Medicare Rural Health Provider Payment Extension Act (H.R. 5118)

H.R. 5118 would renew the federal government's commitment to ensuring access to quality and affordable health care in rural communities throughout America by extending certain Medicare payment relief to rural health care providers through 2011.

Extends 5% payment adjustment for home health services provided in rural areas (Sec. 421 of MMA, currently scheduled to expire on 01/01/07).

Rural home health delivery costs can be as much as 12 to 15 percent higher than in urban areas. Long distances between patients in rural areas result in additional travel costs and less patient volume per day, increasing per-patient and per-visit costs and threatening the ability of home health providers to stay in business. This provision would help ensure that home health providers in rural areas – including the 22 operating in central, southern and eastern Oregon – are able to keep their doors open to provide quality and affordable care.

Extends outpatient PPS hold harmless treatment for sole community hospitals and small rural hospitals (Sec. 411 of MMA, expired on 01/01/06).

535 sole community hospitals across America currently provide inpatient health services for residents in isolated, rural communities, including St. Charles Medical Center in Bend, Mid Columbia Medical Center in The Dalles and Merle West Medical Center in Klamath Falls. However, these hospitals are often reimbursed by Medicare at rates that are outdated or incommensurate with costs incurred. As a result, some hospitals choose to reduce services or patient capacity, as recently evidenced by Good Shepherd Medical Center in Hermiston reducing the number of patients it services so they would fall into a more equitable reimbursement category. This provision will allow these hospitals to continue providing valuable advanced and specialty care in rural communities throughout America.

Extends Medicare incentive payment program for physicians practicing in designated Physician Scarcity Areas (Sec. 413 of MMA, currently scheduled to expire on 01/01/08).

In central, southern and eastern Oregon, there are eight counties with seven or fewer doctors, two of which have none at all. And three counties in the district do not have hospitals. Nationwide, there are nearly 1,500 counties and many other communities outside of these whole counties designated as Physician Scarcity Areas. The Medicare incentive program has encouraged doctors to provide basic physician services and specialty care to these areas, improving access to care for rural Oregonians and rural Americans across the country.

Extends the 1.0 floor on Medicare work geographic adjustment applied to physician payments through 2011 (Sec. 412 of MMA, currently scheduled to expire on 01/01/07).

Although rural physicians put in as much time, skill and intensity into their work as physicians in urban areas, rural physicians were paid less for their work prior to this provision in MMA. If allowed to expire, geographic adjustments to reimbursements will result in lower payments for rural areas despite the often higher cost of health care delivery in these areas. The 1.0 floor on reimbursements ensures that physicians in rural areas receive fair compensation and payments are not reduced simply due to geography.

Extends Medicare 2% bonus payments for ambulance trips in rural areas through 2011 (Sec. 414 of MMA, currently scheduled to expire on 01/01/07).

As a result of greater driving distances, ambulance services in rural areas are more expensive than urban areas, and this cost is only compounded further with today's rising gasoline prices. The 2% bonus reimbursement helps offset these higher costs, allowing patients in rural areas to continue receiving critical emergency medical services.

Extends reasonable cost payment for clinical lab tests performed by rural hospitals as part of their outpatient services through July 2011 (Sec. 416 of MMA, currently scheduled to expire on 07/01/07).

Many critical access hospitals provide lab services for patients receiving home care or care in nursing homes or clinics. However, because these patients are not receiving care in the hospital, a lower reimbursement rate is paid for their lab work despite the fact that the actual lab work conducted for is the same regardless of where the patient receives his or her care. This reimbursement discrepancy may make it prohibitive for critical access hospitals to continue testing for off-site patients, limiting access to routine lab test and analyses in rural areas for patients in nursing homes or those that are home-bound.

Support for H.R. 5118

American Hospital Association · National Rural Health Association
American Osteopathic Association · National Association for Home Care and Hospice

H.R. 5118 Cosponsors

(denotes non-original cosponsors)*

Greg Walden	Doc Hastings	Collin Peterson
Earl Pomeroy	Stephanie Herseth	John Peterson
Rodney Alexander	Maurice Hinchey	Chip Pickering*
Thomas Allen	Ruben Hinojosa	Rick Renzi
Marion Berry	Darlene Hooley	Mike Ross
Sanford Bishop	Ron Kind	Bernie Sanders
Rick Boucher	Sheila Jackson-Lee	Bill Shuster
Allen Boyd	Jim Marshall	Mike Simpson
Shelley Moore Capito	Jim Matheson	Ike Skelton
Ed Case	John McHugh	Bart Stupak
Jerry Costello	Mike McIntyre	John Sweeney
Barbara Cubin*	Cathy McMorris	John Tanner
Jo Ann Davis	Michael McNulty*	Gene Taylor
Lincoln Davis	Jerry Moran	Tom Udall
Peter DeFazio	Charlie Norwood*	Ed Whitfield
Jo Ann Emerson	James Oberstar	Roger Wicker
Lane Evans	Solomon Ortiz	Don Young
Sam Graves	Ron Paul	

For additional information, please contact Congressman Greg Walden's office (202.225.6730) or Congressman Earl Pomeroy's office (202.225.2611).