1989, we published revised relative weights based on CHAMPUS claims data. As a result, the weights, and therefore, the payments, nearly doubled on average. At that time OCHAMPUS retroactively adjusted all claims which had been processed using the previous lower weights. We have continued to refine the PM–DRG weights and classifications involving complications during subsequent annual updates.

In addition, at the time we adopted the PM–DRGs, we examined the possible application of additional DRGs to children who are older than newborns. We contracted with the RAND Corporation to investigate the use of PM–DRGs for this pediatric population. RAND's results showed that almost no difference in payments would occur, so we elected not to make any changes for the pediatric age groups.

To recognize the higher costs of pediatric patients and hospitals with more than their share of high-cost patients, CHAMPUS included a generous provision for calculating the cost outlier for children's hospitals and for neonatal services. Any discharge for services in a children's hospital or for neonatal services which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or \$13,500 qualifies as a cost outlier, resulting in reimbursement of the DRG-based amount plus the differential, plus a percentage of all costs exceeding the threshold. Since the threshold is so low, a considerable number of cases receive this additional payment consideration.

As an added safeguard, CHAMPUS will continue for an interim period to exempt certain high-cost conditions from payment under the DRG-based payment system to protect acute care and children's hospitals from incurring unexpectedly high costs for care related to children under 18 years of age who are HIV seropositive, for all services related to pediatric bone marrow transplants and for all services related to pediatric cystic fibrosis.

In 1990, New York adopted some very minor classification changes to their neonatal DRGs which resulted in some reductions in payments; CHAMPUS reviewed the classification changes but elected not to make similar changes. We have continually consulted with NACHRI.

Since we have implemented all of the special measures Congress identified and since the Congressional intent was that the hospital-specific differential be used only "for a transitional period of 3 years," it is appropriate that a national differential for children's hospitals be implemented at this time. During the

three-year transition, children's hospitals were held harmless via a reconciliation calculation that ensured payments that recognized hospitalspecific costs for high-volume hospitals. The transition period for using the "hold harmless" hospital-specific and low-volume differentials ended March 31, 1992. Reconciliations after the "hold harmless" period will be calculated applying the national differential rate in accordance with Congressional direction. Under the national differential, eighteen hospitals will receive a higher differential, and fifteen hospitals will receive a lower differential. Although a small number of high-volume hospitals will experience a reduction in CHAMPUS payments, we remain convinced that our payments, especially in light of the differential and other special considerations outlined above, will fairly compensate children's hospitals for their services. Even with a national differential, our payments will be significantly higher for all children's hospitals than for all other hospitals subject to DRG-based payments. The national differential is expected to encourage efficiency, and comply with Congressional intent and direction in controlling future CHAMPUS costs.

CHAMPUS recognizes that on average, children's hospitals have a more costly mix of pediatric patients than nonexempt hospitals. CHAMPUS is also aware that pediatric patients in general may be more expensive than adults because of the requirement for more nursing care and specialized services. Because of these higher costs, CHAMPUS has proceeded slowly and built in safeguards to protect children's hospitals against untoward financial repercussions. We believe all of these safeguards, as well as the numerous refinements we have outlined, will result in a fair and equitable payment to the children's hospitals. We feel confident that sufficient time has been allotted to identify and implement any classification changes which were found necessary. Of course, CHAMPUS will continue to refine PM-DRGs on an ongoing basis, just as we currently do for adult DRGs.

Following are the national differentials:

Area	All hospitals
Large Urban: Labor Non-labor	\$1,945.99 689.42
Oth on I lish on.	2,635.41
Other Urban: Labor	1,483.21

Area	All hospitals
Non-labor	525.47
	2,008.68

Dated: April 24, 1995.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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## Record of Decision for the Final Programmatic Environmental Impact Statement (FPEIS) for the Ballistic Missile Defense (BMD) Program

**AGENCY:** Ballistic Missile Defense Organization (BMDO).

SUMMARY: On April 23, 1995, the Ballistic Missile Defense Organization (BMDO) signed the Record of Decision (ROD) on research, development, and testing of Ballistic Missile Defense (BMD) capability. The decision included in this ROD has been made in consideration of, but not limited to, the information contained in the Ballistic Missile Defense Final Programmatic Environmental Impact Statement (Final PEIS) filed with the U.S. Environmental Protection Agency on November 18, 1994. Other factors considered in this decision include the present and projected threat, cost, and administrative and congressional directives.

The BMD programmatic alternatives arose from existing and potential national security needs. The need for further research and development of BMD capability comes from the threat posed by the global proliferation of missile technology, and the accompanying production and development of weapons of mass destruction. This threat is compounded by improvements to missile performance and weapon design by other nations, as well as increases in the number of missile-armed nations. The ROD documents the BMDO decision between the programmatic alternatives.

The BMD program includes both National Missile Defense (NMD) and Theater Missile Defense (TMD) segments under the direction of BMDO. The NMD segment of the program considers developing ground and spacebased elements, including Ground-Based Sensor (GBS), Ground-Based Interceptor (GBI), Space-Based Sensor (SBS), and Battle Management/Command, Control, and Communications (BM/C3) elements, to defend the United States against longrange missiles. The TMD segment