American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 8, 2012

The Honorable Tom Reed
United States House of Representatives
1037 Longworth House Office Building
Washington, DC 20515

Dear Representative Reed:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 42,000 individual members, the American Hospital Association (AHA) is pleased to support *The Rural Hospital Access Act of 2012*, and applauds your commitment to America's rural health care providers.

This legislation would reauthorize both the Medicare-dependent Hospital (MDH) program and provide an extension of the enhanced low-volume Medicare adjustment for prospective payment system (PPS) hospitals for one year through September 30, 2013.

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment.

To reduce this risk and support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the MDH program in 1987. The approximately 200 MDHs are eligible to receive the sum of their PPS payment rate, plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities. Your legislation would extend this important program for one year.

In addition, your legislation would continue the enhanced low-volume Medicare adjustment. Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect the costs of furnishing services. Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment had existed in the inpatient PPS prior to fiscal year 2011, CMS had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year.

The current, improved low-volume adjustment better accounts for the relationship between cost and volume and helps level the playing field for low-volume providers and also sustains and improves access to care in rural areas. If it were to expire, these providers would once again be put at a disadvantage and have severe challenges serving their communities.

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