this logic and have modified language accordingly.

Treatment plans must be completed within 10 days; clinical formulations no longer have a specific deadline, but must be completed prior to development of the interdisciplinary treatment plan.

9. Family Therapy. A large number of commenters raised the issue of logistical problems which present difficulty in accomplishing family therapy for CHAMPUS beneficiaries. An example frequently used was the deployment of military members which caused geographic separations. The argument was made that CHAMPUS should be more flexible regarding this requirement.

Response. Family therapy is not a new requirement for CHAMPUS beneficiaries. Geographical distance is not considered a reason to exclude the family from a treatment plan. For patients separated from their families by deployment or for other reasons, CHAMPUS allows geographically distant family therapy. If one or both parents reside a minimum of 250 miles from the RTC, the RTC has the flexibility to arrange for therapy with parents at the distant locality. If family therapy is clinically contraindicated, rationale for this conclusion must be documented in the patient's record.

10. Annual Facility Evaluation. We received several comments arguing that a service specific annual evaluation was overly burdensome to facilities and "unheard of" outside academic settings.

Response. The proposed rule identified this requirement in the context of facility development of a strategic plan which contains specific goals and objectives for each program component or service and patient population served. Sound business practices would suggest regular organizational assessments to identify progress toward established performance and fiscal goals and objectives. The Department, as well as other accrediting agencies, expect governing bodies, through their CEOs, to provide sufficient resources to achieve the organization's missions, goals, philosophy and objectives. Without a clear idea of resource allocation and performance across the range of services provided, it is unclear how facilities would evaluate outcomes, or the need for change. We do not agree that this is overly burdensome and find it surprising that such reviews would be limited only to academic settings.

11. Education Hours in Partial Hospitalization Programs. The proposed rule does not count educational hours towards total hours for "full day" partial

hospitalization programs. Several commenters argued that, by not including time spent in school, those hours, combined with the required six hours for a full day partial program, result in an excessively long day for patients.

Response. Patients who meet the criteria for admission to partial hospitalization programs do not require a professionally managed milieu twenty-four hours a day, as do individuals in residential treatment programs. Therefore, we find it reasonable to expect that school hours may be accommodated separately from the hours spent in therapy and other treatment activities. Determinations as to school hours vs. time spent in treatment or other activities should be considered as part of an overall assessment of the patient's needs and addressed in an individualized treatment plan.

12. Benefit Limitations. One provider association objected to CHAMPUS limits on treatment of substance use disorders, stating that these limits do not consider the chronic nature of this problem.

Response. Compared to many third party payers, CHAMPUS provides one of the more generous benefits for treatment of substance use disorders. We do recognize the chronic as well as individual nature of these problems and, consistent with that, provide an allowance for waivers of benefit limits when continued treatment is justified.

13. Burden and Expense Associated With Cost Based Reimbursement. The overwhelming majority of comments on the proposed cost based reimbursement system argued that the cost and administrative burden associated with these changes, for both the Department and providers, far exceeded any benefit to the government. A number of commenters pointed out that the GAO reports which provided impetus for payment reform were based on outdated information which did not reflect the results of earlier initiatives. Commenters suggested that, if DoD is required to implement additional cost containment measures, these could be accomplished more efficiently through adjustments to existing payment mechanisms.

Response. After full consideration of comments from the provider community, as well as our continuing analysis of costs associated with implementation of a cost based system for mental health, we agree that implementation of the proposed system is not appropriate at this time. Although cost containment and utilization management programs have achieved program savings, we agree with GAO

conclusion that additional improvements are needed. While the GAO report may not reflect the full measure of cost and quality improvements achieved by earlier efforts, continuing program reviews and findings gathered through utilization management programs suggest CHAMPUS mental health programs require additional controls.

In keeping with comments from the industry and our own analysis, additional cost containment in CHAMPUS mental health programs will be accomplished through adjustments to current reimbursement mechanisms. For specialty psychiatric hospitals and units, payment will be held at FY95 rates for two years, beginning in FY96 and extending through FY97. Additionally, April 6, 1995, payment will be capped at a rate not to exceed the 70th percentile of payment rates in all high volume CHAMPUS psychiatric hospitals. We estimate that these adjustments will result in CHAMPUS payments at the level of average aggregate costs for psychiatric hospitals and units, thereby addressing concerns expressed by the GAO.

The general lack of availability with respect to RTC cost information presented some difficulties in our attempt to analyze impact of payment reforms for this community. In measures similar to those for psychiatric hospitals, RTC payment rates for facilities at or above the 30th percentile of all CHAMPUS RTC payment rates in FY95 will be held constant, with no additional update through fiscal years FY96 and FY97. Additionally, effective April 6, 1995, payments will be capped at level not to exceed the 70th percentile of all RTC rates nationally. For those RTCs paid at levels below the 30th percentile of national CHAMPUS RTC rates, payments will be updated by the lesser of the CPI-U for medical care or the amount that brings the rate up to the 30th percentile level. The update factor for payments beginning in FY98 will be the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system. In order to determine the effectiveness of RTC cost containment measures established in this final rule, the Department will continue to explore avenues for obtaining accurate cost data for RTC services.

## V. Rulemaking Procedures

This rule is a significant regulatory action as determined by the Office of Management and Budget. Also, we certify that this rule will not significantly affect a large number of