Appendix C to Part 153—Military Power of Attorney Preamble

This is a military Power of Attorney prepared pursuant to section 1044b of title 10, United States Code, and executed by a person authorized to receive legal assistance from the Military Service. Federal law exempts this power of attorney from any requirement of form, substance, formality, or recording that is prescribed for powers of attorney by the laws of a State, the District of Columbia, or a commonwealth, territory, or possession of the United States. Federal law specifies that this power of attorney shall be given the same legal effect as a power of attorney prepared and executed in accordance with the laws of the jurisdiction where it is presented.

Appendix D to Part 153—Military Advance Medical Directive

This is a military advance medical directive prepared pursuant to section 1044c of title 10, United States Code. It was prepared by an attorney authorized to provide legal assistance for an individual eligible to receive legal assistance under section 1044 of title 10, United States Code. Federal law exempts this advance medical directive from any requirement of form, substance, formality, or recording that is provided for advance medical directives under the laws of a State. Federal law specifies that this advance medical directive shall be given the same legal effect as an advance medical directive prepared and executed in accordance with the laws of the State concerned.

Dated: August 22, 2001.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 01–21635 Filed 8–27–01; 8:45 am]

BILLING CODE 5001–08–U

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[RIN 0720–AA58]

TRICARE; Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Payments for Professional Services in Low-Access Locations

AGENCY: Office of the Secretary, DOD.

ACTION: Final rule.

SUMMARY: This final rule implements 10 U.S.C. 1097b(a), as added by section 716 of the National Defense Authorization Act for Fiscal Year 2000 which allows higher provider reimbursement rates than normally allowable, with certain limitations, when necessary to ensure an adequate TRICARE Prime network of qualified providers. This final rule also implements 10 U.S.c. 1079(h)(5), as added by section 747 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, to remedy circumstances in which TRICARE beneficiaries face very severe limitations on access to needed health care services.

EFFECTIVE DATE: September 27, 2001.

ADDRESSES: TRICARE Management Activity (TMA), Program Operations Directorate, 5111 Leesburg Pike, Suite 810, Falls Church, VA 22041–3206.

FOR FURTHER INFORMATION CONTACT: Mr. Mike Talisnik, Office of the Assistant Secretary of Defense (Health Affairs)/ TRICARE Management Activity, telephone (703) 681–0064 or Mr. Stan Regensberg, telephone (303) 676–3742.

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

SUPPLEMENTARY INFORMATION:

I. Background on TRICARE and CHAMPUS Payments to Providers

The relationship of DoD payment levels to Medicare's for institutional and professional health care services is central to the ongoing success of TRICARE. Payment levels have significant effects on DoD's ability to implement managed care programs, to assure beneficiary access to the full spectrum of health services, and to do this in a cost-effective manner.

Legislative initiatives have linked DoD's payment rates for health care to Medicare, beginning in the early 1980s, with the initial focus on institutional services. Similar initiatives in the late 1980s linked DoD's payment levels for professional services to Medicare.

A key principle of DoD's efforts in the linkage of reimbursement rates to Medicare has been the protection of access to services. In a 1996 report to Congress, it was found that 86 percent of the time providers accepted the TRICARE payment limits called CMACs (CHAMPUS Maximum Allowable Charges) as payment in full. Most recently, that percentage has increased to over 94 percent acceptance. However, the very high rate of acceptance overall may hide the access problems in certain localities.

When the CMAC payment approach was implemented in 1992, national payment levels were adjusted to reflect local economic conditions in over 200 localities, the same as those used by Medicare. Since that time, the number of localities has been reduced to fewer than 100, with the introduction of more and more statewide payment localities.

In 1999, DoD undertook revisions to one statewide locality, Alaska, in recognition of the differences in acceptability of TRICARE payments in Anchorage compared to the rest of the state. Overall, CMAC's are accepted as full payment over 90 percent of the time in Alaska; however, the vast majority of services are provided in Anchorage, so that severe access problems elsewhere in the state are hidden. In an effort to increase acceptability of TRICARE payment rates outside of Anchorage, DoD created a new locality, including all of Alaska except Anchorage. While this action addressed one locality, DoD's current regulatory authority may not be sufficient in some other localities. Accordingly, this final rule provides for the mechanism to increase access to health care providers for TRICARE beneficiaries where access to health care services is severely impaired or where there is an inadequate number of qualified network providers.

II. Overview of the Rule

This final rule would add a new § 199.14(h)(1)(iv)(D) authorizing the establishing of higher payment rates for specific services than would otherwise be allowable, if it is determined that access to health care services is severely impaired. Payment rates could be established through addition of a percentage factor to an otherwise applicable payment amount, or by calculating a prevailing charge, or by using another governmental payment rate. Higher payment rates could be applied to all similar services performed in a locality, or a new locality could be defined for application of the higher payment rates.

Other factors in determining the authority to establish a higher payment shall be based on the number of providers in a locality, the number of providers who are TRICARE participating providers, the number of eligible beneficiaries in the locality, and the availability of Military Treatment Facility providers.

The final rule would also add a new § 199.14(h)(1)(iv)(E) allowing the reimbursement of higher payment rates for health care services for services that would otherwise be allowable, if it is determined necessary to ensure adequate Preferred Provider networks. The amount of reimbursement for health care services would be limited to the lesser of: (1) An amount equal to the local fee for service charge in the area where the service is provided; or (2) 115 percent of the otherwise allowable TRICARE rate for the service. The higher rate will be authorized only if all reasonable efforts have been exhausted

in attempting to create an adequate network and that it is cost-effective and appropriate to pay the higher rate to ensure an appropriate mix of primary care and specialists in the network.

We have also added to the final rule a new definition of ''Director'' to clear up any confusion associated with continued use in the CHAMPUS/TRICARE regulation to ''Director, OCHAMPUS.'' The TRICARE Management Activity (TMA) has replaced the old Office of CHAMPUS, and the Director of TMA exercises the authorities previously exercised by the Director, OCHAMPUS.

III. Review of Comments

The proposed rule was published in the **Federal Register** on May 30, 2000 (65 FR 34423). We received one comment from a managed care support contractor who felt that rate adjustments should be available in rural and/or medically under-served areas that are non TRICARE Prime areas.

Response: The Department recognizes the need to ensure that access to health care is protected in areas that are medically underserved or in rural areas where there are few providers available. This final rule establishes new mechanisms to identify and address locations where access to care is severely impaired.

IV. Rulemaking Procedures

Section 801 of title 5, United States Code, and Executive Order 12866 requires certain regulatory assessments and procedures for any major rule or 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 major rule under 5 U.S.C. 801. It is a significant regulatory action but not economically significant under E. O. 12866, and it would not have a significant impact on a substantial number of small entities. In addition, the final rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 55).

This rule is being issued as a final rule.

List of Subjects in 32 CFR Part 199

Claims, Fraud, Health care, Health insurance, Individuals with disabilities, Military personnel.

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.

2. Section 199.2 is amended by revising the definition of ''Director, OCHAMPUS'' and adding the definition of ''Director'' in alphabetical order to read as follows:

§ 199.2 Definitions.

* * * * *

Director. The Director of the TRICARE Management Activity or Director, Office of CHAMPUS. Any references to the Director, Office of CHAMPUS, or OCHAMPUS, shall mean the Director, TRICARE Management Activity. Any reference to Director shall also include any person designated by the Director to carry out a particular authority. In addition, any authority of the Director may be exercised by the Assistant Secretary of Defense (Health Affairs).

* * * * *

3. Section 199.14 is amended by adding new paragraphs (h)(1)(iv)(D) and (E) to read as follows:

§ 199.14 Provider reimforcement methods.

* * * * *

(h) * * *

(1) * * *

(iv) * * *

(D) *Special locality-based exception to applicable CMACs to assure adequate beneficiary access to care.* In addition to the authority to waive reductions under paragraph (h)(1)(iv)(C) of this section, the Director may authorize establishment of higher payment rates for specific services than would otherwise be allowable, under paragraph (h)(1) of this section, if the Director determines that available evidence shows that access to health care services is severely impaired. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of providers who are CHAMPUS participating providers, the number of CHAMPUS beneficiaries in the locality, the availability of military providers in the location or nearby, and any other factors the Director determines relevant.

(1) Procedure. Providers or beneficiaries in a locality may submit to the Director, a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access to health care services is severely impaired. The Director, will consider and respond to all petitions. A decision to authorize a higher payment amount is subject to review and determination or modification by the Director at any time if circumstances change so that adequate access to health care services would no longer be severely impaired. A decision by the Director, to authorize, not authorize, terminate, or modify authorization of higher payment amounts is not subject to the appeal and hearing procedures of § 199.10 of the part.

(2) Establishing the higher payment rate(s). When the Director, determines that beneficiary access to health care services in a locality is severely impaired, the Director may establish the higher payment rate(s) as he or she deems appropriate and cost-effective through one of the following methodologies to assure adequate access:

(i) A percent factor may be added to the otherwise applicable payment amount allowable under paragraph (h)(1) of this section;

(ii) A prevailing charge may be calculated, by applying the prevailing charge methodology of paragraph (h)(1)(ii) of this section to a specific locality (which need not be the same as the localities used for purposes of paragraph (h)(1)(iv)(A) of this section; or another government payment rate may be adopted, for example, an applicable state Medicaid rate).

(3) Application of higher payment rates. Higher payment rates defined under paragraph (h)(1)(iv)(D) of this section may be applied to all similar services performed in a locality, or, if circumstances warrant, a new locality may be defined for application of the higher payments. Establishment of a new locality may be undertaken where access impairment is localized and not pervasive across the existing locality. Generally, establishment of a new, more specific locality will occur when the area is remote so that geographical characteristics and other factors significantly impair transportation through normal means to health care services routinely available within the existing locality.

(E) Special locality-based exception to applicable CMACs to ensure an adequate TRICARE Prime preferred network. The Director, may authorize reimbursements to health care providers participating in a TRICARE preferred provider network under § 199.17(p) of this part at rates higher than would

otherwise be allowable under paragraph (h)(1) of this section, if the Director, determines that application of the higher rates is necessary to ensure the availability of an adequate number and mix of qualified health care providers in a network in a specific locality. This authority may only be used to ensure adequate networks in those localities designated by the Director, as requiring TRICAR preferred provider networks, not in localities in which preferred provider networks have been suggested or established but are not determined by the Director to be necessary. Appropriate evidence for determining that higher rates are necessary may include consideration of the number of available primary care and specialist providers in the network locality, availability (including reassignment) of military providers in the location or nearby, the appropriate mix of primary care and specialists needed to satisfy demand and meet appropriate patient access standards (appointment/waiting time, travel distance, etc.), the efforts that have been made to create an adequate network, other cost-effective alternatives, and other relevant factors. The Director, may establish procedures by which exceptions to applicable CMACs are requested and approved or denied under paragraph (h)(1)(iv)(E) of this section. A decision by the Director, to authorize or deny an exception is not subject to the appeal and hearing procedures of § 199.10. When the Director, determines that it is necessary and cost-effective to approve a higher rate or rates in order to ensure the availability of an adequate number of qualified health care providers in a network in a specific locality, the higher rate may not exceed the lesser of the following:

(1) The amount equal to the local fee for service charge for the service in the service area in which the service is provided as determined by the Director, based on one or more of the following payment rates:

(i) Usual, customary, and reasonable;

(ii) The Health Care Financing Administration's Resource Based Relative Value Scale;

(iii) Negotiated fee schedules;

(iv) Global fees; or

(v) Sliding scale individual fee allowances.

(2) The amount equal to 115 percent of the otherwise allowable charge under paragraph (h)(1) of the section for the service.

* * * * *

Dated: August 22, 2001.

L.M. Bynum,

Alternate Federal Register Notice Liaison Officer, Department of Defense.

[FR Doc. 01–21634 Filed 8–27–01; 8:45 am]

BILLING CODE 5001–08–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 414

[CMS–1010–F]

RIN 0938–AK66

Medicare Program; Replacement of Reasonable Charge Methodology by Fee Schedules for Parenteral and Enteral Nutrients, Equipment, and Supplies

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule implements fee schedules for payment of parenteral and enteral nutrition (PEN) items and services furnished under the prosthetic device benefit, defined in section 1861(s)(8) of the Social Security Act. The authority for establishing these fee schedules is provided by the Balanced Budget Act of 1997, which amended the Social Security Act at section 1842(s). Section 1842(s) of the Social Security Act specifies that statewide or other areawide fee schedules may be implemented for the following items and services still subject to the reasonable charge payment methodology: medical supplies; home dialysis supplies and equipment; therapeutic shoes; parenteral and enteral nutrients, equipment, and supplies; electromyogram devices; salivation devices; blood products; and transfusion medicine. This final rule describes changes made to the proposed fee schedule payment methodology for these items and services and provides that the fee schedules for PEN items and services are effective for all covered items and services furnished on or after January 1, 2002. Fee schedules will not be implemented for electromyogram devices and salivation devices at this time since these items are not covered by Medicare. In addition, fee schedules will not be implemented for medical supplies, home dialysis supplies and equipment, therapeutic shoes, blood products, and transfusion medicine at this time since the data required to establish these fee schedules are inadequate.

DATES: These final regulations are effective January 1, 2002.

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

SUPPLEMENTARY INFORMATION: *Copies:* To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $9. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access, a service of the U.S. Government Printing Office. The Website address is http://www.access.gpo.gov/nara/index.html.

I. Background

The provisions of sections 1833 and 1842 of the Social Security Act (the Act) set forth the general payment authority for most physician and other medical and health services furnished under Part B of the Medicare program. Section 1842(s) of the Act, added by section 4315 of the Balanced Budget Act of 1997 (BBA), (Pub. L. 105–33) provides authority for implementing statewide or other areawide fee schedules to be used for payment of the following items and services that are paid on a reasonable charge basis when covered:

- Medical supplies.
- Home dialysis supplies and equipment.
- Therapeutic shoes.
- Parenteral and enteral nutrients, equipment, and supplies.
- Electromyogram devices.
- Salivation devices.
- Blood products.
- Transfusion medicine.

Section 1842(s)(1) of the Act provides that if fee schedules are established for any of the covered items and services listed above, the fee schedules are to be updated on an annual basis by the percentage increase in the consumer price index for all urban consumers (CPI–U) for the 12-month period ending