

under the transitional corridor provisions of the statute.

Since small rural hospitals may not be able to achieve the same level of operating efficiencies as larger rural hospitals and urban hospitals, we were concerned that the possible decrease in payments to these hospitals resulting from the elimination of the transitional corridor payments could result in these hospitals having to decrease or altogether cease to provide certain outpatient services. A reduction of services could have consequences for Medicare beneficiaries and their continued access to care in rural areas. In light of these concerns, we stated in the August 12, 2003 proposed rule that one thing we could do is to provide increased APC payments for clinic and emergency room visits furnished by rural hospitals having 100 or fewer beds. Any adjustment to payments for these hospitals would be made under the authority granted to the Secretary under section 1833(t)(2)(E) of the Act, to establish in a budget neutral manner adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals. In the August 12, 2003 proposed rule, we invited comments on whether we should provide an adjustment, such as the one described above, for small rural hospitals.

We received a few comments regarding the elimination of transitional corridor payments, which are summarized below along with our responses.

Comment: Two commenters stated that the loss of transitional corridor payments would dramatically affect revenues for rural hospitals; therefore, they supported increased payments to rural hospitals for clinic and emergency room visits. One hospital association recommended that we provide appropriate payment protections for small rural hospitals that provide emergency services to safeguard them from any adverse consequences stemming from the elimination of transitional corridor payments and to avoid life-threatening consequences by protecting beneficiaries' timely access to emergency services. Two additional commenters contended that our proposal would be inadequate and that to avoid curtailing services to Medicare beneficiaries relief is needed for small rural hospitals, sole community hospitals, and rural referral centers. They recommended that we continue transitional corridor payments using the authority we have to make adjustments under section 1833(t)(2)(E) of the Act. One commenter stated that our proposal failed to address other outpatient

services that will be underpaid and suggested that transitional corridor payments be continued for a year while a more broad based payment methodology is developed for small rural hospitals. Another commenter recommended a rural APC add-on adjustment for all APCs paid to rural hospitals to acknowledge that these hospitals cannot achieve the same level of operating efficiencies as larger rural and urban hospitals. Another commenter argued that termination of transitional corridor payments was detrimental to all hospitals and recommended retaining transitional corridor payments for all hospitals.

One commenter opposed shifting payments from larger hospitals in order to increase payments to small rural hospitals. The commenter stated that all hospitals, regardless of size and location, struggle with gaining operating efficiencies under the OPPIs. One hospital association indicated that transitional corridor payments have been a critical source of financial support for many teaching hospitals and payments to these hospitals deserve further analyses by us, which would likely result in the conclusion that a teaching hospital adjustment is warranted. Several hospital associations expressed concern about our proposal to create differential payment rates between urban and rural hospitals for clinic and emergency room visits, and one questioned our legal authority to pay differently for the same service. One of the associations added that as a preferred alternative, it is urging the Congress to allocate additional resources to extend the transitional corridor and hold harmless provisions to all providers as well as urging the Congress to increase payments for clinic and emergency room visits for all hospitals. Another of the hospital associations stated that it does not support a budget neutral, redistributive adjustment through regulation, but is instead urging the Congress to allocate additional resources to assist rural hospitals by increasing payment rates for clinic and emergency room visits for all hospitals.

The Medicare Payment Advisory Commission (MedPAC) commented that the August 12, 2003 proposed rule failed to provide a rationale for proposing increased payments for emergency room and clinic visits as a means of supporting small rural hospitals and recognized that only limited cost report data are available to assess the performance of small rural hospitals under the OPPIs. MedPAC stated that we should consider other regulatory options to ensure access to

care for rural beneficiaries, such as a low-volume adjustment and pointed out that any payment adjustment should be accompanied by an analysis of how small rural hospitals have fared under the OPPIs, the impact of any payment adjustment, and the impact of other policies that affect rural hospitals such as conversion to critical access status. MedPAC also stated that legislative remedies could include extending the hold harmless policy or providing a transition from hold harmless status.

Response: Although we expressed concerns in the August 12, 2003 proposed rule that the sunset of transitional corridor payments might significantly impact small rural hospitals and we invited comments about whether we should provide for some type of adjustment to payments for these hospitals, we did not receive a large number of comments and the comments we did receive are mixed on the issue. Although some commenters called for an extension of hold harmless transitional corridor payments for small rural hospitals, we do not believe that is a viable option because any adjustment we would make under the authority of section 1833(t) of the Act would have to be made on a budget neutral basis and would result in decreased APC payments for all providers. Because we did not receive a strong response in favor of increased visit payments to small rural hospitals or compelling evidence that clearly supported the position that an adjustment for small rural hospitals is necessary to ensure access to hospital outpatient services in areas served by small rural hospitals, we will not adopt a payment adjustment for small rural hospitals. We will continue to seek information related to specific situations that demonstrate that access to care is a problem for Medicare beneficiaries.

XI. Other Policy Decisions and Changes

A. Hospital Coding for Evaluation and Management (E/M) Services

Facilities code clinic and emergency department visits using the same [Physicians'] Current Procedural Terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are currently five levels of care. Because these codes were defined to reflect only the activities of physicians, they are inadequate to describe the range and mix of services provided to patients in the clinic and emergency department settings (for example, ongoing nursing care, preparation for diagnostic tests, and patient education).