

The assistant legislative clerk proceeded to call the roll.

Mr. BARRASSO. I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BARRASSO. I ask unanimous consent to speak for up to 15 minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

#### EXTENSION OF MORNING BUSINESS

Mr. BARRASSO. I ask unanimous consent that morning business be extended until 4:15 p.m.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

#### CRAIG THOMAS RURAL HOSPITAL AND PROVIDER EQUITY ACT

Mr. BARRASSO. Mr. President, it will come as no surprise to many that rural health care issues are near and dear to my heart. Prior to my service in the Senate, I practiced medicine in Casper, WY, for almost a quarter of a century. I have firsthand knowledge of the obstacles families face in obtaining medical care throughout rural America. I also understand the challenges hospitals and providers must overcome in delivering quality care to families in remote areas with limited resources.

To give a snapshot of Wyoming's health care landscape, we have only 26 hospitals spread over nearly 100,000 square miles. With vast distances, complex medical cases, and increased demand for technology and advanced medical care, the rural health care delivery system is not a one-size-fits-all system. I have fought, and will continue to fight each and every day, to protect Wyoming's hospitals, providers, and the patients they serve. This is one of my top legislative priorities. That is why I am an active member of the Senate rural health caucus. For decades the caucus has built a reputation of bipartisan and bicameral collaboration and cooperation. Each Congress we come together to design rural and frontier-specific health care legislation. These efforts have produced incredible results.

For example, when Congress enacted the Medicare Modernization Act of 2003, it included a comprehensive health care package specifically tailored with rural communities, rural hospitals, and rural providers in mind. The Medicare Modernization Act finally put rural providers on a level playing field with other doctors and hospitals across the country.

In Wyoming, that meant hospitals in Worland, Lander, and Torrington could keep their doors open and serve patients as close to home as possible. With the passage of that act, Congress put into place commonsense Medicare

payment equity provisions critical to maintaining access to quality health care in isolated and underserved areas. Rural and frontier America achieved a significant victory. There was much to celebrate. But the mission is not complete. Several of the act's rural health provisions have expired, and many are set to expire soon.

That brings us to the Craig Thomas Rural Hospital and Provider Equity Act or R-HoPE. I have joined Senators CONRAD, ROBERTS, and HARKIN in introducing a comprehensive rural health care bill. The legislation is titled the "Craig Thomas Rural Hospital and Provider Equity Act." This bill reauthorizes expiring rural provisions included in the Medicare Modernization Act. It also takes additional steps to address inequities in the Medicare payment system. These inequities continually place rural providers at a disadvantage.

But there are additional challenges. We have a great need for adequate outpatient reimbursement in smaller towns, towns such as Rawlins, Kemmerer, and Laramie. Rural hospitals such as these are more dependent on Medicare payments as part of their total revenue. In fact, Medicare accounts for approximately 70 percent of total revenue for small rural hospitals. Rural hospitals have lower patient volumes. But these same hospitals must compete nationally to recruit doctors and nurses. This is due to an alarming shortage of nurses and other health care professionals across the country. Additional burdens are placed on these hospitals and providers due to higher rates of uninsured and underinsured patients who live in rural areas. Also, seniors living in rural areas have more financial needs and have increased rates of chronic disease. This legislation would preserve achievements in the Medicare Modernization Act and give much needed relief to rural doctors, nurses, and hospitals.

First, this bill equalizes payments that are known as Medicare disproportionate share hospital payments. These are payments that help hospitals cover the extra costs associated with serving a high proportion of low-income and uninsured patients. It is time we bring rural hospital payments in line with the benefits big city hospitals receive when they are providing medical care to the uninsured.

Second, the bill recognizes that low-volume hospitals do have a higher cost per case, which further puts Wyoming's similar hospitals in the red. This bill would give these unique rural hospitals extra payments, payments that will give Wyoming's low-volume hospitals the resources to continue to provide high-quality, lifesaving medical care. There are several hospitals in my State located in Laramie, Rawlins, Kemmerer, and Lander that need this critical provision.

In addition to the Medicare hospital payment provision, this bill also

strengthens over 3,500 rural health clinics across the country. Many of these communities depend on these clinics for important preventive health care. Currently, rural health clinics receive an all-inclusive capped payment rate that has not been adjusted, except for inflation, since 1988. That is 21 years. So to recognize the rising cost of health care, this measure would raise the rural health clinic cap from \$72 to \$92. This increase makes it comparable to the reimbursement urban community health centers currently receive.

Since every small town cannot support a full-service hospital, rural health clinics are a key component to deliver medical care all across Wyoming. To see how critical this program is, all we have to do is visit two towns in northeastern Wyoming: Moorcroft, a population of 807; and Hulett, population of 434. Residents in these ranching and mining towns depend on their rural health clinics to receive primary medical care as close to home as possible.

Finally, the legislation would help rural areas maintain important emergency medical services. Rural EMS providers are primarily volunteers. They have difficulty recruiting, difficulty retaining, and spend additional time educating EMS personnel. These volunteers have day jobs as farmers, ranchers, teachers, and lawyers. They volunteer because the community needs their help.

Not all Wyoming cities and towns have the resources to pay for this service. Even less have the means to buy and upgrade essential lifesaving equipment. This legislation will allow ambulance providers to collect payments for transporting patients to the hospital after they answer a 911 call—regardless of the final diagnosis of the patient.

Wyoming is blessed with pristine landscapes. These landscapes, though, also present significant challenges. Longer distances, bad weather, and other challenges make obtaining and providing quality health care often difficult. Our unique circumstances require us to work together to share resources and to develop networks.

I believe the Federal Government must continue to recognize the important differences between urban and rural health care and respond with appropriate policy. Washington must remember that one payment system does not fit all. Rural providers provide care for their patients under circumstances much different than their urban counterparts.

This legislation is designed to make sure rural hospitals, rural clinics, rural ambulance providers, rural home health agencies, rural mental health providers, rural doctors, and other critical health clinicians are paid accurately and fairly.

I strongly encourage my colleagues with an interest in rural health to co-sponsor this legislation.

Mr. President, I yield the floor and suggest the absence of a quorum.