certification of an act of terrorism pursuant to section 102(1) of the Act.

(b) *Complete notice.* Treasury will review requests for advance approval and determine whether additional information is needed to complete the notice.

(c) *Treasury response or deemed approval.* Within 30 days after Treasury's receipt of a complete notice, or as extended in writing by Treasury, Treasury may issue a written response and indicate its partial or full approval or rejection of the proposed settlement. If Treasury does not issue a response within 30 days after Treasury's receipt of a complete notice, unless extended in writing by Treasury, the request for advance approval is deemed approved by Treasury. Any settlement is still subject to review under the claim procedures pursuant to § 50.50.

(d) *Notice format.* A notice of a proposed settlement should be entitled, ''Notice of Proposed Settlement—Request for Approval,'' and should provide the full name and address of the submitting insurer and the name, title, address, and telephone number of the designated contact person. An insurer must provide all relevant information, including the following, as applicable:

(1) A brief description of the insured's underlying claim, the insured's loss, the amount of the claim, the operative policy terms, defenses to coverage, and all damages sustained;

(2) A certification by the insurer that the settlement is for a third-party's loss the liability for which is an insured loss under the terms and conditions of the underlying commercial property and casualty insurance policy;

(3) An itemized statement of all damages by category (*i.e.*, actual, economic and non-economic loss, punitive damages, etc.);

(4) A statement from the insurer or its attorney in support of the settlement.;

(5) The total dollar amount of the proposed settlement;

(6) Indication as to whether the settlement was negotiated by counsel;

(7) The amount to be paid that will compensate for any items such as fees and expenses of attorneys, experts, and other professionals for their services and expenses related to the insured loss and/or settlement and the net amount to be received by the third-party after such payment;

(8) The amount received from the United States pursuant to any other Federal program for compensation of insured losses related to an act of terrorism;

(9) The proposed terms of the written settlement agreement, including release language and subrogation terms;

(10) If requested by Treasury, other relevant agreements, including:

(i) Admissions of liability or insurance coverage;

(ii) Determinations of the number of occurrences under a commercial property and casualty insurance policy;

(iii) The allocation of paid amounts or amounts to be paid to certain policies, or to specific policy, coverage and/or aggregate limits; and

(iv) Any other agreement that may affect the payment or amount of the Federal share of compensation to be paid to the insurer;

(11) A statement indicating whether the proposed settlement has been approved by the Federal court or is subject to such approval and whether such approval is expected or likely; and

(12) Such other information that is related to the insured loss as may be requested by Treasury that it deems necessary to evaluate the proposed settlement.

**§ 50.84 Subrogation.**

An insurer shall not waive its rights of subrogation under its property and casualty insurance policy and preserve the subrogation right of the United States as provided by section 107(c) of the Act by not taking any action that would prejudice the United States' right of subrogation.

Dated: July 23, 2004.

**Wayne A. Abernathy,**

*Assistant Secretary of the Treasury.*

[FR Doc. 04–17235 Filed 7–26–04; 9:22 am]

**BILLING CODE 4810–42–P**

## DEPARTMENT OF DEFENSE

### Office of the Secretary

### 32 CFR Part 199

**RIN 0720–AA78**

## TRICARE; Individual Case Management Program; Program for Persons With Disabilities; Extended Benefits for Disabled Family Members of Active Duty Service Members; Custodial Care

**AGENCY:** Office of the Secretary, DoD.

**ACTION:** Final rule.

**SUMMARY:** The Department is publishing this final rule to implement requirements enacted by Congress in section 701(g) of the National Defense Authorization Act for Fiscal Year 2002 (NDAA–02), which terminates the Individual Case Management Program. The Department withdraws its proposed rule published at 66 FR 39699 on August 1, 2001, regarding the Individual Case Management Program. This rule also implements section 701(b) of the NDAA–02 which provides additional benefits for certain eligible active duty dependents by amending the TRICARE regulations governing the Program for Persons with Disabilities. The Program for Persons with Disabilities is now called the Extended Care Health Option. Other administrative amendments are included to clarify specific policies that relate to the Extended Care Health Option, custodial care, and to update related definitions.

**DATES:** Termination of the Individual Case Management Program (§ 199.4(i)) became effective December 28, 2001. The remainder of this rule is effective July 1, 2004.

**ADDRESSES:** TRICARE Management Activity, Medical Benefits and Reimbursement Systems, 16401 East Centretech Parkway, Aurora, CO 80011.

**FOR FURTHER INFORMATION CONTACT:** Michael Kottyan, Medical Benefits and Reimbursement Systems, TRICARE Management Activity, telephone (303) 676–3520. Questions regarding payment of specific claims should be addressed to the appropriate TRICARE contractor.

**SUPPLEMENTARY INFORMATION:**

### I. Background

*The Individual Case Management Program (ICMP).* Under the provisions of section 704(3) of the NDAA–93 [Pub. L. 102–484], 10 U.S.C. 1079(a)(17) was enacted which allowed the DoD to establish the ICMP, also known as the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP–PEC). This allowed a reasonable deviation from the restrictive statutory coverage of health services for patients who had exceptionally serious, long-range, costly and incapacitating conditions. The ICMP was officially implemented in March 1999 as a waiver program that provided coverage for care and services that were normally restricted from coverage under the Basic Program. Specifically, when a beneficiary was determined to meet the TRICARE definition of custodial care, coverage under the Basic Program was limited to one hour of skilled nursing care per day, twelve physician visits per year related to the custodial condition, durable medical equipment and prescription medications. The Department recognized that the exclusion of coverage when a family member is deemed to be a custodial care patient is both a financial and emotional burden. Consequently, the Department used the ICMP/ICMP–PEC authority to cover medically necessary care and to

enable TRICARE case managers to maximize available resources for these beneficiaries.

*Repeal of the ICMP.* Section 701(g) of the NDAA–02 repealed 10 U.S.C. 1079(a)(17), the statutory authority for the ICMP. However, section 701(d) allows the Department to continue to provide payment for home health care or custodial care services not otherwise authorized under the Basic Program as if the ICMP were still in effect. Payment may occur when a determination is made that discontinuation of payment would result in the provision of services inadequate to meet the needs of the eligible beneficiary and would be unjust to the beneficiary. Eligible beneficiaries are defined in section 701(d)(3) as covered beneficiaries who were regarded as custodial care patients under the ICMP/ICMP–PEC and received medically necessary skilled services for which the Secretary provided payment before December 28, 2001.

*Custodial Care.* Section 701(c) of the NDAA–02 provides a statutory definition of custodial care that is more consistent with other federal programs. The change also results in the narrowing of the statutory exclusions of custodial care that has the effect of eliminating current program restrictions on paying for certain medically necessary care.

**Note:** The statutory definition of custodial care under section 701(c) began on December 28, 2001, the effective date of the NDAA–02. Public notice of the substitution of the new statutory definition of the former custodial care definition in 32 CFR 199.2 was published in the **Federal Register** at 67 FR 40597 on June 13, 2002.

*Program for Persons with Disabilities (PFPWD).* This program is now renamed the Extended Health Care Option (ECHO). The PFPWD was established by Congress in 1966 and was originally called the Program for the Handicapped (PFTH). The name was changed to PFPWD in 1997 to reflect the national shift away from the label of handicapped and in an effort to be more sensitive to our beneficiaries with special needs. The program was established to provide financial assistance for active duty family members who are moderately or severely mentally retarded or have a serious physical disability. The purpose of the program was to help defray the cost of services not available either through the Basic Program or through other public agencies as a result of state residency requirements. Section 701(b) of the NDAA–02 strikes 10 U.S.C. 1079(d), (e), and (f), which were the statutory authority for the PFPWD, and re-authorizes the program with new subsections (d), (e), and (f). These new subsections add an extraordinary physical or psychological condition as a qualifying condition and limits the requirement to use public facilities to the extent that they are available and adequate to certain benefits under subsection (e). They also include discretion to increase the monthly Government cost-share for allowable services from a maximum of $1,000 per month and expand the benefit to allow for coverage of ECHO home health care and services beyond the Basic program. Section 701(e) also includes the discretion to allow coverage for custodial care and respite care.

## II. The Extended Care Health Option (ECHO)

*Purpose.* The primary purpose of the ECHO is to provide extended benefits to eligible beneficiaries that assist in the reduction of the disabling effects of an ECHO qualifying condition and that are not available through the Basic Program. Under 10 U.S.C. 1079(e), ECHO benefits may be provided only to the extent such service, supply or equipment is not a covered benefit under the Basic Program. This may include comprehensive health care services, including services necessary to maintain, minimize or prevent deterioration of, function of an eligible beneficiary.

*Eligibility.* Participation in the ECHO is voluntary and is available only for TRICARE-eligible family members of active duty service members who have a qualifying condition. Qualifying conditions are limited under 10 U.S.C. 1079(d)(3)(B) to beneficiaries who have

(a) Moderate or severe mental retardation; or

(b) A serious physical disability, as defined in 32 CFR 199.2; or

(c) An extraordinary physical or psychological condition, as defined in 32 CFR 199.2.

*ECHO Benefits.* ECHO benefits established herein include diagnostic procedures to establish a qualifying condition, inpatient, outpatient, and comprehensive home health care supplies and services, training, habilitative or rehabilitative services, special education, assistive technology devices, institutional care within a State when a residential environment is required, transportation under certain circumstances, certain other services such as assistive services of a qualified interpreter or translator for deaf or blind beneficiaries in conjunction with receipt of other allowed ECHO benefits, equipment adaptation and maintenance, and respite care, and ECHO home health care.

*ECHO Respite Care.* Under 10 U.S.C. 1079(e)(6), the Department may provide respite care under the ECHO program. Respite care is defined in 32 CFR 199.2 as short term care for a patient in order to provide rest and change for those who have been caring for the patient at home, usually the patient's family. DoD recognizes that caring for a special needs beneficiary poses special challenges, especially for active duty families. This rule establishes an ECHO benefit to provide a maximum of 16 hours per month of respite care. The respite care benefit is available for ECHO beneficiaries in any month during which the beneficiary receives ECHO benefits other than respite care under the ECHO Home Health Care benefit. Respite care services will be provided by a TRICARE-authorized home health agency and will provide health care services for the covered beneficiary, and not baby-sitting or child-care services for other members of the family. The benefit is not cumulative, that is, any respite care hours not used in one-month will not be carried over or banked for a subsequent month(s). The Government's cost-share incurred for the ECHO respite care services accrue to the ECHO maximum monthly benefit of $2,500.

*Government Cost-share Liability for ECHO.* The Government's monthly cost-share of all benefits provided to a beneficiary in a particular month under the PFPWD was statutorily limited to $1,000 by 10 U.S.C. 1079(e)(2). The Government's monthly cost-share of any benefits provided under ECHO is now statutorily limited to $2,500 by section 701(b) of the NDAA–02 (10 U.S.C. 1079(f)(2)(A)) for benefits related to training, rehabilitation, special education, assistive technology devices, and institutional care in private, non-profit, public, and state institutions and facilities, and if appropriate, transportation to and from such institutions and facilities. Because the NDAA–02 provided no statutory limitation concerning the amount of the Government's monthly cost-share for all other benefits under ECHO, the Department has discretion to determine the maximum monthly Government cost-share. Therefore, this rule increases the monthly Government cost-share from $1,000 to $2,500 for all benefits under ECHO, except for the new ECHO Home Health Care (EHHC) benefit as established herein. The primary reason for this increase is that the maximum government cost-share has not been adjusted since 1980. We will continue to review this issue to insure that the

government's cost-share reasonably meets the needs of beneficiaries.

*ECHO Home Health Care (EHHC).* Under 10 U.S.C. 1079(e), extended benefits may be provided to eligible beneficiaries to the extent such benefits are not provided under provisions of chapter 55, title 10, United States Code, other than under this section. Under 10 U.S.C. 1079(e)(2), the ECHO may include ''comprehensive home health care supplies and services which may include cost effective and medically appropriate services other than part-time or intermittent services (within the meaning of such terms as used in the second sentence of section 1861(m) of the Social Security Act).'' Section 701(a) of the NDAA–02 requires home health care services under the Basic Program be provided in the manner and under the conditions described in section 1861(m) of the Social Security Act. Therefore, this rule establishes an ECHO Home Health Care (EHHC) benefit for qualifying beneficiaries.

*EHHC Eligibility.* To qualify for EHHC, the beneficiary must meet all general ECHO program eligibility requirements and must

(a) Physically reside within the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, or Guam; and

(b) Be homebound, as defined in § 199.2 and as modified in this rule; and

(c) Require medically necessary skilled services that exceed the maximum level of coverage provided under the Basic Program's home health care benefit, or

(d) Require frequent interventions, other than skilled medical services, by the primary caregiver(s) (as ''primary caregiver'' is defined in § 199.2) such that EHHC services are necessary to allow primary caregiver(s) the opportunity to rest; and

(e) Be case managed (as ''case management'' is defined in § 199.2), including a periodic assessment of needs, and receive services as outlined in a written plan of care; and

(f) Receive home health care services from a TRICARE-authorized home health agency as described in § 199.6(b)(4)(xv).

*EHHC Benefit.* Covered TRICARE-authorized home health agency services are the same as, and provided under the same conditions as, those services provided under the TRICARE Basic Program under § 199.4(e)(21), with the exception that the EHHC benefit is not limited to part-time or intermittent home health care. Therefore, this rule sets out that TRICARE beneficiaries who are eligible for the ECHO and require home health care services beyond the coverage limits under the Basic Program will receive all home health care services under EHHC and no portion will be provided under the Basic Program.

*EHHC Plan of Care.* The level of ECHO home health care services authorized will be based on a written plan of care that supports the medical necessity of those services in excess of what can be authorized by the Basic Program, or, in the case of a beneficiary who requires frequent interventions, the need for EHHC in order to allow the primary caregiver(s) the opportunity to rest. The plan of care must include identification of the professional qualifications or skill level of the person required to provide the care. Reasonable justification for the medical necessity of the level of provider must be included in the plan of care, otherwise, reimbursement will not be authorized for that level of provider.

*EHHC Respite Care.* This rule establishes respite care within the EHHC benefit specifically tailored for families with a beneficiary who has a medical condition(s) that requires frequent interventions by the primary caregiver. For the purpose of this respite care, the term ''frequent'' means ''more than two interventions during the eight-hour per day period that the primary caregiver would normally be sleeping.'' The service performed during the interventions may have been taught to the primary caregiver by a medical professional, but the services performed by the primary caregiver are such that they can be performed safely and effectively by the average non-medical person without direct supervision of a licensed nurse or other health care provider. Therefore, when an eligible beneficiary's care plan reflects a need for frequent interventions by the primary caregiver, the beneficiary is eligible for EHHC respite care services in lieu of the ECHO respite care benefit. EHHC beneficiaries in this situation are eligible for eight hours per day for five (5) days per week of respite care by a TRICARE-authorized home health agency. The home health agency will provide health care services for the covered beneficiary so that the primary caregiver is relieved of his/her responsibility for providing such care for the duration of that period of respite care in order that the primary caregiver(s) may rest. The TRICARE-authorized home health agency will not provide baby-sitting or child care services for other members of the family. The benefit is not cumulative, that is, respite care hours not used in a given day will not be carried over or banked for use on another occasion. Also, EHHC respite care periods will not be provided consecutively, that is, a respite care period on one day will not be immediately followed by an EHHC respite care period the next day, thus prohibiting a continuous sixteen hour period of respite care. The government's cost-share incurred for these services accrue to the fiscal year maximum ECHO Home Health Care benefit.

*Government Cost-share Liability for EHHC.* TRICARE-authorized home health agencies who provide services under the Basic Program are reimbursed under § 199.14(h) using the same methods and rates as used under the Medicare home health agency prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1385fff) and 42 CFR part 484, subpart E, except for children under age ten and except as otherwise necessary to recognize distinct characteristics of TRICARE beneficiaries and as described in instructions issued by the Director, TRICARE Management Activity. However, the Medicare home health agency prospective payment system is designed to reimburse providers who provide part-time or intermittent services; it is not designed to reimburse providers for services that exceed those limits. Therefore, this rule set outs that the Department will reimburse home health agencies the allowable charges or negotiated rates. The maximum annual fiscal year cap for EHHC services is what the highest locally wage-adjusted maximum Medicare Resource Utilization Grouping (RUG–III) category cost to the Department would be if such services were provided in a TRICARE-authorized skilled nursing facility. (*See* **Federal Register** 67 FR 40597, June 13, 2002, concerning the TRICARE Sub-Acute Care Program; Uniform Skilled Nursing Facility Benefit; Home Health Care Benefit; Adopting Medicare Payment Methods for Skilled Nursing Facilities and Home Health Care Providers). Because the highest RUG–III category is used to determine the EHHC fiscal year cap, the Department will not attempt to determine what RUG–III category would apply to the beneficiary if such beneficiary were in fact admitted for care into a TRICARE-authorized skilled nursing facility. The fiscal year cap will be recalculated each year following publication of the ''Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update; Notice'', or similar, by the Centers for Medicare and Medicaid Services in the **Federal Register**.

The maximum monthly Government cost-share to be paid to the home health agency for ECHO home health care will

be the allowable charges or negotiated rates, but in no case will such payment exceed one-twelfth of the fiscal year cap calculated as above.

When EHHC beneficiaries move within the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, or Guam, the annual fiscal year cap will be recalculated as above to reflect the correct wage-adjusted maximum RUG–III category cost for the beneficiary's new location and will apply for the remaining portion of that fiscal year.

*EHHC Reimbursement.* A TRICARE-authorized home health agency must bill for all authorized ECHO home health care services through established TRICARE claims mechanisms. No special billing arrangements will be authorized in coordination with coverage that may be provided by Medicaid (subject to any State Agency Billing Agreements), or other Federal, State, community or private programs.

For authorized ECHO home health care and respite care, TRICARE will reimburse the allowable charges or negotiated rates.

*Beneficiary Cost-share Liability for ECHO, including EHHC.* Under 10 U.S.C. 1079(f), members are required to share in the cost of any benefits provided to their dependents under ECHO. ECHO benefits are not subject to a deductible amount. Regardless of the number of ECHO eligible family members, the sponsor's monthly cost-share for allowed ECHO benefits is based upon the rank of the uniformed service member. Under 10 U.S.C. 1079(f)(1)(A), members with a rank of E–1 are required to pay the first $25 incurred per month, and members with a rank of O–10 are required to pay the first $250 incurred per month. This rules sets out the cost-share for members with ranks in-between such that the majority will pay less than $100 per month, with the most senior enlisted member paying less than $50 per month.

Sponsor rank-based cost-sharing (refer to Table 1, 32 CFR 199.5) applies to benefits covered by the ECHO and these cost-shares do not apply toward the Basic Program's catastrophic cap under 10 U.S.C. 1079(b)(5). Also, the waiver of cost-shares for active duty family members enrolled in TRICARE Prime does not apply to ECHO as the statutory basis for the ECHO program and its cost-shares is separate and distinct from the Basic Program, including TRICARE Prime.

*Other Requirements.* Other ECHO requirements are as follows:

*Registration.* Sec 701(b) of the NDAA–02 (10 U.S.C. 1079(d)(1)) requires registration to receive ECHO benefits. Sponsors of potentially qualifying beneficiaries will seek to register their family member(s) for ECHO benefits through the applicable Managed Care Support Contractor (MCSC). The MCSC will determine eligibility and update the Defense Enrollment Eligibility Reporting System (DEERS) to reflect the beneficiary's ECHO eligibility. No ECHO benefits may be authorized unless the beneficiary is registered in DEERS as ECHO-eligible.

*EFMP Enrollment.* Each of the Military Services has its own Exceptional Family Member Program (EFMP). Although the EFMPs can interface with the Military Health System, they are actually military personnel programs. The purpose of those programs is to require military personnel offices to evaluate the ability of a military and civilian community to provide appropriate medical and/or educational services to service members' dependents who have special medical or educational needs before the Service re-assigns the member to a new location. Although each Service requires its members who have family members with special needs to enroll in the EFMP, some members do not comply with this requirement. The result is that some members arrive at assignment locations that are unable to accommodate the special medical and/or educational needs of their dependent(s). Dependents of members required to be enrolled in EFMP are similar if not identical to those who qualify for the ECHO program. The Services do not routinely provide EFMP enrollments to TRICARE, therefore, to provide a greater degree of coordination of services for TRICARE beneficiaries, this rules sets out that members will be required to provide evidence they are enrolled in their Services' Exceptional Family Member Program when registering for ECHO benefits. This requirement will enhance the probability that personnel are assigned to locations where there are sufficient qualified individual or institutional providers to provide the ECHO benefit to their dependents.

*Use of Public Facilities.* For ECHO benefits related to training, rehabilitation, special education, assistive technology devices, and institutional care in private, non-profit, public, and state institutions and facilities, and if appropriate, transportation to and from such institutions and facilitates, the statute expressly requires use of public facilities to be the extent such facilities are available and adequate as determined under this regulation.

## III. Public Comments

We provided a 60-day public comment period following publication of the Proposed Rule in the **Federal Register** at 68 FR 46526 on August 6, 2003. Two individuals provided several comments, summarized below.

*Comment:* The first commentor questioned the Department's decision regarding where the ECHO, in particular ECHO Home Health Care and respite care, will be available.

*Response:* The ECHO will generally be available wherever there are TRICARE beneficiaries eligible for the ECHO and appropriate TRICARE-authorized providers.

The focus of the ECHO Home Health Care benefit is to provide ECHO beneficiaries with the same benefit structure as provided by the Basic Program's Home Health Agency Prospective Payment System (HHA–PPS) but without its limitation that the services be provided on a ''part-time or intermittent'' basis. In order to assure the quality of care for TRICARE beneficiaries, the HHA–PPS provides that only Medicare-authorized Home Health Agencies are eligible for designation as TRICARE-authorized providers. Likewise, the Department also elected to utilize those same home health agencies to provide the ECHO respite care. Consequently, ECHO respite care and the ECHO Home Health Care benefits are limited to locations where there are Medicare-authorized home health agencies. Currently that is limited to the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam.

*Comment:* That commentor also remarked about the cost of transportation to receive ECHO-authorized benefits.

*Response:* This rule sets out that costs for public and private transportation necessary to receive authorized ECHO benefits will be reimbursed subject to the limits herein.

*Comment:* The second commentor requested the Department provide the ECHO respite care benefit to multiple TRICARE beneficiaries within group settings, such as a day care center, and prorate the allowable cost among those receiving the respite care.

*Response:* The Department has identified several issues regarding the comment. First, other than when allowed by specific exceptions to its policies, TRICARE professional outpatient benefits are provided one-on-one, that is, one patient with one provider per episode of care. Consequently, there is no general provision for ''group'' type episodes-of-care or settings.

Second, the regulatory language at 32 CFR 199.2 defines respite care as '' * * * short-term care for a patient in order to provide rest and change for those who have been caring for the patient at home, usually the patient's family.'' Although there is no statutory restriction on where respite care services are provided, it is the Department's decision that such care be provided in the beneficiary's primary residence.

Last, as set out in this rule, both the ECHO respite care and the ECHO Home Health Care respite care benefits will be provided by TRICARE-authorized home health agencies. These providers will be reimbursed on the basis of allowable charges or negotiated rates, neither of which provides pro-rated assignment of TRICARE benefits nor pro-rated payments based on multiple TRICARE beneficiaries receiving care in a group setting.

**IV. Summary of Regulatory Modifications**

The following modifications were made as a result of developing the implementing instructions:

(1) We clarified that TRICARE reimbursement for ECHO home health care and respite care will be the allowable charges or negotiated rates.

**V. Regulatory Procedures**

*Executive Order (EO) 12866*

Executive Order 12866 requires that a comprehensive regulatory impact analysis be performed on any economically significant regulatory action, defined as one that would result in an annual effect of $100 million or more on the national economy or which would have other substantial impacts. The Regulatory Flexibility Act (RFA) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities. This rule is not an economically significant regulatory action and will not have a significant impact on a substantial number of small entities for purposes of the RFA. This rule, although not economically significant under Executive Order 12866, is a significant rule under Executive order 12866 and has been reviewed by the Office of Management and Budget.

*Paperwork Reduction Act*

This rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511). Existing DoD information systems to include the Defense Enrollment Eligibility Reporting System (DEERS) will be upgraded to reflect ECHO registration.

**List of Subjects in 32 CFR part 199**

Case management, Claims, Custodial care, Health insurance, Individuals with disabilities, Military personnel.

■ For the reasons set out in the preamble, the Department of Defense amends 32 CFR part 199 as follows:

**PART 199—[AMENDED]**

■ 1. The authority citation for part 199 continues to read as follows:

**Authority:** 5 U.S.C. 301; 10 U.S.C. chapter 55.

■ 2. Section 199.2 is amended in paragraph (b) by removing the definitions of ''*Program for Persons with Disabilities (PFPWD)*'' and ''*Extraordinary condition*'', by revising paragraph (v) of the definition of ''*Double coverage plan*'', by revising the definitions of ''*Durable equipment*'', ''*Homebound*'', and ''*Primary caregiver*'', and by adding the definitions of ''*Duplicate equipment*'', ''*Extended Care Health Option (ECHO)*'', and ''*Extraordinary physical or psychological condition*'' in alphabetical order to read as follows:

**§ . 199.2 Definitions.**

* * * * *

(b) * * *

*Double coverage plan.* * * *

(v) Part C of the Individuals with Disabilities Education Act for services and items provided in accordance with Part C of the IDEA that are medically or psychologically necessary in accordance with the Individual Family Service Plan and that are otherwise allowable under the CHAMPUS Basic Program or the Extended Care Health Option (ECHO).

* * * * *

*Duplicate equipment.* An item of durable equipment or durable medical equipment, as defined in this section that serves the same purpose that is served by an item of durable equipment or durable medical equipment previously cost-shared by TRICARE. For example, various models of stationary oxygen concentrators with no essential functional differences are considered duplicate equipment, whereas stationary and portable oxygen concentrators are not considered duplicates of each other because the latter is intended to provide the user with mobility not afforded by the former. Also, a manual wheelchair and an electric wheelchair, both of which otherwise meet the definition of durable equipment or durable medical equipment, would not be considered duplicates of each other if each is found to provide an appropriate level of mobility. For the purpose of this part, durable equipment or durable medical equipment that are essential to provide a fail-safe in-home life support system or that replaces in like kind an item of equipment that is not serviceable due to normal wear, accidental damage, a change in the beneficiary's condition, or has been declared adulterated by the U.S. FDA, or is being or has been recalled by the manufacturer, is not considered duplicate equipment.

*Durable equipment.* A device or apparatus which does not qualify as durable medical equipment and which is essential to the efficient arrest or reduction of functional loss resulting from, or the disabling effects of a qualifying condition as provided in § 199.5.

* * * * *

*Extended Care Health Option (ECHO).* The TRICARE program of supplemental benefits for qualifying active duty family members as described in § 199.5.

* * * * *

*Extraordinary physical or psychological condition.* A complex physical or psychological clinical condition of such severity which results in the beneficiary being homebound as defined in this section.

* * * * *

*Homebound* A beneficiary's condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment or in an adult day-care program certified by a state, or accredited to furnish adult day-care services in the state shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. For the purposes of the preceding sentence, any absence for purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an

infrequent basis and are of relatively short duration. In addition to the above, absences, whether regular or infrequent, from the beneficiary's primary residence for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.

* * * * *

*Primary caregiver.* An individual who renders to a beneficiary services to support the activities of daily living (as defined in § 199.2) and specific services essential to the safe management of the beneficiary's condition.

* * * * *

**§ 199.3 [Amended]**

■ 3. Section 199.3 is amended by revising the term ''Program for Persons with Disabilities'' or the acronym ''PFPWD'' to read ''Extended Care Health Option'' or the acronym ''ECHO,'' respectively, in paragraphs (b)(2)(iii)(A)(*1*), (c)(2)(i)(C), (c)(2)(ii)(B), (c)(2)(iii)(B), (c)(3)(i)(C), (c)(3)(ii)(B), (c)(4)(i)(B), (c)(4)(ii)(B), (c)(4)(iii)(B), (c)(5)(i)(C), (c)(5)(ii)(B), (c)(5)(iii)(B), (c)(5)(iv)(C)(*2*), (c)(6)(ii), (c)(7)(i)(C), (c)(7)(ii)(B), (c)(8)(ii), (c)(9)(i)(B), (c)(9)(ii)(B), and (c)(10)(ii) wherever they appear.

■ 4. Section 199.4 is amended by removing and reserving paragraph (e)(20); adding paragraph (g)(59); revising paragraph (g)(73); and removing paragraph (i) Case management program in its entirety; to read as follows:

**§ 199.4 Basic program benefits.**

* * * * *

(g) * * *

(59) *Duplicate equipment.* As defined in § 199.2, duplicate equipment is excluded.

* * * * *

(73) *Economic interest in connection with mental health admissions.* Inpatient mental health services (including both acute care and RTC services) are excluded for care received when a patient is referred to a provider of such services by a physician (or other health care professional with authority to admit) who has an economic interest in the facility to which the patient is referred, unless a waiver is granted. Requests for waiver shall be considered under the same procedure and based on the same criteria as used for obtaining preadmission authorization (or continued stay authorization for emergency admissions), with the only additional requirement being that the economic interest be disclosed as part of the request. The same reconsideration and appeals procedure that apply to day limit waivers shall also apply to decisions regarding requested waivers of the economic interest exclusion. However, a provider may appeal a reconsidered determination that an economic relationship constitutes an economic interest within the scope of the exclusion to the same extent that a provider may appeal determination under § 199.15(i)(3). This exclusion does not apply to services under the Extended Care Health Option (ECHO) in § 199.5 or provided as partial hospital care. If a situation arises where a decision is made to exclude CHAMPUS payment solely on the basis of the provider's economic interest, the normal CHAMPUS appeals process will be available.

* * * * *

■ 5. Section 199.5 is revised to read as follows:

**§ 199.5 TRICARE Extended Care Health Option (ECHO).**

(a) *General.* (1) The TRICARE ECHO is essentially a supplemental program to the TRICARE Basic Program. It does not provide acute care nor benefits available through the TRICARE Basic Program.

(2) The purpose of the ECHO is to provide an additional financial resource for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary's qualifying condition. Services include those necessary to maintain, minimize or prevent deterioration of function of an ECHO-eligible beneficiary.

(b) *Eligibility.* (1) The following categories of TRICARE/CHAMPUS beneficiaries with a qualifying condition are eligible for ECHO benefits:

(i) A child or spouse (as described in 10 U.S.C. 1072(2)(A), (D), or (I)) of a member of one of the Uniformed Services; or

(ii) An abused dependent as described in § 199.3(b)(2)(iii); or

(iii) A child or spouse (as described in 10 U.S.C. 1072(2)(A), (D), or (I)) of a member of one of the Uniformed Services who dies while on active duty. In such case the child or spouse remain eligible for benefits under the ECHO for a period of three years from the date the active duty sponsor dies; or

(iv) A child or spouse (as described in 10 U.S.C. 1072(2)(A), (D), or (I)) of a deceased member of one of the Uniformed Services, who, at the time of the member's death was receiving benefits under ECHO, and the member at the time of death was eligible for receipt of hostile-fire pay, or died as a result of a disease or injury incurred while eligible for such pay. In such case the child or spouse remain eligible through midnight of the beneficiary's twenty-first birthday.

(2) *Qualifying condition.* The following are qualifying conditions:

(i) *Mental retardation.* A diagnosis of moderate or severe mental retardation made in accordance with the criteria of the current edition of the ''Diagnostic and Statistical Manual of Mental Disorders'' published by the American Psychiatric Association.

(ii) *Serious physical disability.* A serious physical disability as defined in § 199.2.

(iii) *Extraordinary physical or psychological condition.* An extraordinary physical or psychological condition as defined in § 199.2.

(iv) *Infant/toddler.* Beneficiaries under the age of 3 years who are diagnosed with a neuromuscular developmental condition or other condition that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability, shall be deemed to have a qualifying condition for the ECHO. The Director, TRICARE Management Activity or designee shall establish criteria for ECHO eligibility in lieu of the requirements of paragraphs (b)(2)(i), (ii) or (iii) of this section.

(v) *Multiple disabilities.* The cumulative effect of multiple disabilities, as determined by the Director, TRICARE Management Activity or designee shall be used in lieu of the requirements of paragraphs (b)(2)(i), (ii) or (iii) of this section to determine a qualifying condition when the beneficiary has two or more disabilities involving separate body systems.

(3) *Loss of ECHO eligibility.* Eligibility for ECHO benefits ceases as of 12:01 a.m. of the day following the day that:

(i) The sponsor ceases to be an active duty member for any reason other than death; or

(ii) Eligibility based upon the abused dependent provisions of paragraph (b)(1)(ii) of this section expires; or

(iii) Eligibility based upon the deceased sponsor provisions of paragraphs (b)(1)(iii) or (iv) of this section expires; or

(iv) Eligibility based upon a beneficiary's participation in the Transitional Assistance Management Program ends; or

(v) The Director, TRICARE Management Activity or designee determines that the beneficiary no longer has a qualifying condition.

(4) *Continuity of eligibility.* A TRICARE beneficiary who has an outstanding Program for Persons with Disabilities (PFPWD) benefit authorization on the date of

implementation of the ECHO program shall continue receiving such services for the duration of that authorization period provided the beneficiary remains eligible for the PFPWD. Upon termination of an existing PFPWD authorization, or if the beneficiary seeks benefits under this section before such termination, the beneficiary shall establish eligibility for the ECHO in accordance with this section.

(c) *ECHO benefit.* Items and services that the Director, TRICARE Management Activity or designee has determined are capable of confirming, arresting, or reducing the severity of the disabling effects of a qualifying condition, includes, but are not limited to:

(1) Diagnostic procedures to establish a qualifying condition or to measure the extent of functional loss resulting from a qualifying condition.

(2) Medical, habilitative, rehabilitative services and supplies, durable equipment and durable medical equipment that are related to the qualifying condition. Benefits may be provided in the beneficiary's home or other environment as appropriate.

(3) Training that teaches the use of assistive technology devices or to acquire skills that are necessary for the management of the qualifying condition. Such training is also authorized for the beneficiary's immediate family. Vocational training, in the beneficiary's home or a facility providing such, is also allowed.

(4) Special education as provided by the Individuals with Disabilities Education Act and defined at 34 CFR 300.26 and that is specifically designed to accommodate the disabling effects of the qualifying condition.

(5) Institutional care within a state, as defined in § 199.2, in private nonprofit, public, and state institutions and facilities, when the severity of the qualifying condition requires protective custody or training in a residential environment. For the purpose of this section protective custody means residential care that is necessary when the severity of the qualifying condition is such that the safety and well-being of the beneficiary or those who come into contact with the beneficiary may be in jeopardy without such care.

(6) Transportation of an ECHO beneficiary, and a medical attendant when necessary to assure the beneficiary's safety, to or from a facility or institution to receive authorized ECHO services or items.

(7) *Respite care.* ECHO beneficiaries are eligible for 16 hours of respite care per month in any month during which the qualified beneficiary otherwise receives an ECHO benefit(s). Respite care is defined in § 199.2. Respite care services will be provided by a TRICARE-authorized home health agency and will be designed to provide health care services for the covered beneficiary, and not baby-sitting or child-care services for other members of the family. The benefit will not be cumulative, that is, any respite care hours not used in one month will not be carried over or banked for use on another occasion.

(i) TRICARE-authorized home health agencies must provide and bill for all authorized ECHO respite care services through established TRICARE claims' mechanisms. No special billing arrangements will be authorized in conjunction with coverage that may be provided by Medicaid or other federal, state, community or private programs.

(ii) For authorized ECHO respite care, TRICARE will reimburse the allowable charges or negotiated rates.

(iii) The Government's cost-share incurred for these services accrue to the maximum monthly benefit of $2,500.

(8) *Other services*—(i) *Assistive services.* Services of qualified personal assistants, such as an interpreter or translator for ECHO beneficiaries who are deaf or mute and readers for ECHO beneficiaries who are blind, when such services are necessary in order for the ECHO beneficiary to receive authorized ECHO benefits.

(ii) *Equipment adaptation.* The allowable equipment purchase shall include such services and modifications to the equipment as necessary to make the equipment useable for a particular ECHO beneficiary.

(iii) *Equipment maintenance.* Reasonable repairs and maintenance of beneficiary owned or rented durable equipment or durable medical equipment provided by this section shall be allowed while a beneficiary is registered in the ECHO.

(d) *ECHO Exclusions.* (1) *Basic Program.* Benefits allowed under the TRICARE Basic Program will not be provided through the ECHO.

(2) *Inpatient care.* Inpatient acute care for medical or surgical treatment of an acute illness, or of an acute exacerbation of the qualifying condition, is excluded.

(3) *Structural alterations.* Alterations to living space and permanent fixtures attached thereto, including alterations necessary to accommodate installation of equipment or to facilitate entrance or exit, are excluded.

(4) *Homemaker services.* Services that predominantly provide assistance with household chores are excluded.

(5) *Dental care or orthodontic treatment.* Both are excluded.

(6) *Deluxe travel or accommodations.* The difference between the price for travel or accommodations that provide services or features that exceed the requirements of the beneficiary's condition and the price for travel or accommodations without those services or features is excluded.

(7) *Equipment.* Purchase or rental of durable equipment and durable medical equipment, which are otherwise allowed by this section, are excluded when:

(i) The beneficiary is a patient in an institution or facility that ordinarily provides the same type of equipment to its patients at no additional charge in the usual course of providing services; or

(ii) The item is available to the beneficiary from a Uniformed Services Medical Treatment Facility; or

(iii) The item has deluxe, luxury, immaterial or nonessential features that increase the cost to the Department relative to a similar item without those features; or

(iv) The item is duplicate equipment as defined in § 199.2.

(8) *Maintenance agreements.* Maintenance agreements for beneficiary owned or rented equipment are excluded.

(9) *No obligation to pay.* Services or items for which the beneficiary or sponsor has no legal obligation to pay are excluded.

(10) *Public facility or Federal government.* Services or items paid for, or eligible for payment, directly or indirectly by a public facility, as defined in § 199.2, or by the Federal government, other than the Department of Defense, are excluded for training, rehabilitation, special education, assistive technology devices, institutional care in private nonprofit, public, and state institutions and facilities, and if appropriate, transportation to and from such institutions and facilities, except when such services or items are eligible for payment under a state plan for medical assistance under Title XIX of the Social Security Act (Medicaid). Rehabilitation and assistive technology services or supplies may be available under the TRICARE Basic Program.

(11) *Study, grant, or research programs.* Services and items provided as a part of a scientific clinical study, grant, or research program are excluded.

(12) *Unproven status.* Drugs, devices, medical treatments, diagnostic, and therapeutic procedures for which the safety and efficacy have not been established in accordance with § 199.4 are excluded.

(13) *Immediate family or household.* Services or items provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household, are excluded.

(14) *Court or agency ordered care.* Services or items ordered by a court or other government agency, which are not otherwise an allowable ECHO benefit, are excluded.

(15) *Excursions.* Excursions are excluded regardless of whether or not they are part of a program offered by a TRICARE-authorized provider. The transportation benefit available under ECHO is specified elsewhere in this section.

(16) *Drugs and medicines.* Drugs and medicines that do not meet the requirements of § 199.4 or § 199.21 are excluded.

(17) *Therapeutic absences.* Therapeutic absences from an inpatient facility or from home for a homebound beneficiary are excluded.

(18) *Custodial care.* Custodial care, as defined in § 199.2, is not a stand-alone benefit. Services generally rendered as custodial care may be provided only as specifically set out in this section.

(19) *Domiciliary care.* Domiciliary care, as defined in § 199.2, is excluded.

(20) *Respite care.* Respite care for the purpose of covering primary caregiver (as defined in § 199.2) absences due to deployment, employment, seeking of employment or to pursue education is excluded. Authorized respite care covers only the ECHO beneficiary, not siblings or others who may reside in or be visiting in the beneficiary's residence.

(e) *ECHO Home Health Care (EHHC).* The EHHC benefit provides coverage of home health care services and respite care services specified in this section.

(1) *Home health care.* Covered ECHO home health care services are the same as, and provided under the same conditions as those services described in § 199.4(e)(21)(i), except that they are not limited to part-time or intermittent services. Custodial care services, as defined in § 199.2, may be provided to the extent such services are provided in conjunction with authorized ECHO home health care services, including the EHHC respite care benefit specified herein. Beneficiaries who are authorized EHHC will receive all home health care services under EHHC and no portion will be provided under the Basic Program. TRICARE-authorized home health agencies are not required to use the Outcome and Assessment Information Set (OASIS) to assess beneficiaries who are authorized EHHC.

(2) *Respite care.* EHHC beneficiaries whose plan of care includes frequent interventions by the primary caregiver(s) are eligible for respite care services in lieu of the ECHO general respite care benefit. For the purpose of this section, the term ''frequent'' means ''more than two interventions during the eight-hour period per day that the primary caregiver would normally be sleeping.'' The services performed by the primary caregiver are those that can be performed safely and effectively by the average non-medical person without direct supervision of a health care provider after the primary caregiver has been trained by appropriate medical personnel. EHHC beneficiaries in this situation are eligible for a maximum of eight hours per day, 5 days per week, of respite care by a TRICARE-authorized home health agency. The home health agency will provide the health care interventions or services for the covered beneficiary so that the primary caregiver is relieved of the responsibility to provide such interventions or services for the duration of that period of respite care. The home health agency will not provide baby-sitting or child care services for other members of the family. The benefit is not cumulative, that is, any respite care hours not used in a given day may not be carried over or banked for use on another occasion. Additionally, the eight-hour respite care periods will not be provided consecutively, that is, a respite care period on one calendar day will not be immediately followed by a respite care period the next calendar day. The Government's cost-share incurred for these services accrue to the maximum yearly ECHO Home Health Care benefit.

(3) *EHHC eligibility.* The EHHC is authorized for beneficiaries who meet all applicable ECHO eligibility requirements and who:

(i) Physically reside within the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, or Guam; and

(ii) Are homebound, as defined in § 199.2; and

(iii) Require medically necessary skilled services that exceed the level of coverage provided under the Basic Program's home health care benefit; or

(iv) Require frequent interventions by the primary caregiver(s) such that respite care services are necessary to allow primary caregiver(s) the opportunity to rest; and

(v) Are case managed to include a reassessment at least every 90 days, and receive services as outlined in a written plan of care; and

(vi) Receive all home health care services from a TRICARE-authorized home health agency, as described in §199.6(b)(4)(xv), in the beneficiary's primary residence.

(4) *EHHC plan of care.* A written plan of care is required prior to authorizing ECHO home health care. The plan must include the type, frequency, scope and duration of the care to be provided and support the professional level of provider. Reimbursement will not be authorized for a level of provider not identified in the plan of care.

(5) *EHHC exclusions.* (i) *General.* ECHO Home Health Care services and supplies are excluded from those who are being provided continuing coverage of home health care as participants of the former Individual Care Management Program for Persons with Extraordinary Conditions (ICMP–PEC) or previous case management demonstrations.

(ii) *Respite care.* Respite care for the purpose of covering primary caregiver absences due to deployment, employment, seeking of employment or to pursue education is excluded. Authorized respite care covers only the ECHO beneficiary, not siblings or others who may reside in or be visiting in the beneficiary's residence.

(f) *Cost-share liability.* (1) *No deductible.* ECHO benefits are not subject to a deductible amount.

(2) *Sponsor cost-share liability.* (i) Regardless of the number of family members receiving ECHO benefits or ECHO Home Health Care in a given month, the sponsor's cost-share is according to the following table:

TABLE 1.—MONTHLY COST-SHARE BY MEMBER'S PAY GRADE

| | |
|---|---|
| E–1 through E–5 | $25 |
| E–6 | 30 |
| E–7 and O–1 | 35 |
| E–8 and O–2 | 40 |
| E–9, W–1, W–2 and O–3 | 45 |
| W–3, W–4 and O–4 | 50 |
| W–5 and O–5 | 65 |
| O–6 | 75 |
| O–7 | 100 |
| O–8 | 150 |
| O–9 | 200 |
| O–10 | 250 |

(ii) The sponsor's cost-share shown in Table 1 in paragraph (f)(2)(i) of this section will be applied to the first allowed ECHO charges in any given month. The Government's share will be paid, up to the maximum amount specified in paragraph (f)(3) of this section, for allowed charges after the sponsor's cost-share has been applied.

(iii) The provisions of § 199.18(d)(1) and (e)(1) regarding elimination of copayments for active duty family members enrolled in TRICARE Prime do not eliminate, reduce, or otherwise

affect the sponsor's cost-share shown in Table 1 in paragraph (f)(2)(i) of this section.

(iv) The sponsor's cost-share shown in Table 1 in paragraph (f)(2)(i) of this section does not accrue to the Basic Program's Catastrophic Loss Protection under 10 U.S.C. 1079(b)(5) as shown at §§ 199.4(f)(10) and 199.18(f).

(3) *Government cost-share liability.* (i) *ECHO.* The total Government share of the cost of all ECHO benefits, except ECHO home health care and EHHC respite care, provided in a given month to a beneficiary may not exceed $2,500 after application of the allowable payment methodology.

(ii) *ECHO home health care.* (A) The maximum annual Government cost-share for ECHO home health care, including EHHC respite care may not exceed the local wage-adjusted highest Medicare Resource Utilization Group (RUG–III) category cost for care in a TRICARE-authorized skilled nursing facility.

(B) When a beneficiary moves to a different locality within the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, or Guam, the annual fiscal year cap will be recalculated to reflect the maximum established under paragraph (f)(3)(ii)(A) of this section for the beneficiary's new location and will apply to the EHHC benefit for the remaining portion of that fiscal year.

(g) *Benefit payment.* (1) *Transportation.* The allowable amount for transportation of an ECHO beneficiary is limited to the actual cost of the standard published fare plus any standard surcharge made to accommodate any person with a similar disability or to the actual cost of specialized medical transportation when non-specialized transport cannot accommodate the beneficiary's qualifying condition related needs, or when specialized transport is more economical than non-specialized transport. When transport is by private vehicle, the allowable amount is limited to the Federal government employee mileage reimbursement rate in effect on the date the transportation is provided.

(2) *Equipment.* (i) The TRICARE allowable amount for durable equipment and durable medical equipment shall be calculated in the same manner as durable medical equipment allowable through § 199.4.

(ii) *Allocating equipment expense.* The ECHO beneficiary (or sponsor or guardian acting on the beneficiary's behalf) may, only at the time of the request for authorization of equipment, specify how the allowable cost of the equipment is to be allocated as an ECHO benefit. The entire allowable cost of the authorized equipment may be allocated in the month of purchase provided the allowable cost does not exceed the ECHO maximum monthly benefit of $2,500 or it may be prorated regardless of the allowable cost. Prorating permits the allowable cost of ECHO-authorized equipment to be allocated such that the amount allocated each month does not exceed the maximum monthly benefit.

(A) *Maximum period.* The maximum number of consecutive months during which the allowable cost may be prorated is the lesser of:

(*1*) The number of months calculated by dividing the allowable cost for the item by 2,500 and then doubling the resulting quotient, rounded off to the nearest whole number; or

(*2*) The number of months of expected useful life of the equipment for the requesting beneficiary, as determined by the Director, TRICARE Management Activity or designee.

(B) *Alternative allocation period.* The allowable equipment cost may be allocated monthly in any amount such that the maximum allowable monthly ECHO benefit of $2,500 or the maximum period under paragraph (g)(2)(ii)(A) of this section, is not exceeded.

(C) *Authorization.* (*1*) The amount allocated each month as determined in accordance with paragraph (g)(2)(ii) of this section will be separately authorized as an ECHO benefit.

(*2*) An item of durable equipment or durable medical equipment shall not be authorized when such authorization would allow cost-sharing of duplicate equipment, as defined in § 199.2, for the same beneficiary.

(D) *Cost-share.* A cost-share, as provided by paragraph (f)(2) of this section, is required for each month in which a prorated amount is authorized.

(E) *Termination.* The sponsor's monthly cost-share and the prorated equipment expense provisions provided by paragraphs (f) and (g) of this section, shall be terminated as of the first day of the month following the death of a beneficiary or as of the effective date of a beneficiary's loss of ECHO eligibility for any other reason.

(3) *For-profit institutional care provider.* Institutional care provided by a for-profit entity may be allowed only when the care for a specific ECHO beneficiary:

(i) Is contracted for by a public facility as a part of a publicly funded long-term inpatient care program; and

(ii) Is provided based upon the ECHO beneficiary's being eligible for the publicly funded program which has contracted for the care; and

(iii) Is authorized by the public facility as a part of a publicly funded program; and

(iv) Would cause a cost-share liability in the absence of TRICARE eligibility; and

(v) Produces an ECHO beneficiary cost-share liability that does not exceed the maximum charge by the provider to the public facility for the contracted level of care.

(4) *ECHO home health care and EHHC respite care.* (i) TRICARE-authorized home health agencies must provide and bill for all authorized home health care services through established TRICARE claims' mechanisms. No special billing arrangements will be authorized in conjunction with coverage that may be provided by Medicaid or other federal, state, community or private programs.

(ii) For authorized ECHO home health care and respite care, TRICARE will reimburse the allowable charges or negotiated rates.

(iii) The maximum monthly Government reimbursement for EHHC, including EHHC respite care, will be based on the actual number of hours of EHHC services rendered in the month, but in no case will it exceed one-twelfth of the annual maximum Government cost-share as determined in this section.

(h) *Other Requirements.* (1) *Applicable part.* All provisions of this part, except the provisions of § 199.4 unless otherwise provided by this section or as directed by the Director, TRICARE Management Activity or designee, apply to the ECHO.

(2) *Registration.* Active duty sponsors must register potential ECHO eligible beneficiaries through the Director, TRICARE Management Activity or designee prior to receiving ECHO benefits. The Director, TRICARE Management Activity or designee will determine ECHO eligibility and update the Defense Enrollment Eligibility Reporting System (DEERS) accordingly. Sponsors must provide evidence of enrollment in the Exceptional Family Member Program provided by their branch of Service at the time they register their family member(s) for the ECHO.

(3) *Benefit authorization.* All ECHO benefits require authorization by the Director, TRICARE Management Activity or designee prior to receipt of such benefits.

(i) *Documentation.* The sponsor shall provide such documentation as the Director, TRICARE Management Activity or designee requires as a prerequisite to authorizing ECHO benefits. Such documentation shall describe how the requested benefit will

contribute to confirming, arresting, or reducing the disabling effects of the qualifying condition, including maintenance of function or prevention of further deterioration of function, of the beneficiary.

(ii) *Format.* An authorization issued by the Director, TRICARE Management Activity or designee shall specify such description, dates, amounts, requirements, limitations or information as necessary for exact identification of approved benefits and efficient adjudication of resulting claims.

(iii) *Valid period.* An authorization for ECHO benefits shall be valid until such time as the Director, TRICARE Management Activity or designee determines that the authorized services are no longer appropriate or required or the beneficiary is no longer eligible under paragragh(b) of this section.

(iv) *Authorization waiver.* The Director, TRICARE Management Activity or designee may waive the requirement for a written authorization for rendered ECHO benefits that, except for the absence of the written authorization, would be allowable as an ECHO benefit.

(v) *Public facility use.* (A) An ECHO beneficiary residing within a state must demonstrate that a public facility is not available and adequate to meet the needs of their qualifying condition. Such requirement shall apply to beneficiaries who request authorization for training, rehabilitation, special education, assistive technology, and institutional care in private nonprofit, public, and state institutions and facilities, and if appropriate, transportation to and from such institutions and facilities. The maximum Government cost-share for services that require demonstration of pubic facility non-availability or inadequacy is limited to $2,500 per month per beneficiary. State-administered plans for medical assistance under Title XIX of the Social Security Act (Medicaid) are not considered available and adequate facilities for the purpose of this section.

(B) The domicile of the beneficiary shall be the basis for the determination of public facility availability when the sponsor and beneficiary are separately domiciled due to the sponsor's move to a new permanent duty station or due to legal custody requirements.

(C) Written certification, in accordance with information requirements, formats, and procedures established by the Director, TRICARE Management Activity or designee that requested ECHO services or items cannot be obtained from public facilities because the services or items are not available and adequate, is a prerequisite for ECHO benefit payment for training, rehabilitation, special education, assistive technology, and institutional care in private nonprofit, public, and state institutions and facilities, and if appropriate, transportation to and from such institutions and facilities.

(*1*) An administrator or designee of a public facility may make such certification for a beneficiary residing within the service area of that public facility.

(*2*) The Director, TRICARE Management Activity or designee may determine, on a case-by-case basis, that apparent public facility availability or adequacy for a requested type of service or item cannot be substantiated for a specific beneficiary's request for ECHO benefits and therefore is not available.

(*i*) A case-specific determination shall be based upon a written statement by the beneficiary (or sponsor or guardian acting on behalf of the beneficiary) which details the circumstances wherein a specific individual representing a specific public facility refused to provide a public facility use certification, and such other information as the Director, TRICARE Management Activity or designee determines to be material to the determination.

(*ii*) A case-specific determination of public facility availability by the Director, TRICARE Management Activity or designee is conclusive and is not appealable under § 199.10.

(4) Repair or maintenance of beneficiary owned durable equipment and durable medical equipment is exempt from the public facility use certification requirements.

(5) The requirements of this paragraph (i)(4)(v) notwithstanding, no public facility use certification is required for services and items that are provided under Part C of the Individuals with Disabilities Education Act in accordance with the Individual Family Services Plan and that are otherwise allowable under the ECHO.

(i) *Implementing instructions.* The Director, TRICARE Management Activity or designee shall issue TRICARE policies, instructions, procedures, guidelines, standards, and criteria as may be necessary to implement the intent of this section.

(j) *Implementation transition.* Pending administrative actions necessary for the effective implementation of this section on or after July 1, 2004, this section, as it existed prior to July 1, 2004, shall remain in effect. The dates on or after July 1, 2004, on which this section will be implemented in particular regions of the United States and elsewhere will be established by **Federal Register** notice(s) during 2004.

■ 6. Section 199.6 is amended by revising the section heading and paragraphs (e)(1)(ii), (e)(2) and (e)(3) to read as follows:

**§ 199.6 TRICARE—authorized providers.**

* * * * *

(e) * * *

(1) *General.* * * *

(ii) A Program for Persons with Disabilities (PFPWD) provider with TRICARE-authorized status on the effective date for the Extended Care Health Option (ECHO) Program shall be deemed to be a TRICARE-authorized provider until the expiration of all outstanding PFPWD benefit authorizations for services or items being rendered by the provider.

(2) *ECHO provider categories.* (i) *ECHO inpatient care provider.* A provider of residential institutional care, which is otherwise an ECHO benefit, shall be:

(A) A not-for-profit entity or a public facility; and

(B) Located within a state; and

(C) Be certified as eligible for Medicaid payment in accordance with a state plan for medical assistance under Title XIX of the Social Security Act (Medicaid) as a Medicaid Nursing Facility, or Intermediate Care Facility for the Mentally Retarded, or be a TRICARE-authorized institutional provider as defined in paragraph (b) of this section, or be approved by a state educational agency as a training institution.

(ii) *ECHO outpatient care provider.* A provider of ECHO outpatient, ambulatory, or in-home services shall be:

(A) A TRICARE-authorized provider of services as defined in this section; or

(B) An individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as an ECHO benefit and not otherwise allowable as a benefit of § 199.4, that meets all applicable licensing or other regulatory requirements of the state, county, municipality, or other political jurisdiction in which the ECHO service is rendered, or in the absence of such licensing or regulatory requirements, as determined by the Director, TRICARE Management Activity or designee.

(iii) *ECHO vendor.* A provider of an allowable ECHO item, such as supplies or equipment, shall be deemed to be a TRICARE-authorized vendor for the provision of the specific item, supply or equipment when the vendor supplies such information as the Director, TRICARE Management Activity or

designee determines necessary to adjudicate a specific claim.

(3) *ECHO provider exclusion or suspension.* A provider of ECHO services or items may be excluded or suspended for a pattern of discrimination on the basis of disability. Such exclusion or suspension shall be accomplished according to the provisions of § 199.9.

* * * * *

■ 7. Section 199.7 is amended by revising paragraphs (a)(2) and (b)(2)(xii) to read as follows:

**§ 199.7 Claims submission, review, and payment.**

(a) * * *

(2) *Claim required.* No benefit may be extended under the Basic Program or Extended Care Health Option (ECHO) Program without submission of an appropriate, complete and properly executed claim form.

* * * * *

(b) * * *

(2) * * *

(xii) *Other authorized providers.* For items from other authorized providers (such as medical supplies), an explanation as to the medical need must be attached to the appropriate claim form. For purchases of durable equipment and durable medical equipment under the ECHO, it is necessary also to attach a copy of the preauthorization.

* * * * *

■ 8. Section 199.8 is amended by revising paragraphs (d)(4) and (d)(5) to read as follows:

**§ 199.8 Double coverage.**

* * * * *

(d) * * *

(4) *Extended Care Health Option (ECHO).* For those services or supplies that require use of public facilities, an ECHO eligible beneficiary (or sponsor or guardian acting on behalf of the beneficiary) does not have the option of waiving the full use of public facilities which are determined by the Director, TRICARE Management Activity or designee to be available and adequate to meet a disability related need for which an ECHO benefit was requested. Benefits eligible for payment under a state plan for medical assistance under Title XIX of the Social Security Act (Medicaid) are never considered to be available in the adjudication of ECHO benefits.

(5) *Primary payer.* The requirements of paragraph (d)(4) of this section notwithstanding, TRICARE is primary payer for services and items that are provided in accordance with the Individualized Family Service Plan as required by Part C of the Individuals with Disabilities Education Act and that are medically or psychologically necessary and otherwise allowable under the TRICARE Basic Program or the Extended Care Health Option.

* * * * *

■ 9. Section 199.20 is amended by revising paragraph (p)(2)(i) to read as follows:

**§ 199.20 Continued Health Care Benefits Program (CHCBP).**

* * * * *

(p) * * *

(2) * * *

(i) The Extended Care Health Option (ECHO) under § 199.5.

* * * * *

■ 10. Appendix A to part 199 is amended by adding the term ''ECHO'' and removing the term ''PFPWD'' to read as follows:

**Appendix A to Part 199—Acronyms**

* * * * *

ECHO—Extended Care Health Option

* * * * *

Dated: July 20, 2004.

**L.M. Bynum,**

*Alternate OSD Federal Register Liaison Officer, Department of Defense.*

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## DEPARTMENT OF HOMELAND SECURITY

### Coast Guard

### 33 CFR Part 151

**[USCG–2003–14273]**

**RIN 1625–AA52**

## Mandatory Ballast Water Management Program for U.S. Waters

**AGENCY:** Coast Guard, DHS.

**ACTION:** Final rule.

**SUMMARY:** The Coast Guard is requiring mandatory ballast water management practices for all vessels equipped with ballast water tanks bound for ports or places within the U.S. or entering U.S. waters. This rule will increase the Coast Guard's ability to protect U.S. waters against the unintentional introduction of nonindigenous species via ballast water discharges, which have had significant impacts on the nation's marine and freshwater resources, biological diversity, and coastal infrastructure. It will also comply with the requirements of the Nonindigenous Aquatic Nuisance Prevention and Control Act of 1990 and the National Invasive Species Act of 1996. The Great Lakes ballast water management program remains unchanged.

**DATES:** This final rule is effective September 27, 2004.

**ADDRESSES:** Comments and material received from the public, as well as documents mentioned in this preamble as being available in the docket, are part of docket USCG–2003–14273 and are available for inspection or copying at the Docket Management Facility, U.S. Department of Transportation, room PL–401, 400 Seventh Street SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. You may also find this docket on the Internet at *http://dms.dot.gov.*

**FOR FURTHER INFORMATION CONTACT:** If you have questions on this rule, call Mr. Bivan R. Patnaik, Project Manager, Environmental Standards Division, Coast Guard, telephone 202–267–1744, e-mail: *bpatnaik@comdt.uscg.mil.* If you have questions on viewing the docket, call Andrea M. Jenkins, Program Manager, Docket Operations, telephone 202–366–0271.

**SUPPLEMENTARY INFORMATION:**

### Legislative and Regulatory History

The Nonindigenous Aquatic Nuisance Prevention and Control Act of 1990 (NANPCA) [Pub. L. 101–646], enacted by Congress on November 29, 1990, established the Coast Guard's regulatory jurisdiction over ballast water management (BWM). To fulfill the directives of NANPCA, the Coast Guard published a final rule on April 8, 1993, titled ''Ballast Water Management for Vessels Entering the Great Lakes'' in the **Federal Register** (58 FR 18330). This rule established mandatory BWM procedures for vessels entering the Great Lakes in 33 CFR part 151, subpart C.

A subsequent final rule titled ''Ballast Water Management for Vessels Entering the Hudson River'' was published on December 30, 1994, in the **Federal Register** (59 FR 67632). This final rule amended 33 CFR part 151 to extend the BWM requirements into portions of the Hudson River.

The National Invasive Species Act (NISA) [Pub. L. 104–332] enacted by Congress on October 26, 1996, reauthorized and amended NANPCA. NISA reemphasized the significant role of ships' ballast water in the introduction and spread of nonindigenous species (NIS). NISA authorized the Coast Guard to develop a voluntary national BWM program and mandated the submission of reporting forms without penalty provisions. On