At the request of a segment of the mining community to extend the time to submit comments, we are extending the comment period. The comment period will close September 7, 1999. We believe that this will provide sufficient time for all interested parties to review the ANPRM and submit comments.

Dated: July 21, 1999.

Marvin W. Nichols,

Deputy Assistant Secretary for Mine Safety and Health.

[FR Doc. 99–19159 Filed 7–26–99; 8:45 am]

BILLING CODE 4510–43–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 268

[FRL–6408–5]

RIN–2050–AE54

Potential Revisions to the Land Disposal Restrictions Mercury Treatment Standards; Extension of Comment Period

AGENCY: Environmental Protection Agency (EPA, the Agency).

ACTION: Advance notice of proposed rulemaking (ANPRM); extension of comment period.

SUMMARY: On May 28, 1999 (64 *FR* 28949), EPA issued an ANPRM presenting potential revisions to the 40 CFR part 268 Land Disposal Restrictions treatment standards applicable to mercury-bearing hazardous wastes. The ANPRM requested comment on EPA's waste generation and treatment data for mercury-bearing hazardous waste, as well as on technical and policy issues regarding mercury waste treatment, and potential avenues by which current mercury treatment standards might be revised. The Agency is extending the comment period because several commenters have requested more time to address the Agency's request for comment on potential revisions to the mercury-bearing hazardous waste regulations. This notice extends the comment period for the ANPRM.

DATES: The comment period for this ANPRM is extended from the original closing date of July 27, 1999 to October 25, 1999.

ADDRESSES: If you wish to comment on the ANPRM, you must send an original and two copies of the comments referencing docket number F–1999–MTSP–FFFFF to: RCRA Docket Information Center, Office of Solid Waste (5305G), U.S. Environmental Protection Agency Headquarters (EPA, HQ), 401 M Street, SW, Washington, DC 20460. Hand deliveries of comments should be made to the Arlington, VA, address listed below. You may also submit comments electronically by sending electronic mail through the Internet to: rcradocket@epamail.epa.gov. You should identify comments in electronic format with the docket number F–1999–MTSP–FFFFF. You must submit all electronic comments as an ASCII (text) file, avoiding the use of special characters and any form of encryption. If you do not submit comments electronically, EPA is asking prospective commenters to voluntarily submit one additional copy of their comments on labeled personal computer diskettes in ASCII (text) format or a word processing format that can be converted to ASCII (text). It is essential to specify on the disk label the word processing software and version/edition as well as the commenter's name. This will allow EPA to convert the comments into one of the word processing formats utilized by the Agency. Please use mailing envelopes designed to physically protect the submitted diskettes. EPA emphasizes that submission of comments on diskettes is not mandatory, nor will it result in any advantage or disadvantage to any commenter.

You should not submit electronically any confidential business information (CBI). You must submit an original and two copies of CBI under separate cover to: RCRA CBI Document Control Officer, Office of Solid Waste (5305W), U.S. EPA, 401 M Street, SW, Washington, DC 20460.

You may view public comments and supporting materials in the RCRA Information Center (RIC), located at Crystal Gateway I, First Floor, 1235 Jefferson Davis Highway, Arlington, VA. The RIC is open from 9 a.m. to 4 p.m., Monday through Friday, excluding federal holidays. To review docket materials, we recommend that you make an appointment by calling (703) 603–9230. You may copy a maximum of 100 pages from any regulatory docket at no charge. Additional copies cost $0.15/page.

FOR FURTHER INFORMATION CONTACT: For general information or to order paper copies of this **Federal Register** document, contact the RCRA Hotline, Monday through Friday between 9:00 a.m. and 6:00 p.m. EST, toll free at (800) 424–9346; or (703) 412–9810 from Government phones or if in the Washington, DC local calling area; or (800) 553–7672 for the hearing impaired. For technical information contact Rita Chow at (703) 308–6158 or Josh Lewis (703) 308–7877, Office of Solid Waste (5302W), U.S. Environmental Protection Agency, 401 M Street, SW, Washington, DC 20460.

List of Subjects in 40 CFR Part 268

Environmental protection, Hazardous waste, Reporting and recordkeeping requirements.

Dated: July 20, 1999.

Judy A. Kertcher,

Acting Director, Office of Solid Waste.

[FR Doc. 99–19156 Filed 7–26–99 8:45 am]

BILLING CODE 6560–50–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 414

[HCFA–1010–P]

RIN 0938–AJ00

Medicare Program; Replacement of Reasonable Charge Methodology by Fee Schedules

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

ACTION: Proposed rule.

SUMMARY: We are proposing to implement fee schedules to be used for payment of services, excluding ambulance services, still subject to the reasonable charge payment methodology. The authority for establishing these fee schedules is provided by section 4315 of the Balanced Budget Act of 1997 (Public Law 105–33), which adds to the Social Security Act a new section 1842(s). A fee schedule for ambulance services is mandated by a different statutory provision. Section 1842(s) of the Social Security Act specifies that statewide or other areawide fee schedules may be implemented for the following services: medical supplies; home dialysis supplies and equipment; therapeutic shoes; parenteral and enteral nutrients, equipment, and supplies; electromyogram devices; salivation devices; blood products; and transfusion medicine.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on September 27, 1999.

ADDRESSES: Mail an original and 3 copies of written comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1010–P, P.O. Box 26688, Baltimore, MD 21207–0488.

If you prefer, you may deliver an original and 3 copies of your written comments to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, D.C. 20201, or Room C5–09–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1010–P. 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, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $8. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access, a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is http://www.access.gpo.gov/nara/index.html, by using local WAIS client software, or by telnet to swais.access.gpo.gov, then log in as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then log in as guest (no password required).

FOR FURTHER INFORMATION CONTACT: Joel Kaiser, (410) 786–4499.

SUPPLEMENTARY INFORMATION:

I. Background

A. Payment Under Reasonable Charges

Payment for most services, including supplies and equipment, furnished under Part B of the Medicare program (Supplementary Medical Insurance) is made through contractors known as Medicare carriers. At one point, payment for most of these services was made on a reasonable charge basis by these carriers. The methodology for determining reasonable charges is set forth in section 1842(b) of the Social Security Act (the Act) and 42 CFR part 405, subpart E of our regulations. Reasonable charge determinations are generally based on customary and prevailing charges derived from historic charge data. The reasonable charge for service is generally set at the lowest of the following factors:

- The supplier's actual charge for the service.
- The supplier's customary charge for the service.
- The prevailing charge in the locality for similar services. (The prevailing charge may not exceed the 75th percentile of the customary charges of suppliers in the locality.)
- The inflation indexed charge (IIC). The IIC is defined in § 405.509(a) as the lowest of the fee screens used to determine reasonable charges for services, including supplies, and equipment paid on a reasonable charge basis (excluding physicians' services) that is in effect on December 31 of the previous fee screen year, updated by the inflation adjustment factor. Fee screens are those factors identified above, including the IIC and lowest charge level if applicable, used to determine payment under the reasonable charge methodology. The inflation adjustment factor is based on the current change in the consumer price index for all urban consumers (CPI–U) for the 12-month period ending June 30.

For parenteral and enteral nutrients, equipment, and supplies, an additional factor, the lowest charge level (LCL), is used to determine the reasonable charge. In accordance with § 405.511(c), the LCL is set at the 25th percentile of the charges (incurred or submitted on claims processed by the carrier) for the above services, in the locality designated by the carrier for this purpose, during the 3-month period of July 1 through September 30 preceding the fee screen year (January 1 through December 31) for which the service was furnished.

Sections 405.502(g) and 405.506 permit exceptions to the general rules for determining reasonable charges. Section 405.502(g) gives the carrier the authority to establish special payment limits for a category of service if it determines that the standard rules for calculating payments result in grossly deficient or grossly excessive payments. Section 405.506 provides that a charge which exceeds the customary charge, the prevailing charge, or the LCL ''may be found to be reasonable, but only where there are unusual circumstances, or medical complications requiring additional time, effort or expense which support an additional charge, and only if it is acceptable medical or medical service practice in the locality to make an extra charge in such cases.''

B. Payment Under Fee Schedules

The law gradually replaced the reasonable charge payment methodology with fee schedule payment methodologies for most services furnished under Part B of the Medicare program. Fee schedules have been established for physicians' services, laboratory services, durable medical equipment (DME), prosthetics and orthotics, surgical dressings, and, beginning in the year 2000, ambulance services. Subject to coinsurance and deductible rules, Medicare payment for these services is equal to the lower of the actual charge for the service or the amount determined under the fee schedule methodology.

Section 4315 of the Balanced Budget Act of 1997 (BBA) amends the Act at section 1842 by adding a new subsection(s). Section 1842(s) of the Act provides authority for implementing statewide or other areawide fee schedules to be used for payment of the following services that are currently paid on a reasonable charge basis:

- Medical supplies.
- Home dialysis supplies and equipment (as defined in section 1881(b)(8) of the Act).
- Therapeutic shoes.
- Parenteral and enteral nutrients, equipment, and supplies (PEN).
- Electromyogram devices.
- Salivation devices.
- Blood products.
- Transfusion medicine.

Section 1842(s)(1) of the Act provides that the fee schedules for the services listed above are to be updated on an annual basis by the percentage increase in the CPI–U (United States city average) for the 12-month period ending with June of the preceding year. The fee schedules for PEN, however, may not be updated before the year 2003. Finally, total payments for the initial year of the fee schedules must be approximately equal to the estimated total payments that would have been made under the

reasonable charge payment methodology.

II. Provisions of the Proposed Regulations

A. General

We propose, under section 1842(s) of the Act, to implement fee schedules for those services listed above. Subject to coinsurance and deductible rules, Medicare payment for these services is to be equal to the lower of the actual charge for the service or the amount determined under the applicable fee schedule payment methodology presented below. The fee schedules we propose would apply to services furnished on or after January 1, 1999, and would be calculated using base reasonable charges updated by an inflation update factor.

Section 4315(d) of the BBA requires that the total payments for the initial year of the fee schedules be approximately equal to the estimated total payments that would have been made under the reasonable charge payment methodology. For this reason, for services other than PEN, we are proposing that the fee schedule amounts be based on average reasonable charges from the period July 1, 1996 through June 30, 1997, the same data period used in calculating the 1998 reasonable charges. Furthermore, for the purposes of calculating the 1999 fee schedule amounts, we are proposing that the base fee schedule amounts be increased by the change in the CPI-U for the 12-month period ending with June of 1998, the inflation adjustment factor that would have otherwise been used in calculating the 1999 IICs. This would update the reasonable charge data to the 1999 level, the initial year of the fee schedules. For PEN, which accounts for approximately 90 percent of the Medicare expenditures for services addressed in this rule, we are proposing that the fee schedule amounts be based on the reasonable charges that would have been used in determining payment for PEN in 1999.

The proposed fee schedules would have a minimal, if any, impact on the efforts of HCFA and its contractors to revise their current systems to be millennium or Y2K compliant, as Y2K compliant fee schedule systems are already in place for other services. The proposed fee schedules would be incorporated into these current systems.

B. National Limits

For medical supplies, electromyogram devices, salivation devices, blood products, and transfusion medicine furnished within the continental United States, we propose national limits on the statewide fee schedule amounts similar to those that were mandated by the Congress for DME and surgical dressings in section 1834 of the Act. The Congress mandated ceilings and floors, equal to 100 percent and 85 percent, respectively, of the median of all statewide fee schedule amounts, to limit unreasonably high and low fees resulting from the local fee calculations for DME and surgical dressings. The Congress recognized the unique costs of doing business in areas outside the continental United States and therefore did not apply the national limits for DME and surgical dressings to these areas.

The national limits for DME and surgical dressings have been effective at eliminating outlying fees that cannot be explained by the differences in the costs of doing business in one part of the country versus another. We are therefore proposing that this methodology be applied to the services identified above. Accordingly, the statewide fee schedule amounts for these services may not exceed 100 percent of the median of all statewide fee schedule amounts for areas within the continental United States and may not be less than 85 percent of the median of all statewide fee schedule amounts for areas within the continental United States. The statewide fee schedule amounts for areas outside the continental United States will not be subject to the national limits. National limits are not proposed for home dialysis supplies and equipment, therapeutic shoes, or PEN because the payment amounts for these services are already subject to national limits or are determined on a national basis in the case of PEN.

C. Medical Supplies

Medical supplies are miscellaneous supplies or devices including, but not limited to, casts, splints, and paraffin that are not already included under an existing fee schedule. In addition, intraocular lenses (IOLs) inserted during or subsequent to cataract surgery in a physician's office are considered medical supplies for payment purposes under this rule. For calendar year 1999, we propose statewide fee schedule amounts equal to the weighted average of allowed charges for the services. For these calculations, we will use reasonable charge data with dates of service from July 1, 1996 through June 30, 1997, increased by the change in the CPI-U for the 12-month period ending with June of 1998. The fee schedule amounts are to be updated on an annual basis in accordance with section 1842(s)(1) of the Act. Beginning with the second year of the fee schedule, the statewide fee schedule amounts for IOLs inserted in a physician's office are not to exceed the Medicare allowed payment amount for IOLs furnished by ambulatory surgical centers (ASCs).

D. Home Dialysis Supplies And Equipment

These are services as defined in § 410.52. For calendar year 1999, we propose statewide fee schedule amounts equal to the weighted average of allowed charges for the services. For these calculations, we will use reasonable charge data with dates of service from July 1, 1996 through June 30, 1997, increased by the change in the CPI–U for the 12-month period ending with June of 1998. However, amount of payment under this methodology may not exceed the limit specified for equipment and supplies in § 414.330(c)(2). The fee schedule amounts are to be updated on an annual basis in accordance with section 1842(s)(1) of the Act.

E. Therapeutic Shoes

These services are defined in section 1861(s)(12) of the Act as ''extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes.'' In addition, section 1833(o)(2)(D) of the Act provides that an individual ''may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pairs of inserts (other than the original pair of inserts with respect to such shoes).'' Section 1833(o)(2)(A) of the Act establishes national payment limits for these services. These are upper payment limits, or ceilings, applied to the reasonable charges calculated for these services. The initial year, 1988 limits were $300 for one pair of custom molded shoes (including any inserts that are provided initially with the shoes), $100 for one pair of extra-depth shoes (not including inserts provided with such shoes), and $50 for any pairs of inserts. In accordance with section 1833(o)(2)(C) of the Act, these national payment limits are increased on an annual basis by the same annual percentage increase provided for DME, rounded to the nearest multiple of $1. We may establish limits lower than these limits if shoes and inserts of appropriate quality are readily available at or below the limits. We have determined that, to the extent that reasonable charges for shoes and inserts are lower than the limitations contained in section 1834(o)(2)(A) of the Act, shoes and inserts are readily available at that level. Therefore, we find it appropriate and consistent with the

direction of the BBA to apply fee schedule amounts lower than the limits.

For calendar year 1999, we propose statewide fee schedule amounts equal to the weighted average of allowed charges for the services. For these calculations, we will use reasonable charge data with dates of service from July 1, 1996 through June 30, 1997, increased by the change in the CPI–U for the 12-month period ending with June of 1998. In addition, the statewide fee schedule amounts may not exceed the national payment limits established under section 1833(o)(2) of the Act. The fee schedule amounts are to be updated on an annual basis in accordance with section 1842(s)(1) of the Act.

F. Parenteral and Enteral Nutrients (PEN)

These services are covered by Medicare as prosthetic devices, which are defined in section 1861(s)(8) of the Act. However, PEN is excluded from the prosthetic and orthotic fee schedule payment methodology by section 1834(h)(4)(B) of the Act. In accordance with section 4551(b) of the BBA, the reasonable charges for PEN for the years 1998 through 2002 may not exceed the reasonable charges determined for 1995. The prevailing charges for PEN are currently determined on a nationwide basis (that is, the 75th percentile of the customary charges of suppliers in the entire nation).

As explained above, section 4551(b) of the BBA limits the reasonable charges calculated for 1998 through 2002 for PEN to the reasonable charges calculated in 1995. Therefore, payment under the reasonable charge methodology would be based on the lesser of the charges calculated for the given fee screen year (for example, 1999) or the charges calculated for 1995. For calendar year 1999, we propose nationwide fee schedule amounts equal to the lesser of the charges determined to be reasonable for the services during 1995 or the charges determined to be reasonable for the services during 1998 (using charge data with dates of service from July 1, 1996 through June 30, 1997), increased by the inflation adjustment factor that would have otherwise been used in calculating the 1999 IICs, in effect, the 1999 reasonable charges. Beginning the fee screen year 2003, the fee schedule amounts are to be updated on an annual basis in accordance with section 1842(s)(1) of the Act.

G. Electromyogram Devices And Salivation Devices

The decision regarding Medicare coverage of these services is made at the carrier's discretion. In any carrier area in which these services are covered, for calendar year 1999, we propose statewide fee schedule amounts equal to the weighted average of allowed charges for the services. For these calculations, we will use reasonable charge data with dates of service from July 1, 1996 through June 30, 1997, increased by the change in the CPI–U for the 12-month period ending with June of 1998. The fee schedule amounts are to be updated on an annual basis in accordance with section 1842(s)(1) of the Act.

H. Blood Products

For calendar year 1999, we propose statewide fee schedule amounts equal to the weighted average of allowed charges for the blood products services. These services are not included under the definition of drugs and biologicals in section 1861(t)(1) of the Act. For these calculations, we will use reasonable charge data with dates of service from July 1, 1996 through June 30, 1997, increased by the change in the CPI–U for the 12-month period ending with June of 1998. The fee schedule amounts are to be updated on an annual basis in accordance with section 1842(s)(1) of the Act.

I. Transfusion Medicine

For calendar year 1999, we propose statewide fee schedule amounts equal to the weighted average allowed charges for transfusion medicine services. For these calculations, we will use reasonable charge data with dates of service from July 1, 1996 through June 30, 1997, increased by the change in the CPI–U for the 12-month period ending with June of 1998. The fee schedule amounts are to be updated on an annual basis in accordance with section 1842(s)(1) of the Act.

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, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IV. Regulatory Impact Statement

We have examined the impacts of this proposed rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if 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 suppliers of Medicare Part B services are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, 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 603 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.

We expect suppliers of the Part B services listed in this preamble to be affected by this proposed rule. For 1999, the initial year of the fee schedules, we estimate that there will be a decrease of less than 1 percent in total expenditures for the services addressed in this proposed rule. Therefore, we expect that the overall impact of this proposed rule will be negligible.

With regard to IOLs, beginning with the second year of the fee schedules, we are proposing that the fee schedule amounts not exceed the Medicare allowed payment amount for IOLs furnished by ASCs. Therefore, it is likely that the IOL fee schedule amounts will decrease after the first year of the fee schedules. We do not believe, however, that limiting payment for IOLs furnished in a physician's office to the amount paid for IOLs furnished in an ASC will result in a lack of availability of IOLs to Medicare beneficiaries. The IOLs furnished by ASCs are the same devices that are furnished in a physician's office. The Medicare payment amount for IOLs furnished by ASCs is established through separate regulations and is based on the average price paid by ASCs for these devices. This amount should represent adequate payment to physicians for the cost of the IOL device that they insert in their office.

We expect that total expenditures in the outlying fee schedule years of 2000 and beyond will continue to approximate total expenditures that would have otherwise been made under the reasonable charge methodology in part because the fee schedules are updated using the same factor used in updating the IICs under the reasonable charge methodology.

For these reasons, we are not preparing an analysis for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this proposed rule would 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 Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

42 CFR part 414 would be amended as set forth below:

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

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, 1395hh, and 1395rr(b)(1)).

Subpart A—General Provisions

2. A new § 414.70 is added to read as follows:

§ 414.70 Fee schedules for certain items and services previously paid on a reasonable charge basis.

(a) *General rule.* For services defined in § 400.202 of this chapter furnished on or after January 1, 1999, Medicare pays for the services as described in paragraph (b) of this section on the basis of 80 percent of the lesser of—

(1) The actual charge for the service; or

(2) The fee schedule amount for the service, as determined in accordance with paragraphs (e) through (k) of this section.

(b) *Payment classification.* (1) HCFA or the carrier determines fee schedules for the following categories of services:

(i) Medical supplies, as specified in paragraph (e) of this section.

(ii) Home dialysis supplies and equipment, as specified in paragraph (f) of this section.

(iii) Therapeutic shoes, as specified in paragraph (g) of this section.

(iv) Parenteral and enteral nutrients, equipment, and supplies (PEN), as specified in paragraph (h) of this section.

(v) Electromyogram devices and salivation devices, as specified in paragraph (i) of this section.

(vi) Blood products, as specified in paragraph (j) of this section.

(vii) Transfusion medicine, as specified in paragraph (k) of this section.

(2) HCFA designates the specific services in each category through program instructions.

(c) *Definition. Local payment amount* means the weighted average reasonable charge for the service furnished in a State, the District of Columbia, or a United States territory during the period July 1, 1996 through June 30, 1997, as determined by the carrier, increased by the change in the consumer price index for all urban consumers (CPI–U) for the 12-month period ending with June 1998.

(d) *Updating the fee schedule amounts.* Except for the fee schedule amounts for services described in paragraph (h) of this section, for each year subsequent to 1999, the fee schedule amounts of the preceding year are updated by the percentage increase in the CPI–U for the 12-month period ending with June of the preceding year. For services described in paragraph (h) of this section, for each year subsequent to 2002, the fee schedule amounts of the preceding year are updated by the percentage increase in the CPI–U for the 12-month period ending with June of the preceding year.

(e) *Medical supplies.* (1) This category includes, but is not limited to, cast supplies, splints, paraffin, and intraocular lenses (IOLs) inserted during or subsequent to cataract surgery in a physician's office.

(2) Payment for medical supplies is made in a lump sum amount for purchase of the item based on the applicable fee schedule amount.

(3) The fee schedule amount for an item furnished in 1999 is one of the following:

(i) Within the continental United States, 100 percent of the local payment amount if the local payment amount is neither greater than the median nor less than 85 percent of the median of all local payment amounts for areas within the continental United States.

(ii) Within the continental United States, 100 percent of the median of all local payment amounts for areas within the continental United States if the local payment amount exceeds the median of all local payment amounts for areas within the continental United States.

(iii) Within the continental United States, 85 percent of the median of all local payment amounts for areas within the continental United States if the local payment amount is less than 85 percent of the median of all local payment amounts for areas within the continental United States.

(iv) 100 percent of the local payment amount for areas outside the continental United States.

(4) For each year subsequent to 1999, the fee schedule payment amounts for IOLs inserted in a physician's office may not exceed the Medicare allowed payment amount for IOLs furnished by ambulatory surgical centers.

(f) *Home dialysis supplies and equipment.* (1) This category includes items and services as defined in § 410.52 of this chapter.

(2) Payment for home dialysis supplies and equipment is made in a lump sum based on the applicable fee schedule amount, but may not exceed the limit for equipment and supplies in § 414.330(c)(2).

(3) The fee schedule amount for a service furnished in 1999 is equal to the local payment amount.

(g) *Therapeutic shoes.* (1) This category includes extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, modifications of the shoes, and replacement inserts for the shoes.

(2) Payment for therapeutic shoes is made in a lump sum based on the applicable fee schedule amount.

(3) The fee schedule amount for payment for a service furnished in 1999 is the lesser of—

(i) The local payment amount; or

(ii) The national payment limit specified in section 1833(o)(2) of the Act.

(h) *Parenteral and enteral nutrients, equipment, and supplies (PEN).* (1) Payment for PEN is made in a lump sum based on the applicable fee schedule amount.

(2) The fee schedule amount for payment for a service furnished in 1999 is the lesser of—

(i) The charge determined to be reasonable for the service during 1995; or

(ii) The charge determined to be reasonable for the service during 1998, increased by the inflation adjustment factor used in calculating the 1999 IIC.

(i) *Electromyogram and salivation devices.*

(1) Payment for an electromyogram device or a salivation device is made in a lump sum for purchase of the device or on a monthly rental basis based on the applicable fee schedule amount.

(2) The fee schedule amount for payment for an electromyogram device or a salivation device furnished in 1999 is one of the following:

(i) Within the continental United States, 100 percent of the local payment

amount if the local payment amount is neither greater than the median nor less than 85 percent of the median of all local payment amounts for areas within the continental United States.

(ii) 100 percent of the median of all local payment amounts for areas within the continental United States if the local payment amount within the continental United States exceeds the median of all local payment amounts for areas within the continental United States.

(iii) 85 percent of the median of all local payment amounts for areas within the continental United States if the local payment amount within the continental United States is less than 85 percent of the median of all local payment amounts for areas within the continental United States.

(iv) 100 percent of the local payment amount for areas outside the continental United States.

(j) *Blood products.* (1) Payment for blood products is made in a lump sum based on the applicable fee schedule amount.

(2) The fee schedule amount for payment for a blood product furnished in 1999 is one of the following:

(i) Within the continental United States, 100 percent of the local payment amount if the local payment amount is neither greater than the median nor less than 85 percent of the median of all local payment amounts for areas within the continental United States.

(ii) 100 percent of the median of all local payment amounts for areas within the continental United States if the local payment amount within the continental United States exceeds the median of all local payment amounts for areas within the continental United States.

(iii) 85 percent of the median of all local payment amounts for areas within the continental United States if the local payment amount within the continental United States is less than 85 percent of the median of all local payment amounts for areas within the continental United States.

(iv) 100 percent of the local payment amount for areas outside the continental United States.

(k) *Transfusion medicine.* (1) Payment for transfusion medicine is made in a lump sum based on the applicable fee schedule amount.

(2) The fee schedule amount for payment for transfusion medicine furnished in 1999 is one of the following:

(i) Within the continental United States, 100 percent of the local payment amount if the local payment amount is neither greater than the median nor less than 85 percent of the median of all local payment amounts for areas within the continental United States.

(ii) 100 percent of the median of all local payment amounts for areas within the continental United States if the local payment amount within the continental United States exceeds the median of all local payment amounts for areas within the continental United States.

(iii) 85 percent of the median of all local payment amounts for areas within the continental United States if the local payment amount within the continental United States is less than 85 percent of the median of all local payment amounts for areas within the continental United States.

(iv) 100 percent of the local payment amount for areas outside the continental United States.

Subpart E—Determination of Reasonable Charges Under the ESRD Program

3. In § 414.330 the introductory text of paragraph (a)(2) is revised to read as follows:

§ 414.330 Payment for home dialysis equipment, supplies, and support services.

(a) * * *

(2) *Exception.* If the conditions in paragraphs (a)(2)(i) through (a)(2)(iv) of this section are met, Medicare pays for home dialysis equipment and supplies on a fee schedule basis in accordance with § 414.70, but the amount of payment may not exceed the limit for equipment and supplies in paragraph (c)(2) of this section.

* * * * *

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

Dated: January 3, 1999.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: February 25, 1999.

Donna E. Shalala,

Secretary.

[FR Doc. 99–19115 Filed 7–26–99; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 93–177; FCC 99–126]

Reduction of Regulatory Requirements For AM Broadcasters Using Directional Antennas

AGENCY: Federal Communications Commission

ACTION: Notice of proposed rulemaking.

SUMMARY: In this *Notice of Proposed Rule Making*, the Commission proposes substantial reductions in the proof of performance requirements for AM directional antenna systems. These proposals are intended to alleviate unnecessary financial burdens imposed on AM broadcasters by such requirements without jeopardizing the Commission's policy objectives of controlling interference and assuring adequate community coverage by AM stations. The Commission previously issued a *Notice of Inquiry* in this proceeding in response to a joint petition for rule making by five broadcast consulting engineering firms requesting a thorough reexamination of testing and verification procedures for AM radio stations that use directional antennas.

DATES: Submit comments on or before September 10, 1999 and reply comments on or before September 27, 1999.

ADDRESSES: Parties who choose to file comments concerning this *Notice of Proposed Rule Making* by paper should address their comments to Magalie Roman Salas, Office of the Secretary, TW–A306, Federal Communications Commission, 445 12th Street, S.W., Washington, D.C. 20554. Comments also should be submitted on a 3.5 inch diskette using WordPerfect 5.1 for Windows or compatible software to Son Nguyen, Federal Communications Commission, 445 12th Street, S.W., Room 2–A330, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Son Nguyen, Dale Bickel or William Ball at (202) 418–2660 or snguyen@fcc.gov, dbickel@fcc.gov, or wball@fcc.gov.

SUPPLEMENTARY INFORMATION: Comments and other data may be submitted via electronic mail to http://www.gcc.gov/e-file/ecfs.html.

The Commission proposes to amend 47 CFR Part 73 Subpart A as set forth below:

1. *Computer Modeling versus Proofs of Performance.* Several computer models have been developed over the years to calculate operating characteristics of particular importance to engineers designing, installing and adjusting AM antenna systems. Unlike the mathematical formulas for calculating the radiation characteristics of AM directional antennas contained in 47 CFR 73.150, 73.152 and 73.160, these computer models or ''NEC programs'' deal with ''internal'' array parameters such as impedances, currents and voltages at locations within the power distribution and radiation system. Several commentators suggested that proofs of performance may not be