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Advocacy Agenda
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Challenges short-term and long dominate ASH's advocacy agenda for 2023. In the long term, ASH will continue its advocacy of government reimbursement policies that enable community safety-net hospitals to serve their medically vulnerable communities with effectiveness and integrity. Such policies also must help these hospitals in their pursuit of health equity. To that end, in the short term ASH will continue to serve as the primary voice of community safety-net hospitals while working to rally support for its own proposal to advance health equity by more fairly reimbursing community safety-net hospitals for the care they provide to their low-income and medically vulnerable patients.

Equitable Access to Care: An ASH Initiative

A growing consensus has emerged that Americans today do not enjoy equitable access to quality health care. One of the major factors driving this inequity is who pays for care: when Medicare and Medicaid pay they generally do so poorly, driving some providers out of medically vulnerable communities and leaving those who remain with inadequate resources, consigning them to struggle unendingly with older and often outdated infrastructure, limited access to modern medical technologies and treatments, and patients who also need non-medical community and social supports and services for which no payment system, public or private, will ever reimburse them. The cumulative impact of these and other factors on low-income communities can be seen in the poor health status of their residents: people who are more likely to suffer from heart problems, hypertension, diabetes, asthma, and other medical problems – problems heavily influenced by social determinants of health. Over the years, state and federal governments have attempted to respond to this problem by supplementing their inadequate Medicare and Medicaid payments. These supplemental payments, made in many forms, have helped – but not enough. The problem remains.

Late in 2022 ASH introduced its own proposal for addressing this problem: new, supplemental Medicare and Medicaid payments targeted to communities with the greatest needs. ASH's proposed supplemental Medicare payments – an inpatient and an outpatient payment – are based first on identifying the specific communities where the needs are greatest; then, identifying the individual hospital or hospitals that play outsized roles in serving the disadvantaged residents of those communities; and finally, directing supplemental payments to those providers based on their service to those individuals. Such communities would be identified based not on county or city or hospital market area but on individual zip codes and the health care utilization and health status of their residents based on data that in the past was not available on such a granular level. In addition, ASH proposes a new supplemental Medicaid payment to be made only to providers that meet federal standards for being "deemed" a Medicaid disproportionate share hospital, or

that provide more than 35,000 days of care to Medicaid eligible individuals annually. In this manner, these federal resources would be much more finely targeted to the communities facing the greatest challenges and with the greatest needs rather than being administered so broadly to so many recipients that they fail to achieve their policy objectives.

In 2023 ASH will vigorously advocate its new health equity payments among leaders in the administration and Congress and other advocacy groups. Learn more about the ASH proposal *here*.

Medicaid DSH

The Affordable Care Act called for future reductions of Medicaid disproportionate share (Medicaid DSH) allotments to states to reflect the growing number of people who were expected to obtain health insurance under the 2010 health reform law and a theoretically reduced need for these payments among those hospitals. While the Affordable Care Act has resulted in a considerable increase in the number of insured Americans, hospitals serving predominantly low-income communities still serve large numbers of uninsured and underinsured patients and therefore still need these payments no less than they did before the law was enacted. Congress has acknowledged this and repeatedly postponed billions of dollars in reductions of the federal pool of funds from which Medicaid DSH payments are made. The latest delay in implementing these cuts expires at the end of 2023, so beginning in January of 2024 the federal government is scheduled to implement an $8 billion reduction of state Medicaid DSH allotments. ASH will spend 2023 urging lawmakers to delay this harmful cut once again.

340B

After years of reduced federal reimbursement for 340B-covered prescription drugs and litigation against those reductions, this issue was settled by a federal court in 2022 and the Centers for Medicare & Medicaid Services has agreed to restore 340B payments to their pre-reduction level and to reimburse eligible providers for the payment shortfall they have suffered as a result of the cut since 2018. In 2023, ASH will work to ensure that the federal government lives up to its court-ordered promise to reimburse 340B-eligible providers for the payment shortfalls they have experienced. In addition, ASH will work to ensure that in compensating providers for these lost payments the federal government does not attempt to do so in a budget-neutral manner: by taking money away from other federal health care programs to underwrite these payments. Doing so will be critical to ensuring that community safety-net hospitals are not harmed by spending cuts made to pay for the court-ordered increase in 340B payments.

Surprise Medical Billing

In late 2020 Congress enacted reforms to protect patients from surprise medical bills. Implementation of the No Surprises Act has proven complex and difficult, and so far, the regulations governing the law do not yet reflect some key aspects of what Congress intended. The result has been an imbalanced system that greatly favors health care payers over health care providers. Today, Congress and the administration continue to work to address this challenge, so in 2023 ASH will work with policy-makers and continue to advocate an approach that treats hospitals more fairly.

Behavioral Health

The behavioral health and substance use challenges many Americans face are receiving unprecedented attention today in Washington policy-making circles and there is growing recognition that Medicare and Medicaid policies must be updated to enable those programs to do their part in addressing these challenges. As these efforts continue, ASH will work to remind policy-makers that it is essential that they focus special attention on the patients community safety-net hospitals serve: significant numbers and proportions of low-income, medically vulnerable individuals whose behavioral health problems so often can be traced to inequitable access to care and social determinants of health.

Protecting Government Payments to Community Safety-Net Hospitals

As it has in the past, ASH will work in 2023 to protect existing Medicare and Medicaid payments to community safety-net hospitals and to ensure that policy-makers do not pay for new or past initiatives, whether in the health care arena or elsewhere, by reducing payments to community safety-net hospitals. This will include protecting Medicare disproportionate share (Medicare DSH) and uncompensated care payments for community safety-net hospitals and recognizing and making appropriate adjustments in various programs' eligibility criteria and payment methodologies to reflect the significant changes in health care utilization during the COVID-19 pandemic. ASH also will work to prevent Congress from turning to Medicare and Medicaid in search of spending cuts to reduce the federal deficit, especially at a time when inflation and supply-chain challenges have driven up the cost of labor, goods, and services.

Addressing Workforce Shortages

The past three years have seen the emergence of workforce shortages as a major challenge for community safety-net hospitals. This problem has two aspects: first, hospitals are finding it difficult to hire the qualified health care professionals they need to care for their patients and often must pay an exorbitant premium for such services; and second, post-acute-care providers such as skilled nursing facilities and home health agencies are encountering the same problem and cannot accommodate patients who are ready to be discharged from hospitals. As a result, such patients often remain in the hospital and under hospitals' care long after they no longer need hospitalization – additional stays for which hospitals are not reimbursed by health care payers. In the coming year, ASH will work to ensure that Congress and the administration understand the scope of this problem and its implications while also advocating adoption of a temporary per diem payment for Medicare patients who remain hospitalized because of the absence of appropriate post-acute-care alternatives.

Responding to Challenges as They Arise

As it always does, ASH will speak out on new policy deliberations to ensure that the needs of community safety-net hospitals and the medically vulnerable communities they serve are understood by policy-makers and reflected in the proposals they advance, the legislation they enact, and the regulations they implement.