DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

RIN 0720–AA37

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); TRICARE Program; Reimbursement

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: This final rule revises certain requirements and procedures for reimbursement under the CHAMPUS program, the purpose of which is to implement a comprehensive managed health care delivery system composed of military medical treatment facilities and CHAMPUS. Issues addressed in this rule include: implementation of changes made to the Medicare Prospective Payment System (PPS) upon which the CHAMPUS DRG-based payment system is modeled and required by law to follow wherever practicable, along with changes to make our DRG-based payment system operate better; clarification of payment reduction for noncompliance with required utilization review procedures; clarification of publication of list of ambulatory surgery procedures; limitation on ambulatory surgery group payment rates; extension of the balance billing limitations currently in place for individual and professional providers to non-institutional, non-professional providers; adjustment of the CHAMPUS maximum allowable charge (CMAC) rate in the small number of cases where the CMAC rate is less than the Medicare rate; implementation of the government-wide debarment rule where any provider excluded or suspended from CHAMPUS shall be excluded from all other programs and activities involving Federal financial assistance, such as Medicare or Medicaid; elimination of the requirement for non-participating providers to file claims; and revision of the ambulatory surgery cost-share information to enable the cost-share to be assessed against the facility claim instead of the primary surgeon's claim.

DATES: This rule is effective October 13, 1998, except amendments to:

1. § 199.6, is effective October 1, 1997;
2. § 199.14(h) introductory text, effective January 1, 1999;
3. § 199.15, Paragraph (c)(2), effective July 11, 1995;
4. § 199.15, Paragraph (b)(4)(iii)(B), effective October 1, 1996.

ADDRESSES: Tricare Management Activity, (TMA), Program Development Branch, Aurora, CO 80045–6900.

FOR FURTHER INFORMATION CONTACT: Kathleen Larkin, Office of the Assistant Secretary of Defense (Health Affairs)/ TRICARE Management Activity, telephone (703) 681–1745.

Questions regarding payment of specific claims under the CHAMPUS allowable charge method should be addressed to the appropriate TRICARE/ CHAMPUS contractor.

SUPPLEMENTARY INFORMATION:

I. Introduction and Background

A. Congressional Action

The National Defense Authorization Act for 1984 provided CHAMPUS with a statutory linkage to the Medicare Prospective Payment System, upon which the CHAMPUS diagnosis-related group (DRG) based payment system is modeled and required by law to follow whenever practicable.

In response to the rapid escalation of CHAMPUS costs in the 1980s, the Congress urged DoD, beginning with the Appropriations Act for Fiscal Year 1991 that physician payments under CHAMPUS be brought in line with payments under Medicare.

The National Defense Authorization Act for 1996, section 731, extended the balance billing limit authority to non-institutional, non-professional providers.

Section 2455 of the Federal Acquisition Streamlining Act of 1994, and Executive Order 12549, ''Debarment and Suspension from Federal Financial and Nonfinancial Assistance Programs,'' February 18, 1986, require that any entity debarred, suspended or otherwise excluded under any program or activity involving Federal financial assistance shall also be debarred, suspended or otherwise excluded from all other programs and activities involving Federal financial assistance.

B. Public Comments

The proposed rule was published in the **Federal Register** on November 14, 1997. We received three comment letters. We thank those who provided comments; specific matters raised by commenters are summarized below in the appropriate sections of the preamble.

II. Provisions of the Rule

A. Proposed Changes to the CHAMPUS DRG–Based Payment System

1. Heart and Liver Transplants (revisions to § 199.14(a)(1)(ii)(C)(*2*),(*3*) and (*4*))

Provisions of the Proposed Rule. This paragraph explains that when we first implemented the CHAMPUS DRG-based payment system in 1987, we exempted all services related to heart and liver transplantation. Although both of these types of transplants are subject to the Medicare PPS, we initially exempted them because at that time we had limited experience and claims data for them. We believed these limitations could significantly skew the relative weights we would calculate for such transplants.

Since 1987 we have continued to collect data on these services. From the beginning, heart transplants were grouped to DRG 103 and exempted. For Fiscal Year 1991 the Health Care Financing Administration (HCFA) created DRG 480 for liver transplants, but we continued to exempt them.

In our notice of updated rates and weights for Fiscal Year 1991, which was published on November 5, 1990 (55 FR 46545), we noted that we intended to consider including both heart and liver transplants in our DRG system in the future, and we invited any comments in that regard. We received none.

Since we have enough claims data to calculate accurate weights for these transplants, we proposed to end the DRG exemption for all CHAMPUS covered solid organ transplants for which there is an assigned DRG and enough data to calculate the DRG weight. Just as Medicare does, we will continue to exempt acquisition costs for all CHAMPUS covered solid organ transplants.

Analysis of Major Public Comments. One commenter objected to the provisions of the proposed rule in the belief that DRG weights for the CHAMPUS program would be inappropriate for pediatric transplant services.

Response. Our analysis of recent data indicates that both the average lengths of stay and average billed charges are higher for pediatric liver transplants, but both measures are lower for pediatric heart transplants. Thus, given that the number of cases is sufficiently large and that differences between pediatric and non-pediatric cases are not significant, it seems reasonable to calculate combined pediatric and non-pediatric DRG weights for heart and liver transplants.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

2. Payment Requests for Capital and Direct Medical Education Costs (Revisions to § 199.14(a)(1)(iii)(G)(*3*))

Provisions of the Proposed Rule. Initially we required that hospitals submit their request for payment of capital and direct medical education

costs within three months of the end of the hospital's Medicare cost-reporting period. However, some hospitals encountered difficulties in meeting this deadline, because HCFA implemented changes which resulted in extensions to the filing deadline. Therefore, we often did not enforce our deadline, and as of October 1988 we eliminated the requirement entirely.

We eliminated the requirement because we believed hospitals would submit their requests at the earliest possible time anyway. Also, we believed there would be no adverse impact on CHAMPUS. Neither of these has proven to be correct. We continually receive these requests well after the end of the Medicare cost-reporting period—in some cases several years later. As a result, it is necessary for our contractors to retain claims data in their systems indefinitely, so that they can verify the reported amounts when the requests are submitted. This is proving to be a very burdensome and costly requirement for our contractors.

On June 27, 1995, HCFA published a final rule (60 FR 33137) extending the time frame providers have to file cost reports from no later than 3 months after the close of the period covered by the report to no later than 5 months after the close of that period. The rule also changed the regulations for granting extensions to providers. Under the new regulation, an extension may be granted by the intermediary only when a provider's operations were significantly adversely affected due to extraordinary circumstances over which the provider had no control, such as flood or fire. We proposed to adopt these same requirements for submitting requests for payment of capital and direct medical education costs with CHAMPUS.

Currently, CHAMPUS has no deadline, other than the six year statute of limitations, for submitting payment requests for Medicare cost-reporting periods. In order to allow us to close out our data for these periods, we proposed that any capital and direct medical education payment requests that fall within the six year statute of limitations and October 1, 1998, must be submitted to the appropriate CHAMPUS contractor no later than 5 months after October 1, 1998.

In addition, since capital and direct medical education costs are included in the national children's hospital differential, we proposed to eliminate the clause allowing children's hospitals to request reimbursement of capital and direct medical education costs as an alternative to being paid the national differential.

Analysis of Major Public Comments. We received two comments with respect to the time frame prescribed for requesting payment of capital and direct medical education. One commenter suggested we adopt a one year deadline from the end of the cost reporting period to file information necessary to the initial payment of capital and direct medical education costs. Another commenter suggested we allow a six month period after the close of the fiscal year to submit cost reports, and, since capital and direct medical education costs are included in the national children's hospital differential, requested the differential factor be updated annually with cost report information. The commenter also suggested that the payments come directly to hospitals and not be passed through the TRICARE Managed Care Support contractors.

Response. With respect to the timeframe to submit capital and direct medical education costs, we agree that a one year deadline is appropriate. We disagree with an annual update to the national children's hospital differential since it is designed to reflect the historical relationship of children's hospitals to DRG reimbursed institutional facilities. We also disagree with the suggestion that payments not be passed through our TRICARE managed care support contractors. It is in the Government's interest to continue to use our regional managed care support contractors to process these payments because they provide economies of scale for claims processing and are acting as the government's fiscal agents in these cases.

Provisions of the Final Rule. The final rule includes a one year timeframe to submit capital and direct medical education costs.

3. Indirect Medical Education Adjustment Factor (Revisions to § 199.14(a)(1)(iii)(A)(*3*), (a)(1)(iii)(D)(*2*), and (a)(1)(iii)(E)(*3*)(*i*), (*ii*), (*iii*), (*iv*), and (*v*))

Provisions of the Proposed Rule. An indirect medical education (IDME) adjustment factor is calculated for all hospitals which have teaching programs approved under the Medicare regulation. This factor is calculated using a formula developed by HCFA (see our previous final rules for a discussion of the application of this formula to CHAMPUS), and is based on the number of interns and residents and the number of beds in the hospital. Each DRG-based payment is increased by this factor for that hospital.

Initially, the number of residents and interns for each hospital was derived from the most recently available audited HCFA cost report, and the number of beds was derived from the American Hospital Association Annual Survey of Hospitals. The factors have been updated annually based on data submitted by hospitals on the annual request for payment of capital and direct medical education costs.

While this updating procedure ensures that hospitals' factors are as current as possible, it is dependent upon the hospitals' submission of requests for payment of capital and direct medical education costs. Since the crucial components (number of interns, residents and beds) can change from year to year, and since many hospitals do not submit requests for payment of capital and direct medical education costs, we believe it is necessary to establish an alternative updating method.

We proposed to use the Medicare adjustment factor for any hospital for which a CHAMPUS-specific factor has not been calculated based on the hospital's request for payment of capital and direct medical education costs. We will update the factors using the Medicare amounts as of October 1 of each year when we routinely update the DRG rates and weights. Any hospital which has not submitted a capital and direct medical education payment request to CHAMPUS since the previous October 1, will be assigned the most recent Medicare adjustment factor.

HCFA uses a slightly different formula than that used by CHAMPUS, and we are aware that this will result in a different adjustment factor than would otherwise be used. Nevertheless, we believe this is justified. When the Medicare factor is used, the difference is likely to be small. In addition, CHAMPUS accounts for a very small portion of most hospitals' claims, and those hospitals which do not request payment of capital and direct medical education costs probably have few, if any, CHAMPUS admissions. Therefore, the financial impact of using the Medicare factor will be negligible. Yet it will ensure that the factors are kept current, so that factors which are no longer representative of a hospital's teaching program are not used indefinitely. And, of course, hospitals can ensure that a CHAMPUS-specific factor is used simply by submitting a request for payment of capital and direct medical education costs.

For hospitals which have indirect medical education factors for CHAMPUS but are not subject to the Medicare PPS, we will eliminate the factor if a CHAMPUS-specific factor cannot be calculated based on a current

request from the hospital for payment of capital and direct medical education costs. The factor will be eliminated as of October 1 if no capital and direct medical education payment request has been received since the previous October 1.

In any case where a hospital submits a capital and direct medical education payment request after the Medicare factor has been implemented (or the factor has been eliminated for hospitals not subject to the Medicare PPS, including children's hospitals), the CHAMPUS-specific factor will become effective in accordance with existing requirements. In no case will the CHAMPUS-specific factor be effective retroactively.

For children's hospitals which have indirect medical education factors for CHAMPUS, the factor will be eliminated as of October 1 of each year if during the past year, the hospital did not provide the contractor with updated information on the number of its interns, residents and beds. Since amounts for capital and direct medical education are included in the national children's hospital differential, children's hospitals are not required to submit capital and direct medical education payment requests. Because of this, the contractor is not able to update the CHAMPUS-specific factor unless requested by the children's hospital.

For Fiscal Year 1998, HCFA revised its indirect medical education adjustment formula to gradually reduce the current level of IDME adjustment over the next several years. Since the IDME formula used by CHAMPUS does not include disproportionate share hospitals (DSHs), the variables in the formula are different from Medicare's, however, the percentage reductions that will be applied to Medicare's formula are being adopted by CHAMPUS.

Analysis of Major Public Comments. One commenter suggested that supplemental payments for indirect medical education be continued under CHAMPUS since current Medicare proposed reductions are appropriate for adult populations but children's hospitals would be harmed, therefore they suggested that the percentage reductions implied by the Medicare formula be removed in application to children's hospitals.

Response. We disagree. We believe the incentives associated with the existing IME adjustments are contrary to the Administration's policy of decreasing the number of residents trained in the United States, increasing the relative number of residents trained in primary care, and encouraging more training in nonhospital-based sites thus it is appropriate for CHAMPUS to adopt the Medicare formula.

Provisions of the Final Rule. In our November 14, 1997, proposed rule, we proposed an alternative updating method for the indirect medical education (IDME) adjustment factor. For those hospitals for which a CHAMPUS-specific factor has not been calculated based on the hospital's request for payment of capital and direct medical education costs, we proposed to use the Medicare adjustment factor, if said hospital was subject to the Medicare Prospective Payment System (PPS). We stated HCFA uses a slightly different formula than that used by CHAMPUS, and we were aware this would result in a different adjustment factor than would otherwise be used, however, we believed the difference was likely to be small.

In reassessing the proposed alternative method, we felt it would be more equitable to use the ratio of interns and residents to beds, which is a component of the IDME formula, from HCFA's Provider Specific File (PSF), rather than use Medicare's IDME adjustment factor. The ratio of interns and residents to beds will be provided to the contractors to update each hospital's IDME adjustment factor at the same time we routinely update the DRG rates and weights. The Provider Specific File is sent to us by HCFA each year for use in calculating the updated DRG rates and weights.

This method will be used beginning with the Fiscal Year 1999 DRG update. If after October 1, 1998, the contractor receives a request for payment of capital and direct medical education costs, they shall only change the ratio of interns and residents to beds if the request for payment is for a hospital's cost reporting period ending prior to October 1, 1998. The only other time a hospital's IDME adjustment factor should be changed is if the ratio of interns and residents to beds changes as a result of a Medicare audit. This alternative method shall only apply to those hospitals subject to the Medicare PPS.

For hospitals which have indirect medical education factors for CHAMPUS but are not subject to the Medicare PPS, including children's hospitals, the contractor shall send a notice each August to those hospitals who have not provided the contractor with updated information on the number of its interns, residents and beds, since the previous October 1, and advise them the IDME factor will be eliminated if they fail to provide the contractor with updated information by October 1 of that same year. We anticipate the first notices to be sent in August of 1998.

Based on the above, we are removing the information contained in the proposed rule regarding the alternative updating method for the IDME adjustment factor. Since 32 CFR 199.14 already specifies the DRG payment is to be adjusted for IDME costs, any additional information regarding updating the IDME factor can be obtained from the contractor. This change does not affect the adoption of the percentage reductions being applied to the CHAMPUS IDME formula to gradually reduce the current level of IDME adjustment over the next several years.

4. Length of Stay Outliers (Revisions to 32 CFR 199.14((a)(1)(iii)(E)(*1*)(*i*)(*A*) and (*B*))

Provisions of the Proposed Rule. For Fiscal Year 1998, HCFA eliminated payment for day outliers, referred to as long stay outliers under CHAMPUS. CHAMPUS also eliminated long stay outliers for all cases except children's hospitals and neonates for Fiscal Year 1998. We proposed to eliminate the long stay outliers for children's hospitals and neonates for Fiscal Year 1999. For Fiscal Year 1993, HCFA changed the payment procedures for day outlier per diems under the PPS. Prior to this change, the day outlier per diem was calculated using the DRGs geometric mean length of stay and a marginal payment factor of 60 percent. For discharge occurring on or after October 1, 1992, HCFA revised the day outlier payment policy to reflect that the per diem payment would be calculated using the arithmetic mean and a marginal payment factor of 55 percent. This meant that the per diem day outlier payment under the PPS for operating costs would be determined by dividing the standard DRG payment by the arithmetic mean length of stay for that DRG, and multiplying the result by 55 percent. The change in the payment policy for day outliers provided better protection against costly cases for hospitals, while maintaining a more appropriate level of payment for cases with extraordinary long lengths of stay that were not also extraordinarily costly.

CHAMPUS did not adopt the PPS per diem day outlier changes at that time because it required a regulatory change and there was a moratorium on publication of rules. Over the years, HCFA has reduced the marginal payment factor for day outliers from 55 percent to 47 percent to 44 percent, to 33 percent, to the point of eliminating payment of day outliers, effective with discharges occurring after September 30, 1997. CHAMPUS adopted the day

outlier marginal payment factor of 47 percent for Fiscal Year 1995, 44 percent for Fiscal Year 1996, and 33 percent for Fiscal Year 1997, but has not adopted the arithmetic mean to calculate the per diem payment. As a result, CHAMPUS has been paying more than Medicare on claims qualifying for long-stay day outliers. Although we eliminate the long stay outliers for all cases except children's hospitals and neonates for Fiscal Year 1998, and proposed to eliminate the long stay outliers for them in Fiscal Year 1999, we still proposed to adopt the arithmetic mean to calculate the per diem, in order to be consistent with the Medicare PPS in calculating payments of outlier cases.

Analysis of Major Public Comments. One commenter recommended that children's hospitals' outlier cases be exempt from the 100-day Medicare cap because children, unlike elderly adults in long stay cases are almost never discharged to nursing home care from the hospital.

Response. CHAMPUS does not apply the 100 day Medicare cap to any cases, therefore the comment is not applicable.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

5. Cost Outliers (Revisions to 32 CFR 199.14(a)(1)(iii)(E)(*1*)(*ii*) (*A*) and (*B*))

Provisions of the Proposed Rule. Beginning in Fiscal Year 1998, HCFA adopted a requirement that in determining the additional payment for IME (referred to as IDME under CHAMPUS), the IME adjustment factor will only be applied to the base DRG payment. In addition, the fixed loss cost outlier threshold is based on the sum of the DRG payment plus IME plus a fixed dollar amount. CHAMPUS adopted this requirement in Fiscal Year 1998 for all cases except children's hospitals and neonates. We proposed to adopt this same requirement for children's hospitals and neonates in Fiscal Year 1999.

Analysis of Major Public Comments. One commenter was concerned that this policy is not budget neutral, there is no special per diem for neonates, and that Children's hospitals are not exempt from the 100-day Medicare cap. The commenter suggested that the 1998 HCFA-adopted requirement be implemented in a budget neutral fashion. We agree and we plan to establish an outlier ratio designed to be budget neutral.

Provisions of the Final Rule. Effective October 1, 1998, Children's hospitals will have their cost outlier payments adjusted so that these payments are budget neutral with the FY94 outlier policies for children's hospitals. The Department will calculate an adjustment factor which will be applied to all cost outlier payments in FY99 and thereafter. This adjustment factor will be applied equally to the cost outlier payments for all Children's hospitals. The adjustment factor will be equal to the ratio of CHAMPUS outlier payments using the FY94 CHAMPUS long stay and cost outlier payment methods to the CHAMPUS outlier payment methods using the FY99 cost outlier payment methods. We will calculate this ratio in late FY98 once the CHAMPUS FY99 cost outlier payment policy has been determined. The ratio will be calculated using CHAMPUS claims data from the Children's hospitals in FY95 and FY96. In order to ensure that budget neutrality is achieved with this ratio, the Department will monitor outlier payments and recalculate the ratio of payments under the FY94 outlier policies to actual outlier payments in FY99 using actual cost outlier cases at Children's hospitals in FY99. This calculation will be done in FY 2000. If the ratio has changed significantly, a new ratio will be used to pay Children's hospital outlier cases in FY 2001 and thereafter. The final rule has been modified to reflect these adjustment procedures.

6. Payment for Transfer Cases (Revisions to 32 CFR 199.14(a)(1)(i)(C)(*6*)(*iv*))

Provisions of the Proposed Rule. Beginning in Fiscal Year 1996, HCFA adopted a graduated per diem payment methodology for transfer cases. As of October 1, 1996, CHAMPUS adopted this payment methodology; however, we elected not to offset these additional payments with reductions in outlier payments. Using this payment methodology, CHAMPUS proposed to pay transferring hospitals twice the per diem amount for the first day of any transfer stay plus the per diem amount for each of the remaining days before transfer, up to the full DRG amount. For neonatal cases, other than normal newborns, we proposed paying the transferring hospital twice the per diem amount for the first day of any transfer stay plus 125 percent of the per diem rate for all remaining days before transfer, up to the full DRG amount. This change allows hospitals to be compensated more appropriately for the treatment they furnish to patients before transfer. We proposed continuing to pay transferring hospitals in full for discharges classified into DRG 456 (burns, transferred to another acute care facility or DRG 601 (neonate, transferred less or equal to 4 days old).

Analysis of Major Public Comments. One commenter suggested a higher reimbursement rate of 150 percent for days after the first day for Children's hospitals suggesting that their costs were higher.

Response. We were unable to determine any differences between Children's hospitals and other hospitals in this regard. Thus we have not changed the reimbursement rate.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

7. Elimination of Separate Adjusted Standardized Amounts for Rural Areas (Revision to 32 CFR 199.14(a)(1)(iii)(D)(*1*) and (*5*))

Provisions of the Proposed Rule. Beginning in Fiscal Year 1995, HCFA's average standardized amounts for hospitals located in ''rural'' areas were required to be equal to the average standardized amount for hospitals located in ''other urban'' areas. Based on this, separate national average standardized amounts for ''other urban'' and ''rural'' areas no longer existed. As of Fiscal Year 1995, CHAMPUS no longer differentiated between ''other urban'' and ''rural'' areas. We proposed that the adjusted standardized amounts for ''other urban'' and ''rural'' areas be listed as ''other'' areas.

Analysis of Major Public Comments. No comments were received.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

8. Payment for Blood Clotting Factor (Revisions to 32 CFR Section 199.14(a)(1)(ii)(C)(*10*))

Provisions of the Proposed Rule. For Fiscal Year 1994, HCFA reinstated payments for the cost of administering blood clotting factor to beneficiaries who have hemophilia through discharges occurring before October 1, 1994. CHAMPUS also reinstated payments for the cost of administering blood clotting factor through discharges occurring before October 1, 1994. For Fiscal Year 1998, HCFA again reinstated payments for the cost of administering blood clotting factor. CHAMPUS also proposed to reinstate payments for discharges occurring on or after October 1, 1997.

Analysis of Major Public Comments. No comments were received.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

9. Effect of Change of Ownership on Exclusion of Long-Term Care Hospitals (Revisions to 32 CFR 199.14(a)(1)(ii)(D)(*4*))

Provisions of the Proposed Rule. Beginning in Fiscal Year 1996, HCFA adopted new requirements for certain long-term care hospitals excluded from the PPS. The requirements specify that if a hospital undergoes a change of ownership at the start of a cost reporting period or at any time within the preceding 6 months, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare. CHAMPUS proposed to adopt these new requirements beginning in Fiscal Year 1996.

Analysis of Major Public Comments. No comments were received.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

10. Empty and Low-Volume DRGs (Revision to 32 CFR 199.14(a)(1)(iii)(B))

Provisions of the Proposed Rule. Currently, 32 CFR 199.14(a)(1)(iii)(B) specifies that the Medicare weight shall be used for any DRG with less then 10 occurrences in the CHAMPUS database. Since the CHAMPUS weights are used by military treatment facilities and by an increasingly large number of state Medicaid programs, the direct substitution of the Medicare weight for the CHAMPUS weight, causes inconsistencies. These inconsistencies may pose more of a problem for other payors than it does for CHAMPUS, particularly if they have more cases in the DRG categories where the substitutions have occurred. Because of these inconsistencies, we proposed that the Director, TRICARE Management Activity, or designee, has the authority to consider alternative methods for estimating CHAMPUS weights in these low-volume DRG categories.

Analysis of Major Public Comments. No comments were received.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

11. Hospitals Within Hospitals (Revisions to 32 CFR 199.14(a)(1)(ii)(D)(*5*))

Provisions of the Proposed Rule. For Fiscal Year 1998, HCFA established additional criteria for excluding from the PPS, long-term care hospitals that occupy space in the same building or on the same campus as another hospital, sometimes called ''hospitals within hospitals''. The additional criteria extends the hospital within hospital criteria to excluded hospitals other than long-term care hospitals. CHAMPUS proposed to adopt these requirements beginning in Fiscal Year 1998.

Analysis of Major Public Comments. No comments were received.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

B. Proposed Changes Regarding Elimination of Physician Attestation Requirement (Revision to 32 CFR 199.15(c)(2))

Provisions of the Proposed Rule. On September 1, 1995, Medicare eliminated the requirement for the physician attestation form that requires doctors to certify the accuracy of all diagnoses and procedures before submitting claims for payment. In addition, instead of requiring a physician to sign an acknowledge statement every year, Medicare changed its regulations to require a physician need only sign the acknowledgment statement upon receiving admitting privileges at a hospital. CHAMPUS proposed to adopt these requirements effective the same date.

Analysis of Major Public Comments. One commenter appreciated DoD's elimination of the annual physician attestation policy.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

C. Proposed Changes Regarding Clarification of Payment Reduction for Noncompliance With Required Utilization Review Procedures (revision to 32 CFR 199.15(b)(4)(iii)(B))

Provisions of the Proposed Rule. To cover those situations where network providers have agreements with the managed care contractors for denial of payments of the provider's failure to obtain the required preauthorization, we are proposing to add the words ''at least'' before the words ''ten percent''. By adding the words ''at least'', the managed care support contractor is authorized to apply reductions in payments in accordance with the network provider's contract.

Analysis of Major Public Comments. No comments were received.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

D. Clarification Regarding List of Ambulatory Surgery Procedures

Provisions of the Proposed Rule. On October 1, 1993, we published a final rule (58 FR 51227) which included prospective payment procedures for ambulatory surgery. These procedures were modeled on the Medicare methodology. In that final rule, we stated that ''A list of ambulatory surgery procedures will appear as Attachment 2 (to be published later) to this preamble.'' We subsequently published the list of procedures on October 15, 1993, (58 FR 53411).

The list of procedures published on October 15, 1993, was not made part of the Code of Federal Regulations (CFR) at that time, and it was not, and continues not to be, our intention that it be part of the CFR. However, the final rule did not make this clear. We proposed that the list of procedures to be ''published periodically by the Director, OCHAMPUS,'' as cited in section 199.14 paragraph (d)(1), is contained in the TRICARE/CHAMPUS Policy Manual.

Analysis of Major Public Comments. No comments were received.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

E. Proposed Changes Regarding Limits on Ambulatory Surgery Group Payment Rates (Revisions to 32 CFR 199.14(d)(3)(iv))

Provisions of the Proposed Rule. Effective November 1, 1994, CHAMPUS identified a number of procedures which can be performed safely and effectively as ambulatory surgery and established prospective payment procedures for reimbursing these services. Ambulatory surgery often is less disruptive to the patient's life than an inpatient stay. It also provides a less expensive alternative to an inpatient stay, since the patient does not require a hospital room and all the costs associated with it. As a result, the OCHAMPUS wants to encourage the use of ambulatory surgery whenever it is reasonable, but we do not believe it ever should be more expensive than an inpatient stay. Therefore, we proposed to add a provision that gives discretion to the Director, TMA, to limit the ambulatory surgery group payment rate to the amount that would be allowed if the services were provided on an inpatient basis. To calculate the allowable inpatient amount we proposed multiplying the applicable DRG relative weight times the national large urban adjusted standardized amount (ASA). We proposed to use the large urban ASA rather than the ''other

area'' ASA because it is higher and will not economically disadvantage any provider, and we expect that most ambulatory surgery centers are located in large urban areas.

Analysis of Major Public Comments. No comments were received.

Provisions of the Final Rule. The final rule is consistent with the proposed rule. We want to clarify, however, that the CHAMPUS-determined inpatient allowable amount that serves as a limit on the ambulatory surgery group payment amounts includes adjustments for hospital wage indexes.

F. Proposed Changes Regarding Balance Billing (Revisions to 32 CFR 199.14(h))

Provisions of the Proposed Rule. Section 731 of the National Defense Authorization Act for Fiscal Year 1996, revised 10 U.S.C. 1079(h) which provides the statutory basis for limits on balance billing of CHAMPUS beneficiaries established in section 199.14(h)(1)(i)(D). Section 731 extends the balance billing limit authority to non-institutional, non-professional providers, such as clinical laboratories and ambulance companies.

We proposed that non-institutional, non-professional providers will be limited in the amount they may bill a TRICARE/CHAMPUS-eligible beneficiary an actual charge in excess of the allowable amount. This provides financial protection for our beneficiaries by preventing excessively high billing by providers by establishing the balance billing limit to these new categories of providers as the same percentage as that used for TRICARE/CHAMPUS professional providers: 115 percent of the allowable charge. In order to provide flexibility to continue CHAMPUS benefits in special circumstances in which a beneficiary may feel strongly about using a particular provider, notwithstanding high fees, we proposed that the limitation may be waived on a case-by-case basis.

Analysis of Major Public Comments. While noting that the proposed rule applied to non-institutional, non-professional providers, one commenter was opposed to across-the-board balance billing limits for physicians and called on the Department to articulate and publish criteria for allowing a waiver of the balance billing limits on a case-by-case basis.

Response. As we have stated in the past, we believe it is appropriate to protect beneficiaries against excessive balance billing. We have committed ourselves to monitoring carefully balance billing trends with an objective of assuring that a majority of claims in all localities for all procedures of appreciable volume have zero balance billing. Where this is not maintained, we are willing to maintain CHAMPUS payment rates a level higher than Medicare's. Based on our willingness to do this, we do not believe providers need to also maintain balance billing levels higher than Medicare, absent some special circumstance. As we have noted, in a special circumstance, the limitation can be waived if requested by the beneficiary. We do not have set criteria we use when evaluating and granting a waiver to our balance billing protections, rather each request is evaluated by the Director, TMA, based on the specific facts provided by a beneficiary.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

G. Proposed Changes Regarding CMAC Rates (Revisions to 32 CFR 199.14(h)(1)(iii)(D))

Provisions of the Proposed Rule. CHAMPUS policy, based on Congressional enactment, is to set CHAMPUS Maximum Allowable Charge (CMAC) rates comparable to Medicare rates. For almost all procedure codes, the CMAC rate has been reduced to equal the Medicare rate or is in the process of being phased down to that level. For a very small number of procedures, for unusual reasons or idiosyncrasies of the data used for calculations, however, the CMAC rate is less than the Medicare rate. We proposed to establish a special rule for these cases to permit an increase in the CMAC up to the Medicare rate. This is based on the authority of 10 U.S.C. 1079(h)(4), which allows for exceptions to the normal statutory payment limitation if DoD determines it necessary to assure that beneficiaries have adequate access to health care services. Because the Medicare rates are products of a system that reflects careful governmental judgments of factors suggesting fair payment rates, we proposed to adopt these rates as indicators of payment levels associated with adequate access. In addition, under the applicable Appropriations Act general provision, DoD may increase CMAC rates that are lower than Medicare rates by reference to appropriate economic index data similar to that used by Medicare. We have heretofore utilized only the Medicare Economic Index in this connection, but we proposed to adopt an additional Medicare indicator of economic factors, namely the data used for the Medicare fee determination, to adjust the rates in these special cases. This is set forth in the proposed new section 199.14(h)(1)(iii)(D).

Analysis of Major Public Comments. One commenter was pleased by the proposed change and suggested that we publish the list of procedures that will be increased to the Medicare rates. We agree and we have included the list at the end of the preamble.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

H. Proposed Changes Regarding Government-Wide Effect of Exclusion or Suspension From CHAMPUS (Revisions to 32 CFR 199.9(m))

Provisions of the Proposed Rule. Section 2455 of the Federal Acquisition Streamlining Act of 1994, Pub. L. 103–355, October 13, 1994, and Executive Order 12549, ''Debarment and Suspension from Federal Financial and Nonfinancial Assistance Programs,'' February 18, 1986, required that any entity debarred, suspended, or otherwise excluded under any program or activity involving Federal financial assistance shall also be debarred, suspended, or otherwise excluded from all other programs and activities involving Federal financial assistance. We are restating this requirement in the context specific to CHAMPUS through a proposed addition to section 199.9. The proposed addition provides that any health care provider excluded or suspended from CHAMPUS shall, as a general rule, also be debarred, suspended, or otherwise excluded from all other programs and activities involving the Federal financial assistance. Among these other such programs are Medicare and Medicaid. Other regulations related to this authority are 32 CFR Part 24 (DoD rules) and 45 CFR Part 76 (HHS rules).

In conjunction with implementation of this government-wide debarment rule, we are strengthening the linkage between CHAMPUS and these other programs on the important issue of balance billing by providers. Current regulations generally require providers to limit balancing billing to 15% greater than the CHAMPUS Maximum Allowable Charge (CMAC). These regulations also provide that violations are grounds for exclusion or suspension from CHAMPUS. We are proposing to reinforce these compliance provisions by adding a violation of this requirement to the list of provider actions that are considered abuse of the program for purposes of termination, suspension and other administrative remedies.

A principal effect of this proposed revision is that any provider who

exceeds the balance billing limits risks not only exclusion or suspension from CHAMPUS, but also exclusion or suspension from Medicare, Medicaid, and other Federal programs.

Analysis of Major Public Comments. One commenter suggested that CHAMPUS should require the same level of intent as is currently required for exclusion or suspension in the Medicare and Medicaid programs. They recommended that there be evidence that the physician ''knowingly and willfully'' failed to comply with CHAMPUS requirements.

Response. The comment is not pertinent to the proposed rule because the proposed rule does not make changes to our requirements in 32 CFR 199.6 which sets forth general policies and program requirements for authorized providers.

Provisions of the Final Rule. The final rule is consistent with the proposed rule.

I. Elimination of Mandatory Claims Filing Requirement (Revision to 32 CFR 199.6(a)(11))

This final rule conforms the CHAMPUS regulation to title 10, as revised by a provision of the National Defense Authorization Act for Fiscal Year 1998 that eliminated the requirement that all providers file claims on behalf of CHAMPUS beneficiaries.

J. Revision of Ambulatory Surgery Cost-Share Information (Revision to 32 CFR 199.18(d)(3)(v))

When a dependent of an active-duty member receives approved ambulatory surgery services, the cost-share is $25. This single cost-sharing amount covers the facility claim as well as any claims for professional (surgeon, anesthesia, etc.) services. In order to ensure consistency and for administrative ease, we have required that the $25 cost-share be assessed against the facility claim. When the regulation for the TRICARE uniform HMO benefit was published (32 CFR 199.18), that part inadvertently stated that the ambulatory surgery cost-share is to be assessed against the claim for the primary surgeon's services. Since this does not conform to established practices, we are revising this paragraph to enable the cost-share to be assessed against the facility claim. This will have no effect on either the collection or the amount of the cost-share.

III. Regulatory Procedures

Executive Order 12866 requires certain regulatory assessments for any ''significant regulatory action,'' defined as one which would result in an annual effect on the economy of $100 million or more, or 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 is not a significant regulatory action under the provisions of Executive Order 12866, and it would not have a significant impact on a substantial number of small entities.

Pursuant to the Paperwork Reduction Act of 1995, the reporting provisions of this rule have been submitted to OMB for review under 3507(d) of the Act.

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Office of the Assistant Secretary of Defense (Health Affairs) announces the collection of information to allow TRICARE to properly reimburse institutional providers based on diagnosis-related groups (DRGs) for their share of these costs. The collection of this information is authorized by 32 CFR 199.14(a)(1)(iii)(G)(*1*) and (*2*). The CHAMPUS DRG-based payment system is modeled on the Medicare Prospective Payment System (PPS) and was implemented on October 1, 1987.

Affected Public: Individuals; business or other for profit.

Annual Burden Hours: 5,532.

Number of Respondents: 5,400.

Responses per Respondent: 1.

Average Burden per Response: 5 minutes for physicians.

Frequency: On occasion.

Respondents are institutional providers and admitting physicians. Institutional providers are requesting reimbursement for allowed capital and direct medical education costs from the TRICARE/CHAMPUS contractor. The information can be submtited in any form, most likely in the form of a letter. The contractor will calculate the TRICARE/CHAMPUS share of capital and direct medical education costs and make a lump-sum payment to the hospital.

Physicians sign a physician acknowledgement, maintained by the institution, at the time the physician is granted admitting privileges. This acknowledgement indicates the physician understands the importance of a correct medical record, and misrepresentation may be subject to penalties.

List of Subjects in 32 CFR Part 199

Claims, Health insurance, Individuals with disability, Military personnel, Reporting and recordkeeping requirements.

Accordingly, 32 CFR Part 199 is amended 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.

§ 199.6 [Amended]

2. Section 199.6 is amended by removing paragraph (a)(11) and redesignating paragraph (a)(12) as (a)(11).

3. Section 199.9 is amended by adding new paragraph (m) to read as follows:

§ 199.9 Administrative remedies for fraud, abuse, and conflict of interest.

* * * * *

(m) *Government-wide effect of exclusion or suspension from CHAMPUS.* As provided by section 2455 of the Federal Acquisition Streamlining Act of 1994, Pub. L. 103–355, October 13 1994, and Executive Order 12549, ''Debarment and Suspension from Federal Financial and Nonfinancial Assistance Programs,'' February 18, 1986, any health care provider excluded or suspended from CHAMPUS under this section shall, as a general rule, also be debarred, suspended, or otherwise excluded from all other programs and activities involving Federal financial assistance. Among the other programs for which this debarment, suspension, or exclusion shall operate are the Medicare and Medicaid programs. This debarment, suspension, or termination requirement is subject to limited exceptions in the regulations governing the respective Federal programs affected. (Note: Other regulations related to this government-wide exclusion or suspension authority are 32 CFR Part 25 and 45 CFR Part 76.)

4. Section 199.14 is amended by revising first sentences of (a)(1) introductory text and (a)(1)(i)(C)(*6*)(*iv*), and by revising paragraphs (a)(1)(ii)(C)(*2*), (*3*), (*4*) and (10) first sentence, (a)(1)(ii)(D)(*4*), redesignating paragraphs (a)(1)(ii)(D)(*5*) through (a)(1)(ii)(D)(*8*) as (a)(1)(ii)(D)(*6*) through (a)(1)(ii)(D)(*9*), (a)(1)(iii)(B), (a)(1)(iii)(D)(*1*) first sentence and (*5*), (a)(1)(iii)(E)(*1*)(*i*)(*A*) and (*B*), (a)(1)(iii)(E)(1)(*ii*)(*A*) and (*B*), (a)(1)(iii)(G)(*3*) introductory text, (d)(3)(iv), and (h) introductory text, and

by adding a new sentence after the first sentence of paragraph (a)(1)(i)(C)(*6*)(*iv*), and by adding new paragraphs (a)(1)(ii)(D)(*5*), and (h)(1)(iii)(D), to read as follows:

§ 199.14 Provider reimbursement methods.

* * * * *

(a) * * *

(1) *CHAMPUS Diagnosis Related Group (DRG)-based payment system.* Under the CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively-determined rates and applied on a per discharge basis using DRGs. * * *

(i) * * *

(C) * * *

(*6*) * * *

(*iv*) *Payment to a hospital transferring an inpatient to another hospital.* If a hospital subject to the CHAMPUS DRG-based payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate (except that in neonatal cases, other than normal newborns, the hospital will be paid at 125 percent of that per diem rate), as determined under instructions issued by TSO, for each day of the patient's stay in that hospital, not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting. For admissions occurring on or after October 1, 1995, the transferring hospital shall be paid twice the per diem rate for the first day of any transfer stay, and the per diem amount for each subsequent day, up to the limit described in this paragraph.

* * * * *

(ii) * * *

(C) * * *

(*2*) All services related to solid organ acquisition for CHAMPUS covered transplants by CHAMPUS-authorized transplantation centers.

(*3*) All services related to heart and liver transplantation for admissions prior to October 1, 1998, which would otherwise be paid under DRG 103 and 480, respectively.

(*4*) All services related to CHAMPUS covered solid organ transplantations for which there is no DRG assignment.

* * * * *

(*10*) For admissions occurring on or after October 1, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, the costs of blood clotting factor for hemophilia inpatients. * * *

(D) * * *

(*4*) *Long-term hospitals.* A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a long-term hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, TSO, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in § 412.23 of Title 42 CFR.

(*5*) *Hospitals within hospitals.* A hospital within a hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a hospital within a hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, TSO, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.22 and the criteria for one or more of the excluded hospital classifications described in § 412.23 of Title 42 CFR.

* * * * *

(iii) * * *

(B) *Empty and low-volume DRGs.* For any DRG with less than ten (10) occurrences in the CHAMPUS database, the Director, TSO, or designee, has the authority to consider alternative methods for estimating CHAMPUS weights in these low-volume DRG categories.

* * * * *

(D) * * *

(*1*) *Differentiate large urban and other area charges.* All charges in the database shall be sorted into large urban and other area groups (using the same definitions for these categories used in the Medicare program.* * *

* * * * *

(*5*) *Preliminary base year standardized amount.* A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the large urban or other area group and dividing by the total number of discharges in the respective group.

* * * * *

(*E*) * * *

(*1*) * * *

(*i*) * * *

(*A*) *Short-stay outliers.* Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's arithmetic LOS shall be classified as a short-stay outlier. Short-stay outliers shall be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the DRG amount divided by the arithmetic mean length-of-stay for the DRG.

(*B*) *Long-stay outliers.* Any discharge (except for neonatal services and services in children's hospitals) which has a length-of-stay (LOS) exceeding a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.82 shall be classified as a long-stay outliner. Any discharge for neonatal services or for services in a children's hospital which has a LOS exceeding the lesser of 1.94 standard deviations or 17 days from the DRG's arithmetic mean LOS also shall be classified as a long-stay outlier. Long-stay outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold. The per diem rate shall equal the DRG amount divided by the arithmetic mean LOS for the DRG. For admissions on or after October 1, 1997, the long stay outlier has been eliminated for all cases except children's hospitals and neonates. For admissions on or after October 1, 1998, the long stay outlier has been eliminated for children's hospitals and neonates.

(*ii*) * * *

(*A*) *Cost outliers except those in children's hospitals or for neonatal services.* Any discharge which has standardized costs that exceed a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.84 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in § 199.14(a)(1)(iii)(D)(*4*) and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. Effective with admissions occurring on or after October 1, 1997, the standardized costs are no longer adjusted for indirect medical education costs.

(*B*) *Cost outliers in children's hospitals and for neonatal services.* Any discharge for services in a children's hospital or for neonatal services which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or $13,500 shall

qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in § 199.14(a)(1)(iii)(D)(*4*) (adjusted to include average capital and direct medical education costs) and adjusting this amount for indirect medical education costs. Cost outliers for services in children's hospitals and for neonatal services shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. Effective with admissions occurring on or after October 1, 1998, standardized costs are no longer adjusted for indirect medical education costs. In addition, CHAMPUS will calculate the outlier payments that would have occurred at each of the 59 Children's hospitals under the FY99 outlier policy for all cases that would have been outliers under the FY94 policies using the most accurate data available in September 1998. A ratio will be calculated which equals the level of outlier payments that would have been made under the FY94 outlier policies and the outlier payments that would be made if the FY99 outlier policies had applied to each of these potential outlier cases for these hospitals. The ratio will be calculated across all outlier claims for the 59 hospitals and will not be hospital specific. The ratio will be used to increase cost outlier payments in FY 1999 and FY 2000, unless the hospital has a negotiated agreement with a managed care support contractor which would affect this payment. For hospitals with managed care support agreements which affect these payments, CHAMPUS will apply these payments if the increased payments would be consistent with the agreements. In FY 2000 the ratio of outlier payments (long stay and cost) that would have occurred under the FY 94 policy and actual cost outlier payments made under the FY 99 policy will be recalculated. If the ratio has changed significantly, the ratio will be revised for use in FY 2001 and thereafter. In FY 2002, the actual cost outlier cases in FY 2000 and 2001 will be reexamined. The ratio of outlier payments that would have occurred under the FY94 policy and the actual cost outlier payments made under the FY 2000 and FY 2001 policies. If the ratio has changed significantly, the ratio will be revised for use in FY 2003.

* * * * *

(G) * * *

(*3*) *Information necessary for payment of capital and direct medical education costs.* All hospitals subject to the CHAMPUS DRG-based payment system, except for children's hospitals, may be reimbursed for allowed capital and direct medical education costs by submitting a request to the CHAMPUS contractor. Beginning October 1, 1998, such request shall be filed with CHAMPUS on or before the last day of the twelfth month following the close of the hospitals' cost reporting period, and shall cover the one-year period corresponding to the hospital's Medicare cost-reporting period. The first such request may cover a period of less than a full year—from the effective date of the CHAMPUS DRG-based payment system to the end of the hospital's Medicare cost-reporting period. All costs reported to the CHAMPUS contractor must correspond to the costs reported on the hospital's Medicare cost report. An extension of the due date for filing the request may only be granted if an extension has been granted by HCFA due to a provider's operations being significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire. (If these costs change as a result of a subsequent audit by Medicare, the revised costs are to be reported to the hospital's CHAMPUS contractor within 30 days of the date the hospital is notified of the change.) The request must be signed by the hospital official responsible for verifying the amounts and shall contain the following information.

* * * * *

(d) * * *

(3) * * *

(iv) *Step 4: standard payment amount per group.* The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group. For cases in which the standard payment amount per group exceeds the CHAMPUS-determined inpatient allowable amount, the Director, TSO or his designee, may make adjustments.

* * * * *

(h) *Reimbursement of individual health care professionals and other non-institutional, non-professional providers.* The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health care professional or other non-institutional, non-professional provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

(1) * * *

(iii) * * *

(D) *Special rule for cases in which the national CMAC is less than the Medicare rate.*

Note: This paragraph will be implemented when CMAC rates are published.

In any case in which the national CMAC calculated in accordance with paragraphs (h)(1)(i) through (iii) of this section is less than the Medicare rate, the Director, TSO, may determine that the use of the Medicare Economic Index under paragraph (h)(1)(iii)(B) of this section will result in a CMAC rate below the level necessary to assure that beneficiaries will retain adequate access to health care services. Upon making such a determination, the Director, TSO, may increase the national CMAC to a level not greater than the Medicare rate.

5. Section 199.15 is amended by revising paragraphs (b)(4)(iii)(B), (c)(2), (d)(2)(iii) and (e)(3)(i) and (ii), to read as follows:

§ 199.15 Quality and utilization review peer review organization program.

* * * * *

(b) * * *

(4) * * *

(iii) * * *

(B) In a case described in paragraph (b)(4)(iii)(A) of this section, reimbursement will be reduced, unless such reduction is waived based on special circumstances. The amount of this reduction shall be at least ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained, but was not obtained.

* * * * *

(c) * * *

(2) The physician acknowledgment required for Medicare under 42 CFR 412.46 is also required for CHAMPUS as a condition for payment and may be satisfied by the same statement as required for Medicare, with substitution or addition of ''CHAMPUS'' when the word ''Medicare'' is used.

* * * * *

(d) * * *

(2) * * *

(iii) Review for physician's acknowledgement of annual receipt of the penalty statement as contained in the Medicare regulation at 42 CFR 412.46.

* * * * *

(e) * * *

(3) * * *

(i) If the diagnostic and procedural information in the patient's medical

record is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the CHAMPUS claim will be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.

(ii) If the information stipulated under paragraph (d)(2) of this section is found not to be correct, the PRO will change the coding and assign the appropriate DRG on the basis of the changed coding.

* * * * *

6. Section 199.18 is amended by revising paragraph (d)(3)(v) introductory text to read as follows:

§ 199.18 Uniform HMO Benefit.

* * * * *

(d) * * *

(3) * * *

(v) For ambulatory surgery services, the per service fee is as follows:

* * * * *

Dated: August 31, 1998.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 98–23842 Filed 9–9–98; 8:45 am]

BILLING CODE 5000–04–M

DEPARTMENT OF COMMERCE

Patent and Trademark Office

37 CFR Part 1

RIN 0651–AA88

Requirements for Patent Applications Containing Nucleotide Sequence and/or Amino Acid Disclosures; Correction

AGENCY: Patent and Trademark Office, Commerce.

ACTION: Correcting amendments.

SUMMARY: This document contains a correction to the rules relating to the format for nucleotide and/or amino acid sequence disclosures in patent applications.

EFFECTIVE DATE: September 10, 1998.

FOR FURTHER INFORMATION CONTACT: Esther M. Kepplinger, by telephone at (703) 308–1495; by mail addressed to: Box Comments—Patents, Assistant Commissioner for Patents, Washington, DC 20231 marked to her attention; by facsimile to (703) 305–3935; or by electronic mail at esther.kepplinger@uspto.gov.

SUPPLEMENTARY INFORMATION: Appendix B to subpart G to part 1 of title 37 of the Code of Federal Regulations is a listing entitled ''Headings for Information Items in § 1.823.'' It contains the headings that were required prior to the June 1, 1998, amendment of the rules.

On June 1, 1998, the Patent and Trademark Office published a final rule entitled ''Requirements for Patent Applications Containing Nucleotide Sequence and/or Amino Acid Disclosures'' in the **Federal Register** (63 FR 29620). The listing of headings in appendix B is no longer correct in view of the final rule. The headings adopted in the final rule replaced those used in appendix B. For this reason, appendix B should have been removed from the final rule. Because appendix B may be misleading, it is now being removed.

List of Subjects in 37 CFR Part 1

Administrative practice and procedure, Courts, Freedom of information, Inventions and patents, Incorporation by reference, Reporting and recordkeeping requirements, Small businesses.

PART 1—RULES OF PRACTICE IN PATENT CASES

Accordingly, 37 CFR Part 1 is corrected by making the following correcting amendment:

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

Authority: 35 U.S.C. 6, unless otherwise noted.

Appendix B To Subpart G To Part 1 [Corrected]

2. Remove Appendix B To Subpart G To Part 1.

Dated: September 4, 1998.

Albin F. Drost,

Deputy Solicitor.

[FR Doc. 98–24358 Filed 9–9–98; 8:45 am]

BILLING CODE 3510–16–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 300

[FRL–6157–8]

National Oil and Hazardous Substances Pollution Contingency Plan National Priorities List

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of deletion for the Golden Strip Septic Tank Superfund Site from the National Priorities List (NPL).

SUMMARY: The Environmental Protection Agency (EPA) Region 4 announces the deletion of the Golden Strip Septic Tank Superfund Site from the National Priorities List (NPL). The NPL constitutes Appendix B of 40 CFR part 300 which is the National Oil and Hazardous Substances Pollution Contingency Plan (NCP), which EPA promulgated pursuant to section 105 of the Comprehensive Environment Response, Compensation and Liability Act (CERCLA) of 1980, as amended. EPA and the State of South Carolina Department of Health and Environmental Control (SCDHEC) have determined that all remedial action objectives have been met and the Site poses no significant threat to public health or the environment. Therefore, further remedial measures are not appropriate.

EFFECTIVE DATE: September 10, 1998.

FOR FURTHER INFORMATION CONTACT: Craig Zeller, P.E., Remedial Project Manager, U.S. Environmental Protection Agency, Region 4, Waste Management Division—North Site Management Branch, 61 Forsyth Street, SW, Atlanta, GA 30303, (404) 562–8827 or toll free at 1–800–435–9233.

SUPPLEMENTARY INFORMATION: The site to be deleted from the NPL is: Golden Strip Septic Tank Superfund Site in Simpsonville, South Carolina.

A Notice of Intent to Delete for this site was published on July 9, 1998, (FR–6121–9) (63 FR 37085). The closing date for comments on the Notice of Intent to Delete was August 10, 1998. EPA received no comments.

EPA identifies sites that appear to present a significant risk to the public health, welfare and the environment and it maintains the NPL as the list of those sites. Any site deleted from the NPL remains eligible for Fund-financed remedial actions in the future. Section 300.425(e)(3) of the NCP states that Fund-financed actions may be taken at sites deleted from the NPL. Deletion of a site from the NPL does not affect responsible party liability or impede agency efforts to recover costs associated with response efforts.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous substances, Hazardous waste, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Dated: August 24, 1998.

A. Stanley Meiburg,

Deputy Regional Administrator, Region 4.

For reasons set out in the preamble, 40 CFR part 300 is amended as follows:

PART 300—[AMENDED]

The authority citation for part 300 continues to read as follows: