Dated: August 6, 1999.

Margaret M. Dotzel,

Acting Associate Commissioner for Policy.

[FR Doc. 99–20991 Filed 8–12–99; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–1050–PN]

RIN 0938–AJ34

Medicare Program; Special Payment Limits for Certain Durable Medical Equipment and Prosthetic Devices

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

ACTION: Proposed notice.

SUMMARY: This notice proposes special payment limits, for five items of durable medical equipment and one prosthetic device, to replace the current fee schedule amounts for these items. Currently, payment under the Medicare program for these items is equal to 80 percent of the lesser of the actual charge for the item or the fee schedule amount for the item. We have determined that the Medicare fee schedule amounts for five durable medical equipment items and one prosthetic device are not inherently reasonable because they are grossly excessive relative to the amounts paid for these items by the Department of Veterans Affairs. This notice proposes that payment for these items be 80 percent of the actual charges for the items or the special payment limits we set for these items, whichever is less. It is intended to prevent continuation of excessive payment for these items. The special payment limits would be based on the median wholesale prices paid by the Department of Veterans Affairs for these items plus an appropriate markup.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, by 5 p.m. on October 12, 1999.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1050–PN, P.O. Box 9016, Baltimore, MD 21244–9016.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–16–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1050–PN. 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).

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

SUPPLEMENTARY INFORMATION: *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, Discover, or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 (or toll free at 1–888–293–6498) 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**.

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I. Background

A. Payment Under Reasonable Charges

Before January 1, 1989, payment for all durable medical equipment (DME) and prosthetic devices furnished under Part B of the Medicare program (Supplementary Medical Insurance) was made on a reasonable charge basis through contractors known as Medicare carriers and intermediaries. Reasonable charge determinations were generally based on customary and prevailing charges derived from historic charge data. The reasonable charges were established by the carriers using the methodology set forth in sections 1833 and 1842(b) of the Social Security Act (the Act) and 42 CFR part 405, subpart E of our regulations. The reasonable charge for an item was generally set at the lowest of the following factors:

- The supplier's actual charge for the item.
- The supplier's customary charge.
- The prevailing charge in the locality for the item.

(The prevailing charge could not exceed the 75th percentile of the customary charges of suppliers in the locality.)

- The inflation indexed charge. (The inflation indexed charge is defined in § 405.509(a) as the lowest of the fee screens used to determine reasonable charges for services, 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.)

B. Payment Under Fee Schedules

Sections 1834(a) and (h) of the Act provide that Medicare payment for DME and prosthetics and orthotics, respectively, is equal to 80 percent of the lesser of the actual charge for the item or the fee schedule amount for the item. Section 1834(a) of the Act classifies DME into the following payment categories:

- Inexpensive or other routinely purchased DME.
- Items requiring frequent and substantial servicing.
- Customized items.
- Oxygen and oxygen equipment.
- Other covered items (other than DME).
- Other items of DME (capped rental items).

There is a separate methodology for determining the fee schedule payment amount for each category of DME.

The fee schedules for DME and prosthetic devices are calculated using average reasonable charges from 1986 and 1987 and are generally adjusted annually by the change in the Consumer Price Index for all Urban Consumers (CPI–U), that is, the covered item update, for the 12-month period ending June 30 of the preceding year. Section 1834(h)(2)(B) of the Act requires that regional fee amounts be calculated for prosthetic devices. The regional fee

amounts are equal to the weighted average of the local (Statewide) fee amounts in each of our 10 regions. In addition, the fee schedules for DME and prosthetics and orthotics are limited by a ceiling (upper limit) and floor (lower limit). For DME, the ceiling and floor are equal to 100 percent and 85 percent, respectively, of the median (mid-point) of the local (Statewide) fee amounts. For prosthetics and orthotics, the ceiling and floor are equal to 120 percent and 90 percent, respectively, of the regional fee amounts. The fee schedule amounts for areas outside the continental United States are not subject to the ceiling and floor limits for DME or the regional fee amounts and ceiling and floor limits for prosthetic devices. The local fee schedule amounts for areas outside the continental United States are not included in the calculation of the ceiling and floor limits or regional fee amounts.

C. Exception to the Standard Payment Methodologies—Special Payment Amounts

Section 1842(b)(8) of the Act states that we may establish special payment amounts for particular items or services, other than physicians' services, that are covered under Medicare Part B, for which we determine that the application of standard Part B pricing rules results in grossly excessive or grossly deficient payment amounts. The applicable regulations are located at § 405.502(g) and require us to consider relevant information in establishing payment limits that are realistic and equitable. The special payment limit is either a specific dollar amount or is based on a special method to be used in determining the payment amount.

Section 405.502(g)(1) provides the following examples of circumstances that may result in grossly deficient or excessive charges:

- The marketplace is not competitive.
- Medicare and Medicaid are the sole or primary source of payment for a category of items or services.
- The payment amounts do not reflect changing technology, increased facility with that technology, or changes in acquisition, production, or supplier costs.
- The payment amounts for a category of items or services in a particular locality are grossly higher or lower than the payment amounts in other comparable localities for the category of items or services, taking into account the relative costs of furnishing the category of items or services in the different localities.
- The payment amounts for a category of items or services are grossly higher or lower than acquisition or production costs for the category of items or services.
- There have been increases in payment amounts for a category of items or services that cannot be explained by inflation or technology.
- The payment amounts for a category of items or services are grossly higher or lower than the payments made for the same category of items or services by other purchasers in the same locality.

Section 405.502(g)(3) requires that we publish for public comment proposed payment limits in the **Federal Register**. We allow 60 days for receipt of public comments on the proposal. After we have considered all timely comments, we publish in the **Federal Register** a final notice announcing the special payment limits and our analyses and responses to the comments.

D. Items for Which Adjustments Are Proposed

Using the authority discussed above, we reviewed the current Medicare payment amounts for the following items:

- Folding walker (pickup), adjustable or fixed height—code E0135 in the HCFA Common Procedure Coding System (HCPCS).
- Folding walker, wheeled, without seat—HCPCS code E0143.
- Commode chair, stationary, with fixed arms—HCPCS code E0163.
- Transcutaneous Electrical Nerve Stimulator (TENS), two lead, localized stimulation—HCPCS code E0720.
- TENS, four lead, larger area/multiple nerve stimulation—HCPCS code E0730.
- Vacuum erection system—HCPCS code L7900.

Section 134 of the Social Security Act Amendments of 1994 specifically mandates that we review our payments for decubitus care equipment, TENS devices, and other items we consider appropriate. We gathered payment data on 20 items identified as either decubitus care equipment or TENS devices and 80 additional items drawn from a list of top 100 items ranked by Medicare expenditures. Based on a review of retail prices, wholesale prices, and prices paid by payers other than Medicare, we identified 20 items from this list of 100 items that warranted further review. We then obtained data on the average payments made by the Department of Veterans Affairs (VA) for these 20 items and, based on a review of this data, and as we explain below, we determined that payment adjustments were necessary for the six items listed above. These six items represent items that are generally purchased as opposed to being rented. We feel that more data on rental costs and services is needed in order to address the reasonableness of the Medicare payment amounts for rental items for which we obtained the VA data, that is, items which are generally furnished to Medicare beneficiaries on a rental basis.

With the exception of HCPCS code L7900, all items are covered as DME and classified under the inexpensive or routinely purchased DME fee schedule category. Medicare payment for these items is made on either a purchase or a rental basis. Total Medicare payment for rentals is limited to 100 percent of the fee schedule amount for purchase of the item. HCPCS code L7900 identifies a prosthetic device for which Medicare payment is made under the fee schedule on a purchase basis only. All of the items above are high volume items in terms of Medicare expenditures.

The 1998 fee schedule amounts for purchase of these items for areas within the continental United States range from $67.97 to $79.97 for code E0135; $97.48 to $114.68 for code E0143; $89.42 to $105.20 for code E0163; $298.02 to $350.61 for code E0720; $300.43 to $353.45 for code E0730; and $357.76 to $477.01 for code L7900. The 1998 fee schedule amounts for purchase of these items for areas outside the continental United States (that is Alaska, Hawaii, and Puerto Rico) range from $90.66 to $115.45 for code E0135; $107.85 to $145.22 for code E0143; $109.00 to $138.62 for code E0163; $207.89 to $465.26 for code E0720; $338.93 to $508.22 for code E0730; and $394.65 to $473.37 for code L7900.

Based on a comparison of Medicare payment amounts and payment amounts from the VA, we determined that the current payment amounts for these items are grossly excessive.

E. Comparison With the Department of Veterans Affairs

The VA also administers a national program that includes the furnishing of DME and prosthetic devices. Unlike Medicare, which is a payer of services and not a provider of services, the VA generally obtains these items by direct acquisition from manufacturers and wholesalers and provides them directly to veterans through its network of medical centers located throughout the United States. Therefore, the prices paid by the VA for these items represent wholesale prices as opposed to retail prices charged by outlets that supply these items to Medicare beneficiaries. To make a valid comparison between Medicare and VA payments, a price

markup must be applied to the VA wholesale prices to approximate retail prices.

We obtained the median wholesale payment amount for the items identified in section D above from a number of VA medical centers across the nation. We received data from 109 (approximately 63 percent) of the VA medical centers across the nation. We increased the median wholesale amount by a markup of 67 percent; that is, a two-thirds markup.

The amount of the markup was based on data we compiled from over 200 HCPCS coding recommendations submitted by the industry to us for medical equipment and devices from 1989 to 1998. When submitting recommendations for new HCPCS codes, the requester, usually the manufacturer of the item, is required to list the wholesale and suggested retail prices for the item. The median markup calculated using these data was 67 percent. We consider 67 percent to be the upper end of a range of acceptable markups. If public comments or additional research indicate that a markup of less than 67 percent is appropriate, we reserve discretion to establish a markup of less than 67 percent. It should be noted that requests for new HCPCS codes generally involve new products or technology; therefore, it can be assumed that the markups for these items will be, in general, higher than markups for items that have been on the market for a number of years.

The VA and Medicare payments are compared in the table below.

Code	VA Payment	VA+67%	Medicare floor*	Medicare ceiling*
E0135	$30.24	$50.50	$67.97	$79.97
E0143	45.44	75.88	97.48	114.68
E0163	37.64	62.85	89.42	105.20
E0720	89.89	150.11	298.02	350.61
E0730	124.00	207.08	300.43	353.45
L7900	131.65	219.86	357.76	477.01

*Highest and lowest 1998 fee schedule amounts for States within the continental United States.

II. Provisions of This Proposed Notice

Below are the amounts we are proposing as the special payment limits:

A. Folding Walker (Pickup), Adjustable or Fixed Height—HCPCS Code E0135

The median VA wholesale payment amount for this item is $30.24. Using a markup of 67 percent results in an estimated retail payment amount of $50.50. We propose that the special payment limit for purchase of this item, when new and when furnished in the continental United States, be equal to $50.50. This amount is approximately 37 percent below the 1998 Medicare ceiling of $79.97 and 26 percent below the 1998 Medicare floor of $67.97. In keeping with the Medicare policy for calculating fee schedule amounts for the purchase of used equipment and the rental of equipment for which base fee schedule data (that is, reasonable charge data from 1986 and 1987) are not available (see section 5102.2.A.2 of the Medicare Carriers Manual), we propose that the special payment limit for purchase of this item, when previously used by other patients and when furnished in the continental United States, be equal to $37.88 or 75 percent of the special payment limit for purchase of a new item. We propose that the special payment limit for the monthly rental of this item, when furnished in the continental United States, be equal to $5.05 or 10 percent of the special payment limit for purchase of a new item.

B. Folding Walker, Wheeled, Without Seat—HCPCS Code E0143

The median VA wholesale payment amount for this item is $45.44. Using a markup of 67 percent results in an estimated retail payment amount of $75.88. We propose that the special payment limit for purchase of this item, when new and when furnished in the continental United States, be equal to $75.88. This amount is approximately 34 percent below the 1998 Medicare ceiling of $114.68 and 22 percent below the 1998 Medicare floor of $97.48. We propose that the special payment limit for purchase of this item, when previously used by other patients and when furnished in the continental United States, be equal to $56.91 or 75 percent of the special payment limit for purchase of a new item. We propose that the special payment limit for the monthly rental of this item, when furnished in the continental United States, be equal to $7.59 or 10 percent of the special payment limit for purchase of a new item.

C. Commode Chair, Stationary, With Fixed Arms—HCPCS Code E0163

The median VA wholesale payment amount for this item is $37.64. Using a markup of 67 percent results in an estimated retail payment amount of $62.85. We propose that the special payment limit for purchase of this item, when furnished in the continental United States, be equal to $62.85. This amount is approximately 40 percent below the 1998 Medicare ceiling of $105.20 and 30 percent below the 1998 Medicare floor of $89.42. We propose that the special payment limit for purchase of this item, when previously used by other patients and when furnished in the continental United States, be equal to $47.14 or 75 percent of the special payment limit for purchase of a new item. We propose that the special payment limit for the monthly rental of this item, when furnished in the continental United States, be equal to $6.29 or 10 percent of the special payment limit for purchase of a new item.

D. Transcutaneous Electrical Nerve Stimulator (TENS), Two Lead, Localized Stimulation—HCPCS Code E0720

The median VA wholesale payment amount for this item is $89.89. Using a markup of 67 percent results in an estimated retail payment amount of $150.11. We propose that the special payment limit for purchase of this item, when furnished in the continental United States, be equal to $150.11. This amount is approximately 57 percent below the 1998 Medicare ceiling of $350.61 and 50 percent below the 1998 Medicare floor of $298.02.

E. TENS, Four Lead, Larger Area/ Multiple Nerve Stimulation—HCPCS Code E0730

The median VA wholesale payment amount for this item is $124.00. Using a markup of 67 percent results in an estimated retail payment amount of $207.08. We propose that the special payment limit for purchase of this item, when furnished in the continental United States, be equal to $207.08. This amount is approximately 41 percent below the 1998 Medicare ceiling of

$353.45 and 31 percent below the 1998 Medicare floor of $300.43.

F. Vacuum Erection System—HCPCS Code L7900

The median VA wholesale payment amount for this item is $131.65. Using a markup of 67 percent results in an estimated retail payment amount of $219.86. We propose that the special payment limit for purchase of this item, when furnished in the continental United States, be equal to $219.86. This amount is approximately 46 percent below the highest 1998 Medicare regional fee schedule amount of $406.34 and 43 percent below the lowest 1998 Medicare regional fee schedule amount of $382.96.

G. Areas Outside the Continental United States

The 1998 DME and prosthetic device fee schedule amounts for areas outside the continental United States are, on average, 10 percent greater than the 1998 DME and prosthetic device fee schedule amounts for areas within the continental United States. For the six items identified above, we propose using a modified approach to set special payment limits for areas outside the continental United States (that is, Alaska, Hawaii, Puerto Rico). We propose that special payment limits be established by reducing the 1998 fee schedule amounts for these areas by the percentage difference between the 1998 national ceilings, or the highest regional fee schedule amount in the case of HCPCS code L7900, and the special payment limits proposed above for the continental United States. However, in no case can the special payment limit for an area outside the continental United States be lower than the special payment limit for the continental United States increased by 10 percent. We are, therefore, proposing that the special payment limits for areas outside the continental United States be at least 10 percent greater than the special payment limits for areas within the continental United States because of the unique costs of doing business in these areas. We base this 10 percent parameter on the fact that the fee schedule amounts for all DME and prosthetic devices for areas outside the continental United States, in general, are, on average, 10 percent greater than the fee schedule amounts for areas within the continental United States.

H. Applicability

The initial special payment limits we propose would apply to items furnished on or after the effective date of the published final notice. We propose that the fee schedule amounts for the six items identified be reduced incrementally by a factor of 15 percent or less per year until they are equal to the special payment limits applicable to each item. For each calendar year after the calendar year in which the proposed special payment limits are fully in effect, the special payment limits would be adjusted using the applicable covered item update (see ''I. B. Payment Under Fee Schedules'') for the appropriate calendar year. For example, as noted above, the 1998 fee schedule amounts for HCPCS code L7900 for areas within the continental United States range from $382.96 to $406.34. The special payment limit of $219.86 that we are proposing would be phased in over a number of years so that in any given year no adjustment would exceed 15 percent. We are proposing that the special payment amounts be phased in so that the impact of the reductions is spread out over multiple years and gives the suppliers an extended period in which to adjust to the reductions in payment. In addition, most DME suppliers are small businesses and applying the payment limits at one time would impose a serious burden on these types of entities, particulary those that specialize in furnishing the items addressed in this notice. The proposed special payment limit of $219.86 for HCPCS code L7900 would be phased in as follows:

Calendar year	Range in limits within continental U.S.
1998	$382.96 to $406.34.
1999	$325.52 to $345.39.
2000	$276.69 to $293.58.
2001	$235.19 to $249.54.
2002	$219.86 (special limit fully implemented).

For each calendar year after 2002, the special payment limit for HCPCS code L7900 would be equal to the special payment limit for the preceding calendar year increased by the appropriate covered item update for prosthetic devices. The ranges in the proposed payment limits, by calendar year, for all six HCPCS codes, for items furnished within the continental United States, are listed in the table below.

HCPCS	1999	2000	2001	2002	2003	2004
E0135	57.77 to 67.97	50.50 to 57.77	50.50[1]	([2])	([2])	([2])
E0143	82.86 to 97.48	75.88 to 82.86	75.88[1]	([2])	([2])	([2])
E0163	76.01 to 89.42	64.61 to 76.01	62.85 to 64.61	62.85[1]	([2])	([2])
E0720	253.32 to 298.02	215.32 to 253.32	183.02 to 215.32	155.57 to 183.02	150.11 to 155.57	[1]150.11
E0730	255.37 to 300.43	217.06 to 255.37	[1]207.08 to 217.06	207.08	([2])	([2])
L7900	325.52 to 345.39	276.69 to 293.58	235.19 to 249.54	[1]219.86[1]	([2])	([2])

[1] Special payment limit fully implemented.
[2] Special payment limit equal to the special payment limit for the preceding calendar year increased by the appropriate covered item update.

I. Proposed Payment

We propose that payment for the six items identified equal 80 percent of the lesser of the actual charge for the system or the appropriate special payment limit, as described in sections A. through G. above.

J. Carrier-Granted Exceptions

Section 405.502(h)(3) states that we must set forth the criteria and circumstances, if any, under which a carrier may grant an exception to a special payment limit. We are not proposing any circumstances under which a carrier may grant an exception to the application of the proposed special payment limits. We are interested in receiving comments on any circumstances for which a commenter believes an exception should be granted.

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 major comments in the preamble to that document.

IV. Regulatory Impact Statement

We have examined the impacts of this proposed notice as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Pub. L. 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). A regulatory impact analysis must be prepared for major rules with economically significant effects ($100 million or more annually). The reductions in total expenditures over the next 5 years are estimated to be: $10 million in 1999; $20 million in 2000; $30 million in 2001; $30 million in 2002; and $30 million in 2003. Since the proposed notice results in reductions in total expenditures of less than $100 million per year, this notice is not a major rule as defined in Title 5, United States Code, section 804(2) and is not an economically significant rule under Executive Order 12866.

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. Individuals and States are not included in the definition of a small entity. Based on data from the Small Business Administration (SBA), we estimate that 98 percent of suppliers of DME and prosthetic devices would be defined as small entities for purposes of the RFA. We estimate that 106,000 entities bill Medicare for DME, prosthetics, orthotics, surgical dressings, and other equipment and supplies each year. We believe the impact on small businesses will be minimal because the implementation of the payment amounts will be phased in over several years. The annual adjustment in payment will be no greater than 15 percent per year. Total Medicare expenditures for DME and prosthetics devices is approximately $5 billion per year. As indicated above, we estimate that the proposed payment reductions, when fully implemented, will reduce these expenditures by approximately $30 million per year. Therefore, the overall impact on the total industry annual receipts will be small, that is, less than 1 percent reduction in Medicare revenue. However, while the overall impact is small, some suppliers would be seriously affected as a result of the mix of DME and prosthetics that they furnish to Medicare beneficiaries.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a proposed notice 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 less than 50 beds. We are not preparing a rural impact analysis since we have determined that this proposed notice would not have a significant economic impact on the operation of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any proposed notice that may result in an annual expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100 million. The proposed notice would not have an effect on the governments mentioned, and private sector costs would be less than the $100 million threshold.

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

Authority: Sections 1834(a) and 1842(b) of the Social Security Act (42 U.S.C. 1395m and 1395u).

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

Dated: January 27, 1999.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: April 28, 1999.

Donna E. Shalala,

Secretary.

[FR Doc. 99–20989 Filed 8–12–99; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–3022–N]

Medicare Program; Meeting of the Drugs, Biologics, and Therapeutics Panel of the Medicare Coverage Advisory Committee—September 15 and 16, 1999

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a meeting of the Drugs, Biologics, and Therapeutics Panel of the Medicare Coverage Advisory Committee. The Panel will discuss presentations from interested persons regarding the combination of high dose chemotherapy and stem cell transplantation for the treatment of multiple myeloma. This meeting is open to the public and complies with the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)(1) and (a)(2)).

DATES: *The Meeting:* September 15, 1999, from 1 p.m. until 4 p.m., E.D.T., and September 16, 1999, from 8 a.m. until 4 p.m., E.D.T.

Deadline for Presentation Submissions: August 20, 1999, 5 p.m., E.D.T.

Deadline for Submission of Final Comments: September 30, 1999, 5 p.m., E.D.T.

ADDRESSES: *The Meeting:* The meeting will be held at the Baltimore Convention Center, One West Pratt Street, Rooms 327–329, Baltimore, Maryland 21201–2499.

Presentations and Comments: Submit written presentations and comments to Lauren K. Geyer, MHS, Executive Secretary; Office of Clinical Standards and Quality; Health Care Financing Administration; 7500 Security Boulevard; Mail Stop S3–02–01; Baltimore, MD 21244.

FOR FURTHER INFORMATION CONTACT: Lauren K. Geyer, MHS, Executive Secretary, (410) 786–2004.

SUPPLEMENTARY INFORMATION: We have established the Medicare Coverage Advisory Committee (MCAC) to provide advice and recommendations to us about clinical coverage issues. The MCAC is composed of an Executive Committee and six panels, each containing members with expertise in one or more of the following fields: clinical and administrative medicine, biologic and physical sciences, public health administration, health care data and information management and