

emergency care in certain critical access hospitals (CAHs) in frontier areas (an area with fewer than six residents per square mile) or remote locations (locations designated in a State's rural health plan that we have approved).

As required by statute this final rule also announced that the physician fee schedule update for CY 2003 was -4.4 percent, the initial estimate of the sustainable growth rate (SGR) for CY 2003 was 7.6 percent, and the CF for CY 2003 was \$34.5920, effective March 1, 2003. However, on February 28, 2003 (68 FR 9567), after enactment of the Consolidated Appropriations Resolution of 2003 (Pub. L. 108-7), we published a final rule that revised the estimates used to establish the SGRs for fiscal years 1998 and 1999 and announced a 1.6 percent increase in the CY 2003 physician fee schedule CF for March 1 to December 31, 2003. The CF from March 1 to December 31, 2003 is \$36.7856. The anesthesia CF for this period is \$17.05. All other provisions of the December 31, 2002 final rule were unchanged by the rule published February 28, 2003.

II. Provisions of the Proposed Rule

This proposed rule would affect the regulations set forth at Part 410, Supplementary medical insurance (SMI) benefits and part 414, Payment for Part B and other health services.

A. Resource-Based Practice Expense Relative Value Units

1. Resource-Based Practice Expense Legislation

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103-432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in 1998. In developing the methodology, we were to consider the staff, equipment, and supplies used in providing medical and surgical services in various settings. The legislation specifically required that, in implementing the new system of practice expense RVUs, we apply the same budget-neutrality provisions that we apply to other adjustments under the physician fee schedule.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33), enacted on August 5, 1997, amended section 1848(c)(2)(ii) of the Act and delayed the effective date of the resource-based practice expense RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period

from charge-based practice expense RVUs to resource-based RVUs.

Further legislation affecting resource-based practice expense RVUs was included in the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113) enacted on November 29, 1999. Section 212 of the BBRA amended section 1848(c)(2)(ii) of the Act by directing us to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations. These data would supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002. (In the 1999 final rule (64 FR 59380), we extended, for an additional 2 years, the period during which we would accept supplementary data.)

2. Current Methodology for Computing the Practice Expense Relative Value Unit System

Effective with services furnished on or after January 1, 1999, we established a new methodology for computing resource-based practice expense RVUs that used the two significant sources of actual practice expense data we have available—the Clinical Practice Expert Panel (CPEP) data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. The methodology was based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs for physicians' services across specialties. The methodology allocated these aggregate specialty practice costs to specific procedures and, thus, can be seen as a "top-down" approach.

a. Major Steps

A brief discussion of the major steps involved in the determination of the practice expense RVUs follows. (Please see the November 1, 2001 final rule (66 FR 55249) for a more detailed explanation of the top-down methodology.)

- *Step 1*—Determine the specialty specific practice expense per hour of physician direct patient care. We used the AMA's SMS survey of actual aggregate cost data by specialty to determine the practice expenses per hour for each specialty. We calculated the practice expenses per hour for the specialty by dividing the aggregate practice expenses for the specialty by

the total number of hours spent in patient care activities.

- *Step 2*—Create a specialty specific practice expense pool of practice expense costs for treating Medicare patients. To calculate the total number of hours spent treating Medicare patients for each specialty, we used the physician time assigned to each procedure code and the Medicare utilization data. We then calculated the specialty specific practice expense pools by multiplying the specialty practice expenses per hour by the total physician hours.

- *Step 3*—Allocate the specialty specific practice expense pool to the specific services performed by each specialty. For each specialty, we divided the practice expense pool into two groups based on whether direct or indirect costs were involved and used a different allocation basis for each group.

- (i) Direct costs—For direct costs (which include clinical labor, medical supplies, and medical equipment), we used the procedure specific CPEP data on the staff time, supplies, and equipment as the allocation basis.

- (ii) Indirect costs—To allocate the cost pools for indirect costs, including administrative labor, office expenses, and all other expenses, we used the total direct costs combined with the physician fee schedule work RVUs. We converted the work RVUs to dollars using the Medicare CF (expressed in 1995 dollars for consistency with the SMS survey years).

- *Step 4*—For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients.

b. Other Methodological Issues

(i) Non-Physician Work Pool

For services with physician work RVUs equal to zero (including the technical components of radiology services and other diagnostic tests), we created a separate practice expense pool using the average clinical staff time from the CPEP data and the "all physicians" practice expense per hour.

We then used the adjusted 1998 practice expense RVUs to allocate this pool to each service. We have removed services from the non-physician work pool if the requesting specialty predominates utilization of the service. Also, for all radiology services that are assigned physician work RVUs, we used the adjusted 1998 practice expense RVUs for radiology services as an