American Hospital Association™
Advancing Health in America

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June 26, 2019

The Honorable Richard Neal
Chairman
Committee on Ways & Means
United States House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways & Means
United States House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

Dear Chairman Neal and Ranking Member Brady:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, our clinical 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, we applaud the Committee for considering legislation to improve the quality of and access to critical services for Medicare beneficiaries, help train the physician workforce of the future and reduce the administrative burden on rural hospitals.

Opioid Workforce Act of 2019
We are pleased to support H.R. 3414, the Opioid Workforce Act of 2019, which would help reduce the national shortage of opioid treatment providers by increasing the number of resident physician slots in hospitals with programs focused on substance use disorder (SUD) treatment. As the nation continues to struggle with the devastating public health crisis stemming from the opioid epidemic, we recognize that the shortage of SUD treatment providers has led to lengthy waiting periods for treatment and increased mortality from opioid misuse and addiction. A recent report from the National Academies of Sciences, Engineering and Medicine highlighted the dearth of clinicians with specialized training in Medication-assisted Treatment, and the Substance Abuse and Mental Health Services Administration has estimated that only 10% of the 22 million Americans with an SUD receive treatment.

The AHA last year endorsed the SUPPORT Act, P.L. 115-271, multifaceted legislation to combat the opioid crisis and prevent further addiction; however, Congress did not include in that law provisions to increase the number of physicians who specialize in SUD treatment. H.R. 3414 would address existing shortages by adding 1,000 Medicare-funded training positions in approved residency programs in addiction medicine,

addiction psychiatry or pain management. These new slots would constitute a major step toward increasing access to SUD treatment for communities in need.

HEARTS and Rural Relief Act

The AHA strongly supports the inclusion of language to extend the enforcement moratorium on direct supervision requirements for outpatient therapeutic services provided in critical access and small, rural hospitals in the HEARTS and Rural Relief Act. This would provide regulatory relief to small, rural hospitals for 2017, 2020 and 2021 and ensure these communities will continue to have access to outpatient therapeutic services. As you know, these services have always been provided by licensed, skilled professionals under the overall supervision of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician. While hospitals recognize the need for direct supervision for certain outpatient services that pose a high risk or are very complex, the Centers for Medicare & Medicaid Services' (CMS) policy generally applies to even the lowest risk services. The AHA applauds your consideration of this provision on behalf of rural hospitals and the patients they serve and looks forward to continuing to work with you to secure a permanent enforcement moratorium.

BETTER Act of 2019

Hospitals' roles in their communities as providers of emergency, inpatient and outpatient care, as well as their relationships with community-based organizations, have made them central to addressing community wide behavioral health care needs. The BETTER Act's expansion of telehealth for psychiatric services will help hospital emergency departments (ED) effectively assist this patient population by greatly reducing the elapsed time between a patient's arrival at the ED and interaction with a psychiatrist. Telepsychiatry can also address the need for behavioral health services in rural communities, where the availability of behavioral health providers is particularly scare. While coverage for telepsychiatry and other services would be maximized if CMS covered all services that are safe to provide, rather than a small list of approved services, we strongly support taking the interim step of adding telepsychiatry to the list of covered telehealth services. We also support the waiver of the geographic site requirements for the delivery of telepsychiatry services, and the inclusion of the patient's home as an eligible originating site for the delivery of these services. We encourage Congress to eliminate all geographic and setting requirements so patients outside of rural areas can also benefit from services safe for delivery via telehealth.

We also applaud the inclusion of H.R. 3425, the Advancing Medical Resident Training in Community Hospitals Act of 2016, as Section 201 of this legislation. This bipartisan legislation would help alleviate the nation's physician shortage by partially addressing CMS's interpretation of the law capping Medicare-funded residency slots.

In 2015, CMS ruled that community hospitals that accept medical resident "rotators" from a teaching hospital risk establishing a very low permanent cap on the number of

Medicare-funded slots, should they choose to open a teaching program at any point in the future. Such hospitals also risk establishing a low permanent resident amount, which is used to determine Medicare direct graduate medical education payments for teaching hospitals. By contrast, under current law, a community hospital that has never accepted a "rotator" is eligible to open a teaching program without statutory limitations on the number of Medicare-funded residents it may train while developing its cap or on the Medicare reimbursement it may receive for such training. CMS's interpretation, therefore, unfairly disadvantages many hospitals that have hosted "rotators" and limits the ability of willing community hospitals to address their communities' workforce needs.

Your legislation would provide relief to hospitals harmed by CMS's policy by eliminating the caps on prospective slots for those hospitals that have hosted up to the equivalent of three full-time equivalent residents. At the same time, numerous hospitals have hosted in excess of that threshold and would not be aided by the bill's provisions. We appreciate the Committee's efforts to begin addressing this issue and look forward to working with you on a more comprehensive approach to clarify that community hospitals that accepted "rotators" for a brief training period are eligible to open a teaching program in the future subject to the same parameters as a hospital that has never accepted "rotators."

National Quality Forum Reauthorization
Finally, the AHA also supports the reauthorization of the National Quality Forum (NQF). NQF's multi-stakeholder, consensus-driven measure endorsement process helps enhance the scientific rigor of the measures used in quality reporting and value programs by evaluating the evidence to support a measure's use, as well as the reliability, accuracy and feasibility of measures. In addition, the statutorily mandated Measure Applications Partnership process ensures that multiple stakeholders have the opportunity to provide input on measures that CMS is considering for future quality programs.

The AHA applauds the Committee's consideration of these important provisions, and we look forward to working with you to enact them into law.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

Cc: Members of the Ways and Means Committee