(xiv) Pawnee Tribe of Oklahoma.
(xv) Ponca Tribe of Oklahoma.
(xvi) Tonkawa Tribe of Oklahoma.
(xvii) Wichita and Affiliated Tribes of Oklahoma.
(12) For the following tribes located in the former Indian Territory (Oklahoma):
(i) Chickasaw Nation.
(ii) Choctaw Nation.
(iii) Thlopthlocco Tribal Town.
(iv) Seminole Nation.
(v) Eastern Shawnee Tribe.
(vi) Miami Tribe.
(vii) Modoc Tribe.
(viii) Ottawa Tribe.
(ix) Peoria Tribe.
(x) Quapaw Tribe.
(xi) Wyandotte Tribe.
(xii) Seneca-Cayuga Tribe.
(xiii) Osage Tribe.

Dated: October 29, 1997.

Ada E. Deer,

Assistant Secretary—Indian Affairs.

[FR Doc. 97–29938 Filed 11–13–97; 8:45 am]

BILLING CODE 4310–02–P

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: Proposed rule.

SUMMARY: This rule proposes to revise certain requirements and procedures for reimbursement under the TRICARE 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 proposed 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; extension of the balance billing limitations currently in place for individual and professional providers to non-institutional, non-professional providers; adjusting the CHAMPUS maximum allowable charge (CMAC) rate in the small number of cases where the CMAC rate is less than the Medicare rate; and implementing the government-wide debarment rule where any provider excluded or suspended form CHAMPUS shall be excluded from all other programs and activities involving Federal financial assistance, such as Medicare or Medicaid, and adding violations of our balance billing or claims filing requirements to the list of provider actions considered violations of the TRICARE/CHAMPUS program.

DATES: Comments must be received on or before January 13, 1998.

ADDRESSES: Tricare Support Office (TSO), Program Development Branch, Aurora, CO 80045–6900.

FOR FURTHER INFORMATION CONTACT: Kathleen Larkin, Office of the Assistant Secretary of Defense (Health Affairs), telephone (703) 695–3350.

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

SUPPLEMENTARY INFORMATION:

I. Proposed Changes Regarding The Champus DRG-Based Payment System

The final rule published on September 1, 1987, (52 FR 32992) set forth the basic procedures used under the CHAMPUS DRG-based payment system. This was subsequently amended by final rules published on August 31, 1988 (53 FR 33461), October 21, 1988 (53 FR 41331), December 16, 1988 (53 FR 50515), May 30, 1990 (55 FR 21863), and October 22, 1990 (55 FR 42560). This rule proposes to amend 32 CFR 199 to conform to 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 whenever practicable. In addition, the rule proposes to: eliminate the requirement for the physician attestation form and change the requirement for physician acknowledgment statements; clarify authorized payment reductions by managed care support contractors for noncompliance with required utilization review procedures and; limit the ambulatory surgery group payment rate to the amount that would be allowed if the services were provided on an inpatient basis.

A. Heart and Liver Transplants

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 are proposing 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.

B. Payment Requests for Capital and Direct Medical Education Costs

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 TRICARE/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 are proposing to adopt these same requirements for submitting requests for payment of capital and direct medical education costs with TRICARE/CHAMPUS.

Currently, TRICARE/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 up to close out our data for these periods, we are proposing that any capital and direct medical education payment requests that fall within the six year statute of limitations and the effective date of this change must be submitted to the appropriate TRICARE/CHAMPUS contractor no later than 5 months after the effective date of this change.

In addition, since capital and direct medical education costs are included in the national children's hospital differential, we are proposing 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.

C. Indirect Medical Education Adjustment Factor

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 hopsital.

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 are proposing 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 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 hospital's 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.

D. Long Stay Outliers

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 are proposing 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 discharges 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 extraordinarily 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 eliminated the long stay outliers for all cases except children's hospitals and neonates for Fiscal Year 1998, and are proposing to eliminate the long stay outliers for them in Fiscal Year 1999, we are still proposing to adopt the arithmetic mean to calculate the per diem, in order to be consistent with the Medicare PPS in calculating payments for transfer cases.

E. Cost Outliers

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 are proposing to adopt this same requirement for children's hospitals and neonates Fiscal Year in 1999.

F. Payment for Transfer Cases

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 will 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, the transferring hospital will be paid 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 proposed change will allow hospitals to be compensated more appropriately for the treatment they furnish to patients before transfer. Transferring hospitals will continue to be paid 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).

G. Elimination of Separate Adjusted Standardized Amounts for Rural Areas

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. The adjusted standardized amounts for ''other urban'' and ''rural'' areas are now listed as ''other'' areas.

H. Payment for Blood Clotting Factor

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 reinstated payments for discharges occurring on or after October 1, 1997.

I. Effect of Change of Ownership on Exclusion of Long-Term Care Hospitals

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 also adopted these new requirements beginning in Fiscal Year 1996.

J. Empty and Low-Volume DRGs

Currently, 32 CFR 199.14 (a)(1)(iii)(B) specifies that the Medicare weight shall be used for any DRG with less than 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 are proposing that the Director, TSO, or designee, has the authority to consider alternative methods for estimating CHAMPUS weights in these low-volume DGR categories.

K. Hospitals Within Hospitals

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 also adopted these requirements beginning in Fiscal Year 1998.

II. Proposed Changes Regarding Elimination of Physician Attestation Requirement

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 acknowledgment 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 adopted these requirements effective the same date.

III. Proposed Changes Regarding Clarification of Payment Reduction for Noncompliance with Required Utilization Review Procedures

To cover those situations where network providers have agreements with the managed care contractors for denial of payments for 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.

IV. Clarification Regarding List of Ambulatory Surgery Procedures

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 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. 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.

V. Proposed Changes Regarding Limits On Ambulatory Surgery Group Payment Rates

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, TSO 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 are adding a provision that gives discretion to the Director, TSO, 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 will multiply the applicable DRG relative weight times the national large urban adjusted standardized amount (ASA). We will 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.

VI. Proposed Changes Regarding Balance Billing

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.

This paragraph explains 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, the proposed rule states that the limitation may be waived on a case-by-case basis.

VII. Proposed Changes Regarding CMAC Rates

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 propose 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 propose 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 propose to adopt an additional Medicare indicator of economic factors, namely the data used for the Medicare fees determination, to adjust the rates in these special cases. This is set forth in the proposed new section 199.14(h)(1)(iii)(D).

VIII. Proposed Changes Regarding Government-Wide Effect Of Exclusion Or Suspension From Champus

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, 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. 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 25 (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 issues of submittal of claims and balance billing by providers. Current regulations generally require providers to file claims on behalf of beneficiaries and to limit balance 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 violations of these requirements 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 these proposed revisions is that any provider who fails to file CHAMPUS claims or 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.

IX. 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 proposed 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 proposed public information collection and seeks public comment on the provisions thereof. Comments are invited on: (1) whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have any practical utility; (2) the accuracy of the agency's estimated burden of the proposed information collection; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

The collection of information allows TRICARE to collect the information necessary 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)(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, 1 hour for institutions.

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 submitted 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.

Comments on these requirements should be submitted to the Office of Information and Regulatory Affairs, OMB, 725 17th Street, N.W., Washington, DC 20503, marked ''Attention Desk Officer for Department of Defense, Health Affairs.'' Copies should be sent to the Office of the Assistant Secretary of Defense (Health Affairs), 1200 Pentagon, Washington, DC 20301–1200, Attention: Kathleen Larkin. When the Department of Defense promulgates the Final Rule, the Department will respond to comments by OMB or the public regarding the information collection provisions of the rule.

The is a proposed rule. Public comments are invited. All comments will be considered. A discussion of the major issues raised by public comments will be included with issuance of the final rule, anticipated approximately 60 days after the end of the comment period.

List of Subjects in 32 CFR Part 199

Administrative practice and procedure, Claims, Fraud, Health care, Health insurance, individuals with disabilities, Military personnel.

Accordingly, 32 CFR Part 199 is proposed to be 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.

2. Section 199.9 is proposed to be 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.

3. Section 199.14 is proposed to be amended by revising the first sentence of (a)(1) introductory text, and paragraphs (a)(1)(i)(C)(*6*)(*iv*), (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*), revising (a)(1)(iii)(a)(*3*), (a)(1)(iii)(B), (a)(1)(iii)(D) (*1*), (*2*) 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 new paragraphs (a)(1)(ii)(D)(*5*), (a)(1)(iii)(E)(*3*) (*i*), (*ii*), (*iii*), (*iv*), and (*v*), 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 service furnished by hospitals subject to the system is made on the basis of prospectively-determined rates and applies 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 patients. * * *

(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 § 412.22 and the criteria for one or more of the excluded hospital classifications described in § 412.23 of Title 42 CFR.

* * * * *

(iii) * * *

(A) * * *

(*3*) *Indirect medical education standardization.* The charges shall be standardized for the cost effects of indirect medical educational factors. If the Medicare adjustment factor was used in calculating a teaching hospital's indirect medical education adjustment factor, the Medicare factor shall be used when standardizing the charges.

* * * * *

(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).

(*2*) *Indirect medical education standardization.* The charges shall be standardized for the cost effects of indirect medical education factors. If the Medicare adjustment factor was used in calculating a teaching hospital's indirect medical education adjustment factor, the Medicare factor shall be used when standardizing the charges.

* * * * *

(*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 outlier. 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 $13,800 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, the cost outlier thresholds for children's hospitals and neonatal services are the same as other hospitals and the standardized costs are no longer adjusted for indirect medical education costs.

* * * * *

(*3*) * * *

(*i*) The indirect medical education adjustment factor is calculated for all hospitals which have teaching programs approved under the Medicare regulation. The factor is based on the number of interns, residents and beds in the hospital. Each DRG-based payment is increased by this factor for that hospital. The factors are updated yearly based on data submitted by hospitals on the annual request for payment of capital and direct medical education costs.

(*ii*) To ensure the indirect medical education factors are as current as possible, the Medicare adjustment factor will be used 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. The factors will be updated using the Medicare amounts as of October 1 of each year; the same time the DRG rates and weights are updated. 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.

(iii) For hospitals which have indirect medical education factors for CHAMPUS but are not subject to the Medicare prospective payment system, the indirect medical education adjustment factor will be eliminated 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.

(iv) 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 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.

(v) 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 prospective payment system, including children's hospitals), the CHAMPUS specific factor will become effective in accordance with existing requirements. In no case will the CHMPUS-specific factor be effective retroactively.

* * * * *

(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. Such request shall be filed with CHAMPUS on or before the last day of the fifth 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.* 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.

* * * * *

4. Section 199.15 is proposed to be 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 acknowledgment 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.

* * * * *

Dated: November 7, 1997.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 97–29975 Filed 11–13–97; 8:45 am]

BILLING CODE 5000–04–M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 60 and 63

[FRL–5921–1]

Hazardous Waste Combustors; Continuous Emissions Monitoring Systems; Proposed Rule—Notice of Data Availability

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of data availability.

SUMMARY: This announcement is a notice of advanced availability of a test report pertaining to the proposed requirement for Particulate Matter (PM) Continuous Emissions Monitoring Systems (CEMS) for hazardous waste combustors: ''Draft Particulate Matter Continuous Emissions Monitoring Systems Demonstration'', dated October 1997. The report documents PM CEMS demonstration tests conducted between September 1996 and May 1997 at the DuPont, Inc. Experimental Station On-Site Incinerator, in Wilmington, Delaware. Included in the report are the testing scheme, raw data, and discussion of results. Appendices to the report include: Method 5I—Determination of Low Level Particulate Matter Emissions from Stationary Sources; Revised Draft Performance Specification 11—Specifications and Test Procedures for PM CEMS in Stationary Sources; and Appendix F to 40 CFR Part 60, Quality Assurance Requirements for PM CEMS used for Compliance Determination.

FOR FURTHER INFORMATION CONTACT: To obtain the October 1997, Draft PM CEMS Demonstration test report, call the RCRA Hotline at 1–800–424–9346 or TDD 1–800–553–7672 (hearing impaired). Callers within the Washington Metropolitan Area must dial 703–412–9810 or TDD 703–412–3323 (hearing impaired). The RCRA Hotline is open Monday–Friday, 9:00 a.m. to 6:00 p.m., Eastern Time.

SUPPLEMENTARY INFORMATION: On April 19, 1996, EPA proposed the Revised Standards for Hazardous Waste Combustors (i.e., incinerators, cement and lightweight aggregate kilns that burn hazardous waste). The revised standards would limit emissions of PM at these facilities and address the application of PM CEMS for compliance monitoring. See 61 FR 17358. On March 21, 1997, EPA published a Notice of Data Availability (NODA) that further examined the issues concerning PM CEMS as compliance instruments. See 62 FR 13776. EPA published an additional NODA on May 2, 1997, to inform the public of: (1) Significant changes the Agency is considering on aspects of the proposal based on public comments and new information; and (2) the Agency's own re-evaluation of MACT standard-setting approaches based on new data and public comments.

The proposed rule would require that PM CEMS be used to document compliance with the proposed PM standards. To be effective for compliance monitoring, the Agency determined that commercially available PM CEMS must meet certain performance specifications. The results of the demonstration tests assist in the development of these PM CEMS performance specifications.

EPA plans to follow today's NODA with a second NODA which will discuss issues pertaining to the demonstration test report and PM CEMS implementation considerations. The second NODA will provide the opportunity to comment on the report and the issues.

Dated: November 5, 1997.

David Bussard,

Acting Director, Office of Solid Waste.

[FR Doc. 97–30019 Filed 11–13–97; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 76

[CS Docket No. 95–184; MM Docket No. 92–260; FCC 97–376]

Inside Wiring

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: The Commission has adopted a *Report and Order and Second Further Notice of Proposed Rulemaking* which addresses rules and policies concerning cable inside wiring. The *Report and Order* segment of this decision may be found elsewhere in this issue of the Federal Register. The *Second Further Notice of Proposed Rulemaking* (''*Second Further Notice*'') segment seeks comment on proposed amendments to the Commission's regulations relating to exclusive service contracts, application of cable inside wiring rules to all multichannel video programming distributors (''MVPDs''), signal leakage reporting requirements, and simultaneous use of home run wiring. This action was necessary because exclusive service contracts and