American Hospital Association™
Advancing Health in America

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November 6, 2023

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act.

The bill reflects the thoughtful, bipartisan work of the Committee over the past year to address numerous issues of importance to the hospital field. The AHA is pleased to support several provisions in the bill to improve access to behavioral health care and delay Medicaid disproportionate share hospital (DSH) reductions. Our comments on specific sections of the bill follow.

Section 104. Medicare incentives for behavioral health integration with primary care.

The integration of behavioral health services into team-based care models is proven to improve patient outcomes for both mental and physical ailments. Although payment systems for these models have existed for some time, their uptake has been limited due to a lack of clarity in their application and continued low reimbursement for all behavioral health services. The AHA supports the committee's efforts to encourage providers to offer integrated behavioral health care by increasing payment rates for specific codes representing these services in a non-budget neutral manner. We also support the extension of technical assistance in applying the codes and offer to be of assistance in this endeavor.

Section 107. Ensuring timely communication regarding telehealth and interstate licensure requirements.

A key tool for supporting and expanding the behavioral health workforce is revising policies that make it harder for existing providers to treat patients. Reducing barriers to licensure can help maximize provider capacity, particularly in areas that are experiencing shortages. The AHA supports efforts to ensure that licensure processes are streamlined for providers employed by hospitals and health systems operating across state lines, and we urge Congress to fund additional research on the feasibility, infrastructure, cost and secondary effects of licensure requirements.

Section 301. Delaying certain disproportionate share hospital payment reductions under the Medicaid program.

The AHA supports this provision to delay for two years the Medicaid DSH reductions. Congress established the Medicaid DSH program to provide financial assistance to hospitals serving a disproportionate number of low-income patients to ensure Medicaid and uninsured patients have access to health care services. These hospitals also provide critical community services, such as trauma and burn care, maternal and child health care, high-risk neonatal care and disaster preparedness resources. The patients they serve are among those who need care the most and who often experience challenges accessing it, including children, individuals with lower incomes, people with disabilities and older Americans.

Reductions to the Medicaid DSH program were enacted as part of the Affordable Care Act, with the reasoning that hospitals would have less uncompensated care as health insurance coverage increased. Unfortunately, the projected coverage levels have not been realized, and hospitals continue to care for patients for whom they are not receiving adequate payment. Consequently, the need for Medicaid DSH payments is still vital for the hospitals that rely on the program.

Section 302. Extension of State option to provide medical assistance for certain individuals who are patients in certain institutions for mental diseases.

Arbitrary and outdated payment policies continue to reflect the undervaluing of behavioral health services. Since 1965, the institutions for mental diseases (IMD) exclusion has prohibited federal payments to states for services for adult Medicaid beneficiaries between the ages of 21 and 64 who are treated in facilities that have more than 16 beds and provide inpatient or residential behavioral health — substance use disorder (SUD) and mental illness — treatment. The discriminatory IMD policy was established at a time when SUDs were not considered medical conditions on the same level as physical health conditions. The AHA supports this provision, which would ease this prohibition by permanently granting state Medicaid programs the option to receive federal matching payments for SUD treatment provided in certain IMDs. Medicaid

waivers initially enacted as part of the 2018 SUPPORT Act have allowed our member hospitals to provide behavioral health care through IMDs as well as other parts of the care continuum, and we have heard from these hospitals how impactful this flexibility has been — in many cases reducing the need for long-term hospitalizations.

Section 403. Extension of the work geographic index floor under the Medicare program.

The AHA supports this provision to extend the physician payment work GPCI floor for calendar year 2024. This one-year extension will be helpful for physicians, particularly those in rural hospitals.

Section 404. Extending incentive payments for participation in eligible alternative payment models.

The AHA supports extending the Advanced APM incentive payment for calendar year 2026 period for qualifying APM participants. However, we would prefer that the committee extend the payment amount to the original 5% level instead of the 1.75% payment amount for 2026 that is included in the bill.

Section 407. Increase in support for physicians and other professionals in adjusting to Medicare payment changes.

The AHA supports this section and the committee's efforts to further mitigate scheduled physician payment cuts by changing the conversion factor increase adjustment from 1.25% to 2.5% for 2024. As CMS charges ahead with a 3.34% decrease to the conversion factor in the 2024 Medicare Physician Fee Schedule rule, it is imperative that physicians in our hospitals and health systems are given all the funding and tools necessary so that patients' access to care is not negatively impacted.

Section 408. Revised phase-in of Medicare clinical laboratory test payment changes.

The AHA supports this provision, which would delay harmful cuts to the Clinical Laboratory Fee Schedule, as well as the next round of reporting of private payer rates, which are both scheduled to take effect on Jan. 1, 2024 under the Protecting Access to Medicare Act. Without congressional action, hospital laboratories would face cuts as large as 15% on some of the most common tests, reducing access to clinical laboratory services.

Conclusion

Thank you for considering the AHA's comments on this bill. We look forward to working with the Committee to address these important issues on behalf of the patients and communities we serve.

Sincerely,

/s/

Stacey Hughes
Executive Vice President

cc: Members of the Committee on Finance