MHA ADVOCACY TRIP

Block Medicaid Disproportionate Share Funding Reductions

Issue

The Patient Protection and Affordable Care Act of 2010 called for significant cuts to Medicaid DSH payments beginning in 2014. MHA applauds Congress for enacting legislation that has reduced and/or delayed the implementation of these cuts, including recent action delaying the cuts until Jan.1, 2025. If the Medicaid DSH cuts occur, rural hospitals in Missouri will face significant funding decreases.

Impact

The total reduction in federally funded allotments is projected to be $8 billion in FFY 2025. According to the Medicaid and Children's Health Insurance Program Payment and Access Commission, Missouri's share of the payment reductions will be approximately $400 million per year.

Request for Action

MHA urges Congress to enact legislation, such as the Supporting Safety Net Hospitals Act (H.R. 2665), introduced by Rep. Yvette Clark (D-N.Y.) and referred to the House Committee on Energy and Commerce, and H.R. 9351, introduced by Rep. Nick LaLota (R-N.Y.) and referred to the House Committee on Energy and Commerce, that would block implementation of the Medicaid DSH funding cuts. **MHA thanks Rep. Emanuel Cleaver for co-sponsoring H.R. 2665.**

Extend Enhanced Medicare Low-Volume Payment Adjustments

Issue

Existing legislation to provide additional payments for rural hospitals with a low number of discharges will expire on Jan. 1, 2025.

Impact

If Congress does not act, 16 rural Missouri hospitals will receive payment reductions in Medicare inpatient PPS payments.

Request for Action

MHA urges Congress to enact legislation, such as the Rural Hospital Support Act (S. 1110), introduced by Sen. Bob Casey (D-Pa.) and referred to the Senate Committee on Finance and the Assistance for Rural Community Hospitals (ARCH) Act (H.R. 6430), introduced by Rep. Carol Miller (D-W.Va.) and referred to the House Committee on Ways and Means, that would permanently extend the enhanced Medicare low-volume payment adjustments. **MHA thanks Sen. Josh Hawley for cosponsoring S. 1110.**

Enact Legislation to Prevent Harmful Physician Fee Schedule Payment Cuts

Issue

Contrary to assertions that hospitals purchase independent practices to obtain higher Medicare PPS payments, several physicians recently told the Energy and Commerce Committee's Subcommittee on Health that Medicare PFS payment rate insufficiency is the root cause of clinicians selling or closing their practices. Section 1848(d)(19) of the Social Security Act mandates a 0.0% Medicare conversion factor rate increase through 2025. Subsequent legislative actions are reducing the update, causing negative rate adjustments. Until Congress fixes Medicare payments to physicians, private practices and physician offices owned by the hospital will continue to be strained and seek alternative means for higher reimbursement.

Impact

CMS now has proposed to reduce payments under the Medicare PFS by 2.8% in CY 2025 by removing the short-term conversion factor increase, applying a 0.0% increase as prescribed by statute and applying a 0.05% increase to account for budget neutrality adjustments.

Request for Action

MHA urges Congress to enact long-term legislation that provides yearly conversion factor increases, applied to the final prior year conversion rate. MHA supports the Physician Fee Stabilization Act (S. 4935), introduced by Sen. John Boozman (R-Ark.) and referred to the Senate Committee on Finance, that would increase the budget neutrality threshold and provide regular indexing to the Medicare Economic Index for 2026. MHA urges Congress to enact legislation that prevents the payment reductions that take effect in 2025.

Block Further Payment Cuts

Issue

MedPAC commented within its 2024 Report to Congress that overall Medicare fee-for-service margins in 2022 "declined over 5 percentage points to a record low of -11.6% when including the FFS Medicare share of federal coronavirus relief funds (and declined to -12.7% exclusive of these funds)." Payment rates from Medicare are inadequate and need to be improved.

Request for Action

As Congress works to enact an appropriations package for FFY 2025, MHA urges action to address the issues described above without additional provisions that further harm hospitals' financial viability. Specifically, MHA urges members of Congress to oppose the following.

- **Site-neutrality payments** — Congress has viewed site-neutrality policies as a means to pay for additional spending. Such policies would decrease hospital payment rates to a physician fee schedule rate. MHA opposes site-neutrality payment reductions.
- **Sequestration** — In prior years, Congress has used sequestration as a blunt instrument to fund Medicare payment extensions and prevent Medicaid DSH funding reductions. MHA urges Congress to end this practice and prevent further extensions of the sequestration.
- **Statutory PAYGO** — Congress enacted the Statutory Pay-As-You-Go Act of 2010 which requires mandatory spending reductions if the cost of legislation would increase the federal budget deficit over a 5- 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 4%. If PAYGO were to reduce Medicare payments, providers in Missouri would sustain an estimated $200 million in additional payment reductions. Although Congress has enacted legislation that would trigger PAYGO, Congress has always acted to waive the reductions, including the current waiver through 2024. MHA urges Congress once again to waive the reductions for 2025.

PROTECT AND PRESERVE THE 340B PROGRAM

Congress created the 340B Drug Pricing Program to protect specified safety-net providers from escalating drug costs. Certain safety-net hospitals are among the entities currently eligible to receive drug discounts — critical access hospitals, children's and cancer hospitals, sole community hospitals, rural referral centers and disproportionate share hospitals — which serve a disproportionate share of low-income patients. Most Missouri hospitals that qualify for 340B are DSH hospitals and CAHs.

Issue

The 340B program is under attack by commercial payers and drug manufacturers, that impose unilateral policy restrictions on covered entities' ability to avail themselves of discounted medications for their patients. The Health Resources and Services Administration oversees the program and has issued guidance stating that these practices violate the program's intent. HRSA lacks rulemaking authority and has limited enforcement authority, so insurers and drug companies largely have ignored its policy directives.

Insurance companies restrict access to 340B by attempting to retain the discounts for themselves, steering beneficiaries away from 340B-covered entities and restricting pharmacy networks that distribute discounted drugs. Drug manufacturers limit the program's benefit by restricting the number of contract pharmacies that a covered entity may use to dispense 340B medications. These practices limit patient access to medications they need and financially harm hospitals.

In the absence of congressional action, states have begun to pass measures protecting the entities for whom the program was enacted, including hospitals. Missouri is one of eight states to pass a law prohibiting manufacturers from limiting access to contract pharmacies. Pharmaceutical companies have sued to challenge those laws in at least eight states, with four lawsuits pending in Missouri, four in Kansas, three in Louisiana and two in Arkansas, despite the 8th Circuit Court of Appeals upholding the Arkansas law in a challenge dating back to 2021.

Request for Action

Congress must act to unequivocally state the intent of the 340B program, which is to pass the savings from discounted drugs on to the providers who are eligible to participate in the program. Please tell Big Pharma and commercial payers that they are endangering safety-net and small and rural providers in Missouri by enacting legislation that stops their unilateral attacks on the program, such as:

- The 340B PATIENTS Act (H.R. 7635), sponsored by Rep. Doris Matsui (D-Calif.) and referred to the House Energy and Commerce Subcommittee on Health.
- The PROTECT 340B Act (H.R. 2534), sponsored by Rep. Davis Spanberger (D-Va.) and referred to the House Energy and Commerce Subcommittee on Health and the House Committee on Ways and Means. **MHA thanks Reps. Emanuel Cleaver and Sam Graves for signing as co-sponsors.**

MEDICARE ADVANTAGE REFORM

Medicare beneficiaries may choose a traditional Medicare fee-for-service plan or a Medicare Part C plan, also known as Medicare Advantage. In 2022, CMS paid contracted MA plans approximately $466.7 billion, an increase of 100.6% since 2018. MA plans now receive approximately 2.2 times that of total traditional Medicare payments for hospital care. More than 50% of all Medicare beneficiaries in Missouri are enrolled in a MA plan.

Issue

Nefarious actions by MA plans are causing hospitals significant financial hardship. MA plans often pay less than traditional Medicare for equivalent services, reduce payments through routine denials, implement overly burdensome appeals processes, unilaterally impose site-of-service limitations and restrict inpatient transfers. MA plans also use tactics that delay patient discharges by refusing to authorize appropriate post-discharge services. The frequency of these extended patient stays is reducing empirical Medicare DSH payments and can jeopardize 340B eligibility. MA plans are forcing hospitals to accept these conditions or cancel contracts. Neither solution is sustainable.

MA plans also engage in tactics solely intended to enrich the insurer. While denying claims and downgrading coding, they frequently intensify the claim data to enrich the plan. Since MA insurers receive case rates that are adjusted for the clinical complexity of each covered beneficiary, insurers routinely add diagnosis codes that intensify the complexity of managing the care which increases the capitated payment rate. MA plans also use artificial intelligence to assign diagnosis codes after the fact without the knowledge of a treating physician or the patient to further this conduct.

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 raising red flags over MA plans, even finding they "sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules."[1] In a separate study, the OIG expressed concerns that some MA plans may have "inappropriately leveraged" chart reviews to maximize the risk-adjusted payments they receive from CMS.[2] While the OIG issued recommendations to stop the practice, MA plans have seemingly ignored the guidance. In its March 2024 report to Congress, MedPAC also expressed concerns about escalating costs, noting 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 MA reforms, which are being creatively interpreted by the plans. Until Congress intervenes, MA plans 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 them 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), introduced by Sen. Bill Cassidy (R-La.) and referred to the Senate Committee on Finance. This bipartisan bill prohibits plans from downcoding patient claims to pay hospitals less and intensifying the coding to obtain higher payment rates from CMS.

MHA also urges Congress to enact the Improving Seniors' Timely Access to Care Act (H.R. 8702), introduced by Rep. Mike Kelly (R-Pa.) and referred to the House Committee on Energy and Commerce and the House Committee on Ways and Means and (S. 4532), introduced by Sen. Roger Marshall (R-Kan.) and referred to the Senate Committee on Finance, that would streamline MA prior authorization requirements to promote uniformity in process and increase the specificity of prior authorization data reported by plans. **MHA thanks Reps. Cori Bush and Emanuel Cleaver and Sens. Josh Hawley and Eric Schmitt for co-signing the legislation.**

Endnotes

[1] OIG Report: Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (OEI-09-18-00260) (hhs.gov)

[2] OIG Report: Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments, OEI-03-17-00474 (hhs.gov)

REINSTATE NECESSARY PROVIDER STATUS TO AID RURAL HOSPITALS

The Medicare Critical Access Hospital designation was designed to address the financial vulnerability of rural hospitals while improving access to health care. To become a CAH, a hospital must furnish 24-hour emergency care, have no more than 25 inpatient or swing beds and maintain 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 allowed states to deem a hospital a "necessary provider," which waives the mileage eligibility restriction.

Issue

According to the HHS, 75% of all CAHs attained such status through a necessary provider designation. In Missouri, all but two CAHs achieved eligibility in this manner. 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 and supports the following bills:

- Section 114 of the Save America's Rural Hospitals Act (H.R. 833), introduced by Rep. Sam Graves (R-Mo.) and referred to the House Energy and Commerce Subcommittee on Health, the House Committee on Ways and Means and the House Budget Committee. **MHA thanks Rep. Graves for his support and leadership on this issue.**
- The Rural Hospital Closure Relief Act (S. 1571), introduced by Sen. Dick Durbin (D-Ill.) and referred to the Senate Committee on Finance.
- The Rural Health Care Access Act (H.R. 1128), introduced by Rep. Mark Green (R-Tenn.) and referred to the House Committee on Ways and Means.

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. Data from the HRSA show nearly every Missouri county qualifies as both a primary care and mental health provider shortage area. A consistent supply 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 — equating to approximately 30% of total residencies in Missouri 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. Still, 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), introduced by Rep. Terri Sewell (D-Ala.) and referred to the House Committee on Ways and Means and the House Energy and Commerce Subcommittee on Health, and (S. 1302), introduced by Sen. Bob Menendez (D-N.J.) and referred to the Senate Committee on Finance. This act would help address physician shortages by adding 14,000 Medicare-funded residency slots. **MHA thanks Reps. Cori Bush and Emanuel Cleaver for co-sponsoring H.R. 2389.**
- The Conrad State 30 and Physician Access Reauthorization Act (H.R. 4942), introduced by Rep. Brad Schneider (D-Ill.) and referred to the House Committee on the Judiciary, and (S. 665), introduced by Sen. Amy Klobuchar (D-Minn.) and referred to the Senate Committee on the Judiciary, which would reauthorize the Conrad 30 program for three years and expand the number of waivers granted to each state. **MHA thanks Reps. Emanuel Cleaver and Blaine Luetkemeyer for co-sponsoring H.R. 4942.**
- Doctors in our Borders Act (H.R. 4875), introduced by Rep. Mike Lawler (R-N.Y.) and referred to the House Committee on the Judiciary, which would increase the limit on Conrad 30 waivers from 30 to 100 per state.

Key Priorities for the 118th Congress

ACTION:
Enact legislation to block implementation of the Medicaid DSH funding cuts.

PROPOSED LEGISLATION:
Supporting Safety Net Hospitals Act (H.R. 2665) and H.R. 9351

IMPLICATIONS:
Congress has enacted legislation to delay the Medicaid DSH cuts through Dec. 31, 2024. **If Congress does not intervene, the Missouri share of the payment reductions will be approximately $400 million per year.**

PROJECTED REDUCTION TO TOTAL OPERATING REVENUE

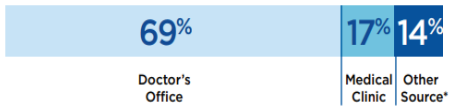
Rural	Urban	Total
2.4%	1.1%	1.9%

ACTION:
Enact legislation to prevent harmful physician fee schedule payment cuts.

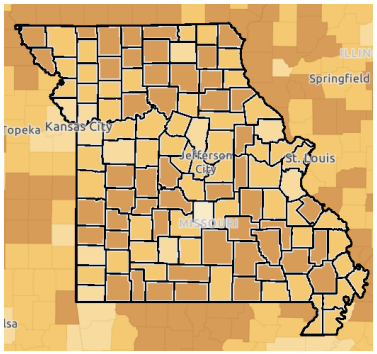
PROPOSED LEGISLATION:
The Physician Fee Stabilization Act (S. 4935)

IMPLICATIONS:
CMS has proposed to reduce payments under the Medicare physician fee schedule by 2.8% in CY 2025. **This will lead to further clinic consolidation practices.**

USUAL SOURCE OF CARE*



(*Includes Other Clinic/Healthcare Center, Hospital-Outpatient, ED, Managed Care Center)



Population Age 65+, Percent by County, ACS 2018-22

- Over 20.0%
- 16.1 - 20.0%
- 12.1 - 16.0%
- Under 12.1%
- No Data or Data Suppressed

ACTION:
Enact legislation to extend the enhanced Medicare low-volume payment adjustments.

PROPOSED LEGISLATION:
Rural Hospital Support Act (S. 1110) and the Assistance for Rural Community Hospitals (ARCH) Act (H.R. 6430)

IMPLICATIONS:
Congress has enacted legislation to delay the Medicaid DSH cuts through Dec. 31, 2024.
If Congress does not intervene, 16 rural Missouri hospitals will receive reductions in Medicare inpatient PPS payments.

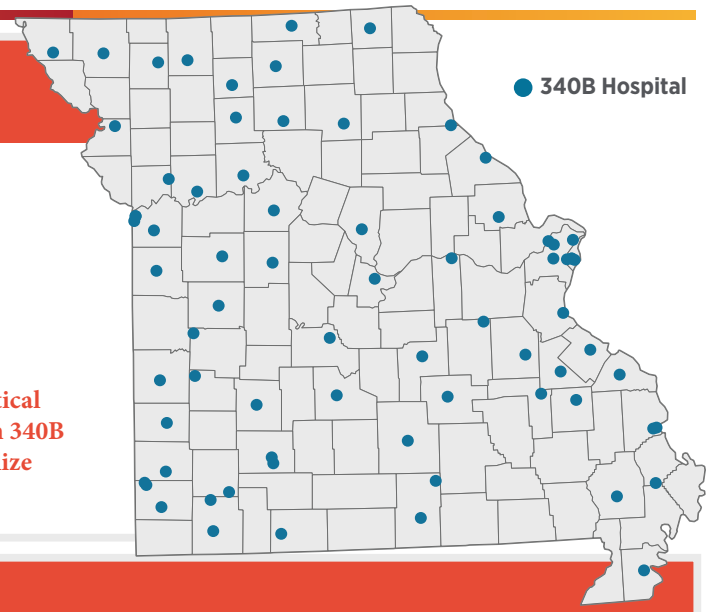
	2019-2024	Unless Congress Intervenes, 2025+
Road miles from nearest like hospital	15	25
Discharge Limit	3,800 ***total*** discharges	200 ***total*** discharges
Payment Adjustment	If 500 or less total discharges, 25% increase for Medicare discharges	If 200 or less total discharges, 25% increase for Medicare discharges
	If > 500 total discharges, the percent increase per Medicare discharge is calculated as follows: [(95/330) (number of total discharges/13,200)]	N/A

ACTION:
Enact appropriations or continuing resolution packages without harming rural hospitals by cutting payments.

MHA opposes:
- » Continued use of sequestration as a 'pay for' mechanism
- » Implementation of the Statutory PAYGO that would reduce Medicare payments by 4% or approximately $200 million per year
- » Enacting site-neutrality policies that will continue to increase rural hospital fiscal instability

MHA supports improving Medicare payment rates:
- » If Medicare payment rates do not improve, hospital Medicare margins will continue to be stressed. MedPAC commented within its 2024 Report to Congress that overall Medicare fee-for-service margins in 2022 "declined over 5 percentage points to a record low of -11.6%."

ACTION:
Congress must act to unequivocally protect and preserve the 340B program.



STATE ACTION:
The Missouri General Assembly enacted a new law that prohibits manufacturers from restricting the number of contract pharmacies a hospital can use. Although the law will help provide contract pharmacy protections, the law does not grant 340B payment parity protections. Pharmaceutical companies now are filing lawsuits to prevent the law from allowing any contract pharmacy to obtain 340B pricing.

PROPOSED LEGISLATION:
The 340B PATIENTS Act (H.R. 7635) and the PROTECT 340B Act (H.R. 2534) would ensure the use of contract pharmacies that provide medications to patients located in rural areas and would provide parity for drugs purchased under the 340B program.

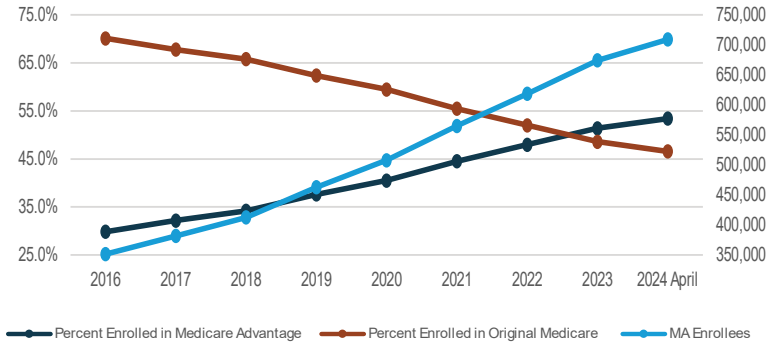
IMPLICATIONS:
Insurance companies and pharmaceutical manufacturers will continue to siphon 340B proceeds that will continue to destabilize rural hospitals' fiscal stability.

ACTION:
Protect rural hospitals from nefarious Medicare Advantage insurer policies.

PROPOSED LEGISLATION:
MHA supports the Improving Seniors' Timely Access to Care Act (H.R. 8702) and S. 4532 that would streamline MA prior authorization requirements to promote uniformity in process and increase the specificity of prior authorization data reported by the plans.

IMPLICATIONS:
If unchecked, MA plans will continue to restrict patient access and cause unnecessary fiscal harm to rural hospitals while costing CMS more.

Medicare Beneficiary Enrollment



ACTION:
Help struggling rural hospitals by reinstating necessary provider status.

PROPOSED LEGISLATION:
MHA supports Section 114 of the Save America's Rural Hospitals Act (H.R. 833), the Rural Hospital Closure Relief Act (S. 1571) and the Rural Health Care Access Act (H.R. 1128).

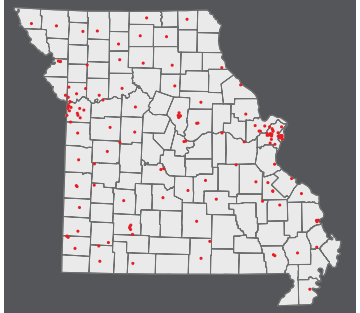
IMPLICATIONS:
Without necessary provider status, certain hospitals will have limited options for restructuring how Medicare pays for services that can lead to hospital closure. Enacting legislation that allows states to issue necessary provider status will help ensure stability and survival of struggling small rural hospitals.

ACTION:
Help hospitals attract and retain physicians.

PROPOSED LEGISLATION:
MHA supports the Resident Physician Shortage Reduction Act (H.R. 2389 and S. 1302) that would increase Medicare-funded residency slots by 14,000, the Conrad State 30 and Physician Access Reauthorization Act (H.R. 4942 and S. 665) that would reauthorize the Conrad 30 program for three years while increasing the number of waivers granted to each state, and the Doctors in our Borders Act (H.R. 4875) that would increase the limit on Conrad 30 waivers from 30 to 100 per state.

IMPLICATIONS:
Enacting legislation that increases Medicare-funded residency slots while reauthorizing and expanding the Conrad 30 program would help ensure a steady pipeline of clinicians to serve Missouri residents.

PROFILE OF MISSOURI HOSPITALS



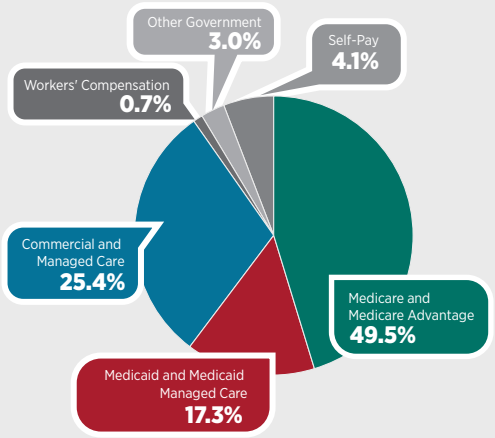
139
MHA MEMBER HOSPITALS

66
RURAL HOSPITALS

66	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
67	private, not-for-profit organizations
31	state or local government acute care hospitals
6	psychiatric hospitals owned by DMH

RURAL

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **73.9%**

OPERATING MARGIN

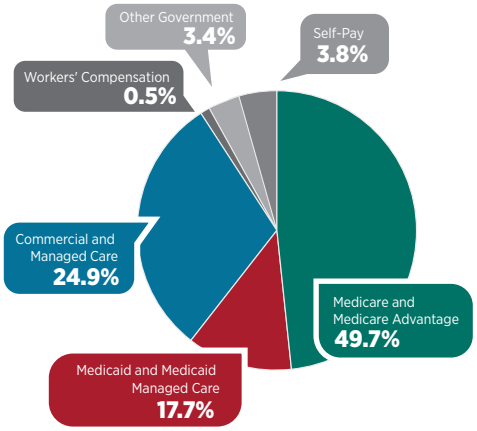
Percent of hospitals operating at a loss/gain

Average Operating Margin **2.8%**

Percent with negative margins	*Percent with Positive margins*
46.6% ▼	53.4% ▲

RURAL PPS

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **74.6%**

OPERATING MARGIN

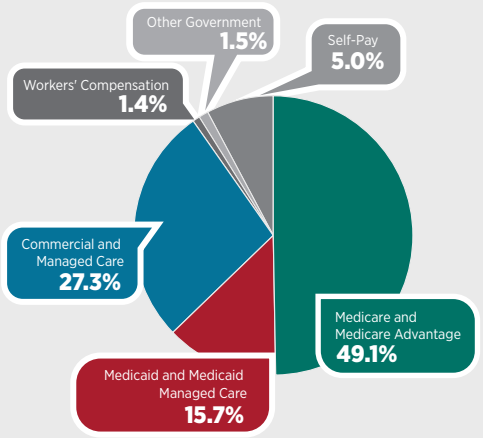
Percent of hospitals operating at a loss/gain

Average Operating Margin **4.8%**

Percent with negative margins	*Percent with Positive margins*
50.0% ▼	50.0% ▲

CAH

HOSPITAL PAYER MIX



PERCENT OF BUSINESS THAT REIMBURSES LESS THAN COST *(governmental and self-pay)* **71.3%**

OPERATING MARGIN

Percent of hospitals operating at a loss/gain

Average Operating Margin **1.4%**

Percent with negative margins	*Percent with Positive margins*
44.1% ▼	55.9% ▲

Information based on the 2022 Annual Licensing Survey