American Hospital Association

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June 26, 2007

The Honorable Earl Pomeroy
United States House of Representatives
1501 Longworth House Office Building
Washington, DC 20515

Dear Representative Pomeroy:

The Honorable Greg Walden
United States House of Representatives
1210 Longworth House Office Building
Washington, DC 20515

Dear Representative Walden:

On behalf of our 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) is pleased to support the *Health Care Access and Rural Equity Act of 2007* (H-CARE). We applaud your commitment to America's rural health care providers.

By extending critical provisions of the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA) and the *Deficit Reduction Act of 2006* (DRA), the bill would ensure that rural providers continue to receive the assistance they need, and that Congress intended them to have, to take care of patients.

Congress demonstrated its commitment to rural health care by passing several significant provisions in the MMA and DRA, including extension of the outpatient hold-harmless for rural hospitals with fewer than 100 beds, a 2 percent add-on for ambulance trips in rural areas and a 5 percent rural add-on for home health services. Your legislation takes the next step by extending these important provisions.

The AHA also supports extending Section 508 of the MMA to allow certain Medicare wage index reclassifications to proceed in a non-budget neutral way. In contrast to the pending Senate legislation, your bill would extend this provision to all hospitals that qualify under the MMA. It also would rectify an unintended consequence of the original language that prevents other hospitals in the same area as a Section 508 hospital from participating in group reclassifications.

And we appreciate that your legislation introduces new provisions that are vital to rural hospitals, including the removal of the cap on the disproportionate-share adjustment percentages for all hospitals, the rebasing of sole community hospital payments, grants

for the adoption of health information technology and expansion of the 340B drug discount program. The legislation also includes important provisions for Critical Access Hospitals (CAHs), including cost-based reimbursement for outpatient lab services, regardless of where the patient is physically located, the removal of the isolation test for CAH ambulance services, the establishment of minimum payments to CAHs that serve Medicare Advantage patients, regardless of whether they have a contract with the plan; and CAH flexibility with the daily 25 bed limit.

Again, we are pleased to support this legislation and look forward to working with you and your colleagues to achieve its passage.

Sincerely,

Rick Pollack
Executive Vice President