NUCLEAR REGULATORY COMMISSION

Draft Regulatory Guide; Issuance, Availability

The Nuclear Regulatory Commission has issued for public comment a proposed revision of a guide in its Regulatory Guide Series. This series has been developed to describe and make available to the public such information as methods acceptable to the NRC staff for implementing specific parts of the NRC's regulations, techniques used by the staff in evaluating specific problems or postulated accidents, and data needed by the staff in its review of applications for permits and licenses.

The draft guide, temporarily identified by its task number, DG–9001 (which should be mentioned in all correspondence concerning this draft guide), is a proposed Revision 1 of Regulatory Guide 9.3 and is titled ''Information Needed for an Antitrust Review of Initial Operating License Applications for Nuclear Power Plants.'' This proposed revision is being developed to identify the type of information that the NRC staff considers germane for a decision as to whether a second antitrust review is required at the initial operating license stage.

This draft guide has not received complete staff approval and does not represent an official NRC staff position.

Comments may be accompanied by relevant information or supporting data. Written comments may be submitted to the Rules and Directives Branch, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555. Copies of comments received may be examined at the NRC Public Document Room, 2120 L Street NW., Washington, DC. Comments will be most helpful if received by January 14, 2000.

You may also provide comments via the NRC's interactive rulemaking website through the NRC home page (http://ruleforum.llnl.gov). This site provides the availability to upload comments as files (any format), if your web browser supports that function. For information about the interactive rulemaking website, contact Ms. Carol Gallagher, (301) 415–5905; e-mail *CAG@NRC.GOV*. For information about the draft guide and the related documents, contact Mr. M.J. Davis at (301) 415–1016; e-mail MJD1@NRC.GOV.

Although a time limit is given for comments on this draft guide, comments and suggestions in connection with items for inclusion in guides currently being developed or improvements in all published guides are encouraged at any time.

Regulatory guides are available for inspection at the Commission's Public Document Room, 2120 L Street NW., Washington, DC. Requests for single copies of draft or final guides (which may be reproduced) or for placement on an automatic distribution list for single copies of future draft guides in specific divisions should be made in writing to the U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Reproduction and Distribution Services Section; or by fax to (301) 415–2289, or by e-mail to <DISTRIBUTION@NRC.GOV>. Telephone requests cannot be accommodated. Regulatory guides are not copyrighted, and Commission approval is not required to reproduce them.

(5 U.S.C. 552(a))

Dated at Rockville, Maryland, this 20th day of October 1999.

For the Nuclear Regulatory Commission.

Charles E. Ader,

Director, Program Management, Policy Development & Analysis Staff, Office of Nuclear Regulatory Research.

[FR Doc. 99–28535 Filed 10–29–99; 8:45 am]

BILLING CODE 7590–01–P

OFFICE OF MANAGEMENT AND BUDGET

Cost of Hospital and Medical Care Treatment Furnished by The United States

Certain Rates Regarding Recovery From Tortiously Liable Third Persons

By virtue of the authority vested in the President by Section 2(a) of Pub. L. 87–693 (76 Stat. 593; 42 U.S.C. 2652), and delegated to the Director of the Office of Management and Budget by Executive Order No. 11541 of July 1, 1970 (35 FR 10737), the three sets of rates outlined below are hereby established. These rates are for use in connection with the recovery, from tortiously liable third persons, of the cost of hospital and medical care and treatment furnished by the United States (Part 43, Chapter I, Title 28, Code of Federal Regulations) through three separate Federal agencies. The rates have been established in accordance with the requirements of OMB Circular A–25, requiring reimbursement of the full cost of all services provided. The rates are established as follows:

1. Department of Defense

The FY 2000 Department of Defense (DoD) reimbursement rates for inpatient, outpatient, and other services are provided in accordance with Section 1095 of title 10, United States Code. Due to size, the sections containing the Drug Reimbursement Rates (Section III.E) and the rates for Ancillary Services Requested by Outside Providers (Section III.F) are not included in this package. The Office of the Assistant Secretary of Defense (Health Affairs) will provide these rates upon request. The medical and dental service rates in this package (including the rates for ancillary services, prescription drugs or other procedures requested by outside providers) are effective October 1, 1999. Pharmacy rates are updated on an as-needed basis.

2. Health and Human Services

The development of FY 2000 tortiously liable rates for Indian Health Service health facilities incorporate a refinement in the method used in the development of the FY 1999 rates. This year the Department has elected to use Medicare cost reports to develop the FY 2000 tortiously liable rates.

The obligations for the Indian Health Service hospitals participating in the cost report project were identified and combined with applicable obligations for area offices costs and headquarters costs. The hospital obligations were summarized for each major cost center providing medical services and distributed between inpatient and outpatient. Total inpatient costs and outpatient costs were then divided by the relevant workload statistic (inpatient day, outpatient visit) to produce the inpatient and outpatient rates. In calculation of the rates, the Department's unfunded retirement liability cost and capital and equipment depreciation costs were incorporated to conform to requirements set forth in OMB Circular A–25.

In addition, the obligations for each cost center include obligations from certain other accounts, such as Medicare and Medicaid collections and Contract Health fund, that were used to support direct program operations. Obligations were excluded for certain cost centers that primarily support workloads outside of the directly operated hospitals or clinics (public health nursing, public health nutrition, health education).

These obligations are not a part of the traditional cost of hospital operations and do not contribute directly to the inpatient and outpatient visit workload. Overall, these rates reflect a more accurate indication of the cost of care in the Department's hospital facilities.

Separate rates per inpatient day and outpatient visit were computed for

Alaska and the rest of the United States. This gives proper weight to the higher cost of operating medical facilities in Alaska.

3. Department of Veterans Affairs

Actual direct and indirect costs are compiled by type of care for the previous year, and facility overhead costs are added. Adjustments are made using the budgeted percentage changes for the current year and the budget year to compute the base rate for the budget year. The budget year base rate is then adjusted by estimated costs for depreciation of buildings and equipment, central office overhead, Government employee retirement benefits, and return on fixed assets (interest on capital for land, buildings, and equipment (net book value)), to compute the budget year tortiously liable reimbursement rates. Also shown for the tortiously liable inpatient per diem rates are breakdowns into three cost components: Physician; Ancillary; and Nursing, Room and Board. As with the total per diem rates, these breakdowns are calculated from actual data by type of care.

The tortiously liable rates shown will be used to seek recovery for VA medical care or services provided or furnished to persons in the following situations: tort feasor, humanitarian emergency, VA employee, family member, ineligible person, and allied beneficiary.

The interagency rates shown will be used when VA medical care or service is furnished to a beneficiary of another Federal agency, and that care or service is not covered by an applicable local sharing agreement. Government employee retirement benefits and return on fixed assets are not included in the interagency rates, but in all other respects the interagency rates are the same as the tortiously liable rates. When the medical care or service is obtained at the expense of the Department of Veterans Affairs from a non-VA source, the charge for such care or service will be the actual amount paid by the VA for that care or service.

Inpatient charges will be at the per diem rates shown for the type of bed section or discrete treatment unit providing the care. Prescription Filled charge in lieu of the Outpatient Visit rate will be charged when the patient receives no service other than the Pharmacy outpatient service. This charge applies whether the patient receives the prescription in person or by mail.

1. Department of Defense

For the Department of Defense, effective October 1, 1999 and thereafter:

Medical and Dental Services

Fiscal Year 2000—Inpatient, Outpatient and Other Rates and Charges

I. Inpatient Rates [1 2]

Per inpatient day	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
A. Burn Center	$3,080.00	$5,529.00	$5,840.00
B. Surgical Care Services (Cosmetic Surgery)	1,411.00	2,533.00	2,675.00
C. All Other Inpatient Services (Based on Diagnosis Related Groups (DRG) [3])			

1. FY 2000 Direct Care Inpatient Reimbursement Rates

Adjusted standard amount	IMET	Interagency	Other (full/third party)
Large Urban	$2,921.00	$5,498.00	$5,775.00
Other Urban/Rural	3,236.00	6,532.00	6,883.00
Overseas	3,606.00	8,520.00	8,941.00

2. Overview

The FY 2000 inpatient rates are based on the cost per DRG, which is the inpatient full reimbursement rate per hospital discharge weighted to reflect the intensity of the principal diagnosis, secondary diagnoses, procedures, patient age, etc. involved. The average cost per Relative Weighted Product (RWP) for large urban, other urban/rural, and overseas facilities will be published annually as an inpatient adjusted standardized amount (ASA) (see paragraph I.C.1. above). The ASA will be applied to the RWP for each inpatient case, determined from the DRG weights, outlier thresholds, and payment rules published annually for hospital reimbursement rates under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 32 CFR 199.14(a)(1), including adjustments for length of stay (LOS) outliers. The published ASAs will be adjusted for area wage differences and indirect medical education (IME) for the discharging hospital. An example of how to apply DoD costs to a DRG standardized weight to arrive at DoD costs is contained in paragraph I.C.3., below.

3. Example of Adjusted Standardized Amounts for Inpatient Stays

Figure 1 shows examples for a nonteaching hospital in a Large Urban Area.

a. The cost to be recovered is DoD's cost for medical services provided in the non-teaching hospital located in a large urban area. Billings will be at the third party rate.

b. DRG 020: Nervous System Infection Except Viral Meningitis. The RWP for an inlier case is the CHAMPUS weight of 2.3446. (DRG statistics shown are from FY 1998).

c. The DoD adjusted standardized amount to be charged is $5,775 (i.e., the third party rate as shown in the table).

d. DoD cost to be recovered at a non-teaching hospital with area wage index of 1.0 is the RWP factor (2.3446) in 3.b., above, multiplied by the amount ($5,775) in 3.c., above.

e. Cost to be recovered is $13,540

FIGURE 1.—THIRD PARTY BILLING EXAMPLES

DRG No.	DRG description	DRG weight	Arithmetic mean LOS	Geometric mean LOS	Short stay threshold	Long stay threshold
020 ...	Nervous System Infection Except Viral Meningitis	2.3446	8.1	5.7	1	29

Hospital	Location	Area wage rate index	IME adjustment	Group ASA	Applied ASA
Non-teaching Hospital	Large Urban	1.0	1.0	$5,775	$5,775

Patient	Length of stay	Days above threshold	Relative weighted product			TPC
			Inlier*	Outlier**	Total	Amount***
#1	7 days	0	2.3446	000	2.3446	$13,540
#2	21 days	0	2.3446	000	2.3446	$13,540
#3	35 days	6	2.3446	0.8144	3.1590	$18,243

*DRG Weight
**Outlier calculation = 33 percent of per diem weight × number of outlier days = .33 (DRG Weight/Geometric Mean LOS) × (Patient LOS—Long Stay Threshold)
= .33 (2.3446/5.7) × (35 − 29)
= .33 (.41133) × 6 (take out to five decimal places)
= .13574 × 6 (take out to five decimal places)
= .8144 (take out to four decimal places)
*** Applied ASA × Total RWP

II. Outpatient Rates[1] [2] Per Visit

MEPRS code[4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
	A. Medical Care			
BAA	Internal Medicine	$104.00	$194.00	$204.00
BAB	Allergy	53.00	99.00	105.00
BAC	Cardiology	87.00	163.00	172.00
BAE	Diabetic	61.00	114.00	121.00
BAF	Endocrinology (Metabolism)	102.00	190.00	201.00
BAG	Gastroenterology	146.00	272.00	287.00
BAH	Hematology	179.00	334.00	352.00
BAI	Hypertension	106.00	198.00	208.00
BAJ	Nephrology	208.00	387.00	409.00
BAK	Neurology	121.00	225.00	238.00
BAL	Outpatient Nutrition	42.00	79.00	83.00
BAM	Oncology	134.00	250.00	264.00
BAN	Pulmonary Disease	153.00	285.00	301.00
BAO	Rheumatology	101.00	188.00	199.00
BAP	Dermatology	78.00	146.00	154.00
BAQ	Infectious Disease	178.00	332.00	350.00
BAR	Physical Medicine	83.00	155.00	163.00
BAS	Radiation Therapy	128.00	238.00	251.00
BAT	Bone Marrow Transplant	115.00	214.00	226.00
BAU	Genetic	367.00	683.00	721.00
	B. Surgical Care			
BBA	General Surgery	148.00	276.00	291.00
BBB	Cardiovascular and Thoracic Surgery	320.00	595.00	628.00
BBC	Neurosurgery	173.00	323.00	341.00
BBD	Ophthalmology	90.00	168.00	177.00
BBE	Organ Transplant	399.00	742.00	783.00
BBF	Otolaryngology	106.00	197.00	207.00
BBG	Plastic Surgery	131.00	244.00	258.00
BBH	Proctology	84.00	157.00	165.00

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
BBI	Urology	112.00	209.00	221.00
BBJ	Pediatric Surgery	167.00	311.00	328.00
BBK	Peripheral Vascular	78.00	146.00	154.00
	Surgery			
BBL	Pain Management	97.00	180.00	190.00
	C. Obstetrical and Gynecological (OB–GYN) Care			
BCA	Family Planning	57.00	106.00	112.00
BCB	Gynecology	89.00	165.00	175.00
BCC	Obstetrics	74.00	138.00	146.00
BCD	Breast Cancer Clinic	184.00	342.00	361.00
	D. Pediatric Care			
BDA	Pediatric	62.00	115.00	121.00
BDB	Adolescent	65.00	122.00	129.00
BDC	Well Baby	42.00	79.00	83.00
	E. Orthopaedic Care			
BEA	Orthopaedic	93.00	174.00	183.00
BEB	Cast	59.00	110.00	117.00
BEC	Hand Surgery	69.00	129.00	136.00
BEE	Orthotic Laboratory	67.00	125.00	132.00
BEF	Podiatry	56.00	105.00	111.00
BEZ	Chiropractic	25.00	47.00	50.00
	F. Psychiatric and/or Mental Health Care			
BFA	Psychiatry	124.00	230.00	243.00
BFB	Psychology	93.00	174.00	184.00
BFC	Child Guidance	57.00	105.00	111.00
BFD	Mental Health	104.00	194.00	204.00
BFE	Social Work	102.00	190.00	200.00
BFF	Substance Abuse	99.00	184.00	195.00
	G. Family Practice/Primary Medical Care			
BGA	Family Practice	74.00	138.00	146.00
BHA	Primary Care	77.00	143.00	151.00
BHB	Medical Examination	80.00	148.00	156.00
BHC	Optometry	50.00	93.00	98.00
BHD	Audiology	35.00	65.00	69.00
BHE	Speech Pathology	101.00	188.00	199.00
BHF	Community Health	66.00	123.00	130.00
BHG	Occupational Health	73.00	136.00	143.00
BHH	TRICARE Outpatient	56.00	104.00	109.00
BHI	Immediate Care	107.00	200.00	211.00
	H. Emergency Medical Care			
BIA	Emergency Medical	126.00	234.00	247.00
	I. Flight Medical Care			
BJA	Flight Medicine	88.00	164.00	173.00
	J. Underseas Medical Care			
BKA	Underseas Medicine	43.00	79.00	84.00
	K. Rehabilitative Services			
BLA	Physical Therapy	41.00	77.00	81.00
BLB	Occupational Therapy	61.00	114.00	120.00

III. Ambulatory Procedure Visit (APV)[6] Per Visit

MEPRS code[4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
	Medical Care			
BB	Surgical Care	937.00	1,740.00	1,836.00
BD	Pediatric Care	233.00	430.00	454.00
BE	Orthopaedic Care	1,179.00	2,192.00	2,313.00
	All other B clinics not included above (BA, BC, BF, BG, BH, BI, BJ, BK and BL).	430.00	797.00	841.00

IV. Other Rates and Charges[1 2] Per Visit

MEPRS code[4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
FBI	A. Immunization	$16.00	$30.00	$32.00
DGC	B. Hyperbaric Chamber[5]	153.00	285.00	301.00
	C. Family Member Rate (formerly Military Dependents Rate)	10.85		
	D. Reimbursement Rates For Drugs Requested By Outside Providers[7]			

The FY 2000 drug reimbursement rates for drugs are for prescriptions requested by outside providers and obtained at a Military Treatment Facility. The rates are established based on the cost of the particular drugs provided based on the DoD-wide average per National Drug Code (NDC) number. Final rule 32 CFR Part 220, which has still not been published when this package was prepared, eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR Part 220. The list of drug reimbursement rates is too large to include here. These rates are available on request from OASD (Health Affairs)—see Tab O for the point of contact.

E. Reimbursement Rates for Ancillary Services Requested By Outside Providers[8]

Final rule 32 CFR Part 220, which has still not been published when this package was prepared, eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR Part 220. The list of FY 2000 rates for ancillary services requested by outside providers and obtained at a Military Treatment Facility is too large to include here. These rates are available on request from OASD (Health Affairs)—see Tab O for the point of contact.

F. Elective Cosmetic Surgery Procedures and Rates

Cosmetic surgery procedure	International Classification Diseases (ICD–9)	Current Procedural Terminology (CPT)[9]	FY 2000 charge[10]	Amount of charge
Mammaplasty—augmentation.	85.50, 85.32, 85.31	19325, 19324, 19318	Inpatient Surgical Care Per Diem Or APV	(a) (b)
Mastopexy	85.60	19316	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate.	(a b c)
Facial	86.82	15824	Inpatient Surgical Care Per Diem Or APV	(a b)
Rhytidectomy	86.22			
Blepharoplasty	08.70, 08.44	15820, 15821, 15822, 15823.	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate.	(a b c)
Mentoplasty	76.68	21208	Inpatient	(a)
(Augmentation/Reduction).	76.67	21209	Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate.	(b c)
Abdominoplasty	86.83		Inpatient Surgical Care Per Diem	(a)
Lipectomy Suction per region[11].	86.83	15876, 15877, 15878, 15879.	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate.	(a b c)
Rhinoplasty	21.87, 21.86	30400, 30410	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate.	(a b c)
Scar Revisions beyond CHAMPUS.	86.84	1578__	Inpatient Surgical Care Per Diem Or APV or applicable Outpatient Clinic Rate.	(a b c)
Mandibular or Maxillary Repositioning.	76.41		Inpatient Surgical Care Per Diem	(a)
Dermabrasion		15780	APV or applicable Outpatient Clinic Rate	(b c)
Hair Restoration		15775	APV or applicable Outpatient Clinic Rate	(b c)
Removing Tattoos		15780	APV or applicable Outpatient Clinic Rate	(b c)
Chemical Peel		15790	APV or applicable Outpatient Clinic Rate	(b c)
Arm/Thigh Dermolipectomy.	86.83	15836/15832	Inpatient Surgical Care Per Diem Or APV	(a b)

Cosmetic surgery procedure	International Classification Diseases (ICD–9)	Current Procedural Terminology (CPT) [9]	FY 2000 charge [10]	Amount of charge
Refractive surgery			APV or applicable Outpatient Clinic Rate	([b c])
Radial Keratotomy		65771		
Other Procedure (if applies to laser or other refractive surgery).		66999		
Otoplasty		69300	APV or applicable Outpatient Clinic Rate	([a b c])
Brow Lift	86.3	15839	Inpatient Surgical Care Per Diem Or APV	([a b])

G. Dental Rate [12] Per Procedure

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency & other Federal agency sponsored patients	Other (full/third party)
Dental Services	ADA code and DoD established weight..	$45.00	$109.00	$115.00

H. Ambulance Rate [13] Per Visit

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency & other Federal agency sponsored patients	Other (full/third party)
FEA	Ambulance	$62.00	$116.00	$122.00

I. Ancillary Services Requested by an Outside Provider [8] Per Procedure

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency & other Federal agency sponsored patients	Other (full/third party)
	Laboratory procedures requested by an outside provider CPT '99 Weight Multiplier.	$13.00	$20.00	$21.00
	Radiology procedures requested by an outside provider CPT '99 Weight Multiplier.	$57.00	$86.00	$90.00

J. AirEvac Rate [14] Per Visit

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency & other Federal agency sponsored patients	Other (full/third party)
	AirEvac Services—Ambulatory	$195.00	$364.00	$384.00
	AirEvac Services—Litter	$567.00	$1,056.00	$1,114.00

K. Observation Rate [15] Per hour

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency & other Federal agency sponsored patients	Other (full/third party)
	Observation Services—Hour	$17.00	$31.00	$32.00

Notes on Cosmetic Surgery Charges

[a] Per diem charges for inpatient surgical care services are listed in Section I.B. (See notes 9 through 11, below, for further details on reimbursable rates.)

[b] Charges for ambulatory procedure visits (formerly same day surgery) are listed in Section III.C. (See notes 9 through 11, below, for further details on reimbursable rates.) The ambulatory procedure visit (APV) rate is used if the elective cosmetic surgery is performed in an ambulatory procedure unit (APU).

[c] Charges for outpatient clinic visits are listed in Sections II.A–K. The outpatient clinic rate is not used for services provided in an APU. The APV rate should be used in these cases.

Notes on Reimbursable Rates

[1] Percentages can be applied when preparing bills for both inpatient and outpatient services. Pursuant to the provisions of 10 U.S.C. 1095, the inpatient Diagnosis Related Groups and inpatient per diem percentages are 98 percent hospital and 2 percent professional charges. The outpatient per visit percentages are 89 percent outpatient services and 11 percent professional charges.

[2] DoD civilian employees located in overseas areas shall be rendered a bill when services are performed.

[3] The cost per Diagnosis Related Group (DRG) is based on the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal and secondary diagnoses, surgical procedures, and patient demographics involved. The adjusted standardized amounts (ASA) per Relative Weighted Product (RWP) for use in the direct care system is comparable to procedures used by the Health Care Financing Administration (HCFA) and the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS). These expenses include all direct care expenses associated with direct patient care. The average cost per RWP for large urban, other urban/rural, and overseas will be published annually as an adjusted standardized amount (ASA) and will include the cost of inpatient professional services. The DRG rates will apply to reimbursement from all sources, not just third party payers.

[4] The Medical Expense and Performance Reporting System (MEPRS) code is a three digit code which defines the summary account and the sub account within a functional category in the DoD medical system. MEPRS codes are used to ensure that consistent expense and operating performance data is reported in the DoD military medical system. An example of the MEPRS hierarchical arrangement follows:

MEPRS CODE
Outpatient Care (Functional Category)—B
Medical Care (Summary Account)—BA
Internal Medicine (Subaccount)—BAA

[5] Hyperbaric service charges shall be based on hours of service in 15-minute increments. The rates listed in Section III.B. are for 60 minutes or 1 hour of service. Providers shall calculate the charges based on the number of hours (and/or fractions of an hour) of service. Fractions of an hour shall be rounded to the next 15-minute increment (*e.g.,* 31 minutes shall be charged as 45 minutes).

[6] Ambulatory procedure visit is defined in DOD Instruction 6025.8, ''Ambulatory Procedure Visit (APV),'' dated September 23, 1996, as immediate (day of procedure) pre-procedure and immediate post-procedure care requiring an unusual degree of intensity and provided in an ambulatory procedure unit (APU). An APU is a location or organization within an MTF (or freestanding outpatient clinic) that is specially equipped, staffed and designated for the purpose of providing the intensive level of care associated with APVs. Care is required in the facility for less than 24 hours. All expenses and workload are assigned to the MTF-established APU associated with the referring clinic. The BB, BD and BE APV rates are only to be used by clinics that are subaccounts under these summary accounts (see ([4]) for an explanation of MEPRS hierarchical arrangement). The All Other APV rate is to be used only by those clinics that are not a subaccount under BB, BD or BE.

[7] Prescription services requested by outside providers (*e.g.,* physicians or dentists) that are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for prescription services when beneficiaries who have medical insurance obtain medications from a Military Treatment Facility (MTF) that are prescribed by providers external to the MTF. Eligible beneficiaries (family members or retirees with medical insurance) are not personally liable for this cost and shall not be billed by the MTF. Medical Services Account (MSA) patients, who are not beneficiaries as defined in 10 U.S.C. 1074 and 1076, are charged at the ''Other'' rate if they are seen by an outside provider and only come to the MTF for prescription services. The standard cost of medications ordered by an outside provider that includes the cost of the drugs plus a dispensing fee per prescription. The prescription cost is calculated by multiplying the number of units (*e.g.,* tablets or capsules) by the unit cost and adding a $6.00 dispensing fee per prescription. Final rule 32 CFR Part 220, which has still not been published when this package was prepared, eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR Part 220. The elimination of the threshold also eliminates the need to bundle costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeded $25.00. The elimination of the threshold is effective as per date stated in final rule 32 CFR Part 220.

[8] Charges for ancillary services requested by an outside provider (physicians, dentists, etc.) are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for ancillary services when beneficiaries who have medical insurance obtain services from the MTF which are prescribed by providers external to the MTF. Laboratory and Radiology procedure costs are calculated by multiplying the DoD established weight for the Physicians' Current Procedural Terminology (CPT '99) code by either the laboratory or radiology multiplier (Section III.J). Eligible beneficiaries (family members or retirees with medical insurance) are not personally liable for this cost and shall not be billed by the MTF. MSA patients, who are not beneficiaries as defined by 10 U.S.C. 1074 and 1076, are charged at the ''Other'' rate if they are seen by an outside provider and only come to the MTF for ancillary services.

Final rule 32 CFR Part 220, which has still not been published when this package was prepared, eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR Part 220. The elimination of the threshold also eliminates the need to bundle costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeded $25.00. The elimination of the threshold is effective as per date stated in final rule 32 CFR Part 220.

[9] The attending physician is to complete the CPT '99 code to indicate the appropriate procedure followed during cosmetic surgery. The appropriate rate will be applied depending on the treatment modality of the patient: ambulatory procedure visit, outpatient clinic visit or inpatient surgical care services.

[10] Family members of active duty personnel, retirees and their family members, and survivors shall be charged elective cosmetic surgery rates. Elective cosmetic surgery procedure information is contained in Section III.G. The patient shall be charged the rate as specified in the FY 2000 reimbursable rates for an episode of care. The charges for elective cosmetic surgery are at the full reimbursement rate (designated as the ''Other'' rate) for inpatient per diem surgical care services in Section I.B., ambulatory procedure visits as contained in Section III.C, or the appropriate outpatient clinic rate in Sections II.A-K. The patient is responsible for the cost of the implant(s) and the prescribed cosmetic surgery rate. (Note: The implants and procedures used for the augmentation mammaplasty are in compliance with Federal Drug Administration guidelines.)

[11] Each regional lipectomy shall carry a separate charge. Regions include head and neck, abdomen, flanks, and hips.

[12] Dental service rates are based on a dental rate multiplier times the American Dental Association (ADA) code and the DoD established weight for that code.

[13] Ambulance charges shall be based on hours of service in 15 minute increments. The rates listed in Section III.I are for 60 minutes or 1 hour of service. Providers shall calculate the charges based on the number of hours (and/or fractions of an hour) that the ambulance is logged out on a patient run. Fractions of an hour shall be rounded to the next 15 minute increment (*e.g.,* 31 minutes shall be charged as 45 minutes).

[14] Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient. The appropriate charges are billed only by the Air Force Global Patient Movement Requirement Center (GPMRC). These charges are only for the cost of providing medical care. Flight charges are billed by GPMRC separately using the commercial rate effective the date of travel plus $1.

[15] Observation Services are billed at the hourly charge. Begin counting when the patient is placed in the observation bed and round up to the nearest hour. If a patient status changes to inpatient, the charges for observation services are added to the DRG assigned to the case and not billed separately. If a patient is released from Observation status and is sent to an APV, the charges for Observation services are not billed separately but are added to the APV rate to recover all expenses.

2. Department of Health and Human Services

For the Department of Health and Human Services, Indian Health Service, effective October 1, 1999 and thereafter:

	Hospital Care Inpatient Day	
General Medical Care	Alaska	$1,925
	Rest of the United States	1,313
	Outpatient Medical Treatment	
Outpatient Visit	Alaska	308
	Rest of the United States	211

3. Department of Veterans Affairs

Effective October 1, 1999, and thereafter:

	Tortiously liable rates	Interagency rates
Hospital Care, Rates Per Inpatient Day		
General Medicine:		
Total	$1610	$1476
Physician	193	
Ancillary	420	
Nursing, Room, and Board	997	
Neurology:		
Total	1927	1757
Physician	282	
Ancillary	509	
Nursing, Room, and Board	1136	
Rehabilitation Medicine:		
Total	1065	974
Physician	121	
Ancillary	325	
Nursing, Room, and Board	619	
Blind Rehabilitation:		
Total	1009	928
Physician	81	
Ancillary	501	
Nursing, Room, and Board	427	
Spinal Cord Injury:		
Total	970	885
Physician	120	
Ancillary	244	
Nursing, Room, and Board	606	
Surgery:		
Total	3023	2788
Physician	333	
Ancillary	917	
Nursing, Room, and Board	1773	
General Psychiatry:		
Total	640	577
Physician	60	
Ancillary	101	
Nursing, Room, and Board	479	
Substance Abuse (Alcohol and Drug Treatment):		
Total	339	308
Physician	32	
Ancillary	78	
Nursing, Room, and Board	229	
Intermediate Medicine:		
Total	491	446
Physician	24	
Ancillary	72	
Nursing, Room, and Board	395	
Nursing Home Care, Rates Per Day		
Nursing Home Care:		
Total	339	307
Physician	11	
Ancillary	46	
Nursing, Room, and Board	282	

	Tortiously liable rates	Interagency rates
Outpatient Medical and Dental Treatment		
Outpatient Visit (other than Emergency Dental)	254	236
Emergency Dental Outpatient Visit	157	140
Prescription Filled	36	35

For the period beginning October 1, 1999, the rates prescribed herein superseded those established by the Director of the Office of Management and Budget October 16, 1998 (61 FR 56360).

Jacob J. Lew,

Director, Office of Management and Budget.

[FR Doc. 99–28115 Filed 10–29–99; 8:45 am]

BILLING CODE 3110–01–P

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Pub. L. 94–409, that the Securities and Exchange Commission will hold the following meeting during the week of November 1, 1999.

A closed meeting will be held on Wednesday, November 3, 1999, at 11:00 a.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the closed meeting. Certain staff members who have an interest in the matters may also be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, one or more of the exemptions set forth in 5 U.S.C. 552b(c) (4), (8), (9)(A) and (10) and 17 CFR 200.402(a) (4), (8), (9)(A) and (10), permit consideration for the scheduled matters at the closed meeting.

Commissioner Carey, as duty officer, voted to consider the items listed for the closed meeting in a closed session.

The subject matter of the closed meeting scheduled for Wednesday, November 3, 1999, will be:

Institution and settlement of injunctive actions.

Institution and settlement of administrative proceedings of an enforcement nature.

Formal order of investigation.

At times, changes in Commission priorities require alterations in the scheduling of meeting items. For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact: The Office of the Secretary at (202) 942–7070.

Dated: October 27, 1999.

Jonathan G. Katz,

Secretary.

[FR Doc. 99–28607 Filed 10–28–99; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–42056; File No. SR–CHX–99–22]

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval of Proposed Rule Change and Amendment Nos. 1, 2 and 3 by the Chicago Stock Exchange, Inc., Relating to Listing Standards for Trust Issued Receipts

October 22, 1999.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on October 7, 1999, the Chicago Stock Exchange, Inc., (''CHX'' or ''Exchange'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. Amendment Nos. 1, 2, and 3 were filed on October 13, 15, and 20, 1999, respectively.[3] The Commission is publishing this notice to solicit comments on the proposed rule change and Amendment Nos. 1, 2, and 3 from interested persons and to grant accelerated approval to the proposed rule change, as amended.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Amendment No. 1 added new text regarding the arbitrage process and the trust issued receipt's trading price. Amendment No. 2 added additional minimum listing requirements for securities to qualify for inclusion in a trust issued receipt. Amendment No. 3 changed the figure for initial distribution of Internet HOLDRs from 150,000 to approximately 3.7 million. *See* Letters from Paul B. O'Kelly, Executive Vice President, Market Regulation and Legal, CHX, to Heather Traeger, Attorney, Division of Market Regulation, SEC, dated October 13, 1999, October 15, 1999 and October 20, 1999.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to add a new Rule 27 to Article XXVIII of the Exchange's rules to adopt listing standards for trust receipts. Once these listing standards have been approved, the Exchange intends to trade Internet Holding Company Depository Receipts (''Internet HOLDRs''), a trust issued receipt. The Exchange also proposes to trade Internet HOLDRs pursuant to unlisted trading privileges (''UTP''). The text of the proposed rule change is available at the Office of the Secretary, CHX and at the Commission.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item III below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange is proposing listing criteria to allow the Exchange to list trust issued receipts, and to trade Internet HOLDRs, a type of trust issued receipt, pursuant to UTP. The Exchange represents that trust issued receipts provide investors with a flexible, cost-effective way to purchase, hold and transfer the securities of one or more specified companies.

a. *Trust Issued Receipts Generally.—Description.* Trust issued receipts are negotiable receipts which are issued by a trust representing securities of issuers that have been deposited and are held on behalf of the holders of the trust