Congress of the United States

Washington, DC 20515

June 11, 2003

The Honorable William M. Thomas
Chairman, Ways and Means
1102 Longworth HOB
Washington, DC 20515

The Honorable Charles B. Rangel
Ranking Member, Ways and Means
1102 Longworth HOB
Washington, DC 20515

The Honorable Billy Tauzin
Chairman, Energy and Commerce
2125 Rayburn HOB
Washington, DC 20515

The Honorable John Dingell
Ranking Member, Energy and Commerce
2125 Rayburn HOB
Washington, DC 20515

Dear Chairmen and Ranking Members:

Thank you for your continuing efforts to strengthen the Medicare program and to improve the health care of rural Medicare beneficiaries. As you know, improvements in the rural health care delivery system are still needed to ensure adequate access to quality care for all our constituents. On behalf of the 176 members of the bipartisan Rural Health Care Coalition (RHCC), we ask for your continued support to improve rural health care by giving favorable consideration to the legislative provisions described below.

Revision of the Labor Share to 62%: The portion of payments – which is called the "labor-related share"– that are adjusted by the wage index is determined by how much hospitals' payments are directly or indirectly affected by labor costs, according to CMS. Under current law, the labor share is set nationally at 71 percent, which means that the wage index is applied to 71 percent of each inpatient payment. The Medicare Payment Advisory Commission (MedPAC) suggest that wage index is being applied to too much of the inpatient payment and should be reduced. This policy recommendation is important to rural hospitals because many have wage index values below 1.0, which means that currently 71 percent of each inpatient payment is adjusted downward as a result of their relatively low wage index. The RHCC supports reducing the labor share percentage to 62 percent. This change would increase inpatient reimbursement for many rural hospitals and more accurately reflect the labor costs of many rural facilities. Hospitals that would face payment reductions from this change would be held harmless.

Full and Permanent Equalization of the Standardized Payment Amount: The FY03 Omnibus Appropriations bill included a temporary measure (which expires at the end of the fiscal year) that equalizes the Medicare inpatient standardized amount payment. Prior to this provision being enacted, hospitals located in cities serving a population of more than 1 million received payments that were 1.6 percent higher than facilities serving smaller areas. MedPAC has recommended that this disparity be eliminated. The RHCC supports full and permanent equalization of the standardized payment amount.

Permanent Increase for Home Health Services Furnished in Rural Areas: Home health care is a critical element of the continuum of care, allowing Medicare beneficiaries to remain in their homes rather than being hospitalized. Until the provision expired earlier this year, home health services received a 10 percent payment boost for patients residing in rural areas, to reflect the higher costs due to distance, as well as the reality that there is often only one provider in rural areas. This special payment expired on April 1, 2003. The RHCC supports permanent reinstatement of the 10% rural home health add-on payment.

Physician Work Component provision: Medicare payments for physician services are based upon a fee schedule, intended to relate payments for a given service to the actual resources used in providing that service. There are three components of this fee schedule – liability, practice and work. The Center for Medicare and Medicaid Services (CMS) defines "physician work" as the amount of time, skill and intensity necessary to provide service. Each component of the fee schedule is multiplied by a geographic index designed to adjust for variations in cost. The geographic index as it relates to "physician work" is lower in rural areas than in urban areas. Thus, although rural physicians put in as much or even more time, skill, and intensity into their work as physicians in urban areas, rural physicians are paid less for their work. The RHCC supports increasing the work geographic index to 1.0 over a four year period for any locality for which such index is below 1.0. Those fee schedule areas that are currently at or above one will not be affected.

Rural Community Hospital Assistance Act: The Rural Community Hospital Assistance Act improves Medicare reimbursement for Critical Access Hospitals and creates a new payment system for "RCH" hospitals (hospitals with 50 beds or less). The RHCC supports the following changes in Medicare reimbursements for hospitals:

- *Critical Access Hospitals*: Even with the cost-based payments for inpatient and outpatient care, many CAHs still have negative total Medicare margins. The Rural Community Hospital Assistance provisions would modify CAH reimbursement to include some additional reimbursement for technology and infrastructure needs and extend cost-based reimbursement to psychiatric and ambulance services as well as post acute care services, including home health, skilled nursing, and rehabilitation.

- *"RCH" hospitals*: Many rural hospitals are too large to qualify for CAH status but too small to absorb the financial risk associated with PPS programs. The Rural Community Hospital Assistance provisions would allow rural hospitals with less than 50 beds to receive Medicare payments based on actual costs for their inpatient, outpatient, home health and ambulance services. RCH hospitals would also receive additional reimbursement for technology and infrastructure needs.

Medicare Ambulance Payment Reform: Rural ambulance providers are being threatened by inadequate Medicare payments and inappropriate payment denials by Medicare claims processors. The continuing difficulties jeopardize the level of care that ambulance services can deliver, and ultimately may increase the time it takes them to respond to patients. RHCC supports the following changes to improve rural ambulance services:

1. Require Medicare to redo the new ambulance fee schedule to set ambulance payment rates at the "national average cost" of providing service.

2. As part of BIPA, Congress required the General Accounting Office to study how to appropriately define a "rural ambulance provider" and how to adequately compensate them for serving a higher proportion of Medicare beneficiaries. This provision requires use of the study's findings to ensure adequate reimbursement for rural ambulance providers, who not only serve a higher percentage of Medicare patients, but also incur higher per-trip costs due to fewer transports and longer travel distances.

3. Ambulance personnel are prohibited by law from making medical diagnoses. However, when filing a claim for payment, they are forced to describe a patient's medical problem by using "diagnosis-based" codes designed for doctors. This mismatched coding system can prevent ambulance personnel from adequately describing a patient's condition and often leads Medicare claims processors to inappropriately reject as "medically unnecessary" a claim for payment. This section would require Medicare to move to "condition-based" codes that allow ambulance personnel to provide better information to Medicare processors by the end of this year.

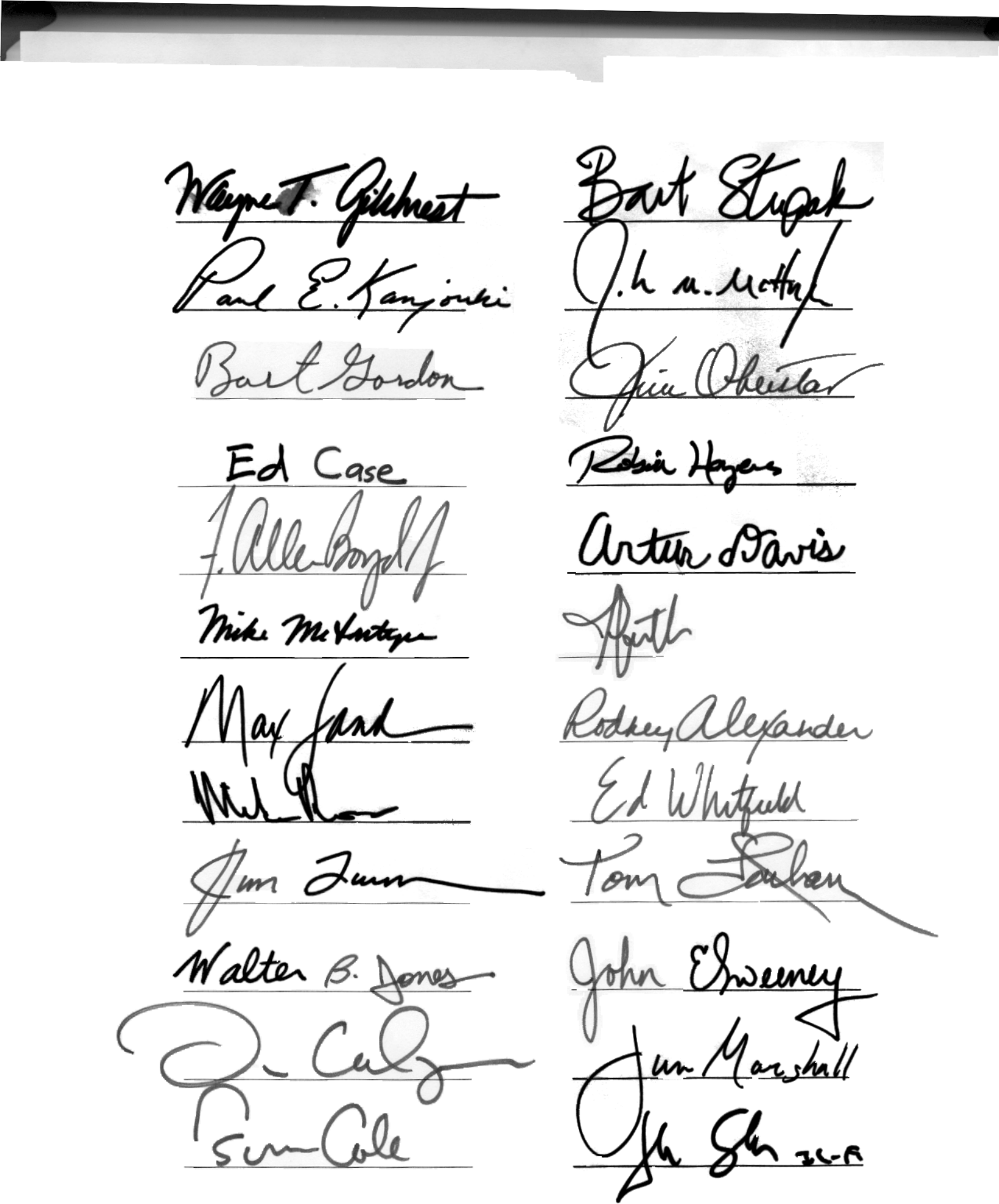
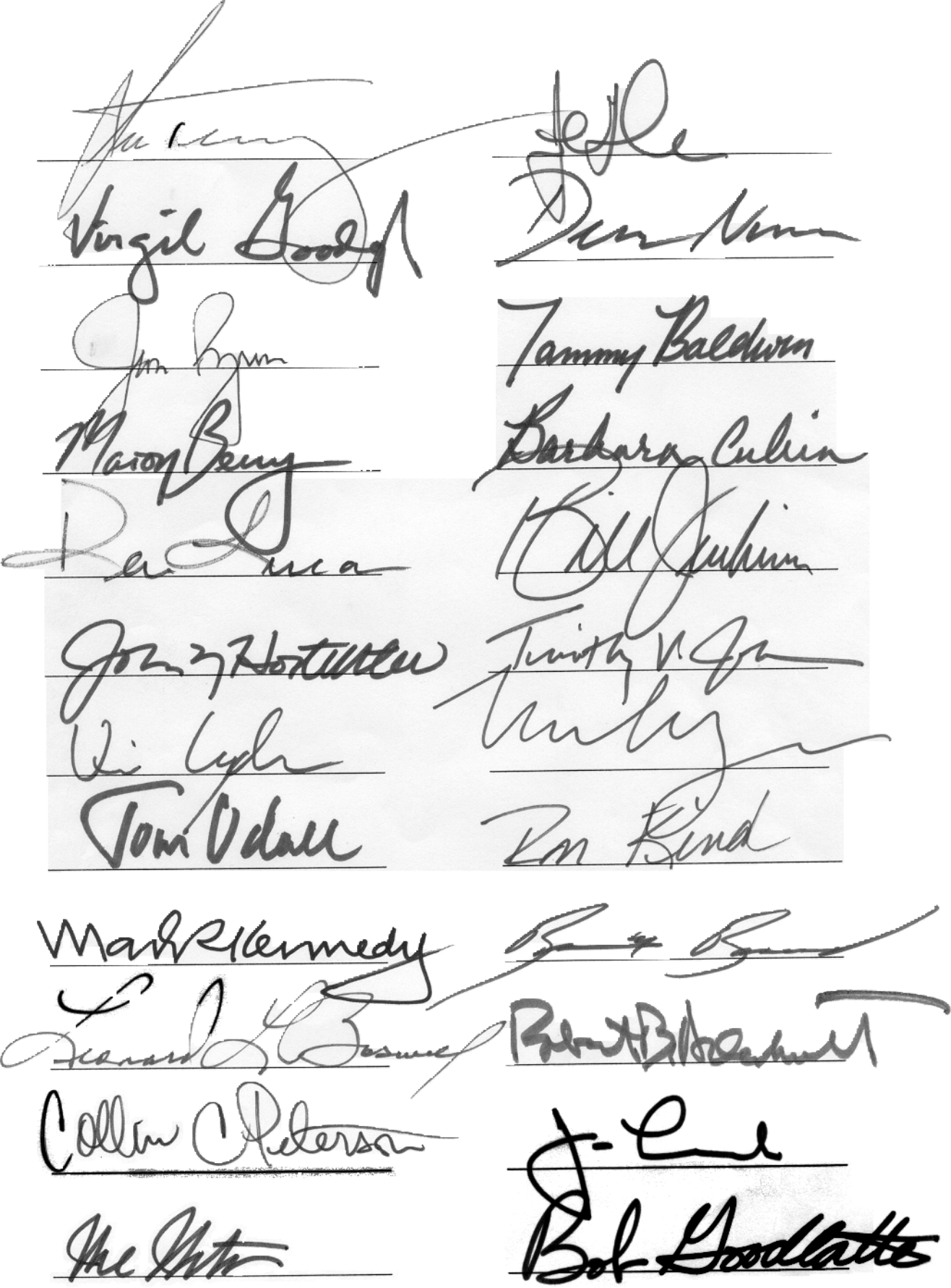
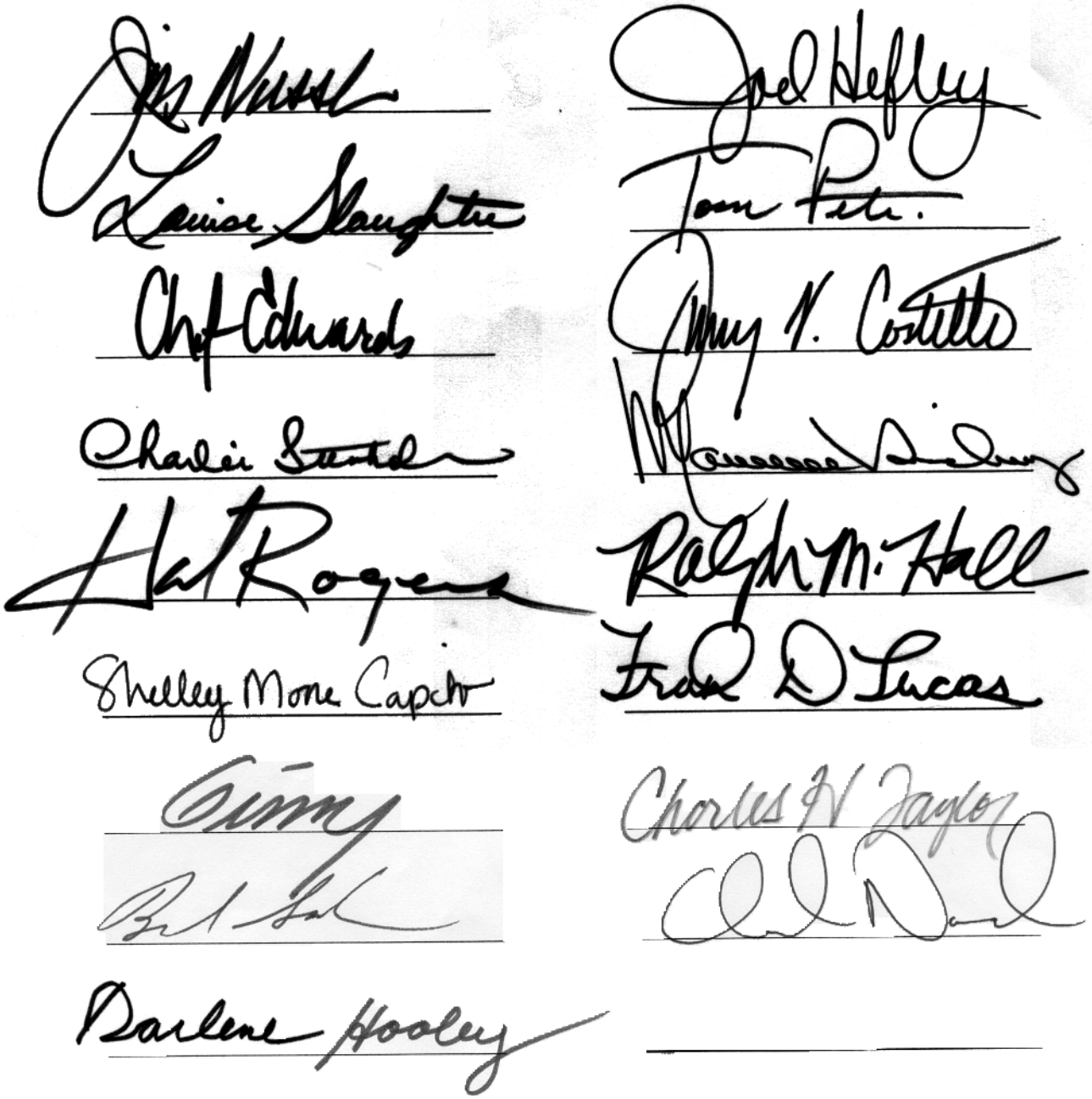
Equalizing Medicare Disproportionate Share Payment: Under current law, hospitals receive add-on payments to help cover the costs of serving a high proportion of uninsured patients. While urban facilities can receive unlimited add-ons corresponding with the amount of patients served, payments for rural hospitals are capped at 5.25 percent of the total amount of the inpatient payment. The RHCC supports removing the cap on rural providers, bringing their payments in line with the benefits urban facilities receive.

Ensuring Rural Communities Retain Access to Independent Lab Services. Recently, due to a change in CMS regulations, independent labs were slated to begin receiving reimbursement directly from hospitals (rather than from Medicare). This would have added a new financial burden on many small, rural facilities. The Benefits Improvement and Protection Act of 2000 temporarily prohibited this payment change from taking place -- allowing labs to continue to bill Medicare. The RHCC supports allowing independent labs to continue receiving reimbursement directly from Medicare.

We feel that these priorities are cost effective and would provide important assistance to our rural health care providers. As you continue to develop a Medicare reform proposal, we look forward to working with you to strengthen the Medicare program and its services to the millions of Americans living in rural and medically underserved areas.

Sincerely,

Jerry Moran
Co-Chairman of the RHCC

Earl Pomeroy
Co-Chairman of the RHCC

Cc: The Honorable J. Dennis Hastert, Speaker
The Honorable Nancy Pelosi, Minority Leader