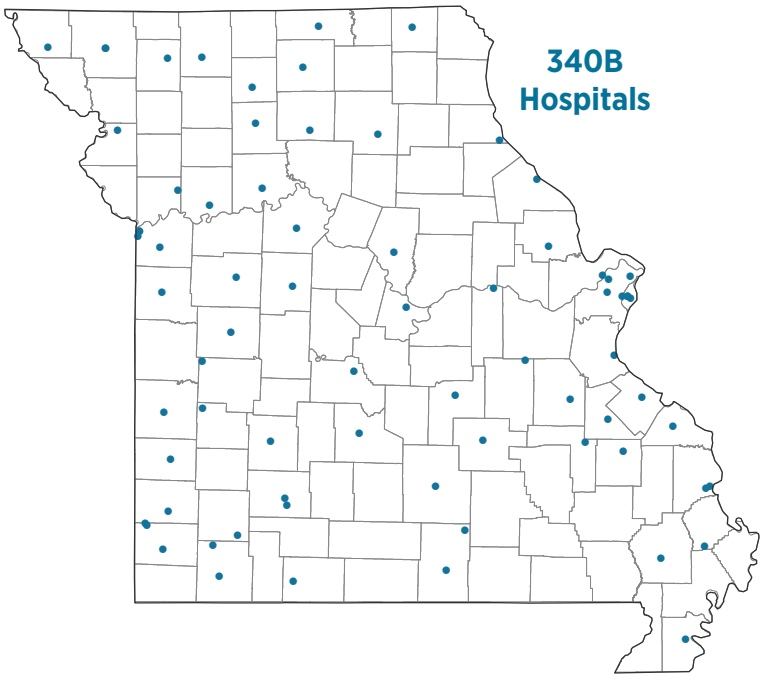
# STOP ATTACKS ON THE 340B PROGRAM

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 Medicare disproportionate share hospitals — which serve a disproportionate share of low-income patients. Most Missouri hospitals that qualify for 340B are Medicare DSH hospitals and CAHs.

## Issue:




The 340B program is under attack by commercial payers and drug manufacturers, that unilaterally impose programs to restrict 340B cost savings and justify such actions based on assertions that 340B-eligible entities are incorrectly using the program proceeds. 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.

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.

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 12 states to pass a law prohibiting manufacturers from limiting access to contract pharmacies. Pharmaceutical companies have sued to challenge nearly all those laws, with four lawsuits pending in Missouri, despite precedent from the 8th Circuit Court of Appeals upholding a similar 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 onto the 340B-participating providers. Congress also must clearly define a 340B-eligible patient. Please tell Big Pharma and commercial payers that they are endangering safety-net and small – rural providers in Missouri by enacting legislation that stops their unilateral attacks on the program.

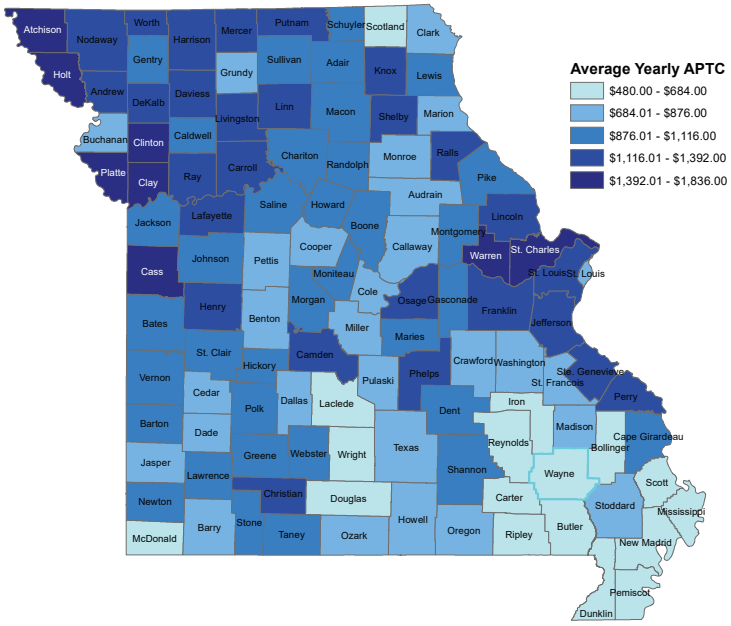
# PRESERVE COVERAGE OPTIONS THROUGH MARKETPLACE PREMIUM TAX CREDITS

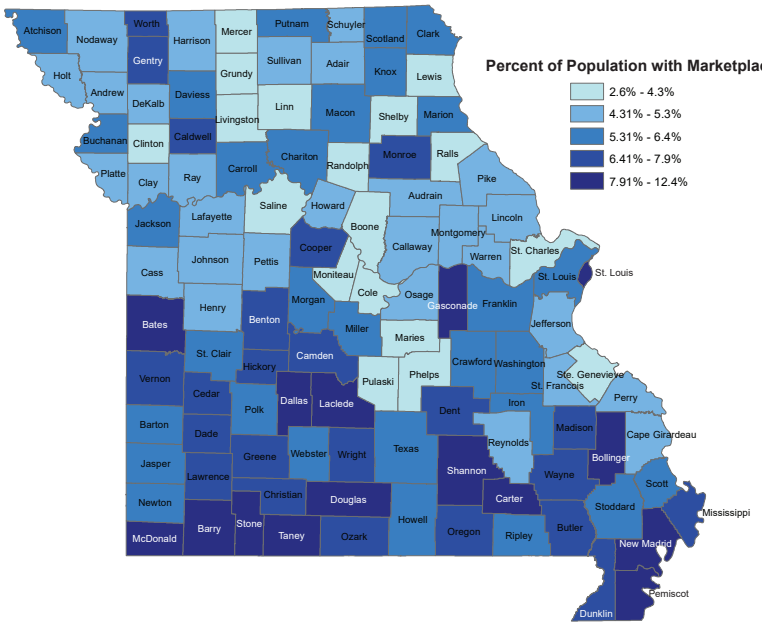
Through the enactment of the Patient Protection and Affordable Care Act, individuals, families and small businesses may obtain health insurance coverage through the Health Insurance Marketplace. To help individuals and families purchase insurance from the Marketplace, the federal government offers enhanced advanced premium tax credits. These tax credits directly reduce the amount of premium that must be paid to obtain coverage. According to the Kaiser Family Foundation, approximately 14.2% of individuals under the age of 65 are enrolled in a Marketplace product in Missouri. Approximately 333,000 receive an annual advance premium tax credit (APTC), averaging $1,100 per consumer.

## Issue:

In 2021, Congress expanded eligibility for the tax credits. According to KFF, premium payments in 2022 would have been 53% higher on average if not for the enhanced tax credits. The number of Missourians who rely on Marketplace coverage increased by 243% between 2020 and 2024. The growth is due in part to the expanded tax credits.

Unless Congress acts, the enhanced APTC will expire at the end of 2025. If the expanded tax credits expire, many Missourians receiving health insurance coverage through the Marketplace will no longer be able to afford coverage. This will lead to additional uncompensated care and place further financial strain on hospitals.




## Request for Action:

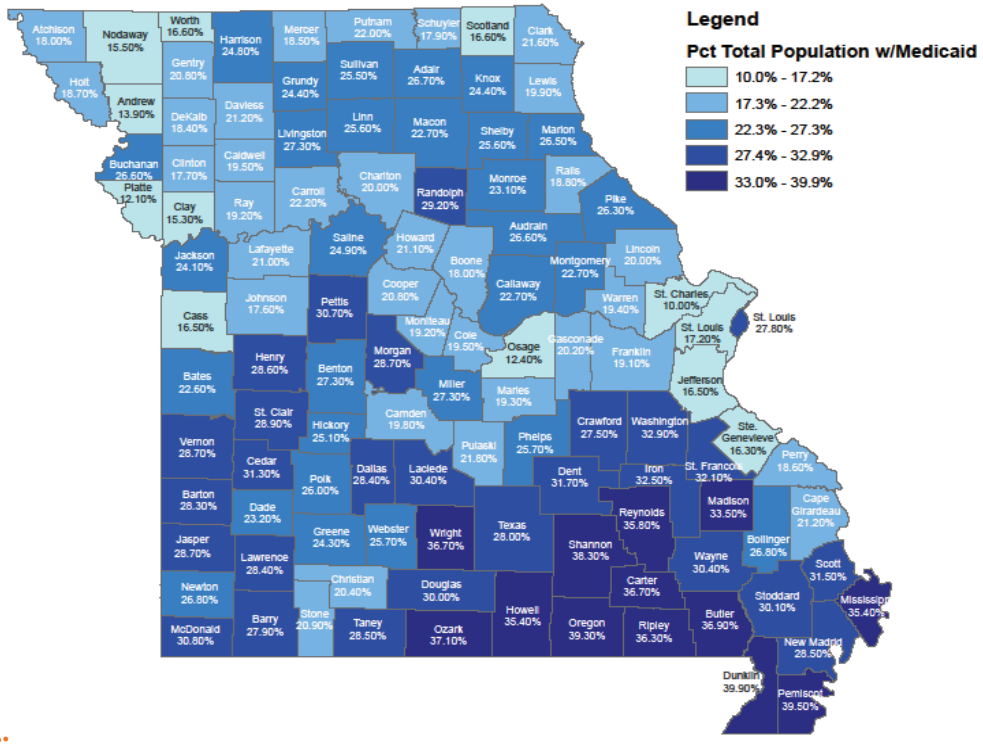
MHA urges Congress to extend enhanced APTC by enacting legislation that will stabilize Marketplace enrollment and help stabilize hospital payer mix.

# REJECT DAMAGING CUTS TO THE MEDICAID PROGRAM

The Missouri Medicaid program provides a crucial safety net for the state's most vulnerable citizens. It provides access to primary and preventive care, maternal and pediatric care, cancer treatment, chronic disease management, and long-term care. This results in better health outcomes, lower maternal mortality, a healthier workforce and lower health care costs associated with chronic disease. Approximately one in four Missourians are covered by Medicaid.

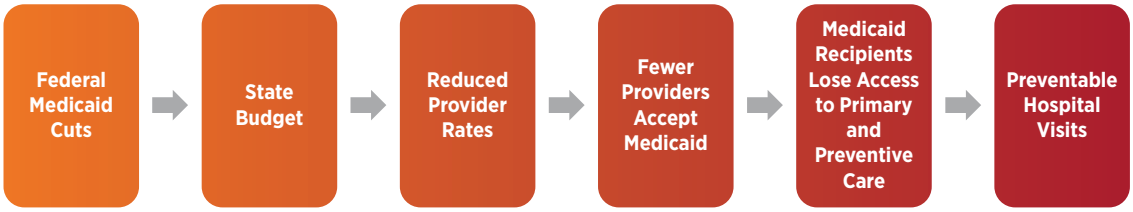
According to the Kaiser Family Foundation 62% of non-elderly Missouri Medicaid beneficiaries are white; the remaining 38% are people of color. More than 65% of adult Medicaid recipients are working.[1] The Missouri Foundation for Health estimates that 48% of Missouri's children are on Medicaid, and the program pays for 39% of all births in the state.[2]

Based on 2025 data from the Washington University Institute of Public Health, the following depicts Medicaid enrollment statistics by county.




## Issue:

Spending reductions would have devastating consequences for the state and its citizens. The state's inability to absorb substantial cuts will reduce provider reimbursement. Physicians and other independent practitioners may elect not to accept Medicaid. Those patients will migrate to emergency departments, increasing the stress on hospitals already chronically underpaid by Medicaid.



Alternatively, the state could **eliminate optional services,** which include vision and dental care, physical and occupational therapy, home and community-based services, prescription drugs, eyeglasses and other diagnostic, screening and preventive services, **reducing access to needed care** for all Medicaid recipients.

## How Federal Reductions Impact Missouri's Medicaid Program[3]

- Eliminate the enhanced federal matching rate for the expansion population: $8.3B[4]
- Per capita caps, all Medicaid: $6.6B
- Per capita caps, expansion only: $2.88B
- Reduce cap on the Federal Reimbursement Allowance to 2.5%: $27.1B[5]

Each 6% decrease in Medicaid funding requires $1B in additional state funding, equal to a 7% increase in state general revenue expenditures. Missouri has limited options to absorb substantial cuts to Medicaid funding:

- Reduce Medicaid eligibility levels to federal minimums for pregnant women, children and infants
- Reduce or eliminate optional services
- Cut other state programs heavily reliant on state funds like education, higher education, infrastructure, other social welfare programs and corrections

## Request for Action:

Medicaid funding cuts will impact **all** Missourians by straining the existing health care system, increasing insurance premiums, and the incidence and burden of chronic disease. **MHA urges Congress to reject cuts to the Medicaid program.**

### Endnotes

[1] MedicaidFactSheet.knit

[2] Missouri-Medicaid-Basics-2023.pdf

[3] Estimated 10-year impacts

[4] Medicaid expansion is enshrined in the Missouri Constitution and cannot be changed without a vote of the people. The state is required to provide eligible adults the same benefits provided to the traditional Medicaid population. If the enhanced matching rate were reduced, Missouri would have to fund approximately $1B of additional costs annually.

[5] Each .1% reduction in the cap results in a $76M loss to the state

# ADVOCACY BRIEF

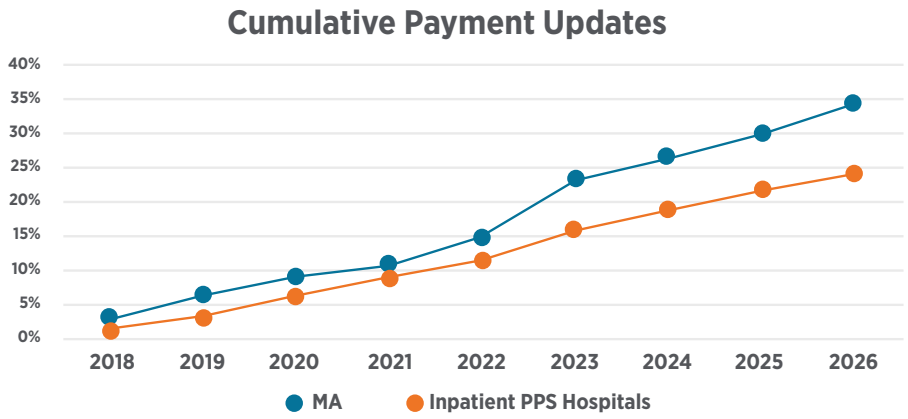
## REIN IN MEDICARE ADVANTAGE ABUSES

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 an 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.




### 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.

Enriching MA insurers does not stop with unilaterally imposed insurer policies. CMS is causing further strain by increasing MA insurer annual payment increases that far exceed Medicare payment updates paid to providers who actually care for people. When comparing FYs 2018-2026, the cumulative difference in payment rate increases exceeds 10 percentage points. Lawmakers and regulators should no longer enrich insurers at the expense of providers.

# REJECT HARMFUL SITE-NEUTRAL PAYMENT POLICIES

Hospital outpatient departments or hospital-owned provider-based clinics are not analogous to freestanding physician practices. They typically serve a greater number of indigent, un- and underinsured patients, who tend to have complex medical needs. As an extension of the hospital, they must meet stricter regulatory and safety requirements, at increased cost. Current Medicare reimbursement policies recognize that hospitals must maintain the capacity to care for patients at all times and respond to natural disasters, public health emergencies and mass casualty events.

## Issue:

As Congress seeks to turn the resolution framework into a reconciliation bill, dramatic spending reductions are on the table. Medicare site-neutral payment policies likely are under consideration. Even without site-neutral payments, Medicare reimbursement rates fail to cover the cost of care. This disproportionately impacts hospitals that serve large numbers of Medicare beneficiaries, such as rural facilities. Further reductions in Medicare reimbursement will jeopardize those hospitals' ability to continue to provide convenient access to primary, preventive and follow-up care, along with chronic disease management and cancer treatment. Ultimately, Medicare beneficiaries will be forced to travel greater distances to receive care or forgo care, resulting in adverse health outcomes.

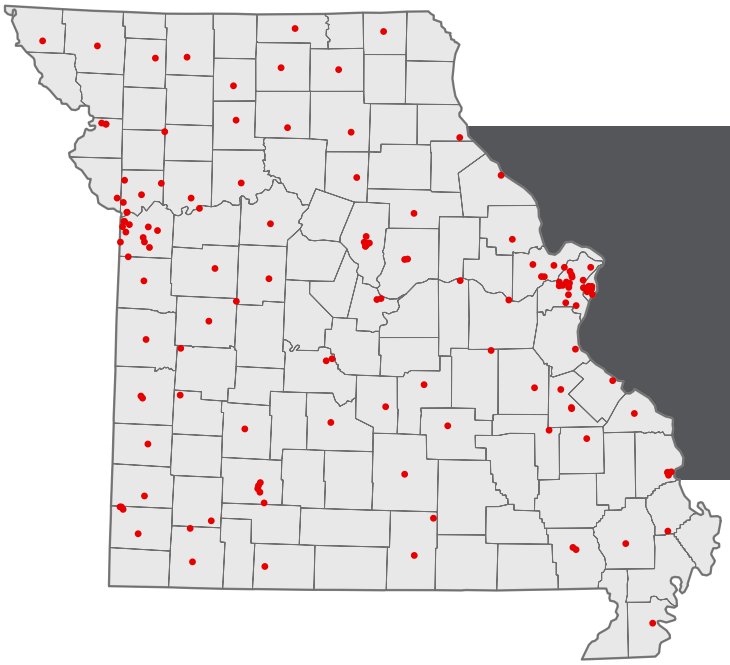
Hospitals are the only provider type that serve patients 24/7/365. They are heavily regulated and must create systems, processes and care environments to meet stringent federal regulatory and accreditation standards. These include physical plant requirements for fire and life safety codes, ventilation and infection control. They are subject to quality assurance and reporting requirements. They must comply with the Emergency Medical Treatment and Labor Act. Freestanding clinics are unregulated in Missouri. The reality is that hospitals and freestanding clinics have very different cost structures, and Medicare reimbursement rates should account for that cost.

## Request for Action:

MHA urges Congress to reject new site-neutral payment policies and protect access to essential, quality care for Medicare beneficiaries.

# MHA PROFILE OF MISSOURI HOSPITALS

## ALL HOSPITALS

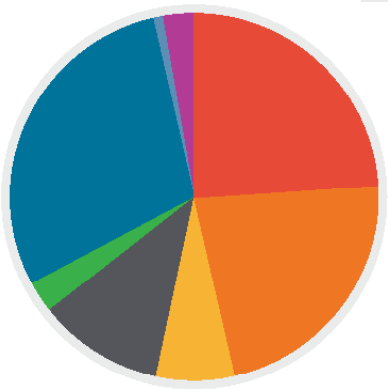


**137** MHA MEMBER HOSPITALS

| | | | |
|---|---|---|---|
| **67** | Medicare acute Inpatient Prospective Payment System hospitals | **6** | rehabilitation hospitals |
| **35** | critical access hospitals | **27** | for-profit organizations |
| **5** | federal military or veterans hospitals | **108** | tax-exempt organizations |
| **5** | general or specialty pediatric hospitals | **65** | private, not-for-profit organizations |
| **14** | psychiatric hospitals | **34** | state or local government acute care hospitals |
| **6** | long-term, acute care hospitals | **7** | psychiatric hospitals owned by the Department of Mental Health |

## HOSPITAL PAYER MIX

- **24.0%** Medicare
- **22.4%** Medicare Advantage
- **7.0%** Medicaid
- **11.1%** Medicaid Managed Care
- **2.7%** Other Government
- **29.2%** Commercial and Managed Care
- **0.9%** Workers' Compensation
- **2.6%** Self-Pay



**69.9%** PERCENT OF BUSINESS REIMBURSING LESS THAN COST

## OPERATING MARGIN

*Percent of hospitals operating at a loss/gain.*

**39.8%** ▼

**60.2%** ▲

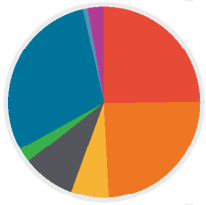
AVERAGE OPERATING MARGIN **2.9%**

*Information is based on the 2023 Annual Licensing Survey Data.*

# MHA | PROFILE OF MISSOURI HOSPITALS

## URBAN

### HOSPITAL PAYER MIX



- 24.9% Medicare
- 24.4% Medicare Advantage
- 6.3% Medicaid
- 8.9% Medicaid Managed Care
- 2.7% Other Government
- 29.3% Commercial and Managed Care
- 0.9% Workers' Compensation
- 2.6% Self-Pay

**69.8%** PERCENT OF BUSINESS REIMBURSING LESS THAN COST

### OPERATING MARGIN

*Percent of hospitals operating at a loss/gain.*

29.3% ▼ | 70.7% ▲

AVERAGE OPERATING MARGIN **2.4%**

## RURAL

### HOSPITAL PAYER MIX

- 28.8% Medicare
- 21.4% Medicare Advantage
- 11.3% Medicaid
- 8.3% Medicaid Managed Care
- 3.2% Other Government
- 23.2% Commercial and Managed Care
- 0.8% Workers' Compensation
- 3.2% Self-Pay

**76.1%** PERCENT OF BUSINESS REIMBURSING LESS THAN COST

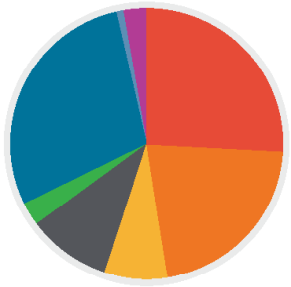
### OPERATING MARGIN

*Percent of hospitals operating at a loss/gain.*

54.4% ▼ | 45.6% ▲

AVERAGE OPERATING MARGIN **0.4%**

## 340B Urban & Rural



### HOSPITAL PAYER MIX

- 26.1% Medicare
- 21.5% Medicare Advantage
- 7.6% Medicaid
- 10.1% Medicaid Managed Care
- 2.8% Other Government
- 28.6% Commercial and Managed Care
- 0.8% Workers' Compensation
- 2.6% Self-Pay

**70.6%** PERCENT OF BUSINESS REIMBURSING LESS THAN COST

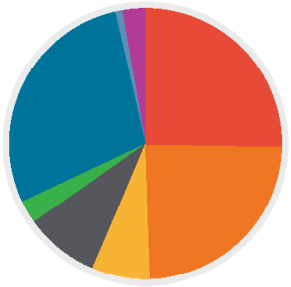
### OPERATING MARGIN

*Percent of hospitals operating at a loss/gain.*

48.6% ▼ | 51.4% ▲

AVERAGE OPERATING MARGIN **-0.1%**

## Inpatient Acute PPS



### HOSPITAL PAYER MIX

- 25.5% Medicare
- 24.0% Medicare Advantage
- 7.1% Medicaid
- 8.8% Medicaid Managed Care
- 2.8% Other Government
- 28.4% Commercial and Managed Care
- 0.9% Workers' Compensation
- 2.6% Self-Pay

**70.6%** PERCENT OF BUSINESS REIMBURSING LESS THAN COST

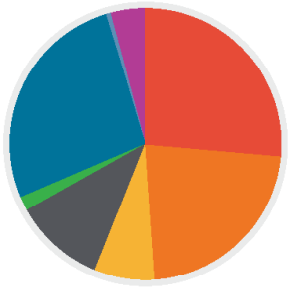
### OPERATING MARGIN

*Percent of hospitals operating at a loss/gain.*

41.5% ▼ | 58.5% ▲

AVERAGE OPERATING MARGIN **2.0%**

## CAH



### HOSPITAL PAYER MIX

- 26.6% Medicare
- 22.5% Medicare Advantage
- 7.1% Medicaid
- 10.7% Medicaid Managed Care
- 1.7% Other Government
- 26.8% Commercial and Managed Care
- 0.6% Workers' Compensation
- 3.9% Self-Pay

**72.6%** PERCENT OF BUSINESS REIMBURSING LESS THAN COST

### OPERATING MARGIN

*Percent of hospitals operating at a loss/gain.*

48.5% ▼ | 51.5% ▲

AVERAGE OPERATING MARGIN **-0.2%**

*Information is based on the 2023 Annual Licensing Survey Data.*