REDUCTION OF STATE MEDICAID DSH ALLOTMENTS

Current federal law calls for significant reductions in states' Medicaid Disproportionate Share Hospital allotments. The allotments are the state-specific amounts of federal matching funds for Medicaid DSH payments. Unless Congress affirmatively acts, the statutory reductions will take effect on October 1, 2019.

The total reduction in Medicaid DSH allotments is $4 billion for FY 2020. While the details of how CMS will distribute the payment loss among the states are uncertain, past regulations suggest that Missouri stands to lose $146 million. The following fiscal year, the national reduction in Medicaid DSH funding doubles to $8 billion. Missouri's share likely would be more than $300 million in FY 2021.

In Missouri, Medicaid DSH payments offset part of hospitals' cost of treating the uninsured. The state share of DSH payments is funded solely by the state hospital provider tax.

Missouri's uninsured rate was 9.1 percent in 2017, the most recent data available. This is well above the majority of states. Uncompensated care costs in Missouri's hospitals grew substantially from 2013 to 2017, topping out at $1.42 billion.

Originally imposed by the Affordable Care and Patient Protection Act of 2010, the Medicaid DSH allotment reductions were to begin in 2014 in conjunction with expanded coverage. The premise underlying them is that the Affordable Care Act would expand coverage and reduce the number of uninsured Americans, eliminating some of the need for federal Medicaid DSH payments to offset hospitals' uninsured costs. Instead, the money could be used to offset some of the cost of expanded coverage. When the U.S. Supreme Court struck down the ACA's mandate for states to expand eligibility for their Medicaid programs, Missouri was one of the states that opted to reject the expansion. Hospitals in Missouri and other nonexpansion states are facing big Medicaid DSH payment cuts with no offsetting coverage benefit.

Congress has delayed the Medicaid DSH allotment reductions four times, in 2013, 2014, 2015 and 2018. With each delay, Congress has extracted more savings from hospital payments.

Missouri has a relatively large Medicaid DSH allotment, and its distribution system directs Medicaid DSH payments to many hospitals. The scheduled cuts, therefore, are particularly ominous for Missouri.

The attached chart shows the projected effect of the Medicaid DSH cuts on Missouri hospitals in the first year of implementation, FY 2020. For each affected hospital, the projected amount of DSH payment loss is calculated as a percentage of that hospital's Medicaid revenue. The data are grouped by percentages, with the number of hospitals in each group.

The House Energy and Commerce Committee approved legislation (H.R. 2328) which delays the Medicaid DSH allotment cuts for two years, until FY 2022.

MHA urges the Missouri congressional delegation to take action to block or delay these Medicaid DSH reductions. Nothing has occurred to make the DSH allotment reductions more justifiable in October 2019 than they were when Congress enacted its previous delays.

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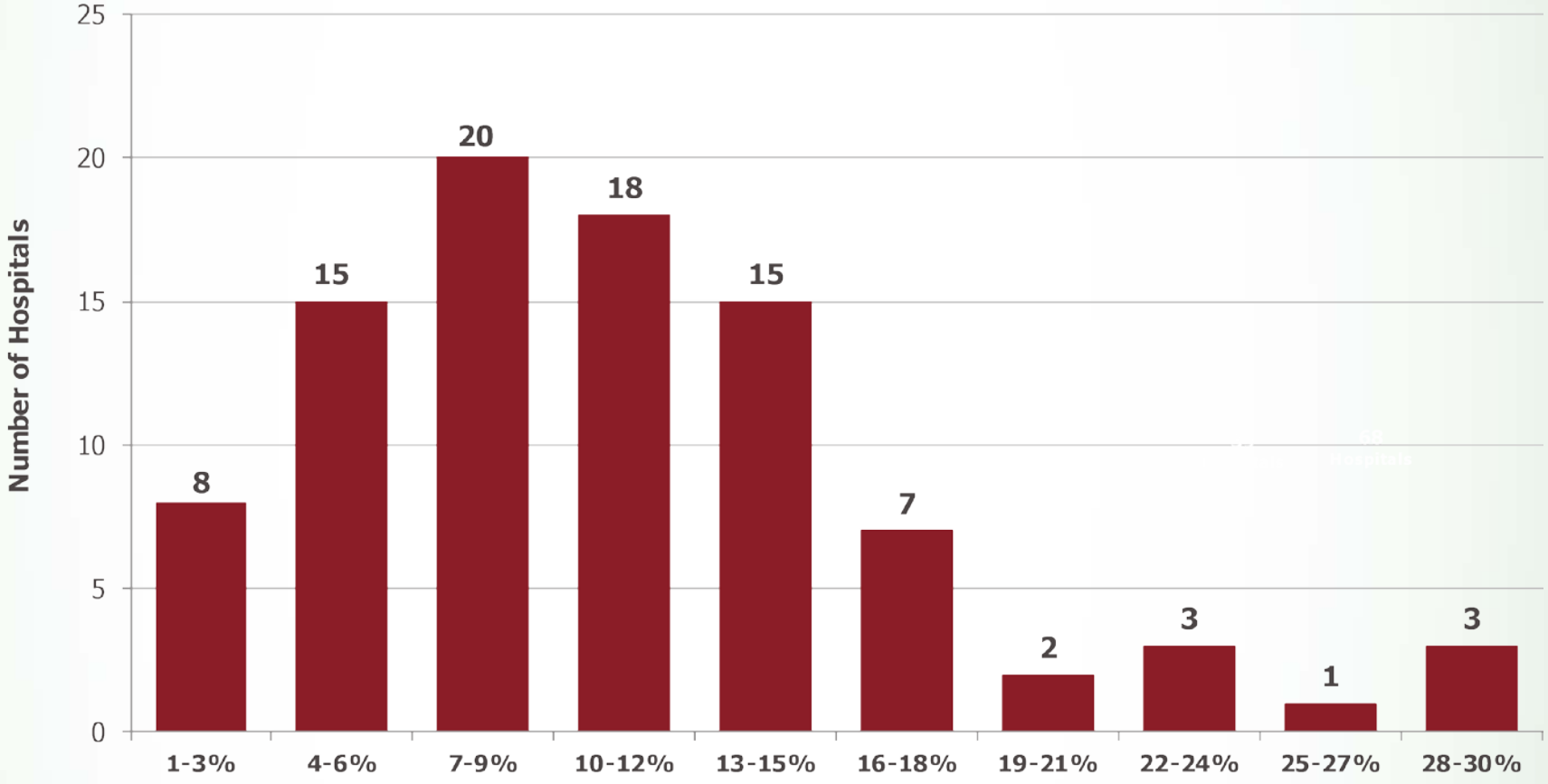
Each Hospital's Estimated SFY 2020 DSH Allotment Reduction As A Percent of Medicaid Revenue



Notes:

1. *Medicaid's share of the SFY 2019 taxable revenue was determined using the 4th prior year cost report.*
2. *The estimated SFY 2020 DSH allotment reduction was calculated using the methodology outlined in the Centers for Medicare & Medicaid Services' July 28, 2017 , regulation that suggested Missouri's share of the allotment reduction would be approximately 4.7 percent.*
3. *Each hospital's SFY 2019 uncompensated care cost was divided by the total UCC (excluding the Institutions of Mental Disease) to arrive at each hospital's share of the DSH allotment reduction.*

SURPRISE BILLING

The Health Subcommittee of the House Energy and Commerce Committee and the Senate Health, Education, Labor and Pensions Committee have been grappling with how to mitigate the negative effects of "surprise billing" by physicians or other practitioners who do not participate in a provider network covered by the patient's insurer. Several bills have been introduced with provisions that include patient notification of nonemergency care services received within an in-network hospital by an out-of-network provider, force out-of-network providers to accept a benchmark payment rate, provide protection to patients from being balanced billed and create grants for states looking to develop or maintain an all-payer claims database.

The Missouri Hospital Association has long supported legislation to address concerns about surprise billing. In 2018, MHA was instrumental in negotiating new state-enacted surprise billing legislation. In 2019, the Missouri General Assembly once again tweaked the law to ensure that participation is mandatory. The legislation protects the patient from surprise bills that occur for emergency services that are performed by an out-of-network practitioner within an in-network institutional provider. The legislation also creates a platform for the insurer and practitioner to negotiate and, if needed, enter into a binding arbitration process to determine a fair payment rate.

The Missouri state law is workable and well-regarded. To that end, **MHA urges Congress not to supersede or undermine state laws that provide a baseline level of protection for the patient.**

As Congress continues to introduce and debate possible legislative proposals, MHA urges Congress to oppose legislation that would mandate a government-directed payment rate. **Rather than be settled by government intrusion into private-sector negotiations, we believe that health care providers and insurers should be allowed to negotiate an appropriate payment rate, to be resolved if necessary, by a system of binding arbitration.**

MHA also asks Congress to reject legislative requirements that are easy to write but extremely complex to do, such as compelling hospitals to inform every patient of each practitioner's status in the patient's particular insurance plan and its provider network. This information commonly is beyond the hospital's knowledge or control. It also is not possible for hospitals to know who will be treating the patient while in the hospital. As an example, if the patient needs a lab test performed, the lab specimen often is not read by a lab pathologist until days later. Notifying the patient of a practitioner's network status is simply unworkable.

We thank Congress for looking into concerns about surprise billing and look forward to working with the Missouri congressional delegation to ensure that the patient is protected, appropriate processes are created to safeguard proper payment rates and federal law does not supersede comparable state laws.

REAUTHORIZATION OF NURSING WORKFORCE DEVELOPMENT PROGRAMS

The *Title VIII Nursing Workforce Reauthorization Act* is pending in Congress. It reauthorizes and refines this important federal funding stream for educating nurses. Currently, federal funding authorization has lapsed.

The current program allows for educational loan forgiveness to promote the development of nurse educators. Shortages of nurses nationally and in Missouri are exacerbated by nursing faculty shortages. The cost of pursuing graduate and doctoral degrees in nursing, coupled with nursing faculty salaries that have not kept pace with those of direct care clinicians, make it difficult to justify a career in nursing education. Without faculty, nursing education programs are unable to train all of the potential students who want and are qualified to enter nursing school.

The pending legislation also funds scholarship programs to enable economically challenged individuals to pursue a nursing career. Title VIII also supports nurses who want to pursue advanced practice and doctoral degrees.

The House Energy and Commerce Committee approved H.R. 728 in July. It not only provides funding authorization through 2024, but also streamlines and modernizes the programs.

The Missouri Hospital Association encourages the members of the Missouri congressional delegation to support and cosponsor the Title VIII Nursing Workforce Reauthorization Act. (H.R. 728, S. 1399)

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Health Care Workforce Challenges

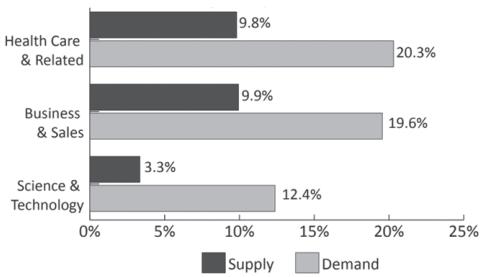
- Nearly all Missouri hospitals are experiencing high rates of vacant positions for nurses and other critical positions.
- In Missouri, an aging physician and nursing workforce and an older and sicker populace highlight the need to recruit or train and retain practitioners, especially in rural areas.
- In the interstate competition for practitioners, state policies can be important. Liability, practice standards that allow full use of capabilities and telemedicine are a few examples.

56,919 projected job openings in the top health care occupations from 2014-2024[1]

LARGEST GAPS

Missouri Labor Supply and Demand 2016

Online job ad **demand** for labor in **Health Care & Related** fields **is high** throughout the state, while the **supply of job seekers pursuing these jobs is low.** There are several opportunities for job seekers to obtain employment in the **Health Care & Related** occupations, even at lower skill levels.[1]



A Snapshot of Missouri's Licensed Primary Care Physicians

	2011		2014	
	Rural	Metro	Rural	Metro
Number of ALL licensed physicians	1,646	12,379	1,402	13,446
Number of licensed primary care physicians in Missouri (PCP)	859	4,639	789	5,201
Percent of physicians who are primary care (PCP)	52%	37%	56%	38%
Average age of ALL physicians	53	51	56.4	54.5
Percent of ALL physicians age 50 and older	62%	53%	68%	61%

- Missouri has 267 active physicians per 100,000 population, which ranks 24 of the 50 states – the state median is 257.6.[1]
- However, there are 87 active primary care physicians per 100,000 population, which ranks 28 of the 50 states – the state median is 90.8.[1] Primary care physicians are essential to provide care in rural Missouri.[2]
- Among practicing physicians in Missouri, 40 percent are older than 55. Physicians in rural Missouri are older than their urban counterparts by at least two years.[3]
- Missouri has 1,069.7 registered nurses per 10,000 population, which ranks 26 of the 50 states.[4]
- The average age of registered nurses in Missouri is 46.4, and 33 percent of working registered nurses are over age 55.[5]
- The nation is facing a shortage of nursing faculty to teach the next generation of nurses. The average ages of doctoral-prepared faculty is 57 years and master's-prepared faculty is 55.1 years.[6]

1 Missouri Economic Research and Information Center. Retrieved from https://www.missourieconomy.org/industry/ind_proj.stm
2 2017 American Medical Association Physician Masterfile, Dec. 31, 2016.
3 Missouri Board of Healing Arts, Missouri Licensed Physician Data Aggregate, 2013.
4 The U.S. Nursing Workforce: Trends in Supply and Education, 2013.
5 Missouri State Board of Nursing. *Fiscal Year 2017 annual report, June 2017.*
6 American Association of Colleges of Nursing report. *2016-2017 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC REAUTHORIZATION

The Missouri Hospital Association urges congressional action to continue a Medicaid demonstration project to deliver mental health services through Certified Community Behavioral Health Clinics. Authorization for the two-year demonstration expired July 14. On July 30, legislation was enacted to extend the program through September 13.

Missouri is one of eight states participating in the CCBHC demonstration. Clinics meeting federal criteria receive a prospectively-determined cost-based global payment for coordinating and delivering services to treat serious mental illness and substance use disorders. They are required to report their performance on 22 quality measures and provide nine types of evidence-based services, including 24-hour crisis care.

The populations of focus for the CCBHC demonstration in the Missouri Medicaid program are:

- Adults with serious mental illness
- Children and adolescents with serious emotional disorders
- Children, adolescents and adults with moderate to severe substance use disorders
- Children and adolescents in state custody who have behavioral health issues
- Young adults with mental illness or substance use disorders identified as in need of treatment by the courts, law enforcement or hospital emergency rooms

Legislation creating the CCBHC demonstration was enacted in 2014 and sponsored by Senators Roy Blunt (R-Mo.) and Debbie Stabenow (D-Mich.). **It has expanded and improved the capacity of the health care system to address the growing need for treatment of mental health and substance use disorders.**

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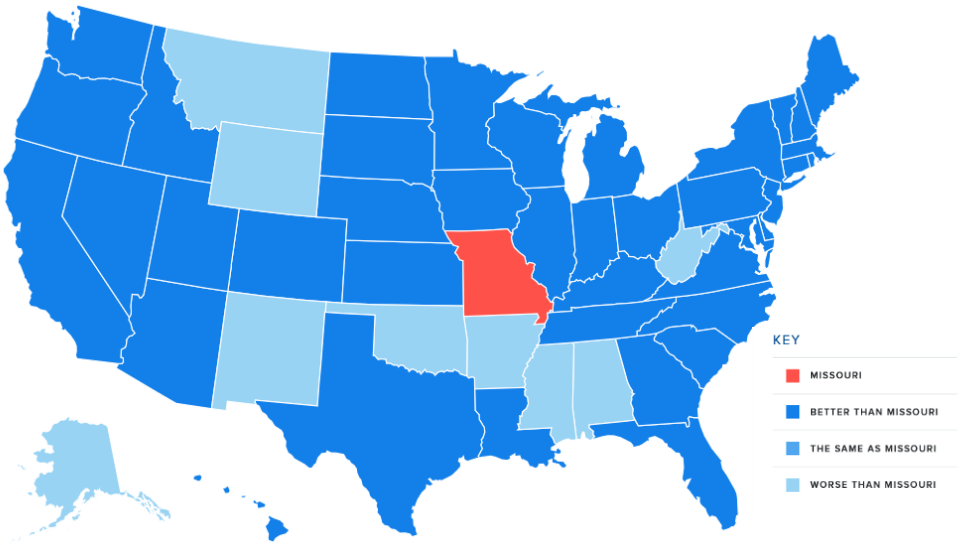
TELEHEALTH

The Centers for Medicare & Medicaid Services define telehealth as "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance." Many Americans tout telehealth as a way to provide patients access to necessary care that they may not otherwise receive. While it holds great promise for expanding access with high efficiency and convenience, two obstacles currently appear to be holding back its benefits for Missourians.

Medicare is the most common insurer for patients of rural Missouri hospitals. In fact, in Missouri as a whole, 45 percent of a hospital's total book of business is treating Medicare beneficiaries. Since Medicare recipients are the largest potential patient population to benefit under telehealth services, hospitals look to how the Medicare telehealth program is outlined and reimbursed. To date, Medicare coverage of telehealth is very restrictive in scope and inconvenient for the patient. A November 2018 CMS report notes that in 2016 only one quarter of one percent of the 35 million Medicare fee-for-service enrollees studied received telehealth services. Medicare makes two payments, one for the place a patient receives telehealth, which is known as the originating site, and a second to the physician being consulted, known as the distant site. In general, Congress and CMS have restricted originating sites to rural hospitals, critical access hospitals, rural health clinics, federally qualified health centers, skilled nursing facilities, community mental health centers, renal dialysis facilities and mobile stroke units. Patients may not receive telehealth services at their home unless they have end-stage renal disease and are receiving home dialysis. Also, the Medicare payment rate of $26.15, of which the patient pays $5.23, is inadequate for the space, technology and infrastructure needed to support telehealth services.

Within Missouri, availability of wireless/broadband is not particularly strong in an interstate comparison. Most states have a higher percentage of population with access to broadband capability of at least 25 MBPS/3 MBPS. The infrastructure needs to be improved in Missouri before greater utilization of telehealth is achieved. MHA applauds Governor Parson for allocating $5 million for improving broadband access.



MHA urges Congress and CMS to create legislation and regulations that loosen the originating site restrictions, improve Medicare reimbursement for those sites and continue to invest in infrastructure to improve broadband access. Until these impediments are addressed, telehealth will not realize a great promise of expanding access to patients with high efficiency and convenience.

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UPDATES ON REGULATORY PAYMENT ISSUES

WAGE INDEX

The Medicare hospital inpatient prospective payment system is designed to pay hospitals a standardized amount adjusted for the patient's condition and treatment received during the hospitalization. The Social Security Act Section 1886(d)(3)(E) requires the standardized amount be adjusted for differences in hospital wage levels. This adjustment is to be implemented in a budget neutral manner. Over time, the wage index has become exceedingly complex and now is creating a downward spiral for those hospitals with low-wage index values. The Centers for Medicare & Medicaid Services finalized a change in regulatory policy that increases the wage index for hospitals in the bottom 25th percentile. This change in policy will increase payments to hospitals in Missouri that have a wage index in the bottom quartile by $6.2 million during fiscal year 2020. CMS is proposing to make similar changes to the wage index for services paid under the outpatient prospective payment system. We thank CMS for these changes within the IPPS and encourage them to finalize the OPPS proposal to include relief for low-wage index hospitals. We also urge that CMS create a "technical advisory group" to study the issue further and recommend additional refinements to the system.

MEDICARE DISPROPORTIONATE SHARE

CMS finalized the final year of a transition to utilize the Medicare cost report, worksheet S-10 to distribute Medicare DSH uncompensated payments. The new formula relies on a measure of uncompensated care costs rather than what had been used — days of inpatient hospital care of Medicaid and Supplemental Security Income enrollees. The change has been phased in throughout three years, culminating the full implementation in FY 2020. During that three-year transition in FYs 2018 to 2020, the formula revision increased Medicare DSH payments to Missouri hospitals by $66 million. We thank CMS for finalizing these changes.

WAGE INDEX MANIPULATION

MHA long has been an advocate to unwind the effects of a provision passed within the Affordable Care Act that forces a national budget neutrality payment adjustment to be made for those hospitals that benefit from the rural floor. Hospitals in Massachusetts instigated the change. Between 2012 and 2019, hospitals in Missouri have incurred Medicare inpatient payment reductions exceeding $74 million. CMS finalized a rule that removes wage data for urban hospitals that reclassify to a rural core-based statistical area when calculating the wage index. This change in methodology will increase payments to hospitals in Missouri by $3 million. We thank CMS for this change in methodology.

MISSOURI'S INVESTMENTS IN RURAL HEALTH

GOV. PARSON'S 2020 RECOMMENDATIONS AND FINAL AUTHORIZATIONS

Expand Access to Behavioral Health Services

✓ $1,000,000	Autism ECHO
✓ $15,500,000	Expanded access to community-psychiatric rehabilitation
✓ $40,400,000	Case management and waiver services for persons with developmental disabilities
↓ ~~$28,800,000~~ $25,900,000	Certified Community Behavioral Health Clinics to continue the Prospective Payment System and statewide behavioral health crisis system and to provide a Medicare Economic Index increase
✓ $9,900,000	Comprehensive Psychiatric Services provider rate increases

Expand Access to Primary Care Providers

✓ $501,000	Loan repayments for providers in Health Professional Shortage Areas
✓ $376,000	Oral disease prevention/oral health services for underserved areas
✓ $425,000	Primary care physician training/ telehealth psychiatry for rural & underserved communities

Increase Access to Care for Substance Use Disorder

↑ ~~$18,100,000~~ $25,900,000	Enhance opioid abuse prevention and treatment
✓ $1,000,000	Expand faith- and community-based recovery support services
✓ $646,000	Expand CSTAR
✓ $2,900,000	Rate increases for alcohol and drug treatment providers

Ensure Access to Quality Health Care

↑ ~~$36,600,000~~ $53,400,000	Rate increases for providers of treatment services for the developmentally disabled
✓ $14,400,000	Rate increases for home and community-based care service providers
↓ ~~$10,000,000~~ $5,900,000	Reimburse schools for transportation costs associated with transporting a student with MO HealthNet coverage to school-based direct services
✓ $20,300,000	Rate increases for Medicaid providers

Reimagine Rural Health

Visit **www.mhanet.com/ReimagineRuralHealth** to explore 10 rural health issues and policy options to address them.

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GOVERNOR PARSON'S FY 2020 BUDGET RECOMMENDATIONS

Allow and Encourage Innovative Payment Models

$34,900,000	Support MO HealthNet transformational efforts
$11,200,000	Funding to sustain/continue replacement of MO HealthNet MMIS
~~**$450,000**~~ **$0**	Development of new MO HealthNet inpatient reimbursement models

Collaborate to Identify and Address Social Determinants of Health

$9,500,000	Increase in LIHEAP (heating assistance) funding
$20,000,000	Child care support enhancements

Expand Telehealth and Telemedicine

$5,000,000	Rural broadband expansion

Advocate for Improved Infrastructure

~~**$351,000,000**~~ **$300,000,000**	Bonding proceeds to repair/replace bridges
~~**$50,000,000**~~ **$0**	Transportation cost-share program with local communities

Broadband expansion also will improve infrastructure.

Empower Partnerships

~~**$5,700,000**~~ **$25,700,000**	MO HealthNet connections to health information networks (includes $10 million of MHA proposed ADT funding.

Other Workforce Enhancements

~~**$22,200,000**~~ **$10,000,000**	"Fast-Track Workforce Grant" Program (higher education grants for adults making less than $80K working toward a degree in high needs areas)
~~**$16,300,000**~~ **$18,915,000**	"Missouri Excels" (for higher education to develop/expand employer-driven training and educational initiatives
~~**$10,000,000**~~ **$9,600,000**	"Missouri One Start" – consolidates and increases initiatives supporting new and expanding businesses

Reimagine **Rural Health**

Visit **www.mhanet.com/ReimagineRuralHealth** to explore 10 rural health issues and policy options to address them.

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Profile of Missouri Hospitals

Operating Margins

Percent of hospitals operating at a loss/gain.

	LOSS	GAIN
All Hospitals	37.6% ▼	62.4% ▲
Rural*	44.8% ▼	55.2% ▲
Urban	30.3% ▼	69.7% ▲
Critical Access	41.2% ▼	58.8% ▲

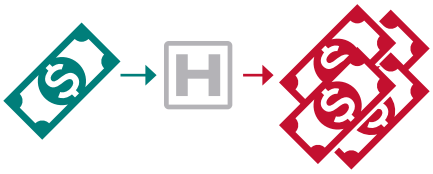
Business Mix

39:1

outpatient vs. inpatient

For every inpatient admission, hospitals treat 39 outpatients.

Community Benefit



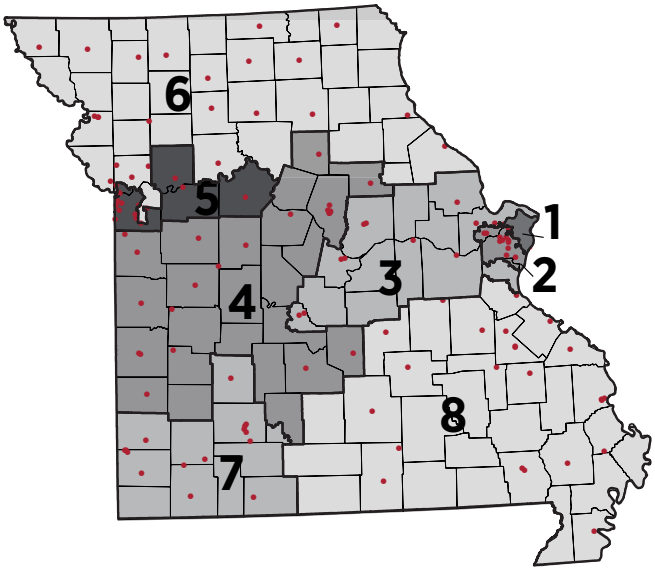
For every **$1 in profit,** hospitals spend **$3.86 in community benefit.**

Annual Licensing Survey. Excludes those that did not complete the ALS, children's and VA hospitals.

Background

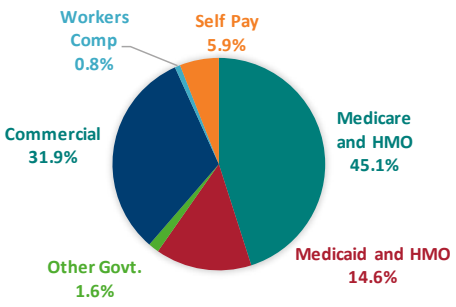
141

MHA-member hospitals

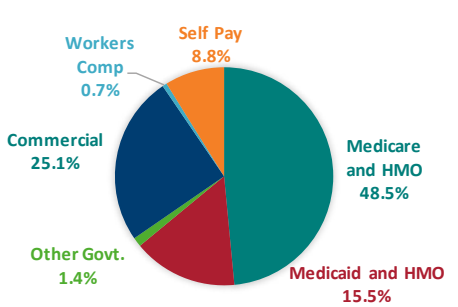


- **72** Medicare acute inpatient prospective payment system hospitals
- **35** critical access hospitals
- **5** federal military or veterans hospitals
- **5** general or specialty pediatric hospitals
- **15** psychiatric hospitals
- **6** long-term, acute-care hospitals
- **5** rehabilitation hospitals
- **30** for-profit organizations
- **111** tax-exempt organizations
- **69** private, not-for-profit organizations
- **31** state or local governmental acute-care hospitals

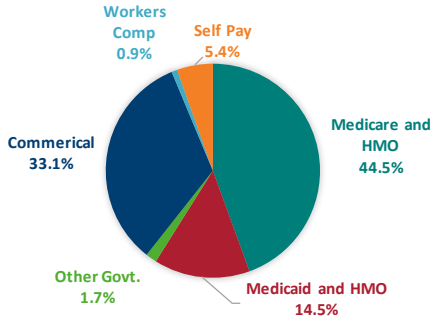
HOSPITAL PAYER MIX



RURAL HOSPITAL PAYER MIX



URBAN HOSPITAL PAYER MIX



FINANCIAL CONTRIBUTIONS OF MISSOURI HOSPITALS (2017)

- $27.1 billion = gross state product linked to Missouri hospitals
- 155,346 = number of full time and part time workers employed by Missouri hospitals
- $10.6 billion = combined payroll and benefits provided to employees of Missouri hospitals
- $1.67 billion = annual capital investments of Missouri hospitals

Impact of Rural Hospital Employment	
Number of Workers	29,038
Wages	$2,212,487
Value Added	**$4,941,634**

Total Community Benefit	
Total	$3.3 billion
Rural	$396.7 million

Uncompensated Care	
Total	$1.4 billion
Rural	$255.4 million

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2018 LOCAL GOVERNMENT HOSPITAL TAX REVENUES

POLITICAL SUBDIVISION	PURPOSE	REVENUE
Barton County	Hospital	$ 794,006
Cass Medical Center (Cass Co.)	General Revenue	$ 2,159,661
Cedar County Memorial Hospital	General Revenue	$ 271,834
City of Excelsior Springs (Clay Co.)	Hospital	$ 277,960
City of St. Louis	Hospital	$ 4,117,354
Ellett Memorial Hospital District (St. Clair Co.)	General Revenue	$ 216,568
Iron County Hospital District (sales tax levy)	Hospital	$ 369,963
Harrison County Hospital District	General Revenue	$ 528,713
Hermann Area Hospital District (Gasconade Co.)	General Revenue	$ 1,336,412
Lincoln County	Hospital	$ 1,357,399
New Liberty Hospital District (Clay Co.)	General Revenue	$ 1,789,367
Pemiscot County	Hospital	$ 839,448
Perry County	Hospital	$ 324,042
Pike County	Hospital	$ 635,130
Putnam County	Hospital	$ 428,914
Ray County	Hospital	$ 615,801
Salem Memorial Hospital District (Dent Co.)	General Revenue	$ 482,941
Samaritan Memorial Hospital (Macon Co.)	General Revenue	$ 440,766
Scotland County Memorial Hospital	General Revenue	$ 388,006
South Barry Co Memorial Hospital	General Revenue	$ 267,343
Ste. Genevieve County	Hospital	$ 753,049
Sullivan County	Hospital	$ 392,398
Washington County	General Revenue	$ 486,975
Western Missouri Medical Center	General Revenue	$ 959,327

Sources: Missouri State Auditor, 2018 Property Tax Rates
Missouri Dept. of Revenue, Financial and Statistical Report, FY 2018

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