Statement by Congressman Greg Walden
Co-Chair, Rural Health Care Coalition

Rural Health Care Coalition Press Conference on H.R. 5118
The Medicare Rural Health Provider Payment Extension Act
April 27, 2006

Good morning and thank you for coming today. My friend and Rural Health Care Coalition Co-Chairman Earl Pomeroy and I would like to extend our appreciation to our colleagues gathered with us here this morning, including John Peterson and Allan Boyd, co-chairs of the House Rural Caucus. We stand before you united behind the critical issue of ensuring access to health care for rural Americans.

As the representative of a district covering approximately 72,000 square miles (larger than any state east of the Mississippi River) and a former member of a hospital board of directors, I understand clearly that rural areas face unique issues and challenges when it comes to health care delivery.

Nearly 25% of Americans live in rural areas, yet only 10% of physicians practice in those areas; rural residents have greater transportation difficulties reaching health care providers, often needing to travel great distances to reach a doctor or hospital; and residents in rural areas tend to be older and have less income than residents in urban areas.

With nearly a quarter of rural Americans receiving Medicare benefits and the baby-boomer population quickly approaching eligibility, ensuring that Medicare payments and reimbursements for rural health providers are fair and reasonable is critical to maintaining access to quality care in isolated and underserved areas.

Three years ago, when Congress enacted the Medicare Modernization Act (MMA), we recognized that health care services in rural areas were in jeopardy and we took steps to remedy the situation by enacting common-sense provisions for Medicare reimbursement methods for providers in those regions. The MMA included the largest rural provider payment package ever considered by Congress. However, six of these critical provisions have expired or are set to expire this year. We now have a responsibility to renew the commitment made by Congress three years ago to the health care needs of rural America.

Earlier this month, Congressman Pomeroy and I introduced the bipartisan Medicare Rural Health Provider Payment Extension Act, H.R. 5118, to reauthorize these expiring provisions through 2011. We were joined by 47 original cosponsors and today we have more than fifty cosponsors on the legislation. As you can see from those gathered today and those on the list of cosponsors, the bill has gathered strong support from both parties and from all parts of this great nation. H.R. 5118 has also earned the strong support of the National Rural Health Association, the American Osteopathic Association, the American Hospital Association and the National Association for Home Care and Hospice. I appreciate them being here today as well.

In Oregon's Second District, which includes twenty counties across the state, there are eight counties that have fewer than seven physicians, and two of these counties have none at all. The scarcity of physicians in rural Oregon is mirrored throughout the nation and only compounds the difficulty in accessing quality health care. The MMA established an incentive program for doctors who provide services in designated physician scarcity areas to encourage heightened levels of care in isolated communities. We cannot afford to lose any of the health care providers currently operating in rural areas and the extension of this incentive program, including in H.R. 5118, is a critical piece of that effort.

There are currently 535 sole community hospitals in America providing rural communities with local access to a wide range of health care services. Sole community hospitals allow Medicare beneficiaries in isolated communities to obtain necessary services otherwise only available at larger, regional medical centers. Another critical provision in H.R. 5118 would ensure that hospitals will continue to be reimbursed at reasonable rates for services provided to patients as opposed to outdated rates or those incommensurate with costs incurred for service. This provision would help ensure the continued viability of sole community hospitals.

An example of what will happen without extension of this provision recently unfolded in my district. Last year, four sole community hospitals operated in central, southern and eastern Oregon. However, one of these facilities recently reduced patient services to achieve a classification other than a sole community hospital, becoming eligible for more fair reimbursements rates. We must reauthorize this provision to ensure that more hospitals are not faced with a similar choice, further isolating rural Americans from specialized health care services.

Additionally, H.R. 5118 would extend the five-percent Medicare payment adjustment to home health agencies that treat beneficiaries in rural areas. It is estimated that costs to provide home care in rural areas can be as much as 12- to 15-percent higher than urban areas given the greater distances between patients. These higher costs threaten the ability of home care providers to stay in business serving rural and isolated areas. There are 22 home health agencies operating in my district providing services to residents in every county in southern, central and eastern Oregon. The five-percent payment adjustment will help these agencies–and those throughout the nation–continue to provide much-needed services.

In Oregon, ambulance service providers are, on average, reimbursed for only 70-percent of costs incurred for emergency medical and transport services for Medicare beneficiaries, which account for a vast majority of their business. This discrepancy is compounded in rural areas given the higher cost of patient transport as a result of greater driving distances and the rising costs of gasoline (which is estimated to be 22-percent higher in rural areas). These high discrepancies could lead to greatly reduced ambulance services in rural communities, which is why H.R. 5118 would extend the two-percent bonus payment for ambulance services in rural areas. This bonus payment would help offset the higher costs of doing business in isolated areas, ensuring that rural Americans continue to have access to crucial emergency medical and ambulance services.

H.R. 5118 would also extend the 1.0 floor on Medicare reimbursements to rural areas to ensure fair and reasonable repayment to facilities and care providers in rural areas. Providers in rural areas are often reimbursed at a rate lower than 1.0 due to a geographic adjustment that does not accurately reflect health care costs. As a result, providers in rural areas receive less than actual costs incurred for services provided to Medicare beneficiaries. A procedure or hospital stay is no different in Portland than it is in Burns, and the physician or facility providing services shouldn't be unjustly penalized based purely on location.

Often, a local rural hospital is the only lab facility serving a given region, and although lab work conducted for patients in the hospital or those in a local nursing home is the same, hospitals are reimbursed at a lower rate for clinical lab work for patients that do not have specimens actually drawn in the hospital. This lower reimbursement rate drives up the overall cost of lab work for patients in the region and could lead to greater inaccessibility for lab work conducted for home bound patients, those in nursing homes or those who live far from the actual hospital. The final provision in H.R. 5118 would extend reasonable cost reimbursements performed by rural hospitals as part of their outpatient services, maintaining accessibility to basic lab services in isolated regions.

H.R. 5118 helps preserve rural Americans' access to a basic level of health care services, including everything from home care and ambulance trips to lab work and access to physicians. It is important that Congress renew the commitment made to rural America through passage of the Medicare Modernization Act of 2003 by passing H.R. 5118 to reauthorize expiring critical rural health provider payment provisions.

Again, I appreciate the support shown by my colleagues who have cosponsored the bill and that of the organizations who have endorsed it. I look forward to working with them as we advance this legislation through Congress on behalf of rural America.