

| FDC Date | State | City | Airport | FDC No. | Subject |
|----------------|-------|--------------------|-----------------------------------|---------|------------------------------|
| 05/31/02 | TX | Houston | Sugar Land Muni/Hull Field | 2/4769 | RNAV (GPS) Rwy 17, Orig. |
| 05/31/02 | LA | New Orleans | Louis Armstrong New Orleans Intl. | 2/4843 | ILS Rwy 28, Amdt 4B. |
| 06/03/02 | PA | Philadelphia | Philadelphia Intl | 2/4932 | ILS Prm Rwy 26, Amdt 1B. |
| 06/03/02 | CA | Monterey | Monterey Peninsula | 2/4949 | ILS Rwy 10R, Amdt 26A. |
| 06/04/02 | CT | Willimantic | Windham | 2/4944 | VOR or GPS-A, Amdt 8A. |
| 06/04/02 | WA | Pasco | Tri-Cities | 2/4955 | VOR or GPS Rwy 21R, Amdt 4A. |
| 06/04/02 | WA | Pasco | Tri-Cities | 2/4956 | ILS Rwy 21R, Amdt 10B. |
| 06/05/02 | TN | Knoxville | McGhee-Tyson | 2/5035 | VOR or GPS Rwy 23L, Amdt 4A. |

[FR Doc. 02-14989 Filed 6-12-02; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1979

[Docket No. C-07]

RIN 1218-AB99

Procedures for the Handling of Discrimination Complaints Under Section 519 of the Wendell H. Ford Aviation Investment and Reform Act for the 21st Century

AGENCY: Occupational Safety and Health Administration, Labor.

ACTION: Interim final rule; reopening of comment period.

SUMMARY: On April 1, 2002, OSHA published an interim final rule titled, "Procedures for the Handling of Discrimination Complaints under section 519 of the Wendell H. Ford Aviation Investment and Reform Act for the 21st Century." The period for submitting written comments is being extended to allow information and data to be collected by those industries and employee groups affected by the rule.

DATES: Comments must be received by June 30, 2002.

ADDRESSES: Submit written comments to: OSHA Docket Office, Docket C-07, Occupational Safety and Health Administration, U.S. Department of Labor, Room N-2625, 200 Constitution Avenue, NW, Washington, DC 20210. Commenters who wish to receive notification of receipt of comments are requested to include a self-addressed, stamped post card or to submit them by certified mail, return receipt requested. As a convenience, comments may be transmitted by facsimile ("FAX") machine to (202) 693-1681. This is not a toll-free number. If commenters transmit comments by FAX and also submit a hard copy by mail, please indicate on the hard copy that it is a duplicate copy of the FAX transmission.

FOR FURTHER INFORMATION CONTACT: John Spear, Occupational Safety and Health Administration, U.S. Department of Labor, Room N-3618, 200 Constitution Avenue, NW, Washington, DC 20210; telephone (202) 693-2187. This is not a toll-free number. The alternative formats available are large print, electronic file on computer disk (Word Perfect, ASCII, Mates with Duxbury Braille System) and audiotape.

SUPPLEMENTARY INFORMATION: On April 1, 2002, at 67 FR 15454, OSHA published an Interim Final Rule titled, "Procedures for the Handling of Discrimination Complaints under Section 519 of the Wendell H. Ford Aviation Investment and Reform Act for the 21st Century." In that document OSHA requested comments on or before May 31, 2002. However, at the request of the Association of Flight Attendants, AFL-CIO, OSHA is extending the comment period an additional 30 days until June 30, 2002, to allow additional time for interested parties to gather information and submit informed comments to assist the Agency.

Authority: This document was prepared under the direction and control of the Assistant Secretary, Occupational Safety and Health Administration, U.S. Department of Labor.

Signed at Washington, DC, this 7th day of June, 2002.

John L. Henshaw,

Assistant Secretary for Occupational Safety and Health.

[FR Doc. 02-14950 Filed 6-12-02; 8:45 am]

BILLING CODE 4510-26-P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

RIN 0720-AA73

TRICARE; Sub-Acute Care Program; Uniform Skilled Nursing Facility Benefit; Home Health Care Benefit; Adopting Medicare Payment Methods for Skilled Nursing Facilities and Home Health Care Providers

AGENCY: Office of the Secretary, DoD

ACTION: Interim final rule.

SUMMARY: This rule partially implements the TRICARE "sub-acute and long-term care program reform" enacted by Congress in the National Defense Authorization Act for Fiscal Year 2002, specifically: Establishment of "an effective, efficient, and integrated sub-acute care benefits program," with skilled nursing facility and home health care benefits modeled after those of the Medicare program; adoption of Medicare payment methods for skilled nursing facility, home health care, and certain other institutional health care providers; adoption of Medicare rules on balance billing of beneficiaries, prohibiting it by institutional providers and limiting it by non-institutional providers; and change in the statutory exclusion of coverage for custodial and domiciliary care. The Department is publishing this rule as an interim final rule to implement the statutory requirements and effective dates. Public comments, however, are invited and will be considered for possible revisions to this rule.

DATES: Written comments will be accepted until August 12, 2002. This rule implements specific statutory requirements with specific statutory effective dates. This rule is effective August 12, 2002, or as soon thereafter as the Director, TRICARE Management Activity can effectively and efficiently implement through contract change. If the rule is not effective August 12, 2002, notice will be published in the **Federal Register** when the contract changes

have been completed to implement the rule.

ADDRESSES: Forward comments to Medical Benefits and Reimbursement Systems, TRICARE Management Activity, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066.

FOR FURTHER INFORMATION CONTACT: For payments to Skilled Nursing Facilities and Skilled Nursing Facility (SNF) services, Tariq Shahid, Medical Benefits and Reimbursement Systems, TRICARE Management Activity, telephone (303) 676-3801. For Home Health Care (HHC) benefits and payment methods, David E. Bennett, TRICARE Management Activity, Medical Benefits and Reimbursement Systems, telephone (303) 676-3494. For payments for clinical laboratory and certain other services in hospital outpatient departments and emergency departments and balance billing limits, Stan Regensberg, Medical Benefits and Reimbursement Systems, TRICARE Management Activity, telephone, (303) 676-3742.

SUPPLEMENTARY INFORMATION:

I. Overview

In the National Defense Authorization Act for Fiscal Year 2002 (NDAA-02), Pub. L. 107-107 (December 28, 2001), Congress enacted several reforms relating to TRICARE coverage and payment methods for skilled nursing and home health care services. The statutory "Sub-Acute and Long-Term Care Program Reform" under section 701 of this Act added a new 10 U.S.C. 1074j, which provides in pertinent part: § 1074j. Sub-Acute Care Program

(a) Establishment.—The Secretary of Defense shall establish an effective, efficient, and integrated sub-acute care benefits program under this chapter * * *

(b) Benefits.—(1) The program shall include a uniform skilled nursing facility benefit that shall be provided in the same manner and under the conditions described in Section 1861(h) and (i) of the Social Security Act (42 U.S.C. 1935x(h) and (i)), except that the limitation on the number of days of coverage under Section 1812(a) and (b) of such Act (42 U.S.C. 1395d(a) and (b)) shall not be applicable under the program. Skilled nursing facility care for each spell of illness shall continue to be provided for as long as medically necessary and appropriate.

* * * * *

(3) The program shall include a comprehensive, part-time or intermittent home health care benefit that shall be provided in the manner and under the conditions described in Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

In addition to these requirements that TRICARE establish an integrated sub-acute care program consisting of skilled

nursing facility and home health care services modeled after the Medicare program, Congress also, in section 707 of NDAA-02, changed the statutory authorization (in 10 U.S.C. 1079(j)(2)) that TRICARE payment methods for institutional care "may be" determined to the extent practicable in accordance with Medicare payment rules to a mandate that TRICARE payment methods "shall be" so determined. This command is effective 90 days after the date of enactment. A third Congressional action in NDAA-02, also in Section 707, is the statutory codification of existing TRICARE policy—modeled after Medicare—that institutional providers are not permitted to balance bill beneficiaries for charges above the TRICARE payment amount and that non-institutional providers may not balance bill in excess of 15 per cent over the TRICARE Maximum Allowable Cost.

A fourth component of this reform program (in Section 701(c)) is the narrowing of the statutory exclusions of custodial and domiciliary care by the adoption of new definitions of "custodial care" and "domiciliary care" that have the effect of eliminating current program restrictions on paying for certain medically necessary care.

This interim final rule implements these statutory requirements. We are adopting for TRICARE a skilled nursing facility benefit similar to Medicare's, but as specified in the statute, without Medicare's day limits. We are also adopting Medicare's prospective payment method for skilled nursing facility care. Similarly, we are adopting the Medicare benefit structure and payment method for home health care services. We are applying to SNF and HHC providers the statutory prohibition against balance billing. In addition, we are incorporating the new statutory definitions of "custodial care" and "domiciliary care." Finally, this rule also provides clarification of existing payment policies for clinical laboratory and rehabilitation therapy services, radiology services procedures, and routine venipuncture in hospital outpatient and emergency departments that were adopted under the allowable charge methodology under 32 CFR 199.14.

We note that the series of sub-acute and long-term care program reforms adopted by Congress in NDAA-02 included several parts that are not being implemented in this interim final rule. Most significant are: repeal of the Case Management Program under 10 U.S.C. 1079(a)(17) (repealed—along with several other related enactments—by Section 701(g)(2) of NDAA-02);

continuation of the Case Management Program for certain beneficiaries currently covered by it (Section 701(d)); and establishment of a new program of extended benefits for disabled family members of active duty services members (Section 701(b)). These and several other related statutory changes will be implemented through regulatory changes in the very near future. In the meantime, the case management process of 32 CFR 199.4(i) will remain available to provide services to eligible beneficiaries of the new extended benefits program, consistent with the statutory specifications.

Finally, we note that Congress included as Section 8101 of the DoD 2002 Appropriations Act, a general provision identical to a provision included in the 2000 (Section 8118) and 2001 (Section 8100) Appropriations Acts concerning implementation of the case management program under 10 U.S.C. 1079(a)(17). Although Sections 8118 and 8100 of the 2000 and 2001 Appropriations Acts were repealed by Section 701(g)(1)(B) and (C) of NDAA-02, the same provision was reenacted in the 2002 Appropriations Act. By its terms, Section 8101 of the DoD 2002 Appropriations Act, exclusively addresses implementation of a program (the case management program under 10 U.S.C. 1079(a)(17)) that has now been repealed. Thus, we consider Section 8101 as not affecting implementation of the sub-acute and long-term care reform program adopted by Congress in NDAA-02.

The program reforms adopted by Congress and implemented in this interim final rule take major steps toward achieving the Congressional objective of an effective, efficient, and integrated sub-acute care benefits program.

II. Skilled Nursing Facility Benefits

As noted above, 10 U.S.C. 1074j requires TRICARE to include a skilled nursing facility benefit that shall for the most part be provided in the manner and under the conditions described under Medicare. As a result, TRICARE is adopting Medicare's three-day-prior-hospitalization requirement for coverage of a SNF admission. Accordingly, for a SNF admission to be covered under TRICARE, the beneficiary must have a qualifying hospital stay (meaning an inpatient hospital stay), of not less than three consecutive days before the beneficiary is discharged from the hospital. The beneficiary must enter the SNF within 30 days after discharge from the hospital, or within such time as it would be medically appropriate to begin an active course of treatment, where the

individual's condition is such that SNF care would not be medically appropriate within 30 days after discharge from a hospital. The skilled services must be for a medical condition that was either treated during the qualifying three-day hospital stay, or started while the beneficiary was already receiving covered SNF care. Additionally, an individual shall be deemed not have been discharged from a SNF, if within 30 days after discharge from a SNF, the individual is again admitted to the same or a different SNF. These coverage requirements are the same as applied under Medicare. We are not, however, adopting Medicare's 100-day limit on SNF services. Consistent with the statute, SNF coverage for each spell of illness shall continue to be provided for as long as medically necessary and appropriate.

III. Payments for Skilled Nursing Facility Services

TRICARE had not to date reformed payment methods applicable to SNFs due to the very small volume of SNF services paid for by TRICARE. The volume of such services is now expected to increase significantly because of the Congressional action in 2000 reinstating TRICARE coverage secondary to Medicare for Medicare-eligible DoD health care beneficiaries (Section 712 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, Pub. L. 106-398). Coincident with Congressional action in directing adoption of Medicare payment methods for institutional providers, we have undertaken a review of the Medicare payment method and rates for SNF care under Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy) and 42 CFR part 413, subpart J. That review and assessment have convinced us that adoption of Medicare SNF payment methods and rates is not only required by law, but also fair, feasible, practicable, and appropriate.

Medicare implemented its per diem Prospective Payment System (PPS) for SNF care covering all costs (routine, ancillary and capital) of Medicare-covered SNF services as of July 1, 1998. The Medicare payment rates are based upon resident assessments. All Medicare-certified SNFs are required to conduct assessments on residents using a standardized assessment tool, called the Minimum Data Set (MDS). Medicare then uses information from this assessment to categorize SNF patients into seven major categories: (1) Rehabilitation; (2) Extensive Services; (3) Special Care; (4) Clinically Complex; (5) Impaired Cognition; (6) Behavior Problems; and (7) Reduced Physical

Function. This is done using the Resource Utilization Group (RUG)—III grouper. The RUG—III grouper is a computer program that converts resident specific assessment data into a case-mix classification. In classifying patients into groups based upon their clinical and functional characteristics, the grouper further subdivides each of these seven categories resulting in 44 specific patient RUGs.

For each of the 44 RUGs, the Medicare SNF per diem payment is calculated as the sum of three parts—the nursing component, the therapy component and the non-case-mix component. Under the nursing and therapy components of the payment rate, each of the 44 RUGs carries a uniquely assigned relative weight factor. This relative weight factor, or case mix index, represents a relative index or resource consumption. Resource-intensive patients are assigned to a RUG that carries a higher relative weight factor. This RUG-specific relative weight factor is multiplied by the applicable nursing and therapy base rates (which vary depending on whether the SNF is urban or rural) to develop the nursing and therapy components of the per diem payment rate. These two components are then added to the non-case-mix adjusted component resulting in the total PPS per diem payment rate.

A key part of the Medicare SNF payment system is the use of the MDS to classify SNF residents into one of the 44 RUG groups. An important issue is whether the RUG—III classification system used by Medicare to classify patients into the 44 RUG groups would be practicable for the TRICARE SNF benefit. We think that it would be practicable. Much of the SNF care for which TRICARE will be paying is as second payer to Medicare for the same patient. Even for non-Medicare-eligible patients (e.g., most patients under age 65), the characteristics recognized by the RUG—III system would be equally applicable. In this regard, we note that more than ten states have decided to use the RUG—III system to classify Medicaid patients into RUGs and several other states are currently in the developmental stages of implementing the RUG—III system. This reflects a broad view that the MDS and RUGs are appropriate for non-Medicare SNF residents. In our review and discussions, we could not identify any significant barriers to the use of the RUG—III system to classify TRICARE patients.

One implementation issue that we have identified related to classification concerns the timing of residents assessments. The Medicare SNF payment system requires periodic

patient assessments. The Centers for Medicare and Medicaid Services (CMS) requires that SNF patients be assessed on days 5, 14, 30, 60, and 90, as well as be reassessed if there are status changes between these periodic assessments. We have considered the level of assessment required after 100 days when TRICARE becomes primary payer for patients whose SNF care must continue beyond the Medicare benefit limit. We believe continuing to assess patients every 30 days would be consistent with Medicare's practice of skilled authorization.

A second implementation issue concerns the use of MDS for neonates and very young children. The MDS was not designed for very young children. As a result, we believe that children under ten should not be assessed using the MDS. We will review the methods used by Medicaid programs and may adopt one of their assessment methods at a later time. Until then, the allowed charge for children under age ten in a SNF will continue to be the billed charge.

We have also considered whether the Medicare SNF payment rates and weights are appropriate for TRICARE. We believe they are. For some of the payment methods TRICARE has adopted for non-SNF providers that are based on the Medicare's system, we have developed DoD-specific weights and rates. In some, such as for physician payments, we implemented our own phase-in process, but have not reached comparability with Medicare. In the case of SNF PPS, the Medicare weights and rates were developed to be used nationally—like TRICARE—thus, we have no special State considerations that some Medicaid programs would have. In addition, the TRICARE population group that will be the primary user of SNF services and the Medicare population group are quite similar. Thus, we believe that there is no reason why the Medicare weights and rates would not be appropriate to use. However, we will carefully monitor the TRICARE SNF patient characteristics to ensure that the weights and rates are appropriate. If necessary, the weights and rates could be modified after one or more years of experience.

Based on all of these considerations and the statutory requirements, the Department is adopting for TRICARE the Medicare payment methods and rates, including MDS assessments, RUG—III classifications, and Medicare weights and per diem rates. For patient stays longer than 90 days, MDS assessment would be required every 30 days.

In adopting the Medicare's SNF payment methodology, we are also incorporating into our rule a provision that has been in the TRICARE Operations Manual requiring that TRICARE-eligible SNFs must be Medicare-certified institutions. We believe this policy facilitates assurance of quality of care and is consistent with the payment approach we are adopting.

IV. Home Health Care Benefits

Home health agencies (HHAs) are currently recognized as authorized providers under TRICARE, but payment only extends to services rendered by otherwise authorized TRICARE individual professional providers, such as registered nurses, physical and occupational therapists, and speech pathologists. Coverage of services provided by home health aides and medical social workers are currently not allowed except under the hospice benefit. Payment is also extended under the TRICARE-allowable charge methodology for medical supplies that are essential in enabling HHA professional staff to effectively carry out physician ordered treatment of the beneficiary's illness or injury. Unlike Medicare, TRICARE currently requires HHAs to have either community Health Accreditation Program or Joint Commission on the Accreditation of Healthcare Organizations accreditation to quality as network providers. These certification requirements will be changed to make them consistent with those of Medicare in order to effectively accommodate adoption of the new HHA prospective payment system; i.e., to require Medicare certification/approval for provider authorization status under TRICARE.

Medicare's home health benefit structure and conditions for coverage are being adopted coincident with implementation of the new prospective payment system including those provisions under Sections 1861(m), 1861(o), and 1891 of the Social Security Act and 42 CFR part 484. In general, coverage extends to part-time or intermittent skilled nursing care and home health aide services from qualified providers. The specific benefit structure and conditions for coverage are set forth in the new Section 199.4(e)(22) of the regulation.

In adopting this new benefit structure for TRICARE, we note the potential need for some transition time or other accommodation for some patients currently receiving home health services under present program coverage rules. Our regulation (Section 199.1(n)) allows the recognition of special circumstance

and authority of the Director to address them.

V. Payment Method for Home Health Care Services

TRICARE is adopting Medicare's benefit structure and prospective payment system for reimbursement of HHAs that are currently in effect for the Medicare program under Section 4603 of the Balanced Budget Act of 1997, as amended by Section 5101 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999, and by Sections 302, 305, and 306 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. This includes adoption of the comprehensive Outcome and Assessment Information Set (OASIS) and consolidating billing requirements.

The adoption of the Medicare HHA prospective payment system replaces the retrospective physician-oriented fee-for-service model currently used for payment of home health services under TRICARE. Under the new prospective payment system, TRICARE will reimburse HHAs a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and non-routine medical supplies provided under the beneficiary's plan of care. Durable medical equipment and osteoporosis drugs receive a separate payment amount in addition to the prospective payment system amount for home health care services.

The variation in reimbursement among beneficiaries receiving home health care under this newly adopted prospective payment system will be dependent on the severity of the beneficiary's condition and expected resource consumption over a 60-day episode-of-care, with special reimbursement provisions for major intervening events, significant changes in conditions, and low or high resource utilization. The resource consumption of these beneficiaries will be assessed using OASIS selected data elements. The score values obtained from these selected data elements will be used to classify home health beneficiaries into one of 80 Home Health Resource Groups (HHRGs) based on their average expected resource costs relative to other home health care patients.

The HHRG classification determines the cost weight; i.e., the appropriate case-mix weight adjustment factor that indicates the relative resources used and costliness of treating different patients. The cost weight for a particular HHRG is then multiplied by a standard average prospective payment amount for a 60-day episode of home health care. The

case-mix adjusted standard prospective payment amount is then adjusted to reflect the geographic variation in wages to come up with the final HHA payment amount.

As indicated above, the ordinary unit of payment is based on a 60-day episode of care. Payment covers the entire episode of care regardless of the number of days of care actually provided during the 60-day period. There are exceptions to this standard payment period under certain conditions that will result in reduced or additional amounts being paid. If the beneficiary is still in treatment at the end of the initial 60-day episode of care, a physician must re-certify that the beneficiary is correctly assigned to one of the HHRGs, and a new episode of care may begin. There is currently no limit on the number of medically necessary consecutive 60-day episodes that beneficiaries may receive under the HHA prospective payment system.

As noted above, the variation in reimbursement among beneficiaries receiving HHC under this newly adopted prospective payment system will be dependent on the severity of the beneficiary's condition and expected resource consumption over a 60-day episode-of-care, with special reimbursement provisions for major intervening events, significant changes in condition, and low or high resource utilization. A case mix system has been developed to measure the severity and projected resource utilization of beneficiaries receiving home health services using selected data elements off of the OASIS assessment instrument (i.e., the assessment document submitted by HHAs for reimbursement) and an additional element measuring receipt of at least ten visits for therapy services. These key data elements are organized and assigned a score value in order to measure the impact of clinical, functional and services utilization dimensions on total resource use. The resulting summed scores are used to assign a beneficiary to a particular severity level within each of the following dimensions:

- *Clinical Dimension*—The clinical dimension has four severity levels (0–3) and takes into account the beneficiary's primary diagnosis and prevalent medical conditions.
- *Functional Dimension*—The functional dimension assesses the beneficiary's ability to perform various activities of daily living (e.g., the beneficiary's ability to dress and bathe) and consists of five severity levels (0–4).
- *Services Utilization Dimension*—The Services utilization dimension has

four severity levels (0–3) and indicates whether the beneficiary was discharged from a skilled nursing facility or rehabilitation hospital within the past 14 days and whether the patient is expected to receive ten or more occupational, physical and/or speech therapy visits.

A case-mix grouper is used for assigning a severity level within each of the above dimensions and for classifying the beneficiary into one of 80 HHRGs. The HHRG indicates the extent and severity of the beneficiary's home health needs reflected in its relative case-mix weight (cost weight). The case-mix weight indicates the group's relative resource use and cost of treating different patients. The case-mix weights for Fiscal Year 2001 ranged from 0.5265 to 2.8113. The standardized prospective payment rate is multiplied by the beneficiary's assigned HHRG case-mix weight to come up with the 60-day episode payment.

As with the SNF MDS classification system, we believe the HHRG should not be used for children under ten. They are thus exempt from the HHA prospective payment system.

VI. Balance Billing Limitations

Consistent with the Congressional action discussed above, we are revising Section 199.6 of the regulation to specify that institutional providers, including SNFs and HHAs, are required, in order to be TRICARE-authorized providers, to be participating providers on all claims. They must accept as payment in full, except for any required beneficiary deductible and copayment amounts, the TRICARE payment as payment in full. Medicare and TRICARE payment rates are designed to fully reimburse the institutions and are required by Medicare and TRICARE to be accepted as full reimbursement. TRICARE eligible hospitals, SNFs, and HHAs must enter into a participation agreement.

VII. Definitions of "Custodial Care" and "Domiciliary Care"

As noted above, Congress adopted definitions of "custodial care" and "domiciliary care" that we are incorporating into the TRICARE regulation. Custodial and domiciliary care continue to be excluded by the statute and regulation. However, the new definitions narrow the exclusions, resulting in increasing coverage of medically necessary care. This is also consistent with the Congressional effort largely to standardize TRICARE and Medicare sub-acute care coverage and payment policies. As a corollary to these definitions, we are also adopting a

definition of the term "activities of daily living."

VIII. Payment Methods for Hospital Outpatient Services

Medicare implemented a new Outpatient Prospective Payment System (OPPS) on August 1, 2000, as a payment methodology for facility charges in hospital outpatient departments and emergency departments. This system replaced Medicare's prior payment methodology for such services, which was largely based on provider cost reports, but included some fee schedules. The Medicare OPPS is being phased in from 2000 to 2004, with a series of transitional payment adjustments that are based partly upon the prior Medicare cost reports and Medicare's prior cost-based methodology. Consistent with the TRICARE payment reform statutory authority and general policy, we plan to follow the Medicare approach. However, because of complexities of the Medicare transition process and the lack of TRICARE cost report data comparable to Medicare's, it is not practicable for the Department to adopt Medicare OPPS for hospital outpatient services at this time. A separate regulatory initiative in the future will address hospital outpatient services not covered by this regulation. We anticipate eventual adoption of the Medicare OPPS for most TRICARE hospital outpatient services covered by the Medicare OPPS.

This rule addresses payments for four categories of hospital based outpatient services. The first three apply to hospital outpatient clinical laboratory services and rehabilitation therapy services and routine venipuncture. For these services, payments are based on the TRICARE-allowable cost method in effect for professional providers.

The fourth category addresses hospital outpatient radiology services procedures for which CHAMPUS Maximum Allowable Charge (CMAC) technical component rates exist. For these procedures, we will use the CMAC technical component rate to reimburse hospital facility costs for radiology services.

IX. Regulatory Procedures

This rule has been reviewed by the Office of Management and Budget as required under Executive Order 12866. This is a major rule under the Congressional Review Act. This rule is economically significant as it would result in reduced TRICARE payments to skilled nursing facilities (SNFs) in excess of \$100 million per year. The projected volume of services is a function of the recent Congressional

action restoring TRICARE eligibility to Medicare-eligible DoD beneficiaries. The estimates of reduction are based on historical TRICARE costs and an assessment of potential users times average benefit costs per person for each of the provisions addressed. The reduction will be at least partially offset by increases in Medicare payments. This rule will result in increased Medicare payments to SNFs, home health agencies, and other institutional providers of \$4 million in FY03. Benefits of the rule include substantially standardizing sub-acute care benefits and payments between Medicare and TRICARE, particularly important because most TRICARE sub-acute care services are for beneficiaries also covered by Medicare. This regulation would affect small entities such as SNFs. Even though this is an economically significant rule, it does not require a regulatory flexibility analysis as the significant policy action was taken by Congress and the rule merely puts it into effect. The policy of the Regulatory Flexibility Act that agencies adequately evaluate all potential options for an action does not apply when Congress has already dictated the action.

This rule will not impose significant additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511). Existing information collection requirements of the TRICARE and Medicare programs will be utilized. Comments on information collection requirements should be submitted to the Office of Information and Regulatory Affairs, OMB, 725 17th Street, NW., Washington, DC 20503, marked "Attention Desk Officer for Department of Defense, Health Affairs."

This rule is being issued as an interim final rule, with comment period, as an exception to our standard practice of soliciting public comments prior to issuance. The Assistant Secretary of Defense (Health Affairs) has determined that following the standard practice in this case would be unnecessary, impractical, and contrary to the public interest.

This rule implements specific statutory requirements with specific statutory effective dates. This rule is effective 60 days from the date of publication in the **Federal Register**, or as soon thereafter as the Director, TRICARE Management Activity can effectively and efficiently implement through contract change. If the rule is not implemented 60 days from the date of publication in the **Federal Register**, notice will be published in the **Federal Register** when the contract changes

have been completed to implement the rule.

Public comments are invited. All comments will be carefully considered. A discussion of the major issues received by public comments will be included with the issuance of the final rule.

List of Subjects in 32 CFR Part 199

Claims, Dental health, 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(b) is amended by revising the definitions of "custodial care", "domiciliary care", "skilled nursing facility" and "skilled nursing services", by adding definitions of "activities of daily living", "case-mix index", "homebound", "home health discipline", "home health market basket index", "intermittent home health aide and skilled nursing services", and "part-time home health aide and skilled nursing services" in alphabetical order, and by removing the definitions of "essentials of daily living" and "private duty (special) nursing services", to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

Activities of daily living. Care that consists of providing food (including special diets), clothing, and shelter; personal hygiene services; observation and general monitoring; bowel training or management (unless abnormalities in bowel function are of a severity to result in a need for medical or surgical intervention in the absence of skilled services); safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and such other elements of personal care that reasonably can be performed by an untrained adult with minimal instruction or supervision. Activities of daily living may also be referred to as "essentials of daily living".

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Case-mix index. Case-mix index is a scale that measures the relative difference in resources intensity among different groups receiving home health services.

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Custodial care. The term "custodial care" means treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that:

- (1) Can be rendered safely and reasonably by a person who is not medically skilled; or
(2) Is or are designed mainly to help the patient with the activities of daily living.

* * * * *

Domiciliary care. The term "domiciliary care" means care provided to a patient in an institution or homelike environment because:

- (1) Providing support for the activities of daily living in the home is not available or is unsuitable; or
(2) Members of the patient's family are unwilling to provide the care.

* * * * *

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

Home health discipline. One of six home health disciplines covered under the home health benefit (skilled nursing services, physical therapy services, occupational therapy services, speech-language pathology services, and medical social services).

Home health market basket index. An index that reflects changes over time in the prices of an appropriate mix of goods and services included in home health services.

* * * * *

Intermittent home health aide and skilled nursing services. Intermittent means:

(1) Up to and including 28 hours per week of skilled nursing and home health aide services combined, provided on a less-than-daily basis;

(2) Up to 35 hours per week of skilled nursing and home health aide services combined that are provided on a less-than-daily basis, subject to review by managed care support contractors on a case-by-case basis, based upon documentation justifying the need for and reasonableness of such additional care; or

(3) Up to and including full-time (i.e., eight hours per day) skilled nursing and home health aide services combined which are provided and needed seven days per week for temporary, but not indefinite, periods of time of up to 21 days with allowances for extensions in exceptional circumstances where the need for care in excess of 21 days is finite and predictable.

* * * * *

Part-time home health aide and skilled nursing services. Part-time means:

(1) Up to and including 28 hours per week of skilled nursing and home health aide services combined for less than eight hours per day; or

(2) Up to 35 hours per week of skilled nursing and home health aide services combined for less than eight hours per day subject to review by managed care support contractors on a case-by-case basis, based upon documentation justifying the need for and reasonableness of such additional care.

* * * * *

Skilled nursing facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in § 199.6(b)(4)(vi).

Skilled nursing services. Skilled nursing services includes application of professional nursing services and skills by an RN, LPN, or LVN, that are required to be performed under the general supervision/direction of a TRICARE-authorized physician to ensure the safety of the patient and achieve the medically desired result in accordance with accepted standards of practice.

* * * * *

3. Section 199.4 is amended by redesignating the current paragraph (b)(3)(xiv) as (b)(3)(xv), by adding new paragraphs (b)(3)(xiv) and (e)(21), and by removing and reserving paragraphs (c)(2)(xv) and (c)(3)(xii) to read as follows:

§ 199.4 Basic program benefits.

(b) * * *

(3) * * *

(xiv) *Skilled nursing facility (SNF) services.* Covered services in SNFs are the same as provided under Medicare under section 1861(h) and (i) of the Social Security Act (42 U.S.C. 1395x(h) and (i)) and 42 CFR part 409, subparts C and D, except that the Medicare limitation on the number of days of coverage under section 1812(a) and (b) of the Social Security Act (42 U.S.C. 1395d(a) and (b)) and 42 CFR 409.61(b) shall not be applicable under TRICARE. Skilled nursing facility care for each spell of illness shall continue to be provided for as long as necessary and appropriate. For a SNF admission to be covered under TRICARE, the beneficiary must have a qualifying hospital stay meaning an inpatient hospital stay of three consecutive days or more, not including the hospital leave day. The beneficiary must enter the SNF within 30 days of leaving the hospital, or within such time as it would be medically appropriate to begin an active course of treatment, where the individual's condition is such that SNF care would not be medically appropriate within 30 days after discharge from a hospital. The skilled services must be for a medical condition that was either treated during the qualifying three-day hospital stay, or started while the beneficiary was already receiving covered SNF care. Additionally, an individual shall be deemed not to have been discharged from a SNF, if within 30 days after discharge from a SNF, the individual is again admitted to a SNF. Adoption by TRICARE of most Medicare coverage standards does not include Medicare coinsurance amounts. Extended care services furnished to an inpatient of a SNF by such SNF (except as provided in paragraphs (b)(3)(xiv)(C), (b)(3)(xiv)(F), and (b)(3)(xiv)(G) of this section) include:

(A) Nursing care provided by or under the supervision of a registered professional nurse;

(B) Bed and board in connection with the furnishing of such nursing care;

(C) Physical or occupational therapy or speech-language pathology services furnished by the SNF or by others under arrangements with them by the facility;

(D) Medical social services;

(E) Such drugs, biological, supplies, appliances, and equipment, furnished for use in the SNF, as are ordinarily furnished for the care and treatment of inpatients;

(F) Medical services provided by an intern or resident-in-training of a hospital with which the facility has such an agreement in effect; and

(G) Such other services necessary to the health of the patients as are

generally provided by SNFs, or by others under arrangements with them made by the facility.

* * * * *

(e) * * *

(21) *Home health services.* Home health services are covered when furnished by, or under arrangement with, a home health agency (HHA) that participates in the TRICARE program, and provides care on a visiting basis in the beneficiary's home. Covered HHA services are the same as those provided under Medicare under section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) and 42 CFR part 409, subpart E.

(i) *Benefit coverage.* Coverage will be extended for the following home health services subject to the conditions of coverage prescribed in paragraph (e)(21)(ii) of this section:

(A) Part-time or intermittent skilled nursing care furnished by a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse;

(B) Physical therapy, speech-language pathology, and occupational therapy;

(C) Medical social services under the direction of a physician;

(D) Part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Director TMA;

(E) Medical supplies, a covered osteoporosis drug (as defined in the Social Security Act 1861(kk), but excluding other drugs and biologicals) and durable medical equipment;

(F) Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital in the case of an HHA that is affiliated or under common control of a hospital; and

(G) Services at hospitals, SNFs or rehabilitation centers when they involve equipment too cumbersome to bring to the home but not including transportation of the individual in connection with any such item or service.

(ii) *Conditions for Coverage.* The following conditions/criteria must be met in order to be eligible for the HHA benefits and services referenced in paragraph (e)(21)(i) of this section:

(A) The person for whom the services are provided is an eligible TRICARE beneficiary.

(B) The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the TRICARE program.

(C) Physician certifies the need for home health services because the beneficiary is homebound.

(D) The services are provided under a plan of care established and approved by a physician.

(1) The plan of care must contain all pertinent diagnoses, including the patient's mental status, the types of services, supplies, and equipment required, the frequency of visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and any additional items the HHA or physician chooses to include.

(2) The orders on the plan of care must specify the type of services to be provided to the beneficiary, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

(E) The beneficiary must need skilled nursing care on an intermittent basis or physical therapy or speech-language pathology services, or have continued need for occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services has ceased.

(F) The beneficiary must receive, and an HHA must provide, a patient-specific, comprehensive assessment that:

(1) Accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes;

(2) Identifies the beneficiary's continuing need for home care and meets the beneficiary's medical, nursing, rehabilitative, social, and discharge planning needs.

(3) Incorporates the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Director, TRICARE Management Activity.

(G) TRICARE is the appropriate payer.

(H) The services for which payment is claimed are not otherwise excluded from payment.

(I) Any other conditions of coverage/participation that may be required under Medicare's HHA benefit; i.e., coverage guidelines as prescribed under Sections 1861(o) and 1891 of the Social Security Act (42 U.S.C. 1395x(o) and 1395bbb) and 42 CFR Part 484.

* * * * *

4. Section 199.6 is amended by revising paragraphs (a)(8)(i)(A),

(a)(8)(i)(B), (a)(11)(i) and (d)(5), and adding new paragraphs (a)(8)(iii), (b)(4)(vi)(K) and (b)(4)(xv), to read as follows:

§ 199.6 Authorized providers.

- (a) * * *
(8) * * *
(i) * * *

(A) An institutional provider in § 199.6(b), in order to be an authorized provider under TRICARE, must be a participating provider for all claims.

(B) A SNR or a HHA, in order to be an authorized provider under TRICARE, must enter into a participation agreement with TRICARE for all claims.

(iii) Claim-by-claim participation. Individual providers that are not participating providers pursuant to paragraph (a)(8)(ii) of this section may elect to participate on a claim-by-claim basis. They may do so by signing the appropriate space on the claims form and submitting it to the appropriate TRICARE contractor on behalf of the beneficiary.

- (11) * * *

(i) In general. Individual providers including providers salaried or under contract by an institutional provider and other providers who are not participating providers may not balance bill a beneficiary an amount that exceeds the applicable balance billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating practitioners and suppliers.

- (b) * * *
(4) * * *
(vi) * * *

(K) Is an authorized provider under the Medicare program, and meets the requirements of Title 18 of the social Security Act, sections 1819(a), (b), (c), and (d) (42 U.S.C. 1395i-3(a)-(d)).

(xv) Home health agencies (HHAs). HHAs must be Medicare approved and meet all Medicare conditions of participation under sections 1861(o) and 1891 of the Social Security Act (42 U.S.C. 1395x(o) and 1395bbb) and 42 CFR part 484 in relation to TRICARE beneficiaries in order to receive payment under the TRICARE program. An HHA may be found to be out of compliance with a particular Medicare condition of participation and still participate in the TRICARE program as long as the HHA is allowed continued participation in Medicare while the condition of noncompliance is being

corrected. An HHA is a public or private organization, or a subdivision of such an agency or organization, that meets the following requirements:

(A) Engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, speech-language pathology services, or occupational therapy, medical services, and home health aide services.

(1) Makes available part-time or intermittent skilled nursing services and at least one other therapeutic service on a visiting basis in place of residence used as a patient's home.

(2) Furnishes at least one of the qualifying services directly through agency employees, but may furnish the second qualifying service and additional services under arrangement with another HHA or organization.

(B) Policies established by a professional group associated with the agency or organization (including at least one physician and one registered nurse) to govern the services and provides for supervision of such services by a physician or a registered nurse.

(C) Maintains clinical records for all patients.

(D) Licensed in accordance with State and local law or is approved by the State or local licensing agency as meeting the licensing standards, where applicable.

(E) Enters into an agreement with TRICARE in order to participate and to be eligible for payment under the program. In this agreement the HHA and TRICARE agree that the HHA will:

(1) Not charge the beneficiary or any other person for items or services for which the beneficiary is entitled to have payment under the TRICARE HHA prospective payment system.

(2) Be allowed to charge the beneficiary for items or services requested by the beneficiary in addition to those that are covered under the TRICARE HHA prospective payment system.

(F) Abide by the following consolidated billing requirements:

(1) The HHA must submit all TRICARE claims for all services, excluding durable medical equipment (DME), while the beneficiary is under the home health plan without regard to whether or not the item or service was furnished by the HHA, by others under arrangement with the HHA, or under any other contracting or consulting arrangement.

(2) Separate payment will be made for DME items and services provided under the home health benefit which are under the DME fee schedule. DME is

excluded from the consolidated billing requirements.

(3) Home health services included in consolidated billing are:

- (i) Part-time or intermittent skilled nursing;
(ii) Part-time or intermittent home health aide services;
(iii) Physical therapy, occupational therapy and speech-language pathology;
(iv) Medical social services;
(v) Routine and non-routine medical supplies;
(vi) A covered osteoporosis drug (not paid under PPS rate) but excluding other drugs and biologicals;
(vii) Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital in the case of an HHA that is affiliated or under common control of a hospital;
(viii) Services at hospitals, SNFs or rehabilitation centers when they involve equipment too cumbersome to bring home.

(G) Meet such other requirements as the Secretary of Health and Human Services and/or Secretary of Defense may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

(5) Medical equipment firms, medical supply firms, and Durable Medical Equipment, Prosthetic, Orthotic, Supplies providers/suppliers. Any firm, supplier, or provider that is an authorized provider under Medicare or is otherwise designated an authorized provider by the Director, TRICARE Management Activity.

5. Section 199.14 is amended by redesignating paragraphs (h), (i), (j), (k), and (l) as (j), (k), (l), (m) and (n), by adding new paragraphs (a)(5), (h), and (i), and by revising paragraph (b) to read as follows:

§ 199.14 Provider reimbursement methods.

(5) Hospital outpatient services. This paragraph (a)(5) establishes payment methods for certain outpatient services, including emergency services, provided by hospitals.

(i) Clinical laboratory services. Services provided on an outpatient basis by hospital-based clinical laboratories are paid on the same basis as services covered by the allowable charge method under paragraph (h)(1)(viii) of this section.

(ii) Rehabilitation therapy services. Rehabilitation therapy services provided

on an outpatient basis by hospitals are paid on the same basis as rehabilitation therapy services covered by the allowable charge method under paragraph (h)(1) of this section.

(iii) *Venipuncture*. Routine venipuncture services provided on an outpatient basis by hospitals are paid on the same basis as such services covered by the allowable charge method under paragraph (h)(1) of this section. Routine venipuncture services provided on an outpatient basis by institutional providers other than hospitals are also paid on this basis.

(iv) *Radiology services*. TRICARE payments for hospital outpatient radiology services are based on the allowable charge method under paragraph (h)(1) of the section in the case of radiology services for which the CMAC rates establish under that paragraph provide a payment rate for the technical component of the radiology services provided. Hospital charges for an outpatient radiology service are reimbursed using the CMAC technical component rate.

(b) *Skilled nursing facilities (SNFs)*.
(1) *Use of Medicare prospective payment system and rates*. TRICARE payments to SNFs are determined using the same methods and rates used under the Medicare prospective payment system for SNFs under 42 CFR part 413, subpart J, except for children under age ten. SNFs receive a per diem payment of a predetermined Federal payment rate appropriate for the case based on patient classification (using the RUG classification system), urban or rural location of the facility, and area wage index.

(2) *Payment in full*. The SNF payment rates represent payment in full (subject to any applicable beneficiary cost shares) for all costs (routine, ancillary, and capital-related) associated with furnishing inpatient SNF services to TRICARE beneficiaries other than costs associated with operating approved educational activities.

(3) *Education costs*. Costs for approved educational activities shall be subject to separate payment under procedures established by the Director, TRICARE Management Activity. Such procedures shall be similar to procedures for payments for direct medical education costs of hospitals under paragraph (a)(1)(iii)(G)(2) of this section.

(4) *Resident assessment data*. SNFs are required to submit the same resident assessment data as is required under the Medicare program. (The residential assessment is addressed in the Medicare regulations at 42 CFR 483.20.) SNFs must submit assessments according to

an assessment schedule. This schedule must include performance of patient assessments on the 5th, 14th, and 30th days of SNF care and at each successive 30 day interval of SNF admissions that are longer than 30 days. It must also include such other assessments that are necessary to account for changes in patient care needs. TRICARE pays a default rate for the days of a patient's care for which the SNF has failed to comply with the assessment schedule.

* * * * *

(h) *Reimbursement of Home Health Agencies (HHAs)*. HHAs will be reimbursed using the same methods and rates as used under the Medicare HHA prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) and 42 CFR part 484, subpart E, except for children under age ten and except as otherwise necessary to recognize distinct characteristics of TRICARE beneficiaries and as described in instructions issued by the Director, TMA. Under this methodology, an HHA will receive a fixed case-mix and wage-adjusted national 60-day episode payment amount as payment in full for all costs associated with furnishing home health services to TRICARE-eligible beneficiaries with the exception of osteoporosis drugs and DME. The full case-mix and wage-adjusted 60-day episode amount will be payment in full subject to the following adjustments and additional payments:

(1) *Split percentage payments*. The initial percentage payment for initial episodes is paid to an HHA at 60 percent of the case-mix and wage adjusted 60-day episode rate. The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage adjusted 60-day episode rate. The initial percentage payment for subsequent episodes is paid at 50 percent of the case-mix and wage-adjusted 60-day episode rate. The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage-adjusted 60-day episode rate.

(2) *Low-utilization payment*. A low utilization payment is applied when a HHA furnishes four or fewer visits to a beneficiary during the 60-day episode. The visits are paid at the national per-visit amount by discipline updated annually by the applicable market basket for each visit type.

(3) *Partial episode payment (PEP)*. A PEP adjustment is used for payment of an episode of less than 60 days resulting from a beneficiary's elected transfer prior to the end of the 60-day episode or discharge and readmission of a beneficiary to the same HHA before the

end of the 60-day episode. The PEP payment is calculated by multiplying the proportion of the 60-day episode during which the beneficiary remained under the care of the original HHA by the beneficiary's assigned 60-day episode payment.

(4) *Significant change in condition (SCIC)*. The full-episode payment amount is adjusted if a beneficiary experiences a significant change in condition during the 60-day episode that was not envisioned in the initial treatment plan. The total significant change in condition payment adjustment is a proportional payment adjustment reflecting the time both prior to and after the patient experienced a significant change in condition during the 60-day episode. The initial percentage payment provided at the start of the 60-day episode will be adjusted at the end of the episode to reflect the first and second parts of the total SCIC adjustment determined at the end of the 60-day episode. The SCIC payment adjustment is calculated in two parts:

(i) The first part of the SCIC payment adjustment reflects the adjustment to the level of payment prior to the significant change in the patient's condition during the 60-day episode.

(ii) The second part of the SCIC payment adjustment reflects the adjustment to the level of payment after the significant change in the patient's condition occurs during the 60-day episode.

(5) *Outlier payment*. Outlier payments are allowed in addition to regular 60-day episode payments for beneficiaries generating excessively high treatment costs. The outlier payment is a proportion of the imputed costs beyond the outlier threshold for each case-mix (HHRG) group.

(6) *Services paid outside the HHA prospective payment system*. The following are services that receive a separate payment amount in addition to the prospective payment amount for home health services:

(i) *Durable medical equipment (DME)*. Reimbursement of DME is based on the same amounts established under the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule under 42 CFR part 414, subpart D.

(ii) *Osteoporosis drugs*. Although osteoporosis drugs are subject to home health consolidated billing, they continue to be paid on a cost basis, in addition to episode payments.

(7) *Accelerated payments*. Upon request, an accelerated payment may be made to an HHA that is receiving payment under the home health

prospective payment system if the HHA is experiencing financial difficulties because there is a delay by the contractor in making payment to the HHA. The following are criteria for making accelerated payments:

(i) *Approval of payment.* An HHA's request for an accelerated payment must be approved by the contractor and TRICARE Management Activity (TMA).

(ii) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(iii) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as HHA bills are processed or by direct payment by the HHA.

(8) *Assessment data.* Beneficiary assessment data, incorporating the use of the current version of the OASIS items, must be submitted to the contractor for payment under the HHA prospective payment system.

(9) *Administrative review.* An HHA is not entitled to judicial or administrative review with regard to:

(i) Establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payment.

(ii) Establishment of transition period, definition and application of the unit of payment.

(iii) Computation of the initial standard prospective payment amounts.

(iv) Establishment of case-mix and area wage adjustment factors.

(i) *Changes in Federal Law affecting Medicare.* With regard to paragraph (b) and (h) of this section, the Department of Defense must, within the time frame specified in law and to the extent it is practicable, bring the TRICARE program into compliance with any changes in Federal Law affecting the Medicare program that occur after the effective date of the DoD rule to implement the prospective payment systems for skilled nursing facilities and home health agencies.

* * * * *

Dated: June 5, 2002.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 02-14707 Filed 6-12-02; 8:45 am]

BILLING CODE 5001-08-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD07-02-057]

Drawbridge Operation Regulations; Atlantic Intracoastal Waterway, Mile 1069.4 at Dania Beach, Broward County, FL

AGENCY: Coast Guard, DOT.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, Seventh Coast Guard District, has approved a temporary deviation from the regulations governing the operation of the Dania Beach Boulevard bridge, mile 1069.4 at Dania Beach, Florida, from June 4, 2002 to July 31, 2002. This deviation allows this bridge to only open a single-leaf of the bridge every 20 minutes. Double-leaf openings will be available with a two-hour advance notice to the bridge tender. This temporary deviation is required to allow the bridge owner to safely complete repairs to the bridge.

DATES: This deviation is effective from 12:01 a.m. on June 4, 2002 to 8 p.m. on July 31, 2002.

ADDRESSES: Material received from the public, as well as documents indicated in this preamble as being available in the docket, will become part of this docket and will be available for inspection or copying at Commander (obr), Seventh Coast Guard District, 909 S.E. 1st Avenue, Room 432, Miami, FL 33131 between 7:30 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Mr. Michael Lieberum, Project Officer, Seventh Coast Guard District, Bridge Section at (305) 415-6744.

SUPPLEMENTARY INFORMATION: The Dania Beach Boulevard bridge, mile 1069.4 at Dania Beach, Broward County, Florida, has a vertical clearance of 22 feet at mean high water and a horizontal clearance of 45 feet between the down span and the fender system. The existing operating regulations in 33 CFR part 117 require the bridge to open on signal.

PCL Contractors notified the Coast Guard on April 16, 2002, that the work on the bascule leaves had started and due to a safety issue involving welding deck plates, they requested a 20 minute opening schedule. On April 22, 2002, the Coast Guard contacted the Florida Department of Transportation representative, URS, to discuss this

request. It was determined that the contractor did need the bridge to be put on a 20 minute temporary operating schedule. Additionally, URS requested that the bridge be allowed to only open a single-leaf, with double-leaf openings available with a two-hour advance notice to the bridge tender. This action is necessary to facilitate worker's safety during repairs to the bridge without significantly hindering navigation, as a full opening will be provided with a two-hour advance notice to the bridge tender.

The District Commander has granted a temporary deviation from the operating requirements listed in 33 CFR 117.5 to complete repairs to the drawbridge. Under this deviation, the Dania Beach Boulevard bridge, mile 1069.4 at Dania Beach, need only open a single-leaf on the hour, 20 minutes after the hour, and 40 minutes after the hour from 12:01 a.m. on June 4, 2002, to 8 p.m. on July 31, 2002. A double-leaf opening will be available if two-hour advance notice is provided to the bridge tender from 12:01 a.m. on June 4, 2002, to 8 p.m. on July 31, 2002.

Dated: June 4, 2002.

Greg Shapley,

Chief, Bridge Administration Branch, Seventh Coast Guard District.

[FR Doc. 02-14969 Filed 6-12-02; 8:45 am]

BILLING CODE 4910-15-P

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD07-01-144]

RIN 2115-AE47

Drawbridge Operation Regulations; Sanibel Causeway Bridge, Okeechobee Waterway, Punta Rassa, FL

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: The Coast Guard is changing the regulations governing the operation of the Sanibel Causeway bridge, Okeechobee Waterway, mile 151, Punta Rassa, Florida. This rule requires the draw to open on signal, except that from 7 a.m. until 6 p.m., Monday through Friday, except Federal holidays, the draw need only open on the hour and half hour. On Saturday, Sunday, and Federal holidays the draw shall open on signal, except that from 7 a.m. until 6 p.m., the draw need only open on the hour, quarter hour, half hour and three quarter hour. From 10 p.m. until 6 a.m. daily, the draw will open on signal if at