DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 414

[HCFA–1111–IFC]

RIN 0938–AK14

Medicare Program; Criteria for Submitting Supplemental Practice Expense Survey Data

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule establishes criteria for physician and non-physician specialty groups for submitting supplemental practice expense survey data for use in determining payments under the physician fee schedule. This interim final rule solicits public comments on the criteria for supplemental surveys.

DATES: Effective Date: This regulation is effective May 3, 2000.

Comment Period: We will consider comments concerning criteria for supplemental surveys if we receive the comments at the appropriate address, as provided below, no later than 5 p.m. on July 3, 2000.

ADDRESSES: Mail written comments (one original and three copies) to the following address ONLY: Health Care Financing Administration, Department of Health and Human Services, Attn: HCFA–1111–IFC, P.O. Box 8013, Baltimore, MD 21244–8013.

If you prefer, you may deliver by courier, your written comments (one original and three copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201 or C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments mailed to those addresses may be delayed and could be considered late.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1111–IFC.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC 20201, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: Kenneth Marsalek, (410) 786–4502.

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative History

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services.'' The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work and practice and malpractice expenses.

Under the formula set forth in section 1848(b)(1) of the Act, the amount paid for each service under the physician fee schedule is the product of three factors—(1) A nationally uniform relative value for the service; (2) a geographic adjustment factor (GAF) for each physician fee schedule area; and (3) a nationally uniform conversion factor (CF) for the service. The CF converts the relative values into payment amounts.

For each physician fee schedule service, there are three RVU components—(1) Physician work; (2) practice expense; and (3) malpractice expense. In addition, each RVU component has a corresponding geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs of practice expense and malpractice insurance, and of one quarter of the physician work in an area compared to the national average.

The general formula for calculating the Medicare fee schedule amount for a given service in a given fee schedule area is as follows:

Payment = [(RVU work × GPCI work) + (RVU practice expense × GPCI practice expense) + (RVU malpractice × GPCI malpractice)] × CF.

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432) required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service beginning in 1998.

The Balanced Budget Act of 1997 was enacted on August 5, 1997, before publication of the October 1997 final rule on the physician fee schedule (62 FR 59103). Section 4505(a) of the BBA delayed the effective date of the resource-based practice expense RVUs until January 1, 1999, while section 4505(b) provided for a 4-year transition, with resource-based practice expense RVUs becoming fully effective in 2002. In addition, section 4505(d)(1)(A) and (d)(1)(B) of the BBA required us to develop new resource-based practice expense RVUs, and section 4505(d)(1)(C) of the BBA required us to develop a refinement process to be used during each of the 4 years of the transition period.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) requires us to establish a process under which we will accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the practice expense component of the physician fee schedule. Section 212(b) states that the process must be available for payments for the 2001 and 2002 physician fee schedules. This time period is consistent with the last years of the 4-year transition period, noted above. Therefore, we are establishing a process for submission of data in calendar years (CY) 2000 and 2001 for use in computing practice expense RVUs for CYs 2001 and 2002 physician fee schedule, respectively. Section 212(a) requires that we promulgate an interim final regulation that permits submission of data for payment rates for 2001.

B. Current Methodology for Computing Practice Expense Relative Value Units

Effective for services furnished beginning January 1, 1999, we established a new methodology for computing resource-based practice expense RVUs. The methodology uses practice expense data from two significant, accessible sources—HCFA's Clinical Practice Expert Panel (CPEP) data and the American Medical Association's (AMA's) Socioeconomic Monitoring System (SMS) data. Current aggregate specialty practice costs are used in the methodology to establish initial estimates of relative resources used in physicians' services across specialties and allocate them to specific procedures.

The SMS collects information on aggregate practice expenses from a random national survey of approximately 4,000 physicians who spend the greatest proportion of their time in patient care activities. The survey includes AMA member and non-AMA member physicians and office and hospital-based physicians. Actual practice expense data by specialty, derived from the 1995 through 1997

SMS survey data, were used to create six cost pools—administrative labor, clinical labor, medical supplies, medical equipment, office supplies, and all other expenses. The three steps used to create cost pools were as follows:

(1) Determination of practice expenses per hour by cost category, using the SMS survey of actual cost data. The practice expense per hour for each physician respondent's practice was calculated as the practice expenses for the practice divided by the total number of hours spent in patient care activities by the physicians in the practice.

(2) Determination of the total number of physician hours, by specialty, spent treating Medicare patients, using physician time data for each procedure code and Medicare claims data.

(3) Calculation of the practice expense pools by specialty and by cost category by multiplying the practice expenses per hour for each category by the total physician hours.

Since many specialties identified in our Medicare claims data did not correspond exactly to the specialties included in the practice expense tables from the SMS survey data, we crosswalked these specialties to the most appropriate SMS specialty category. (For a more detailed discussion of the methodology, you may refer to the June 1998 proposed rule (63 FR at 30826) and the November 1998 final rule with comment (63 FR at 58816).)

C. Refinement of Practice Expense RVUs

In the June 5, 1998 proposed rule (63 FR 30818) and the November 2, 1998 final rule (63 FR 58814), we established the parameters for a refinement process and indicated that RVUs for all codes would be considered interim for CY 1999 and during the transition (through CY 2001). In the November 1998 final rule, we outlined the initial refinement process and the steps we are taking to resolve outstanding general methodological issues.

In the July 22, 1999 proposed rule (64 FR 39609), we stated that we awarded a one-year contract, beginning May 24, 1999, to The Lewin Group to provide technical assistance in evaluating various aspects of the practice expense methodology. These aspects include the following:

- Evaluation of the validity and reliability of the SMS data for specialty and subspecialty groups.
- Identification and evaluation of alternative and supplementary data from sources such as specialty and multi-specialty societies.
- Development of criteria for accepting other surveys and determination of the appropriate form of these surveys.

In the November 2, 1999 final rule (64 FR 59380), we noted the steps our contractor had taken to date, including issuance of its first draft report, ''Practice Expense Methodology,'' dated September 24, 1999. This report, which contains recommendations about a variety of methodology issues and use of oversampling and supplemental surveys, is discussed below. (The report has been placed on our homepage under the title ''Practice Expense Methodology Report.'' Our homepage can be accessed through the HCFA Internet site at http://www.hcfa.gov/medicare/pfsmain.htm.) Also, in the final rule, we indicated that for CY 2000 we would use supplemental survey data from thoracic surgeons to calculate practice expense because this oversample followed the SMS format and was collected by the AMA contractor, thus helping to assure data consistency.

In the September 24, 1999 report, the contractor recommended that we consider supplemental survey data furnished by physician and non-physician specialty groups that have conducted independent surveys that adhere to uniformity of format, sample frame, contractor, and data analysis of information on practice expense and hours spent in patient care. Specifically, the contractor recommended the following criteria:

- Draw the sample from the AMA Physician Masterfile when possible.
- Survey a large enough number of individuals to assure an adequate number of usable responses.
- Conduct the survey based on the SMS survey instruments and protocols, including administration and follow-up efforts.
- Use the same contractor as the SMS and field the survey during the same timeframe.
- Consistently define, throughout the SMS and all additional surveys, practice expense and hours spent in patient care.
- Assign responsibility for data editing and analysis to the AMA's SMS project team.

II. Provisions of the Interim Final Rule

We are amending the Medicare regulations in § 414.22(b) (Relative value units (RVUs)) to add paragraph (b)(6) to establish criteria for physician and non-physician specialty groups for submitting practice expense surveys that may be used for establishing payments in the 2001 physician fee schedule. We use practice expense survey data to establish the specialty-specific practice expense per-hour, and we will consider supplemental data that is obtained through surveys. We are adopting the criteria recommended by The Lewin Group, with some modifications, for supplemental survey data submitted to us by August 1, 2000 for consideration for use in our computation of RVUs for the 2001 physician fee schedule. In addition, we are soliciting public comment on the criteria that we will consider for survey data submitted between August 2, 2000 and August 1, 2001 for use in computing RVUs for the 2002 physician fee schedule.

Any HCFA-designated specialty group may submit supplemental survey data. (Please see the list below for designated specialties.) However, for survey data submitted for payments in 2001, we will give priority consideration to specialties that are not represented or are underrepresented in the SMS data.

HCFA Specialty Code and Description

01—General Practice
02—General Surgery
03—Allergy/Immunology
04—Otology, Laryn., Rhino
05—Anesthesiology
06—Cardiology
07—Dermatology
08—Family Practice
10—Gastroenterology
11—Internal Medicine
12—Manip. Therapy
13—Neurology
14—Neurosurgery
16—OB-GYN
18—Ophthalmology
19—Oral Surgery
20—Orthopedic Surgery
22—Pathology
24—Plastic Surgery
25—Physical Medicine
26—Psychiatry
28—Colorectal Surgery
29—Pulmonary Disease
30—Radiology
33—Thoracic Surgery
34—Urology
35—Chiropractor, Licensed
36—Nuclear Medicine
37—Pediatrics
38—Geriatrics
39—Nephrology
40—Hand Surgery
41—Optometrist
43—CRNA/AA
44—Infectious Disease
46—Endocrinology
48—Podiatry
50—Nurse Practitioners
62—Psychologist (Billing Independently)
65—Physical Therapist (Indep. Practice)
66—Rheumatology
67—Occupational Therapist
68—Clinical Psychologist
69—Independent Laboratory

70—Clinic or Other Group
76—Peripheral Vascular Disease
77—Vascular Surgery
78—Cardiac Surgery
79—Addiction Medicine
80—Clinical Social Worker
81—Critical Care (Intensivists)
82—Hematology
83—Hematology/Oncology
84—Preventive Medicine
85—Maxillofacial Surgery
86—Neuropsychiatry
89—Clinical Nurse Practitioner
90—Medical Oncology
91—Surgical Oncology
92—Radiation Oncology
93—Emergency Medicine
94—Interventional Radiology
95—Indep. Physiological Lab
97—Gynecology/Oncology

We will use several criteria for evaluating supplemental surveys submitted by August 1, 2000. Our criteria expand upon some of our contractor's recommendations, primarily by adopting more specific sampling criteria. We have not accepted several of our contractor's recommendations, but have modified them; we do not require that physician specialties use only the same contractor as the SMS, or that the AMA's SMS project team be assigned responsibility for data editing and analysis. In addition, as discussed below, it is not possible for the AMA to oversample a specialty in time to affect payments for CYs 2001 and 2002. Following are the specific criteria we will use:

• Physician groups must draw their sample from the AMA Physician Masterfile to ensure a nationally representative sample that includes both members and non-members of a physician specialty group. Physician groups must arrange for the AMA to send the sample directly to their survey contractor to ensure confidentiality of the sample; that is, to ensure comparability in the methods and data collected, specialties must not know the names of the specific individuals in the sample. (To request a sample from the Masterfile, contact Scott Birkhead of the AMA at (312) 464–2569. We understand that there is an approximate 1-week response time and a nominal charge for drawing the sample.)

• Non-physician specialties not included in the AMA's SMS must develop a method to draw a nationally representative sample of members and non-members. At a minimum, these groups must include former members in their survey sample. The sample must be drawn by the non-physician group's survey contractor, or another independent party, in a way that ensures the confidentiality of the sample; that is, to ensure comparability in the methods and data collected, specialties must not know the names of the specific individuals in the sample.

• A group (or its contractors) must conduct the survey based on the SMS survey instruments and protocols, including administration and follow-up efforts, and definitions of practice expense and hours in patient care. In addition, any cover letters or other information furnished to survey sample participants must be comparable to such information previously supplied by the SMS contractor to its sample participants. (A copy of the guidelines and procedures may be obtained by contacting Kenneth Marsalek at (410) 786–4502.)

• Use a contractor that has experience with the SMS or a survey firm with experience successfully conducting national multi-specialty surveys of physicians using nationally representative random samples.

• Submit raw survey data to us, including all complete and incomplete survey responses as well as any cover letters and instructions that accompanied the survey, by August 1, 2000 for data analysis and editing to ensure consistency. All personal identifiers in the raw data must be eliminated. (Send data to Health Care Financing Administration, Department of Health and Human Services, Attn: Kenneth Marsalek, C4–03–06, 7500 Security Boulevard, Baltimore, MD 21244–8013.)

• Raw survey data submitted to us between August 2, 2000 and August 1, 2001 will be considered for use in computing practice expense RVUs for CY 2002.

• The physician practice expense data from surveys that we use in our code-level practice expense calculations are the practice expenses per physician hour in the six practice expense categories—clinical labor, medical supplies, medical equipment, administrative labor, office overhead, and other. Supplemental survey data must include data for these categories. Ideally, we would like to calculate practice expense values with precision; however, we recognize that we must achieve a balance because conducting surveys is expensive and there is a tension between achieving large sample sizes, which increases precision, and smaller ones, which conserves costs.

Based on our review of existing physician practice expense surveys, we believe an achievable level of precision is a coefficient of variation, that is, the ratio of the standard error of the mean to the mean expressed as a percent, not greater than 10 percent, for overall practice expenses or practice expenses per hour. For existing surveys the standard deviation is frequently the same magnitude as the mean. If the standard deviation equals the mean, then a usable sample size of 100 will yield a coefficient of variation of 10 percent. For small, homogeneous subspecialties, the variations in practice expenses may be lower because a smaller sample size achieves this level of precision. Other ways of expressing precision (for example, 95 percent confidence intervals) are also acceptable if they are approximately equivalent to a coefficient of variation of 10 percent or better. We will consider surveys for which the precision of the practice expenses are equal to or better than this level of precision and that meet the other survey criteria. Also, we will require documentation regarding how the practice expenses were calculated and will verify the calculations. Of course, we have the statutory authority to determine the final practice expense RVUs.

Since the physician fee schedule is a national fee schedule, we require that the survey be representative of the target population of physicians nationwide. We can presume national representativeness if a random sample is drawn from a complete nationwide listing of the physician specialty or subspecialty and the response rate, the percent of usable responses received from the sample, is high, for example, 80 to 90 percent. If any of these conditions (random sample, complete nationwide listing, and high response rate) are not achieved, then the potential impacts of the deviations upon national representativeness must be explored and documented. For example, if the response rate is low, then justification must be furnished to demonstrate that the responders are not significantly different from non-responders with regard to factors affecting practice expense. Differential weighting of subsamples may improve the representativeness. Minor deviations from national representativeness may be acceptable.

We believe that it is impossible and impractical to set rigid cutoffs for most of these criteria, especially for national representativeness. We are attempting to be as flexible as possible consistent with our goal of obtaining new surveys of practice expense data that are scientifically sound and methodologically consistent with our existing estimates. For instance, a specialty may include different types of physician practices (for example, urban versus rural, academic versus non-academic, interventional versus non-

interventional) that exhibit different patterns of practice expense. Similarly, a stratified sampling of these different types of practices may be a more efficient sampling strategy than a simple random sample of the entire specialty. We welcome surveys with more sophisticated designs and these types of survey variations if relevance to our criteria is documented.

We would need to make the supplemental survey data that we determine complies with the above criteria consistent with the SMS data we are using. Specifically, we are currently using 1994 through 1996 specialty practice expense per-hour data from the SMS. Thus, we would deflate supplemental survey data to be consistent with the timeframe of the data from other specialties from the SMS. For example, since the midpoint of the SMS data we currently use is 1995, we would deflate supplemental survey data to 1995 using the Medicare Economic Index. Therefore, any comparison between supplemental survey information and the SMS practice expense per-hour data we are currently using should take into account that the data should be deflated to 1995 costs. We will make comparable adjustments to bring future supplemental surveys into the same timeframe as SMS data used in the future.

In addition, if a specialty is represented in the SMS data, we will weight average (based on the number of survey responses) the supplemental data with the existing SMS data already being used. If the specialty is not represented in the SMS data, we will substitute the new data for the crosswalked SMS data currently being used for the specialty. Specialties may also wish to consider that under our methodology for determining practice expenses, we calculate specialty specific practice expense RVUs based on estimates of practice expenses for specific procedures in combination with the SMS data. The specialty specific practice expense RVUs are weight averaged based on the frequency of allowed services performed by a given specialty. Thus, supplemental data from a specialty that represents a small proportion of the allowed services for a given procedure code will have little influence on the procedure's final value in the weighted averaging.

Also, some practitioner services (services of certified registered nurse anesthetists, nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse mid-wives) are paid based on a percentage of the physician fee schedule amount. Since the payment under the physician fee schedule for a service performed by a practitioner is required to be based on a percentage of the amount paid to a physician for a service, we are considering whether to use only physician practice expense data in determining the practice expense RVUs for each practitioner service.

The AMA has provided us with information on its plans for collecting future data on physicians' practice expenses. (We are including this information so that physician specialty groups can take it into account in their plans.) The AMA indicated that most experts agree that the optimal method of obtaining practice expense data is to survey physician practices instead of surveying individual physicians about their share of a practice's expenses, as does the SMS. In addition, the AMA has found that it has become increasingly difficult and expensive to collect practice expense data through the SMS. For example, physicians tend to relocate more frequently, are increasingly unwilling to spend 25 to 30 minutes on the telephone to complete the SMS survey, and are increasingly unlikely to have access to the detailed financial information requested in SMS. Based on these considerations, last year the AMA began developing a new practice-level survey. In designing the new practice survey, the AMA is seeking to address some of the limitations of the SMS survey and the questions regarding its appropriateness for use in developing practice expense RVUs.

Drafts of the practice expense survey have been reviewed with outside experts, potential users of the data, and representatives from specialty societies, including the AMA's Specialty Society Relative Value Update Committee and group practices. The AMA is currently conducting a limited pilot of the practice survey with physician-owned practices. The pilot excludes single specialty practices in radiology, anesthesiology, pathology, and emergency medicine. Accounting for these specialties is more complicated, and separate instrumentation will be required. Collection of practice-level data for these specialties will not be implemented in the first practice survey, unless staff from these specialty societies are able to design a survey instrument that the AMA can use. If the pilot of the survey is successful, the AMA plans to conduct the practice survey initially in 2000 and, in alternate years thereafter, the practice expense survey and the SMS survey.

If the CY 2000 practice expense survey is successful, the AMA plans to drop the expense questions from the SMS beginning with the calendar 2001 SMS survey. If the practice expense survey is unsuccessful, the AMA will reconsider its plans for CY 2001 and future years. Under those circumstances, it may be necessary to retain the expense questions in the SMS. However, cost factors may constrain the extent to which the AMA can conduct a complete SMS survey with practice expense questions in CY 2001. Regardless, there are still 2 years of data from the 1998 and 1999 SMS surveys that we can use in updating future practice expense RVUs.

III. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IV. Use of Interim Final Rule

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved.

In this instance, however, the need to engage in proposed rulemaking is obviated by section 212 of BBRA that requires that we promulgate this regulation on an interim final basis. We are providing a 60-day period for public comment.

V. Information Collection Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This interim final rule requests HCFA-designated specialty groups to submit supplemental survey data to us, which meets the requirements of this section, by August 1, 2000, for consideration for payments in 2001. However, for survey data submitted for payments in 2001, we will give priority consideration to specialties that are not represented or are under represented in the SMS data. The burden associated with these requirements is the time necessary for the provider to submit the required data. However, due to the nature of the request, we estimate the number of submissions to average fewer than 10 on an annual basis. Therefore, these requirements are not subject to the PRA, as defined under 5 CFR 1320.3(c).

We have submitted a copy of this interim final rule to OMB for its' review of the information collection and requirements.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following: Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Attn: John Burke, HCFA–1111–IFC, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, and, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt, HCFA Desk Officer, HCFA–1111–IFC.

VI. Regulatory Impact Statement

We have examined the impacts of this interim final rule as required by Executive Order of 1993 (E.O.) 12866, the Unfunded Mandates Reform Act of 1995 (E.O.) 12875 (UMRA) (Pub. L. 104–4), and the Regulatory Flexibility Act of 1980 (RFA) (Pub. L. 96–354), and the Federalism Executive Order of 1999 (E.O.) 13132. E.O. 12866 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). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, non-profit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by non-profit status or by having revenues of $5 million or less annually. For purposes of the RFA, all physicians and non-physician providers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule 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 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

Since this rule only provides criteria for physicians and non-physicians who wish to provide data to us in computing RVUs under the physician fee schedule, there are no budgetary implications arising from this rule. Furthermore, this rule is required by statute and, thus, reflects the Congress's view of appropriate agency action.

The UMRA also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more in any year. This final rule with comment will have no consequential effect on State, local, or tribal governments. We believe the private sector cost of this rule falls below these thresholds as well.

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of E.O. 12866, this regulation was reviewed by the Office of Management and Budget.

VII. Federalism

We have examined this rule in accordance with E.O. 13132 and have determined that this final rule will not have any negative impact on the rights, roles, or responsibilities of State, local, or Tribal governments.

List of Subjects in 42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and record keeping requirements, Rural areas, X-rays.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

Part 414 is amended as set forth below:

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395(hh), and 1395rr(b)(1)).

2. In § 414.22, the introductory text is republished and a new paragraph (b)(6) is added to read as follows:

§ 414.22 Relative value units (RVUs).

HCFA establishes RVUs for physicians' work, practice expense, and malpractice insurance.

* * * * *

(b) *Practice expense RVUs.* * * *

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(6)(i) HCFA establishes criteria for supplemental surveys regarding specialty practice expenses submitted to HCFA by August 1, 2000 that may be used in determining practice expense RVUs for the 2001 physician fee schedule.

(ii) Any HCFA-designated specialty group may submit a supplemental survey.

(iii) Survey data and related materials submitted to HCFA between August 2, 2000 and August 1, 2001 will be considered for use in determining practice expense RVUs for the 2002 physician fee schedule.

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

Dated: March 20, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: April 10, 2000.

Donna E. Shalala,

Secretary.

[FR Doc. 00–10971 Filed 5–2–00; 8:45 am]

BILLING CODE 4120–01–P