

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