MHA PROFILE OF MISSOURI HOSPITALS

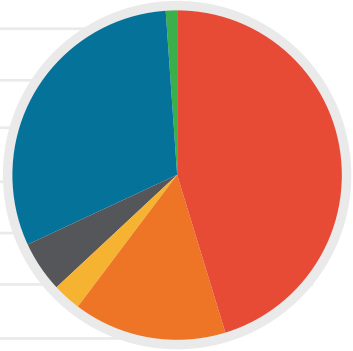
ALL HOSPITALS

139 MHA MEMBER HOSPITALS

64	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
28	for-profit organizations
108	tax-exempt organizations
68	private, not-for-profit organizations
30	state or local government acute care hospitals
6	psychiatric hospitals owned by the Department of Mental Health
3	free-standing children's hospitals

HOSPITAL PAYER MIX

- **45.8%** Medicare and Medicare Advantage
- **17.3%** Medicaid and Medicaid Managed Care
- **30.1%** Commercial and Managed Care
- **1.0%** Workers' Compensation
- **2.6%** Other Government
- **3.2%** Self-Pay



68.9% PERCENT OF BUSINESS REIMBURSING LESS THAN COST

OPERATING MARGIN

Percent of hospitals operating at a loss/gain.

42.9% ▼

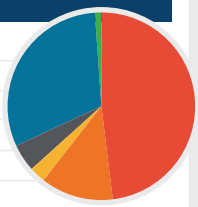
57.1% ▲

AVERAGE OPERATING MARGIN **2.4%**

URBAN

HOSPITAL PAYER MIX

- **48.8%** Medicare and Medicare Advantage
- **14.5%** Medicaid and Medicaid Managed Care
- **30.1%** Commercial and Managed Care
- **1.1%** Workers' Compensation
- **2.6%** Other Government
- **3.0%** Self-Pay



68.8% PERCENT OF BUSINESS REIMBURSING LESS THAN COST

OPERATING MARGIN

Percent of hospitals operating at a loss/gain.

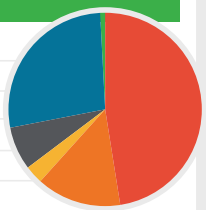
41.5% ▼ **58.5%** ▲

AVERAGE OPERATING MARGIN **1.1%**

RURAL

HOSPITAL PAYER MIX

- **49.5%** Medicare and Medicare Advantage
- **17.3%** Medicaid and Medicaid Managed Care
- **25.4%** Commercial and Managed Care
- **0.7%** Workers' Compensation
- **3.0%** Other Government
- **4.1%** Self-Pay



73.9% PERCENT OF BUSINESS REIMBURSING LESS THAN COST

OPERATING MARGIN

Percent of hospitals operating at a loss/gain.

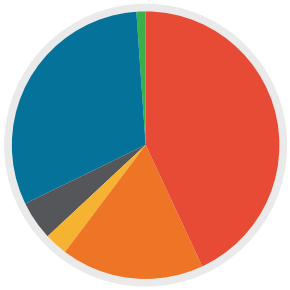
46.6% ▼ **53.4%** ▲

AVERAGE OPERATING MARGIN **2.8%**

Information is based on the 2022 Annual Licensing Survey Data.

PROFILE OF MISSOURI HOSPITALS

340B Urban & Rural



HOSPITAL PAYER MIX

- **46.6%** Medicare and Medicare Advantage
- **16.6%** Medicaid and Medicaid Managed Care
- **29.8%** Commercial and Managed Care
- **0.9%** Workers' Compensation
- **2.8%** Other Government
- **3.4%** Self-Pay

69.4% PERCENT OF BUSINESS REIMBURSING LESS THAN COST

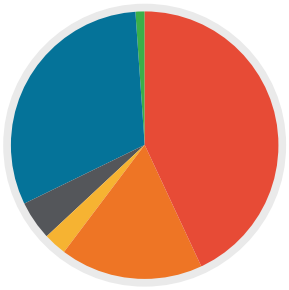
OPERATING MARGIN

Percent of hospitals operating at a loss/gain.

46.0% ▼ | **54.0%** ▲

AVERAGE OPERATING MARGIN **0.8%**

Inpatient Acute PPS



HOSPITAL PAYER MIX

- **48.9%** Medicare and Medicare Advantage
- **14.9%** Medicaid and Medicaid Managed Care
- **29.4%** Commercial and Managed Care
- **1.0%** Workers' Compensation
- **2.6%** Other Government
- **3.1%** Self-Pay

69.6% PERCENT OF BUSINESS REIMBURSING LESS THAN COST

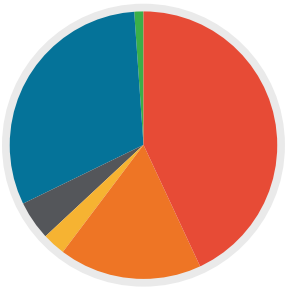
OPERATING MARGIN

Percent of hospitals operating at a loss/gain.

44.6% ▼ | **55.4%** ▲

AVERAGE OPERATING MARGIN **2.5%**

CAH



HOSPITAL PAYER MIX

- **49.1%** Medicare and Medicare Advantage
- **15.7%** Medicaid and Medicaid Managed Care
- **27.3%** Commercial and Managed Care
- **1.4%** Workers' Compensation
- **1.5%** Other Government
- **5.0%** Self-Pay

71.3% PERCENT OF BUSINESS REIMBURSING LESS THAN COST

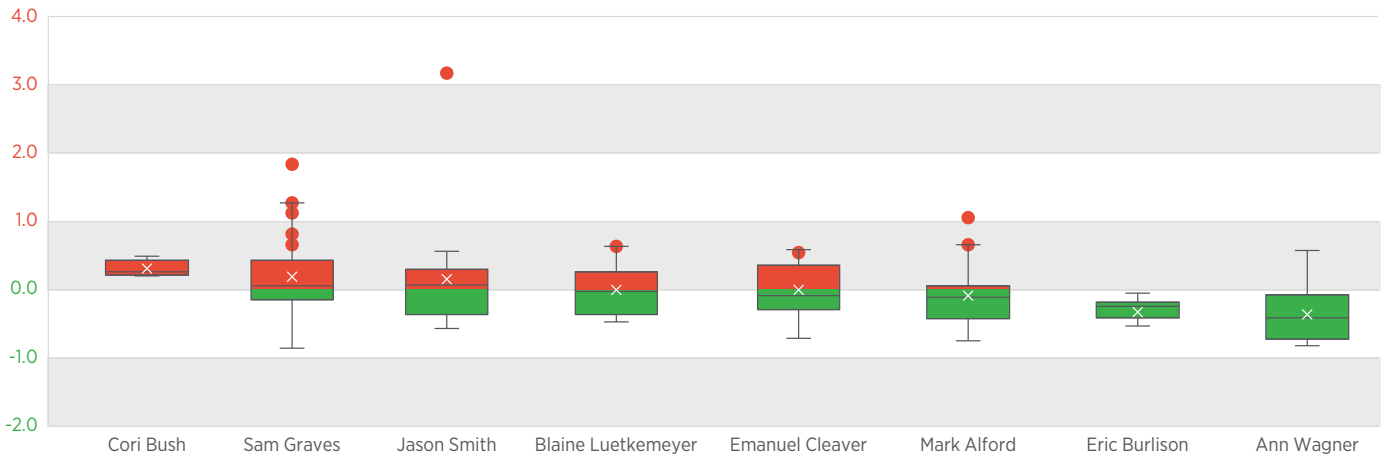
OPERATING MARGIN

Percent of hospitals operating at a loss/gain.

44.1% ▼ | **55.9%** ▲

AVERAGE OPERATING MARGIN **1.4%**

STRESS BY CONGRESSIONAL DISTRICT



Information is based on the 2022 Annual Licensing Survey Data.

STRENGTHEN THE 340B PROGRAM

The 340B Drug Pricing Program was enacted to allow eligible providers serving large numbers of low-income patients to realize savings on certain drugs by requiring pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to those providers. More than 60 Missouri hospitals are participating in the 340B program.

Issue:

The 340B program has been under attack for many years by pharmaceutical manufacturers through unilateral policies restricting the number of contract pharmacies a hospital may use. More recently, insurers are reducing payments for drugs purchased under the 340B program, violating agreed upon contractual rates. These tactics do nothing more than transfer the benefits intended for 340B-eligible providers onto manufacturers and insurers.

Implications:

The 340B program does not cost the federal government anything while providing hospitals relief from high pharmaceutical costs and unreimbursed governmental payer cost. Even with the benefits of the 340B program, eligible Missouri hospitals realize very thin margins, averaging 0.8% in 2022. It is not uncommon for drug manufacturers to enjoy margins exceeding 20% to 30%. Insurers also enjoy margins far exceeding that of 340B-eligible hospitals. If pharmaceutical manufacturers and insurers succeed in reducing or eliminating the 340B benefits, hospitals will be forced to increase cost-shifting onto commercial business and reduce services that benefit the community, while augmenting already healthy margins of pharmaceutical manufacturers and insurers.

Request for Action:

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. Despite urging by the 117th Congress that the U.S. Department of Health and Human Services take action, the lack of authority has led to ongoing litigation. Congressional action is needed to clarify the intent of the law so that 340B-eligible entities and contract pharmacies are protected.

» MHA **supports** the newly introduced **340B PATIENTS Act** (H.R. 7635), sponsored by Rep. Doris Matsui (D-Calif.), and Section 3 of the SUSTAIN 340B discussion draft circulating within the Senate. Both proposals would ensure contract pharmacy choice for patients served by the hospital.

» MHA **supports** the **PROTECT 340B Act** (H.R. 2534), sponsored by Rep. Abigail Davis Spanberger (D-Va.), that would, among other things, prohibit payers from lowering reimbursement for drugs purchased under the 340B program. It also would prohibit payers from unilaterally requiring certain claims identifiers or removing the provider from the payer's network solely because they participate in 340B. **MHA thanks Reps. Cleaver and Graves for signing the PROTECT 340B Act (H.R. 2534) as co-sponsors.**

THANK YOU

MEDICARE ADVANTAGE REFORM

Medicare beneficiaries have a choice to enroll in a traditional Medicare fee-for-service plan or a Medicare Part C plan, also known as Medicare Advantage. In 2021, the Centers for Medicare & Medicaid Services paid contracted MA plans approximately $403.3 billion, an increase of 47.2% since 2019. The amount paid to MA plans now is approximately twice that of total traditional Medicare payments sent to hospitals to care for patients. More than 50% of all Medicare beneficiaries in Missouri are enrolled in a Medicare Advantage plan.

Issue:

Nefarious actions from MA plans are causing significant financial hardship for hospitals. MA plans often pay less than traditional Medicare for equivalent services, create further payment reductions through routine denials, implement overly burdensome appeals processes, unilaterally impose site-of-service limitations and restrict inpatient transfers. MA plans are forcing hospitals to treat MA patients at a loss or cancel contracts. Neither solution is sustainable.

Actions:

Hospitals are not alone in voicing concerns about problematic MA practices. The U.S. Department of Health and Human Services Office of Inspector General has issued multiple reports listing concerns and recommendations. The OIG found that MA plans "sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules."

While MA plans continue to deny and downgrade coding on claims submitted by providers, they often intensified the claim data that enriches the plan. In a separate study, the OIG "raised concerns about the extent to which certain MA companies may have inappropriately leveraged both chart reviews … to maximize risk-adjusted payments." While the OIG issued recommendations, MA plans seemingly have ignored the guidance.

MedPAC now is publishing concerns about MA plans as well. In its March 2024 report to Congress, MedPAC found that "Medicare is paying more for MA than for comparable beneficiaries in FFS Medicare." The cumulative effect of these findings and constituent complaints has caused Congress to begin questioning benefits of the MA program.

Request for Action:

CMS recently finalized various medical necessity and prior authorization reforms. MA plans already are creatively interpreting the guidance, making the regulations inapt. Until Congress intervenes, MA plans seemingly will continue to act as if unregulated. MHA urges Congress to ensure that MA plans are fully compliant with CMS regulations and to enact legislation that clearly compels MA plans to follow traditional Medicare medical necessity and basic benefit coverage policies. Allowing MA plans to weaponize medical necessity to enrich themselves at the cost of Medicare beneficiaries is unconscionable.

» MHA **supports** the **No UPCODE Act** (S. 1002), sponsored by Bill Cassidy (R-La.), a bipartisan bill that prohibits plans from downcoding patient claims that lead to lower payments to hospitals and intensifying the coding to obtain higher payment rates from CMS.

BLOCK SITE-NEUTRALITY PAYMENT LEGISLATION

CMS requires providers to bill based on the costs incurred to treat Medicare beneficiaries, which include professional and facility expenses. Professional costs include the clinician's time to serve a patient while facility expenses include non-physician employees, supplies, physical plant and other supporting expenditures. Independent physicians receive payment to cover both the professional and facility expenses. In the hospital setting, the attending physician receives a lower payment rate for professional cost while the hospital is paid for the facility expenses. Hospitals providing services at sites off the main campus must bill for the facility expenses as an off-campus provider-based department, or hospital outpatient department.

Expenses in an independent clinic often are less than if the same service is provided in a hospital-based setting. Unlike stand-alone physician clinics, hospitals provide emergency services and are subject to EMTALA. They serve all patients regardless of their ability to pay. They maintain stringent infection control programs and backup services for complications that may arise, follow stringent environmental and safety standards and deploy disaster preparedness and response plans. These abundant regulatory requirements raise hospital costs, warranting a differential in the Medicare payment rate when services are provided in an HOPD.

Issue:

Congress first enacted site-neutrality policies in 2015, reducing Medicare outpatient PPS payments for services provided in certain HOPDs. Recent site-neutrality proposals would further reduce Medicare payments to hospitals. Medicare outpatient margins averaged -23.8% in 2021. Existing legislation to reduce Medicare rates for clinician-administered drugs would reduce payments by $3 to $3.8 billion throughout the next 10 years, costing Missouri hospitals an estimated $49 million in Medicare reimbursement. These cuts will jeopardize access to care.

Request for Action:

» MHA **opposes** the **Lower Costs, More Transparency Act** (H.R. 5378), sponsored by Rep. Cathy McMorris Rodgers (R-Wash.), which includes a site-neutrality payment adjustment for clinician administered drugs. This bill passed the House. **MHA thanks Representatives Burlison and Graves for voting in opposition to the bill.**

THANK YOU

» MHA **opposes** **similar provisions in section 302 of the PATIENT Act** (H.R. 3561), sponsored by Rep. Cathy McMorris Rodgers (R-Wash.), and **section 203 of the Health Care Price Transparency Act** (H.R. 4822), sponsored by Rep. Jason Smith (R-Mo.).

» MHA **opposes** the **SITE Act** (S. 1869), sponsored by Sen. Mike Braun (R-Ind.), which would reduce payments for all non-evaluation and management services provided by a grandfathered HOPD, resulting in Medicare payment reductions of $31.2 billion throughout the next 10 years, including an $800.8 million decrease to Missouri hospitals.

» MHA **opposes** the **Bipartisan Primary Care and Health Workforce Act** (S. 2840), sponsored by Sen. Bernie Sanders (I-Vt.), which would prohibit hospitals from charging for a variety of services when provided in hospital-based settings. Of the current site-neutrality proposals, this legislation threatens the largest payment reductions and would create significant operational issues for both hospitals and clinicians.

REINSTATE NECESSARY PROVIDER STATUS

The Medicare Critical Access Hospital designation was designed to address the financial vulnerability of rural hospitals while improving access to health care. The eligibility requirements to become a CAH include furnishing emergency care 24 hours per day, maintaining no more than 25 inpatient or swing beds, and maintaining an annual average length of stay of 96 hours or less per patient for acute inpatient care. Additionally, the facility must be located more than 35 miles from the nearest hospital. Congress previously has allowed states to deem a hospital as a 'necessary provider,' which waives the mileage eligibility restriction.

Issue:

According to the U.S. Department of Health and Human Services, 75% of all CAHs obtained such status as being deemed a necessary provider. In Missouri, all but one CAH achieved eligibility through a necessary provider designation. After Jan. 1, 2006, states no longer were allowed to grant necessary provider designations. For more than 18 years, the distance requirement has prevented hospitals that otherwise qualify from converting to a CAH when fiscally advantageous. Some of these facilities have either closed or ceased certain services to remain financially viable.

Request for Action:

MHA urges Congress to enact legislation that would once again allow states to designate hospitals as necessary providers and allow such status to exempt the hospital from the 35-mile rule.

MHA thanks those members of Congress who have introduced such language, including Rep. Sam Graves (R-Mo.).

THANK YOU

- » MHA **supports** **Section 114 of the Save America's Rural Hospitals Act** (H.R. 833), sponsored by Rep. Sam Graves (R-Mo.), which would allow states to designate hospitals as necessary providers.
- » MHA **supports** the **Rural Hospital Closure Relief Act** (S. 1571), sponsored by Sen. Richard Durbin (D-Ill.), that would revise CAH eligibility to small rural hospitals that serve a HPSA or a high number of low-income individuals, or Medicare or Medicaid beneficiaries, has experienced financial losses for two consecutive years, and attests to having a strategic plan to address financial solvency.
- » MHA **supports** the **Rural Health Care Access Act** (H.R. 1128), sponsored by Rep. Mark Green (R-Tenn.), which would remove the 35-mile rule.

ENSURE ACCESS THROUGH TELEHEALTH FLEXIBILITIES

Medicare beneficiaries have enjoyed unprecedented access to care through the telehealth waivers initiated during the COVID-19 public health emergency and extended to Dec. 31, 2024, through the Consolidated Appropriations Act of 2023. Patients in rural areas particularly have benefited from the ability to obtain routine medical treatment and follow-up care without the necessity of travel and wait times, resulting in better disease management, health outcomes and compliance with post-admission care.

Issue:

Section 1834(m) of the Social Security Act restricts telehealth services to Medicare patients living in certain rural areas who travel to an eligible originating site. Under the existing waivers, all Medicare beneficiaries, regardless of geographic location, can receive telehealth care in their homes. Additionally, certain services currently can be delivered using audio-only communication (telephone) and all eligible Medicare providers may provide telehealth services. The waivers remove the requirements for an in-person visit within six months of an initial mental health telehealth visit and allow Rural Health Clinics and Federally Qualified Health Centers to serve as distant site providers. These flexibilities will expire Dec. 31.

Request for Action:

Medicare patients have come to rely on telehealth flexibilities to ensure continuity of care. Hospitals and health systems have invested in systems and equipment to enhance the virtual care experience. These flexibilities have proven effective at providing safe and convenient care for millions of patients. Medicare beneficiaries and their providers need surety that this method of care will remain a viable option for the foreseeable future.

- » MHA **supports** the **Telehealth Modernization Act of 2024** (H.R. 7623), sponsored by Rep. Earl "Buddy" Carter (R-Ga.).
- » MHA **supports** the **CONNECT for Health Act of 2024** (H.R. 4189), sponsored by Rep. Mike Thompson (D-Calif.)/(S. 2016), sponsored by Sen. Brian Schatz (D-Hawaii).
- » MHA **supports** the **Medicare Telehealth Privacy Act** (H.R. 6364), sponsored by Rep. Troy Balderson (R-Ohio) that would shield the release of the telehealth practitioner's home address when a clinician provides the service at home.

These bills would extend existing flexibilities, ensuring continued access to safe, convenient care.

MHA thanks Rep. Blaine Luetkemeyer for co-sponsoring H.R. 4189 and Sen. Eric Schmitt for co-sponsoring S. 2016.

THANK YOU

ENSURE A STABLE WORKFORCE

A hospital's ability to care for its patients depends on the quality of staff, especially those on the front lines of care. According to the U.S. Bureau of Labor Statistics, the health care system will need 2.6 million more workers in the next eight years to accommodate demand. The current vacancy rate for nurses and nurses' assistants in Missouri is 17.4%, or 6,982 full-time equivalent positions. Due to current and future staffing demands, hospitals will be heavily reliant upon flexible staffing models to appropriately care for each patient's specific needs, and will require funding assistance to procure physicians.

STOP MANDATED NURSE STAFFING RATIOS AND LIMITS TO NURSING OVERTIME

Issue:

When lawmakers and regulators interfere with the hospital's ability to develop staffing models by mandating minimum staffing requirements and limiting nursing overtime, patient access to care will suffer.

Request for Action:

CMS has proposed minimum staffing ratios for nursing facilities based on a premise that this will ensure quality care. In fact, introducing a cookie-cutter approach of arbitrary minimum staffing requirements during a time of widespread staffing shortages is likely to result in large numbers of facility closures, particularly in rural areas. The number of patients for whom a nurse can provide safe, competent and quality care is dependent upon the specific needs of each patient. These factors include acuity, institutional resources, nurse training and experience, caregiver support and environmental factors. Providers are in a better position to determine appropriate staffing based on the needs of each patient. The final rule has been sent to the Office of Management and Budget, but not yet released.

» MHA **opposes** the imposition of minimum staffing levels, which have numerous unintended consequences, especially in rural settings. These include decreased access to inpatient beds, higher costs of care, additional staffing pressures and stifled innovation. The proposal will not improve quality of care or safety for patients and providers, nor will it reduce cost.

» MHA **supports** the **Protecting America's Seniors' Access to Care Act** (H.R. 7513), sponsored by Rep. Michelle Fischbach (R-Minn.) that would prohibit the Secretary of Health and Human Services from finalizing the proposed minimum staffing rule and establish an advisory panel on the skilled nursing facility workforce.

Legislation has been introduced to limit the number of overtime hours certain providers can mandate a nurse to work. If CMS finalizes minimum staffing rules and workforce shortages continue, overtime hours will be needed to serve patient demands. The cost of increasing staff while reducing overtime hours will force institutional providers to close beds and units.

» MHA **opposes** H.R. 7546, sponsored by Rep. Doris Matsui (D-Calif.), and S. 3860, sponsored by Senator Jeff Merkley (D-Ore.), that would limit mandatory nursing overtime hours.

HELP HOSPITALS ATTRACT AND RETAIN PHYSICIANS

Issue:

Missouri hospitals spend an enormous amount of resources training clinicians. Much of that expense is reimbursed by Medicare through Direct Graduate Medical Education payments but unfunded residency positions exist. In Missouri, 30.2% of total residencies are not funded through Medicare DGME. MHA applauds the 117th Congress for adding 1,000 Medicare-funded physician residency slots, which have begun to be awarded, including in Missouri. While beneficial, 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 to other states. Policies and funding opportunities designed to keep residents practicing in Missouri are essential to preventing outmigration.

The Conrad 30 Waiver program is an important physician recruitment and retention tool, which waives the foreign residency requirement for physicians holding J-1 visas who agree to stay in the U.S. for three years to practice in federally designated underserved areas. MHA thanks Congress for extending the Conrad 30 Waiver program through the end of fiscal year 2024 in the recently enacted Further Consolidated Appropriations Act.

Request for Action:

Congress has introduced various proposals to address clinician shortages. The following bills would expand the availability of health care practitioners on which Missouri communities rely. MHA urges Congress to enact legislation that will ensure a steady pipeline of clinicians in Missouri.

» MHA **supports** the **Resident Physician Shortage Reduction Act** (H.R. 2389/S. 1302), introduced by Rep. Terri Sewell (D-Ala.) and Sen. Robert Menendez (D-N.J.), which would add 14,000 Medicare-funded residency slots. **MHA thanks Rep. Cleaver for co-sponsoring H.R. 2389.**

THANK YOU

» MHA **supports** the **Conrad State 30 and Physician Access Reauthorization Act** (H.R. 4942/S. 665), introduced by Reps. Bradley Scott Schneider (D-Ill.) and Amy Klobuchar (D-Minn.). This bill would reauthorize the Conrad 30 Waiver program for three additional years and expand the number of waivers granted to each state. **MHA thanks Reps. Cleaver and Luetkemeyer for co-sponsoring H.R. 4942.**

THANK YOU

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

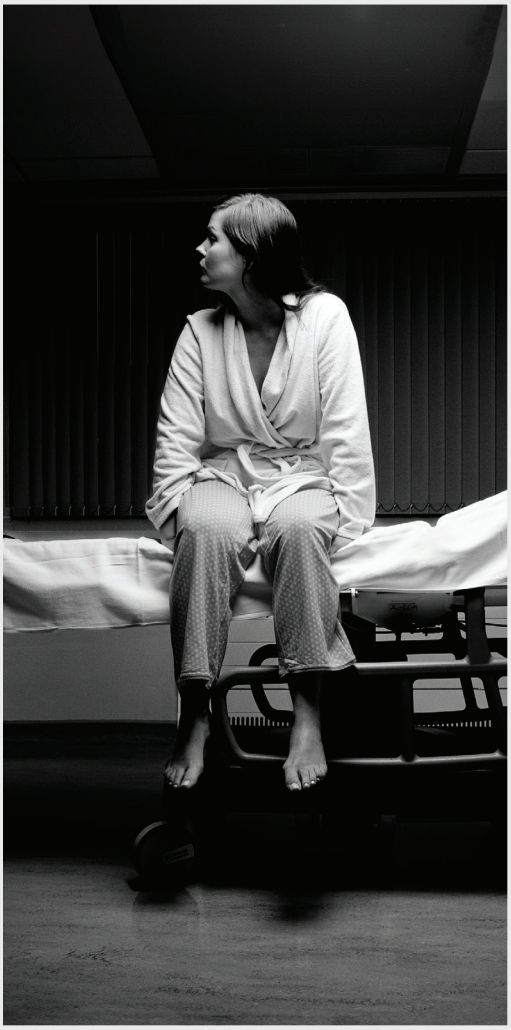
ADDRESS THE MENTAL HEALTH CRISIS

Approximately one in four American adults experience mental illness according to the Substance Abuse and Mental Health Services Administration. Half of them do not seek or receive treatment, citing access and affordability. Over 10% of children and adolescents report episodic depression that severely impairs their ability to function. Individuals suffering an acute mental health episode may seek treatment at a hospital but once stabilized, cannot find an appropriate setting for continued care. These patients end up "boarding" in hospitals for weeks or months at a time, for which the hospital receives no payment.

Issue:

Based on a survey by the Missouri Hospital Association, an estimated **40 Missouri youth** and **30 to 40 Missouri adults** who may have behavioral health disorders but are not in need of hospital care are **boarded in hospitals on any given day**. They are stuck in a system that doesn't have the capacity to care for them in the community, or appropriate psychiatric or residential treatment facilities.

- A 17-year-old female in state custody spent **339 days** boarded in a rural inpatient psychiatric hospital. During her stay she received no schooling. At times, the hospital was required to provide full-time 1:1 caregiver support. No residential treatment center would accept her, and she eventually aged out of care and received adult wrap-around services.
- A 14-year-old male with autism, intellectual disability and a history of aggression was boarded in an urban hospital for **180 days.** His lack of schooling and social interaction increased his aggression and caused caregiver burnout and retention challenges.
- A 39-year-old male with a developmental disability and a history of wandering was boarded at a rural hospital for **60 days.** Hospital staff struggled to find a place to accept him, even after sending 25 referral requests.
- An adult patient, who was deemed too risky for release by law enforcement despite not being charged with a crime, was boarded in an urban hospital for more than **90 days.**



Request for Action:

Funding is needed to increase capacity for community-based and residential treatment programs for individuals suffering from mental illness. Until that capacity exists, hospitals should be appropriately reimbursed for housing patients with nowhere else to go. Investments in inpatient psychiatric care are needed to boost the number of beds available to uninsured and underinsured individuals needing specialized treatment. States and individual communities should be incentivized to evaluate and address gaps in preventive care services so that individuals receive appropriate interventions before a behavioral health condition becomes acute.

- MHA **supports** the **Medicaid Bump Act** (H.R. 4892), sponsored by Rep. Paul Tonko (D-N.Y.), and companion bill S. 3921, sponsored by Sen. Tina Smith (D-Minn.), that would increase the Federal Medical Assistance Percentage for behavioral health expenses. Although this would provide some additional funding, more needs to be done.

- MHA **supports** the **SAVE Act** (H.R. 2584), sponsored by Rep. Larry Bucshon (R-Ind.), and companion bill S. 2768, sponsored by Sen. Joe Manchin (D-W.Va.), that would establish a new criminal offense for knowingly assaulting or intimidating hospital personnel.

- MHA **supports** the **Dr. Lorna Breen Health Care Provider Protection Reauthorization Act** (H.R. 7153), sponsored by Rep. Susan Wild (D-Pa.), and companion bill S. 3679, sponsored by Sen. Tim Kaine (D-Va.), that would extend the act through 2029. The Dr. Lorna Breen Health Care Provider Protection Act provides grants for activities to improve the mental and behavioral health among health care providers.