonization of transparency requirements and require Medicare Advantage Organizations to report about common ownership interests with health care providers, PBMs and pharmaceutical companies. The proposal also would extend transparency requirements to ambulatory surgical centers, certain imaging centers and services, clinical laboratory, certain health insurers and pharmacy benefit managers. Although Section 101 should be revised to align existing methods providers use to meet current rules, the bill would provide a significant amount of additional transparency into the largest stakeholders playing a key role in serving patients. MHA urges Congress to revise section 101 to allow price estimator tools to satisfy the consumer-friendly shoppable service transparency requirement.

ADDENDUM - TRANSPARENCY REQUIREMENTS FOR HOSPITALS

	Law	Regulation	Effective	Applies to	Requirements	Gross Charges	Patient Responsibility	Negotiated Payment Rate for All Insurers	Discounted Cash Price	De-identified maximum negotiated charge	De-identified maximum negotiated charge
Financial Assistance	Patient Protection and Affordable Care Act	IRS Section 501(R)		All tax-exempt hospitals under section 501(C)(3) including those that are government hospitals	Requires hospitals to (1) provide the basis for calculating amounts charged to patients, (2) disclose the method for applying for financial assistance and (3) provide internet accessible financial assistance program documents, (4) ensure the Financial Assistance Policy specifies all financial assistance availability, (5) the gross charges applicable to the discount and (6) limits the amount charged to ABG (amounts generally billed) for emergency or medically necessary care.	X			X		
CMS Regulation	Section 2718(e) of the Patient Protection and Affordable Care Act	CMS-1607-F	April 1, 2014	All nongovernmental hospitals (General Acute Care, Critical Access Hospital, Sole Community Hospitals, Psychiatric Hospitals and Rehabilitation Hospitals)	Required hospitals to either (1) make a public list of their standard charges updated annually or (2) policies for allowing the public to view a list of those charges in response to an inquiry.	X					
CMS Regulation - 1st Revision		CMS-1694-F	January 1, 2019		Revised to require hospitals (1) make available a list of standard charges for all items and services provided by the hospital to include DRGs if applicably, (2) must be updated annually or more often as appropriate, and (3)must be available to patients via the internet in a "machine-readable" format.	X					
CMS Regulation - 2nd Revision		CMS-1717-F2	January 1, 2021		Requires to provide two separate publicly available data sets. (1) All inpatient and outpatient services - requires hospitals to make available in a machine readable format payer-specific standard charge information for all items and services. (2) Requires hospitals to make available in a consumer-friendly format payer-specific standard charges for 300 shoppable services, of which CMS prescribed 70. Price estimator tools are deemed to meet this standard if standard charges are included.	X		X	X	X	X
CMS Regulation - 3rd Revision		CMS-1786-P	Proposed Rule January 1, 2024		Contains additional requirements that build upon CMS-1717-F2 regulations. requires hospitals to (1) utilize a standard template to satisfy machine-readable data requirements, (2) prescribes naming convention of files, (3) prescribes file format, (4) require hospitals to publish on internet a .txt file that contains the names of the machine readable files and other price transparency data.						
No Surprises Act	Consolidated Appropriations Act of 2021	CMS-9909-IFC	January 1, 2022	All providers	If a service is provided by to a patient that is treated in an out-of-network service for emergency care, the patient cannot be charged more than that provided by an in-network provider. Post stabilization care may be billed to the patient. Providers are required to provide a good faith estimate for items and services that the patient might incur while receiving additional services. Patient must sign the GFE.	X					
		CMS-9908-IFC	January 1, 2022	All providers	If a patient is uninsured, providers are required to provide a good faith estimate for the service. The GFE should consist of all items and services (including professional bills unrelated to hospital business).	X					
		CMS-9900-NC	TBD	All Providers and Insurers	For patients requesting a good faith estimate who are insured, the hospital will be required to submit an advanced claim to an insurer and the insurer will be required to issue an advanced explanation of benefits. The AEOB allows the patient to get an estimate of how much the patient will be responsible to pay out-of-pocket.	X	X	X			

HELP HOSPITALS ATTRACT AND RETAIN PHYSICIANS

Regardless of geographic location, all patients deserve access to quality health care. Currently, our country is facing a severe shortage of physicians across practices and specialties, especially in rural areas. In fact, the Health Resource and Services Administration show nearly every Missouri county qualifies as both a primary care and mental health provider shortage area. A consistent availability of newly trained and licensed clinicians will be critical to keeping pace with the growing need to serve an aging population.

Issue

Hospitals in Missouri spend enormous resources training clinicians. Much of the expense is reimbursed by Medicare through Direct Graduate Medical Education payments. Although these programs are beneficial, unfunded residency positions continue to exist — in Missouri, 30.2 percent of total residencies are not funded through Medicare DGME. MHA recognizes and appreciates the action taken during the 117th Congress for adding 1,000 Medicare-funded physician residency slots. CMS finalized rules and has begun awarding the additional residency slots to applicants, including a few Missouri hospitals. While MHA appreciates this action, more funded slots are needed.

Missouri's physician shortage is exacerbated by the fact that once physicians complete a residency program, many choose to relocate and practice medicine in other states. Policies and funding opportunities that are designed to keep residents practicing in Missouri are essential to preventing the practice of outmigration.

Request for Action:

Congress has introduced various proposals to help address clinician shortage. The following bills offer promise for expanding the availability of the health care practitioners on which Missouri communities rely. MHA urges Congress to enact legislation that will ensure a steady pipeline of clinicians in Missouri.

- Resident Physician Shortage Reduction Act (H.R. 2389/S. 1302), introduced by Representative Terri Sewell (D-Ala.) and Senator Robert Menendez (D-N.J.) would help address physician shortages by adding 14,000 Medicare-funded residency slots. MHA thanks Representative Cleaver for cosponsoring H.R. 2389.

- The Conrad State 30 and Physician Access Reauthorization Act (H.R. 4942/S. 665), introduced by Representative Bradley Scott Schneider (D-Ill.) and Amy Klobuchar (D-Minn.), would reauthorize the Conrad 30 program for three years and expand the number of waivers granted to each state. MHA thanks Representative Cleaver for cosponsoring H.R. 4942.

- Doctors in our Borders Act (H.R. 4875), introduced by Representative Michael Lawler (R-N.Y.), would increase the number limit of Conrad 30 waivers to 100.