



Nov. 18, 2003

The Honorable J. Dennis Hastert
Speaker of the House
U.S. House of Representatives
H-232 Capitol Building
Washington, DC 20515

The Honorable Bill Frist
Senate Majority Leader
U.S. Senate
S-230 Capitol Building
Washington, DC 20510

Dear Speaker Hastert and Majority Leader Frist:

On behalf of the more than 1,500 leading, not-for-profit hospitals and health systems allied in Premier, we extend our strong support for the Medicare drug benefit and reform bill (i.e., “agreement in principle”) unveiled on Nov. 16.

In addition to providing meaningful drug coverage for our nation’s seniors, we heartily applaud the bill’s recognition of the *necessity* of adequate and reasonable provider payment improvements. This critical recognition is illustrated by the reported agreement’s inclusion of the following hospital-related provisions:

- A full (marketbasket) hospital inpatient update in FY ‘04, followed by full payment updates in FYs ‘05—‘07, assuming hospitals’ participation in CMS’ Voluntary Hospital Quality (“data reporting”) Initiative;
- Elimination of the Medicaid DSH “cliff” in FY ‘04, via a 16-percent increase in state allotments; also a 16-percent increase in “low-DSH” allotments each year for the next five years;
- Indirect Medical Education (IME) payment increases, via an adjustment of 6.0 percent beginning April 1, 2004, to be followed by adjustments of 5.8 percent for FY ‘05, 5.55 percent for FY ‘06, and 5.35 percent for FY ‘07.

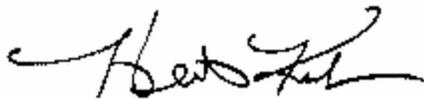
Other provisions in the reported agreement impacting rural providers represents the largest, most comprehensive package of its kind ever considered by Congress, including:

- Receipt by *all* hospitals of the ‘large urban’ standardized payment amount, beginning on April 1, 2004 and extending thereafter;

- Granting of a 62-percent labor share for hospitals with wage indices of less than 1, beginning in FY '05, with all other hospitals being held harmless.
- Increase in Medicare DSH cap from 5.25 percent to 12 percent for rural hospitals and urban hospitals with less than 100 beds, effective April 1, 2004.
- Redefinition of 'low-volume' hospitals to signify less than 800 discharges, with payment adjustment based on empirical relationship between discharges and costs (must meet 25 mile limitation);
- Redistribution of unused graduate medical education payments to rural hospitals and small city hospitals.

To be sure, the reported bill does much to ensure sufficient Medicare funding for the hospitals upon whose care beneficiaries, as well as our communities at large, have come to depend. Again, on behalf of our not-for-profit hospitals and health systems, Premier applauds your leadership in this critical area, and will do its utmost to secure the bill's enactment into law.

Sincerely,



Herb Kuhn
Corporate Vice President
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