this reason, this action is also not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This action merely approves state law as meeting Federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

This rule also does not have tribal implications because it will not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This action merely approves a state rule implementing a Federal standard, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045 ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by April 29, 2003. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (*See* section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Particulate matter, Reporting and recordkeeping requirements.

Dated: February 11, 2003.

Max H. Dodson,

Acting Regional Administrator, Region 8.

Chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart JJ—North Dakota

2. Section 52.1820 is amended by adding paragraph (c)(32) to read as follows:

§ 52.1820 Identification of plan.

* * * * *

(c) * * *

(32) The Governor of North Dakota submitted revisions to the North Dakota State Implementation Plan and Air Pollution Control Rules with a letter dated June 21, 2001. The revisions address air pollution control rules regarding general provisions, emissions of particulate matter and fugitives, exclusions from Title V permit to operate requirements, and prevention of significant deterioration.

(i) Incorporation by reference.

(A) Revisions to the Air Pollution Control Rules as follows: General Provisions 33–15–01–04, 33–15–01–12, and 33–15–01–15; Emissions of Particulate Matter Restricted 33–15–05–04.1; Designated Air Contaminant Sources, Permit to Construct, Minor Source Permit to Operate, Title V Permit to Operate 33–15–14–02.13.b.1, 33–15–14–03.1.c, and 33–15–14–07; Prevention of Significant Deterioration of Air Quality 33–15–15–01.1.hh and 33–15–15–01.2; and Restriction of Fugitive Emissions 33–15–17–01, effective June 1, 2001.

(B) Revisions to the Air Pollution Control Rules as follows: Emissions of Particulate Matter Restricted 33–15–05–03.1, repealed effective July 12, 2000.

[FR Doc. 03–4770 Filed 2–27–03; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 414, and 485

[CMS–1204–F2]

RIN 0938–AL21

Medicare Program; Physician Fee Schedule Update for Calendar Year 2003

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule revises the estimates used to establish the sustainable growth rates (SGRs) for fiscal years 1998 and 1999 for the purposes of determining future updates to the physician fee schedule and announces a 1.6 percent increase in the calendar year (CY) 2003 physician fee schedule conversion factor (CF) for March 1 to December 31, 2003. The physician fee schedule CF from March 1 to December 31, 2003, will be

$36.7856. The anesthesia CF for this period will be $17.05. Any information contained in this final rule related to the CY 2003 physician or anesthesia CFs takes the place of the information contained in the December 31, 2002, final rule. All other provisions of the December 31, 2002, final rule are unchanged by this final rule.

DATES: *Effective date:* This rule is effective on March 1, 2003.

FOR FURTHER INFORMATION CONTACT: Marc Hartstein, (410) 786–4539.

SUPPLEMENTARY INFORMATION:

I. Provisions of the Final Rule

In the physician fee schedule final rule with comment period published on December 31, 2002 (67 FR 80018), following notice and comment, we announced a 4.4 percent reduction in the physician fee schedule conversion factor (CF) for 2003. As explained in the December 31, 2002, final rule, we determined the 4.4 percent reduction to the CF using the formula specified in statute. We explained that the statute did not allow us to use later, after the fact, data to revise estimates that were used to determine the sustainable growth rates (SGRs) for fiscal year (FY) 1998 and FY 1999 for the purposes of determining future updates to the physician fee schedule. We further indicated our preference for revising these estimates and establishing a positive update to CY 2003 physician fee schedule rates, if the Congress changed the law to permit these revisions, and we requested comments on how physician fee schedule rates could and should be recalculated prospectively in the event that the Congress provided the Department with legal authority to revise estimates used to establish the SGRs for FY 1998 and FY 1999 and the MVPS for 1990 through 1996.

On February 13, 2003, the Congress enacted the Consolidated Appropriations Resolution of 2003 (CAR), (Pub. L. 108–7) that was signed into law by the President on February 20, 2003. Before enactment of section 402(a) of the CAR, section 1848(i)(1)(C) of the Social Security Act (the Act) precluded judicial review of ''the determination of conversion factors under subsection (d).'' Section 402(a) of the CAR amended section 1848(i)(1)(C) of the Act to preclude judicial review of ''the determination of conversion factors under subsection (d), including without limitation a prospective redetermination of the sustainable growth rates for any or all previous fiscal years.'' We believe that with this amendment, section 1848, read as a whole, now permits revision of all earlier fiscal year SGRs for the purposes of allowing prospective application of those revisions to future physician fee schedule updates (that is, to the CY 2003 physician fee schedule update). Thus, we are now revising the FY 1998 and FY 1999 SGRs for the purposes of determining future updates to the physician fee schedule including a new physician fee schedule update that will apply from March 1 to December 31, 2003.

As we noted in our final rule of December 31, 2002, CMS believes the estimates used to set the SGRs for FY 1998 and FY 1999 were 6.4 percent lower than if after-the-fact, actual data could have been used, with the greatest differences arising from fee-for-service enrollment in Medicare and real per capita growth in the gross domestic product (GDP). The reasons for the differences between these estimates and later, after-the-fact actual data for 1998 and 1999 are described in more detail below. We noted in our December 31, 2002, final rule that as a result of using estimates in determining the SGRs for FY 1998 and FY 1999, physicians would receive lower payments for their services than if the SGRs and allowed expenditures for those fiscal years were recalculated to reflect later, after-the-fact actual data.

Although the estimates used to set the SGRs for 1998 and 1999 may have been different from later, after-the-fact actual data, before the enactment of section 402(a) of the CAR, section 1848 of the Act did not permit the SGRs for these two fiscal years (1998 and 1999) to be revised later, once ''actual'' data, or better estimated data became available.

In addition to our final rule of December 31, 2002, we set forth this position in several of our annual notices in previous years in which we announced the CF for the coming year. (''We will not be able to make adjustments to the [1998 and 1999] SGRs based on later data.'' 64 FR 53394. *See also* 63 FR 69188.) These notices indicated that section 1848 of the Act did not provide the necessary authority to revise the original estimates used to establish the SGRs for FY 1998 and FY 1999 for the purposes of establishing physician fee schedule updates for future years. We believe that as amended by the recently enacted CAR, section 1848 as a whole now permits the prospective redetermination of SGRs for these two previous years.

Section 402(a) of the CAR added language to the ''non-reviewability'' provisions of section 1848(i) of the Act. Section 402(a) added the phrase ''including without limitation a prospective redetermination of the sustainable growth rate for any or all previous fiscal years'' to a non-reviewability provision that already existed at section 1848(i)(1)(c). Use of the word ''including'' in statutory language is typically constructed to mean ''including but not limited to.'' In other words, we believe that the Congress added the new language as a new, non-exclusive example of the instances of non-reviewability that already exist. The example in the added phrase refers to a ''prospective redetermination of the sustainable growth rate for any or all fiscal years.'' (Emphasis added). Prior to the enactment of section 402(a) of the CAR, the substantive provisions of section 1848 of the Act provided only for the prospective redetermination of the SGR for one ''fiscal year,'' that ''fiscal year'' being FY 2000. The Balanced Budget Refinement Act of 1999 (BBRA) amended section 1848(f)(3) of the Act to change the physician fee schedule to a calendar year system of calculating the SGR beginning in ''calendar year'' 2000. Thus, we believe that section 402(a) demonstrates the Congress's intent that section 1848 as a whole be read to permit a prospective redetermination of the SGRs for ''any or all'' ''fiscal'' years in the plural, to wit, fiscal years 1998 and 1999, in addition to fiscal year 2000. Section 402(a) of the CAR calls for a change in the agency's prior interpretation of section 1848 of the Act as precluding any revision of the SGRs for fiscal years 1998 and 1999 to permit prospective redetermination of SGRs for these ''fiscal years'' in addition to existing authority for fiscal year 2000. This reading of section 402(a) of the CAR is consistent with the congressional intent behind section 402(a). The Conference Report for the CAR notes that section 402(a) is intended to ''[provide] legal protection for the Administration should they make corrections to data errors in the physician payment formula for past fiscal years.'' (House Rpt. 108–10).

These prospective redeterminations will not have, and are not intended to have, any effect on physician fee schedule payment rates for previous years. (We are making no further revisions to the FY 2000 SGR because section 1848(f)(3) of the Act expressly specifies that we were to make the final revisions to the FY 2000 SGR on the basis of the best data available to the Secretary as of September 1, 2001. Accordingly, we made our final revisions to the FY 2000 SGR in a final rule published in the **Federal Register** on November 1, 2001 (66 FR 55319).)

In this final rule, we are announcing that for the purposes of determining

future physician fee schedule updates, including the update for 2003, the SGR was 3.2 percent for FY 1998 and 4.2 percent for FY 1999. This is a change of 1.7 percentage points for FY 1998 and 4.5 percentage points for FY 1999. We will make no further revisions to the SGRs for these years. We are also announcing a 1.6 percent increase to the physician fee schedule CF that will apply from March 1 to December 31, 2003. Therefore, the physician fee schedule CF from March 1 to December 31, 2003, will be $36.7856, an increase of 1.6 percent from the 2002 CF. The anesthesia CF for this period will be $17.05, an increase of 2.7 percent from the 2002 anesthesia CF. In our December 31, 2002 final rule (67 FR 80032), we described our calculation of the 2003 physician fee schedule and anesthesia fee schedule CFs. Any information contained in this final rule related to the 2003 physician or anesthesia fee schedule CFs replaces the information contained in the December 31, 2002, final rule. Further, we are making one revision to our estimate of the CY 2002 SGR. As described below, we are increasing our estimate of the 2002 SGR by 0.2 percentage points to reflect the costs of the new diabetes self-management training benefit. All other provisions of the December 31, 2002, final rule are unchanged by this final rule.

In the December 31, 2002, final rule, we specifically requested comments on the revision of estimates used to establish the Medicare Volume Performance Standard from 1990 through 1996 and the SGRs from FY 1998 and FY 1999. We will respond to any comments received on these issues in a future **Federal Register** publication.

II. Physician Fee Schedule Update

A. Calculation of the Physician Fee Schedule Update

The physician fee schedule update is determined under a methodology specified by statute. Under section 1848(d)(4) of the Act, the update is equal to the product of 1 plus the percentage increase in the Medicare Economic Index (MEI) (divided by 100) and 1 plus the update adjustment factor. For CY 2003, the MEI is equal to 3.0 percent (1.030). The update adjustment factor is now equal to −1.1 percent (0.989). Section 1848(d)(4)(F) of the Act requires an additional −0.2 percent (0.998) reduction to the update for 2003. Thus, the product of the MEI (1.030), the update adjustment factor (0.989), and the statutory adjustment factor (0.998) equals the CY 2003 update of 1.66 percent (1.0166). As described below, we are also making an adjustment of −0.04 percent to maintain budget neutrality for the increase in anesthesia work. With the budget-neutrality adjustment, the increase in the physician fee schedule CF will be 1.62 percent (1.0162).

B. The Update Adjustment Factor

Section 1848(d) of the Act provides that the physician fee schedule update is equal to the product of the MEI and an ''update adjustment factor.'' The update adjustment factor is applied to make actual and target expenditures (referred to in the law as ''allowed expenditures'') equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the SGR. The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

Under section 1848(d)(4)(A) of the Act, the physician fee schedule update for a year is equal to the product of—(1) 1 plus the Secretary's estimate of the percentage increase in the MEI for the year, divided by 100 and (2) 1 plus the Secretary's estimate of the update adjustment factor for the year. Under section 1848(d)(4)(B) of the Act, the update adjustment factor is equal to the sum of the following—

i. *Prior Year Adjustment Component.* An amount determined by—

- Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for such services for that year;
- Dividing that difference by the amount of the actual expenditures for such services for that year; and
- Multiplying that quotient by 0.75.

ii. *Cumulative Adjustment Component.* An amount determined by—

- Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;
- Dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate for the year for which the update adjustment factor is to be determined; and
- Multiplying that quotient by 0.33.

As explained above, we are making final prospective redeterminations to the FY 1998 and FY 1999 SGRs in this final rule for the purposes of determining future physician fee schedule updates. We are also making prospective redeterminations to allowed expenditures for the period from April 1, 1997, to March 31, 1999, because allowed expenditures during this period are affected by revisions to the FY 1998 and FY 1999 SGRs. Further, allowed expenditures in all subsequent periods are based on allowed expenditures from this period and are also being prospectively redetermined. Table 1 shows annual and cumulative allowed expenditures for physicians' services from April 1, 1996, through the end of the current CY, including the transition period to a CY system that occurred in 1999, incorporating the redeterminations we are making to the SGRs for FY 1998 and FY 1999.

TABLE 1

Period	Annual allowed expenditures (billion)	Cumulative allowed expenditures (billion)	FY or CY SGR (percent)
4/1/96–3/31/97	$48.9	$48.9	N/A
4/1/97–3/31/98	50.5	99.4	FY 1998=3.2%
4/1/98–3/31/99	52.6	152.0	FY 1999=4.2%
1/1/99–3/31/99	13.3	(1)	FY 1999=4.2%
4/1/99–12/31/99	42.1	(2)	FY 2000=6.9%
1/1/99–12/31/99	55.3	194.1	FY 1999/FY 2000 [3]
1/1/00–12/31/00	59.4	253.4	CY 2000=7.3%
1/1/01–12/31/01	62.0	315.5	CY 2001=4.5%
1/1/02–12/31/02	67.6	383.1	CY 2002=9.0%

TABLE 1—Continued

Period	Annual allowed expenditures (billion)	Cumulative allowed expenditures (billion)	FY or CY SGR (percent)
1/1/03–12/31/03	72.8	455.9	CY 2003=7.6%

[1] Included in $152.0.
[2] Included in $194.1.
[3] **Note:** Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR and allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR. Allowed expenditures in the first year (April 1, 1996, through March 31, 1997) are equal to actual expenditures during the year. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our Web site under the Medicare Actuary's publications at the following address: *http://www.cms.hhs.gov/statistics/actuary/.* We expect to update the web site with the most current information, including our estimate of the physician fee schedule update for 2004 on or about March 1.

Consistent with section 1848(d)(4)(E) of the Act, Table 1 includes our final revision of allowed expenditures for 2001 and prior periods, a recalculation of allowed expenditures for 2002, and our initial estimate of allowed expenditures for 2003. We will be making further revisions to the 2002 and 2003 SGRs and allowed expenditures later this year through the normal rulemaking process. To determine the update adjustment factor for March 1 to December 31, 2003, we are using cumulative allowed expenditures from April 1, 1996, through December 31, 2002, actual expenditures through December 31, 2002, and the SGR for 2003, as well as annual allowed and actual expenditures for 2002. We are using estimates of allowed expenditures for 2002 and 2003 that will subsequently be revised consistent with section 1848(d)(4)(E) of the Act. Because we are continuing to receive expenditure data for 2002, we are using an estimate for this period. Any differences between current estimates and final figures will be taken into account in determining the update adjustment factor for future years.

We are using figures from Table 1 in the statutory formula illustrated below:

$$UAF = \frac{Target_{02} - Actual_{02}}{Actual_{02}} \times .75 + \frac{Target_{4/96\text{-}12/02} - Actual_{4/96\text{-}12/02}}{Actual_{02} \times SGR_{03}} \times .33$$

UAF = Update Adjustment Factor
$Target_{02}$ = Allowed Expenditures for 2002 or $67.6 billion
$Actual_{02}$ = Estimated Actual Expenditures for 2002 = $69.1 billion
$Target_{4/96–12/02}$ = Allowed Expenditures from 4/1/1996—12/31/2002 = $383.1 billion
$Actual_{4/96–12/02}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2002 = $381.9 billion
SGR_{03} = 7.6 percent (1.076)

$$\frac{\$67.6 - \$69.1}{\$69.1} \times .75 + \frac{\$383.1 - \$381.9}{\$69.1 \times 1.076} \times .33 = -0.011$$

Section 1848(d)(4)(A)(ii) of the Act indicates that 1 should be added to the update adjustment factor determined under section 1848(d)(4)(B) of the Act. Thus, adding 1 to −0.011 makes the update adjustment factor equal to 0.989.

III. Medicare Sustainable Growth Rate

As discussed above, the SGR is an annual growth rate that applies to physicians' services paid for by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the physician fee schedule update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services.

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries.

(3) The estimated projected growth in real GDP per capita.

(4) The estimated change in expenditures due to changes in law or regulations.

In this final rule, we are making prospective redeterminations of the SGRs for FY 1998 and FY 1999 for the purposes of determining future physician fee schedule updates, including the update for 2003. We are also making a minor revision to the SGR for 2002.

A. Revised Sustainable Growth Rate for FY 1998

The revised FY 1998 SGR is 3.2 percent. Table 2 shows the estimated figures that we used to determine the FY 1998 SGR from the October 31, 1997, **Federal Register** (62 FR 59263), and the revised final figures.

TABLE 2

Statutory factors	10/31/97 estimate (percent)	Revised final (percent)
Fees	2.3 (1.023)	2.0 (1.020)
Enrollment	−2.4 (0.976)	−2.3 (0.977)
Real Per Capita GDP	1.1 (1.011)	3.2 (1.032)
Law and Regulation	0.6 (1.006)	0.3 (1.003)
Total	1.5 (1.015)	3.2 (1.032)

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for FY 1998

This factor was calculated as a weighted average of the FY 1998 fee increases for the different types of services included in the definition of physicians' services for the SGR that applied in FY 1998. Medical and other health services paid using the physician fee schedule accounted for approximately 91.5 percent of total allowed charges included in the SGR in FY 1998 and are updated using the MEI. The weighted average of the MEI that applied for the calendar years included in FY 1998 was 2.2 percent. (''Incident to'' drugs, which are also included in the SGR, are paid using the average wholesale price methodology. Consistent with the methodology used prior to 2003, we used the MEI as a proxy for growth in ''incident to'' drug prices for both the FY 1998 and FY 1999 SGRs). Diagnostic laboratory tests represent approximately 8.5 percent of Medicare allowed charges included in the SGR in FY 1998. The costs of these tests are typically updated by the CPI-U. Although section 1833(h)(2)(A)(ii)(IV) of the Act required a 0.0 percent update for laboratory services for 1998 to 2002, we used a 3.0 percent update for laboratory services in 1998 to determine the estimated SGR. We are now using a 0.0 percent update for laboratory services for the 9 months of calendar year 1998 that are included in FY 1998. The weighted average of the laboratory update applied in the calendar years included in FY 1998 was 0.8 percent. We determined a weighted average of the MEI and the laboratory updates that applied in FY 1998 using the following information:

TABLE 3

	Weight	Update
MEI	0.915	2.2
Laboratory	0.085	0.8
Weighted Average	1.000	2.0

After taking into account the elements described in table 3, we now estimate that the weighted-average increase in fees for physicians' services in FY 1998 under the SGR (before applying any legislative adjustments) was 2.0 percent. This figure is 0.3 percentage points lower than the estimate we made of this factor in the October 31, 1997, **Federal Register** (62 FR 59265) because of the revision we have made to the update for laboratory services.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees for FY 1998

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from FY 1997 to FY 1998. Services provided to Medicare+Choice (M+C) plan enrollees are outside the scope of the SGR and are excluded from this estimate. Our actuaries have now determined that the average number of Medicare Part B fee-for-service enrollees actually decreased by 2.3 percent from FY 1997 to FY 1998. Table 4 illustrates how this figure was determined:

TABLE 4

	FY 1998	FY 1999
Overall	36.368 million	36.685 million
Medicare+Choice	4.463 million	5.510 million
Net	31.905 million	31.175 million
Percent Increase		−2.3 percent

As we have stated repeatedly, an important factor affecting fee-for-service enrollment is beneficiary enrollment in M+C plans. Because it is difficult to estimate the size of the M+C enrollee population before the start of a calendar year, we cannot predict how actual enrollment in M+C plans during the year will compare to our Actuary's estimates. Despite the difficulty in predicting these figures, the actual decrease in Medicare fee-for-service enrollment of 2.3 percent was almost identical to the Actuary's estimate in 1997 (−2.4 percent).

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth for FY 1998

Actual growth in real per capita GDP from FY 1997 to FY 1998 was 3.2 percent or 2.1 percentage points higher than the 1.1 percent estimate we made in 1997. The large difference between our estimate and the actual growth in real per capita GDP reflects the difficulty in predicting economic growth before the beginning of a year.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in FY 1998 Compared With FY 1997

The Balanced Budget Act (BBA) of 1997 established or changed coverage for screening mammography, colorectal cancer screening, and screening PAP smears. The BBA also included payment provisions related to nurse practitioners, clinical nurse specialists and physician assistants, Medicare secondary payer, and clinical diagnostic laboratory services. In 1997, we estimated that the net cost of these provisions would increase the FY 1998 SGR by 0.6

percent. Based on the lower than anticipated expenditures for screening mammography and nurse practitioners, clinical nurse specialists and physician assistants, we now estimate that the net cost of these provisions increased the FY 1998 SGR by 0.3 percent.

B. Revised Sustainable Growth Rate for FY 1999

The revised SGR for FY 1999 is 4.2 percent for the purposes of determining future physician fee schedule updates. Table 5 shows the estimated figures that we used to determine the FY 1999 SGR from the November 2, 1998, **Federal Register** (63 FR 59188), and the revised final figures.

TABLE 5

Statutory factors	11/2/98 estimate (percent)	Revised final (percent)
Fees	2.1 (1.021)	2.1 (1.021)
Enrollment	−4.3 (0.967)	−1.1 (0.989)
Real Per Capita GDP	1.3 (1.013)	3.3 (1.033)
Law and Regulation	0.7 (1.007)	−0.1 (0.999)
Total	−0.3 (0.997)	4.2 (1.042)

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for FY 1999

This factor was calculated as a weighted average of the FY 1999 fee increases for the different types of services included in the definition of physicians' services for the SGR that applied in FY 1999. Medical and other health services paid using the physician fee schedule accounted for approximately 92 percent of total allowed charges included in the SGR in FY 1999 and are updated using the MEI. The weighted average of the MEI that applied for the calendar years included in FY 1999 was 2.3 percent. Diagnostic laboratory tests represent approximately 8.0 percent of Medicare allowed charges included in the SGR in FY 1999. During FY 1999, section 1833(h)(2)(A)(ii)(IV) of the Act required a 0.0 percent update for laboratory services. We determined a weighted average of the MEI and the laboratory updates that applied in FY 1999 using the following information:

TABLE 6

	Weight	Update
MEI	0.920	2.3
Laboratory	0.080	0.0
Weighted Average	1.000	2.1

After taking into account the elements described in table 6, we now estimate that the weighted-average increase in fees for physicians' services in FY 1999 under the SGR (before applying any legislative adjustments) was 2.1 percent. This figure is unchanged from our original estimate of the weighted-average increase in fees for physicians' services in FY 1999.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees for FY 1999

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from FY 1998 to FY 1999. Our actuaries have now determined that the average number of Medicare Part B fee-for-service enrollees (net of M+C enrollees) actually decreased by 1.1 percent. Table 7 illustrates how this figure was determined:

TABLE 7

	FY 1998 (million)	FY 1999 (million)
Overall	36.685	36.951
Medicare+Choice	5.510	6.109
Net	31.175	30.841
Percent Increase		−1.1

As indicated above, the difficulty in predicting growth in M+C enrollment before the beginning of the year explains the 3.2 percentage point difference between our 1998 estimate of this factor (−4.3 percent) and the actual measured decrease.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth for FY 1999

Actual growth in real per capita GDP from FY 1998 to FY 1999 was 3.3 percent or 2.0 percentage points higher than the 1.3 percent estimate we made in 1997. The large difference between our estimate and the actual growth in real per capita GDP reflects the difficulty predicting economic growth before the beginning of a year.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in FY 1999 Compared With FY 1998

In the November 2, 1998, **Federal Register** (63 FR 59189) we increased the SGR by 0.7 percentage points to reflect the effects of the BBA on expenditures for physicians' services included in the SGR. However, we are now reducing the SGR by 0.1 percent for savings associated with BBA provisions. These savings are largely associated with the residual effects of the BBA's Medicare secondary payer provisions. We are also removing the costs associated with diabetes self-management training from the FY 1999 SGR because Medicare coverage associated with this service did not become effective until 2001.

C. Revised Sustainable Growth Rate for 2002

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting from Changes in Law or Regulations in 2002 Compared to 2001 Changes

Based on Medicare data from 2001, we have observed very little utilization of diabetes self-management training services. However, we believe it is likely that utilization of this new benefit increased in 2002 and are including an adjustment to the 2002 SGR for this factor. This adjustment will increase the law and regulation factor and the total SGR for 2002 by 0.2 percentage points relative to the figures included in the December 31, 2002, final rule (67 FR 80028). All other factors included in the 2002 SGR are unchanged at this time. As indicated earlier, we expect to make revisions to all figures included in the 2002 SGR for the final time later this year.

IV. Anesthesia and Physician Fee Schedule Conversion Factors

The 2003 physician fee schedule CF will be $36.7856. The 2003 national average anesthesia CF will be $17.05.

The specific calculations to determine the physician fee schedule and anesthesia CFs for 2003 are explained below.

• *Physician Fee Schedule Conversion Factor.*

Under section 1848(d)(1)(A) of the Act, the physician fee schedule CF is equal to the CF for the previous year multiplied by the update determined under section 1848(d)(4) of the Act. In addition, section 1848(c)(2)(B)(ii)(II) of the Act requires that changes to relative value units (RVUs) cannot cause the amount of expenditures to increase or decrease by more than $20 million from the amount of expenditures that would have been made if such adjustments had not been made. We implement this requirement through a uniform budget neutrality adjustment to the CF. There is one change that will require us to make an adjustment to the CF to comply with the budget neutrality requirement in section 1848(c)(2)(B)(ii)(II) of the Act. We are making a 0.04 percent reduction (0.9996) in the CF to account for the increase in anesthesia work resulting from the 5-year review.

We illustrate the calculation for the 2003 physician fee schedule CF in table 8:

TABLE 8

2002 Conversion Factor	$36.1992
2003 Update	1.0166
Budget-Neutrality Adjustment: Increase in Anesthesia Work	0.9996
2003 Conversion Factor	$36.7856

• Anesthesia Fee Schedule Conversion Factor.

As described in the December 31, 2002, final rule (67 FR 80032), anesthesia services do not have RVUs like other physician fee schedule services. For this reason, we are accounting for the changes to anesthesia work and practice expenses through a 1.6 percent (1.016) adjustment to the anesthesia fee schedule CF. In addition, we are also applying the physician fee schedule update and the budget neutrality adjustment for the increase in anesthesia work that also apply to the physician fee schedule CF. To determine the anesthesia fee schedule CF for 2003, we used the following figures:

TABLE 9

2002 Conversion Factor	$16.6055
Adjustments for Work and Practice Expense	1.0106
2003 Update	1.0166
Budget-Neutrality Adjustment: Increase in Anesthesia Work	0.9996
2003 Conversion Factor	$17.0522

V. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on a proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. In addition, the Administrative Procedure Act (APA) normally requires a 30-day delay in the effective date of a final rule. Furthermore, the Congressional Review Act (CRA) generally requires an agency to delay the effective date of a major rule by 60 days in order to allow for congressional review of the agency action.

We find it unnecessary to undertake notice-and-comment rulemaking prior to implementation of the revisions contained in this final rule. The revisions in this final rule constitute technical corrections to the final rule published on December 31, 2002, which are necessary in order to implement the Congress's decision to confer authority for CMS to make prospective redeterminations of the SGRs for the FY 1998 and FY 1999 but do not otherwise change the policies announced in the final rule. In the December 31, 2002, final rule we expressly indicated that we would make these changes in the event that the Congress conferred the requisite authority upon the agency prior to the March 1, 2003, effective date of the rule. Accordingly, because this final rule simply makes technical modifications to a final rule that has previously gone through notice-and-comment rulemaking, we do not believe that this final rule is subject to notice-and-comment or the 30-day delay in the effective date under the APA. Even if this rule were something other than a technical correction or amendment to the final rule published on December 31, 2002, we believe good cause would exist under the APA to waive the requirements of notice-and-comment rulemaking and the 30-day delay in the effective date.

As indicated above, on December 31, 2002, we announced that, effective March 1, 2003, Medicare physician fee schedule rates would be reduced by an average of 4.4 percent. We indicated in our December 31, 2002, final rule (67 FR 79966) that the 4.4 percent reduction would be inappropriate because it would occur under a statutory methodology that did not allow us to reflect actual, after-the-fact data from earlier years in the determination of the SGR and allowed expenditures. We stated the Department was unable to revise those estimates without further congressional action. (''The Department intends to work closely with Congress to develop legislation that could permit a positive update, and hopes that such legislation can be passed before the negative update takes effect.'' Since we published the December 31, 2002, final rule, as described above, the Congress has taken action that evinces the Congress's intent to permit revisions of all prior FY SGRs for the purposes of allowing for prospective application of those revisions to future physician fee schedule updates (that is, to the 2003 physician fee schedule update.)

To go through further notice-and-comment rulemaking at this time would be unnecessary, impracticable, and contrary to the public interest because, in our December 31, 2002, final rule we unequivocally expressed our intent to prospectively redetermine the SGRs for FYs 1998 and 1999 in order to establish the 2003 CF. ''Because the Department would adopt a change in the formula that determines the physician update if the law permitted it, we have examined how proper adjustments to past data could result in a positive update.'' To go through notice-and-comment rulemaking at this point, when we have already stated unequivocally our intent to recompute the CF for 2003 if the Congress were to act to permit a prospective redetermination of the SGRs for fiscal years 1998 and 1999, would be unnecessary and contrary to the public interest.

Because the Department wished to make changes to the physician fee schedule update promptly in the event that the Congress acted legislatively, our December 31, 2002, final rule specifically requested public comment on revisions to the estimates that were used to establish the FY 1998 and FY 1999 SGRs, if the statute were to be amended to provide us with this authority. Because we have already requested public comments on the issues included in this final rule, we believe it is unnecessary and contrary to

the public interest to engage in further notice-and-comment rulemaking.

The comment period for the December 31, 2002, rule has not yet closed, but in the event we receive any comments in response to our December 31, 2002, final rule, we will address them in a subsequent publication in the **Federal Register**. No comments have been received to date.

Further, we believe engaging in notice-and-comment rulemaking and delaying the effective date of this final rule would be contrary to the public interest because the Congress specifically sought to avert the negative update to the physician fee schedule for 2003 that we announced on December 31, 2002, by enacting a law conferring upon CMS the authority to reflect actual, after-the-fact data from earlier fiscal years in the determination and allowed expenditures for the purposes of determining future physician fee schedule updates: the very authority, as previously stated in the **Federal Register**, that we would need to revise our prior estimates of the FY 1998 and FY 1999 SGRs to avoid the 4.4 percent reduction in rates on March 1 and establish a 1.6 percent increase in the physician fee schedule CF. Any delay in implementation of this 1.6 percent increase would be contrary to the public interest of the CAR and would run precisely counter to the intent of the Congress in enacting section 402(a) of the CAR to enable CMS to ''make corrections to data errors in the physician payment formula for past fiscal years.'' (*See* House Rpt, 108–10). Moreover a delay in enacting this final rule could adversely affect the provision of services to Medicare beneficiaries because any delay in implementation of the payment increases for physician services provided under the Medicare program may have an adverse impact on Medicare beneficiaries' access to important healthcare services.

Finally, we also note that notice-and-comment rulemaking is not required in this instance because section 1871(b)(2) of the Act provides that when an effective date is within 150 days of enactment of a law, the notice-and-comment requirement does not apply.

With respect to the requirement of a 60-day delay in the effective date of any final rule pursuant to the CRA, *see* 5 U.S.C. section 801, the CRA provides that the 60-day delayed effective date shall not apply to any rule ''which an agency for good cause finds * * * that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest'' (5 U.S.C. section 808(2)). For the reasons set forth above, we believe that additional notice-and-comment rulemaking on this subject would be impracticable, unnecessary, or contrary to the public interest. Therefore, we do not believe that the CRA requires a 60-day delay in the effective date of this final rule. Moreover, the Congress had 60 days to review the December 31, 2002, final rule. The Congress responded to that final rule by enacting a law to clarify the fee schedule update mechanism described and set forth in the December 31, 2002, final rule. Because we are incorporating this very statutory clarification as the basis for this new final rule, we believe it would be contrary to the CRA and the public interest to provide yet another 60-day review period under the CRA.

VI. Collection of Information Requirements

This document does not impose information collection and record keeping requirements. Consequently, it does not need review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

VII. Regulatory Impact Analysis

We have examined the impact of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for final rules with economically significant effects (that is, a final rule that would have an annual effect on the economy of $100 million or more in any 1 year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities). We estimate that the changes to the physician fee schedule update will increase Medicare expenditures for physicians' services by $1.1 billion in FY 2003, $2.0 billion in FY 2004 and $2.8 billion in FY 2005 or an estimated $15.7 billion over 5 years and $49.6 billion over ten years. Therefore, this rule is considered to be a major rule because it is economically significant, and, thus, we have prepared a regulatory impact analysis.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a Regulatory Flexibility Analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a statement in support of the objectives underlying the action being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area or New England County Metropolitan Area (NECMA) and has fewer than 100 beds.

For purposes of the RFA, physicians, non-physician practitioners, and suppliers, are considered small businesses if they generate revenues of $8.5 million or less. Approximately 96 percent of physicians are considered to be small entities. There are about 700,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the physician fee schedule.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will not result in any unfunded mandates for State, local or tribal governments or the private sector, as defined by section 202.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have examined this final rule in accordance with Executive Order 13132

and have determined that this regulation would not have any significant impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which together with the rest of this preamble meets all assessment requirements. It explains the rationale for, and purposes of, the rule, details the costs and benefits of the rule, analyzes alternatives, and presents the measures we are using to minimize the burden on small entities. As indicated elsewhere, we are increasing the physician fee schedule CF for March 1 to December 31, 2003, by 1.6 percent. The provisions of this rule are changing only Medicare payment rates for physician fee schedule services, and are not imposing any new regulatory requirements that will impose a burden on small entities.

Table 10 shows the average change in Medicare payment by specialty. It shows the impact of changes in RVUs, the physician fee schedule update, the combined impact, and includes the effect of corrections made to the RVUs for several procedure codes. The table is analogous to Table 24 in the December 31, 2002, final rule (67 FR 80037) but includes the revised physician fee schedule update. The tables reflect application of the revised CF for the full calendar year. However, because the increased CF is only in effect from March 1 to December 31, 2003, the actual impacts will be somewhat less than those shown here.

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Table 10
Estimated Impact All Changes
on Total Medicare Allowed Charges
by Specialty

Category	Medicare Allowed Charges ($ in Billions)	5 Year Review/ RVU Changes	Physician Fee Schedule Update	Total
Physicians:				
ALLERGY/IMMUNOLOGY	0.14	2%	1.6%	3%
ANESTHESIOLOGY	1.24	1%	1.6%	3%
CARDIAC SURGERY	0.28	-1%	1.6%	0%
CARDIOLOGY	4.75	1%	1.6%	3%
CLINICS	2.57	0%	1.6%	2%
DERMATOLOGY	1.55	-4%	1.6%	-2%
EMERGENCY MEDICINE	1.17	0%	1.6%	1%
ENDOCRINOLOGY	0.21	0%	1.6%	2%
FAMILY PRACTICE	3.43	0%	1.6%	2%
GASTROENTEROLOGY	1.34	-1%	1.6%	1%
GENERAL PRACTICE	0.84	0%	1.6%	2%
GENERAL SURGERY	1.98	0%	1.6%	1%
GERIATRICS	0.08	0%	1.6%	1%
HEMATOLOGY/ONCOLOGY	0.95	2%	1.6%	3%
INFECTIOUS DISEASE	0.28	-1%	1.6%	1%
INTERNAL MEDICINE	6.77	0%	1.6%	2%
INTERVENTIONAL RADIOLOGY	0.14	-1%	1.6%	1%
NEPHROLOGY	1.09	-4%	1.6%	-2%
NEUROLOGY	0.91	2%	1.6%	4%
NEUROSURGERY	0.38	-1%	1.6%	1%
OBSTETRICS/GYNECOLOGY	0.48	1%	1.6%	3%
OPHTHALMOLOGY	3.86	-1%	1.6%	1%
ORTHOPEDIC SURGERY	2.40	-2%	1.6%	0%
OTOLARNGOLOGY	0.66	0%	1.6%	1%
PATHOLOGY	0.69	0%	1.6%	2%
PEDIATRICS	0.05	1%	1.6%	2%
PHYSICAL MEDICINE	0.49	2%	1.6%	4%
PLASTIC SURGERY	0.25	0%	1.6%	2%
PSYCHIATRY	1.00	-1%	1.6%	1%
PULMONARY DISEASE	1.12	1%	1.6%	2%
RADIATION ONCOLOGY	0.81	1%	1.6%	3%
RADIOLOGY	3.47	1%	1.6%	3%

RHEUMATOLOGY	0.30	0%	1.6%	2%
THORACIC SURGERY	0.43	-1%	1.6%	1%
UROLOGY	1.36	2%	1.6%	4%
VASCULAR SURGERY	0.37	1%	1.6%	3%
Other Practitioners:				
AUDIOLOGIST	0.02	3%	1.6%	4%
CHIROPRACTOR	0.50	-1%	1.6%	1%
CLINICAL PSYCHOLOGIST	0.40	0%	1.6%	2%
CLINICAL SOCIAL WORKER	0.23	-1%	1.6%	1%
NURSE ANESTHETIST	0.38	1%	1.6%	3%
NURSE PRACTITIONER	0.30	0%	1.6%	1%
OPTOMETRY	0.54	-1%	1.6%	1%
PHYSICAL/OCCUPATIONAL THERAPY	0.61	2%	1.6%	4%
PHYSICIANS ASSISTANT	0.23	-1%	1.6%	1%
PODIATRY	1.17	0%	1.6%	1%
Suppliers:				
DIAGNOSTIC TESTING FACILITY	0.51	4%	1.6%	5%
INDEPENDENT LABORATORY	0.43	4%	1.6%	5%
PORTABLE X-RAY SUPPLIER	0.07	4%	1.6%	6%
ALL OTHER	0.29	-1%	1.6%	0%
ALL PHYSICIAN FEE SCHEDULE	53.53	0%	1.6%	2%

Table 11 shows the difference between 2002 and 2003 payment rates (March 1 to December 31) for selected high volume procedures. This table shows the combined impact of changes in RVUs and the physician fee schedule update on total payment for each procedure. The table is analogous to Table 25 in the December 31, 2002, final rule (67 FR 80037) with the revised physician fee schedule update. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and non-facility practice expense refer to § 414.22(b)(5)(i).

Table 11

Impact of Final Rule and Physician Fee Schedule Update

on Medicare Payment for Selected Procedures

			Non-Facility			Facility		
HCPCS	MOD	DESC	Old	New	% Change	Old	New	% Change
11721		Debride nail, 6 or more	$ 36.92	$ 37.52	2%	$ 28.96	$ 29.06	0%
17000		Destroy benign/premlg lesion	$ 62.62	$ 61.43	-2%	32.94	$ 33.11	1%
27130		Total hip arthroplasty	N/A	N/A	N/A	1,452.31	$1,343.41	-7%
27236		Treat thigh fracture	N/A	N/A	N/A	1,113.85	$1,068.99	-4%
27244		Treat thigh fracture	N/A	N/A	N/A	1,137.38	$1,155.44	2%
27447		Total knee arthroplasty	N/A	N/A	N/A	1,514.21	$1,445.67	-5%
33533		CABG, arterial, single	N/A	N/A	N/A	1,827.34	$1,799.18	-2%
35301		Rechanneling of artery	N/A	N/A	N/A	1,061.36	$1,073.77	1%
43239		Upper GI endoscopy, biopsy	$354.75	$337.69	-5%	154.93	$ 155.97	1%
45385		Lesion removal colonoscopy	$571.22	$545.53	-4%	287.78	$ 290.61	1%
66821		After cataract laser surgery	$229.50	$229.17	0%	213.94	$ 212.99	0%
66984		Cataract surg w/iol, 1 stage	N/A	N/A	N/A	669.32	$ 670.60	0%
67210		Treatment of retinal lesion	$603.08	$604.39	0%	546.61	$ 548.47	0%
71010	26	Chest x-ray	$ 9.05	$ 9.20	2%	9.05	$ 9.20	2%
71020	26	Chest x-ray	$ 11.22	$ 11.04	-2%	11.22	$ 11.04	-2%
76091		Mammogram, both breasts	$ 90.50	$ 94.17	4%	N/A	N/A	N/A
76091	26	Mammogram, both breasts	$ 43.44	$ 44.14	2%	43.44	$ 44.14	2%
76092		Mammogram, screening	$ 81.81	$ 82.77	1%	N/A	N/A	N/A
76092	26	Mammogram, screening	$ 35.48	$ 36.05	2%	35.48	$ 36.05	2%
77427		Radiation tx management, x5	$167.96	$168.11	0%	167.96	$ 168.11	0%
78465	26	Heart image (3d), multiple	$ 74.93	$ 75.41	1%	74.93	$ 75.41	1%
88305	26	Tissue exam by pathologist	$ 40.54	$ 40.83	1%	40.54	$ 40.83	1%
90801		Psy dx interview	$144.80	$148.98	3%	137.19	$ 140.52	2%
90806		Psytx, off, 45-50 min	$ 95.93	$ 96.38	0%	91.22	$ 92.70	2%
90807		Psytx, off, 45-50 min w/e&m	$103.53	$102.63	-1%	98.82	$ 100.06	1%
90862		Medication management	$ 51.04	$ 50.76	-1%	46.33	$ 47.82	3%
90921		ESRD related services, month	$273.30	$262.28	-4%	273.30	$ 262.28	-4%
90935		Hemodialysis, one evaluation	N/A	N/A	N/A	76.38	$ 71.36	-7%
92004		Eye exam, new patient	$123.44	$123.60	0%	87.96	$ 88.29	0%
92012		Eye exam established pat	$ 61.18	$ 61.43	0%	35.84	$ 36.05	1%
92014		Eye exam & treatment	$ 91.22	$ 90.86	0%	58.64	$ 58.86	0%
92980		Insert intracoronary stent	N/A	N/A	N/A	790.59	$ 800.45	1%
92982		Coronary artery dilation	N/A	N/A	N/A	584.26	$ 594.46	2%
93000		Electrocardiogram, complete	$ 25.34	$ 26.12	3%	N/A	N/A	N/A
93010		Electrocardiogram report	$ 9.05	$ 8.83	-2%	9.05	$ 8.83	-2%
93015		Cardiovascular stress test	$ 99.91	$104.10	4%	N/A	N/A	N/A

93307	26	Echo exam of heart	$ 48.14	$ 48.19	0%	48.14	$ 48.19	0%
93510	26	Left heart catheterization	$230.59	$231.38	0%	230.59	$ 231.38	0%
98941		Chiropractic manipulation	$ 35.48	$ 35.68	1%	31.13	$ 31.27	0%
99202		Office/outpatient visit, new	$ 61.54	$ 62.54	2%	45.61	$ 45.98	1%
99203		Office/outpatient visit, new	$ 91.95	$ 92.70	1%	69.50	$ 70.26	1%
99204		Office/outpatient visit, new	$130.68	$132.06	1%	102.81	$ 103.74	1%
99205		Office/outpatient visit, new	$166.15	$168.48	1%	136.47	$ 137.58	1%
99211		Office/outpatient visit, est	$ 20.27	$ 20.60	2%	8.69	$ 8.83	2%
99212		Office/outpatient visit, est	$ 36.20	$ 36.42	1%	23.17	$ 23.17	0%
99213		Office/outpatient visit, est	$ 50.32	$ 51.13	2%	34.03	$ 34.58	2%
99214		Office/outpatient visit, est	$ 78.91	$ 79.82	1%	56.11	$ 56.65	1%
99215		Office/outpatient visit, est	$115.84	$116.98	1%	90.50	$ 91.23	1%
99221		Initial hospital care	N/A	N/A	N/A	65.16	$ 65.85	1%
99222		Initial hospital care	N/A	N/A	N/A	108.24	$ 109.25	1%
99223		Initial hospital care	N/A	N/A	N/A	150.95	$ 151.92	1%
99231		Subsequent hospital care	N/A	N/A	N/A	32.58	$ 32.74	0%
99232		Subsequent hospital care	N/A	N/A	N/A	53.57	$ 54.07	1%
99233		Subsequent hospital care	N/A	N/A	N/A	76.38	$ 76.88	1%
99236		Observ/hosp same date	N/A	N/A	N/A	214.66	$ 216.67	1%
99238		Hospital discharge day	N/A	N/A	N/A	66.24	$ 69.16	4%
99239		Hospital discharge day	N/A	N/A	N/A	90.86	$ 93.80	3%
99241		Office consultation	$ 47.06	$ 47.45	1%	33.30	$ 33.11	-1%
99242		Office consultation	$ 87.24	$ 88.29	1%	68.05	$ 68.05	0%
99243		Office consultation	$115.84	$116.61	1%	90.14	$ 90.49	0%
99244		Office consultation	$164.34	$165.90	1%	133.58	$ 134.27	1%
99245		Office consultation	$212.85	$215.20	1%	177.01	$ 177.67	0%
99251		Initial inpatient consult	N/A	N/A	N/A	34.75	$ 34.95	1%
99252		Initial inpatient consult	N/A	N/A	N/A	69.86	$ 70.26	1%
99253		Initial inpatient consult	N/A	N/A	N/A	95.20	$ 96.01	1%
99254		Initial inpatient consult	N/A	N/A	N/A	136.83	$ 137.95	1%
99255		Initial inpatient consult	N/A	N/A	N/A	188.60	$ 189.81	1%
99261		Follow-up inpatient consult	N/A	N/A	N/A	21.72	$ 22.07	2%
99262		Follow-up inpatient consult	N/A	N/A	N/A	43.44	$ 43.77	1%
99263		Follow-up inpatient consult	N/A	N/A	N/A	64.80	$ 65.11	0%
99282		Emergency dept visit	N/A	N/A	N/A	26.43	$ 26.85	2%
99283		Emergency dept visit	N/A	N/A	N/A	59.37	$ 60.33	2%
99284		Emergency dept visit	N/A	N/A	N/A	92.67	$ 94.17	2%
99285		Emergency dept visit	N/A	N/A	N/A	144.80	$ 146.77	1%
99291		Critical care, first hour	$208.87	$210.05	1%	198.37	$ 200.11	1%
99292		Critical care, addl 30 min	$108.24	$107.78	0%	98.82	$ 100.06	1%
99301		Nursing facility care	$ 70.23	$ 71.00	1%	60.09	$ 61.06	2%
99302		Nursing facility care	$ 95.57	$ 96.75	1%	80.72	$ 81.30	1%
99303		Nursing facility care	$118.73	$119.92	1%	100.27	$ 101.16	1%
99311		Nursing fac care, subseq	$ 40.18	$ 40.83	2%	30.05	$ 30.53	2%
99312		Nursing fac care, subseq	$ 61.90	$ 62.54	1%	49.95	$ 50.40	1%

99313	Nursing fac care, subseq	$ 84.34	$ 85.71	2%	70.95	$ 71.73	1%
99348	Home visit, est patient	$ 73.85	$ 74.31	1%	N/A	N/A	N/A
99350	Home visit, est patient	$166.52	$167.74	1%	N/A	N/A	N/A
G0008	Admin influenza virus vac	$ 3.98	$ 7.72	94%	N/A	N/A	N/A
G0009	Admin pneumococcal vaccine	$ 3.98	$ 7.72	94%	N/A	N/A	N/A
G0010	Admin hepatitis b vaccine	$ 3.98	$ 7.72	94%	N/A	N/A	N/A

BILLING CODE 4120–01–C

Impact on Beneficiaries

We do not believe that any problems regarding beneficiary access to care will result from changes in this rule. Moreover, it is possible that potential problems regarding beneficiary access to care that could have resulted from the 4.4 percent reduction contained in the December 31, 2002, final rule (67 FR 79966) will be alleviated by the increase in payment being announced in this rule. Nevertheless, we believe it remains important to continue our efforts to monitor beneficiary access to care.

Any change in Medicare payments will have an impact on beneficiary cost-sharing. If the 4.4 percent reduction were to go into effect and beneficiary access to care were reduced, it is possible that beneficiaries would have lower coinsurance costs but might have problems with access to services (for example, whether physicians continue to see existing or new Medicare beneficiaries). Because we do not know the impact of the 4.4 percent reduction on beneficiary access to care, it is difficult to estimate the effect on out-of-pocket costs. Assuming beneficiary access to care were unaffected, we estimate that the increase in the 1.6 percent increase in the CF compared to a 4.4 percent reduction would increase beneficiary coinsurance liabilities by approximately $300 million in FY 2003 or about $80 million more than if the rates applied in 2002 remained in effect for the remainder of 2003. Some of the increased costs of beneficiary coinsurance may be incurred by the many policies that supplement Medicare. We would note that the 1.6 percent increase will only marginally increase out-of-pocket costs for beneficiaries that do not have any insurance other than Medicare.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this regulation.

This final rule is issued under the authority of sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: February 19, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: February 24, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–4862 Filed 2–26–03; 11:47 am]

BILLING CODE 4120–01–P

DEPARTMENT OF DEFENSE

48 CFR Part 214

Defense Federal Acquisition Regulation Supplement; Technical Amendments; Correction

AGENCY: Department of Defense (DoD).

ACTION: Correction to final rule.

SUMMARY: DoD is issuing a correction to the final rule published at 68 FR 7438–7441 on February 14, 2003, making technical amendments to the Defense Federal Acquisition Regulation Supplement. This correction is needed because the February 14, 2003, final rule contained an incorrect paragraph designation.

EFFECTIVE DATE: February 14, 2003.

FOR FURTHER INFORMATION CONTACT: Ms. Michele Peterson, Defense Acquisition Regulations Council, OUSD (AT&L) DPAP (DAR), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062. Telephone (703) 602–0311; facsimile (703) 602–0350.

Correction

In the issue of Friday, February 14, 2003, on page 7439, in the third column, amendatory instruction 16 and the corresponding regulatory text are corrected by removing ''(vii)'' and adding in its place ''(viii)''.

Michele P. Peterson,

Executive Editor, Defense Acquisition Regulations Council.

[FR Doc. 03–4699 Filed 2–27–03; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 030108004–3044–02; ID 010303B]

RIN 0648–AQ28

Fisheries of the Northeastern United States; Atlantic Sea Scallop Fishery; Framework Adjustment 15

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: NMFS issues this final rule to implement Framework 15 to the Atlantic Sea Scallop Fishery Management Plan (FMP) developed by the New England Fishery Management Council (Council). This final rule implements management measures for the 2003 fishing year, including a days-at-sea (DAS) adjustment, and continuation of a Sea Scallop Area Access Program (Area Access Program) for 2003. The intent of this action is to achieve the goals and objectives of the FMP under the Magnuson-Stevens Fishery Conservation and Management Act and to achieve optimum yield (OY) in the scallop fishery. In addition, this final rule includes regulatory text that codifies an additional gear stowage provision for scallop dredge gear that was established by the Administrator, Northeast Region, NMFS (Regional Administrator) in 2001.

DATES: Effective March 1, 2003.

ADDRESSES: Copies of Framework Adjustment 15, its Regulatory Impact Review (RIR) including the Initial Regulatory Flexibility Analysis (IRFA), and the Environmental Assessment (EA) are available on request from Paul J. Howard, Executive Director, New England Fishery Management Council, 50 Water Street, Newburyport, MA 01950. These documents are also available online at *http://www.nefmc.org*. A copy of the Final Regulatory Flexibility Analysis (FRFA) is available from Patricia A. Kurkul,