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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

DOD-2012-HA-0146

RIN 0720-AB47

TRICARE; Reimbursement of Long Term Care Hospitals

AGENCY: Office of the Secretary, Department of Defense (DoD).

ACTION: Proposed rule.

SUMMARY: This proposed rule requests public comment on proposed implementation for Long Term Care Hospitals (LTCHs) the statutory provision at title 10, United States Code (U.S.C.), section 1079(j)(2) that TRICARE payment methods for institutional care be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. This proposed rule sets forth the proposed regulation modifications necessary to implement a TRICARE reimbursement methodology similar to that applicable to Medicare beneficiaries for inpatient services provided by LTCHs.

DATES: Written comments received at the address indicated below by [insert 60 days from date of publication] will be accepted.

ADDRESSES: You may submit comments, identified by docket number or Regulatory Information Number (RIN) and title, by either of the following methods:

The Web site: http://www.regulations.gov. Follow the instructions for submitting comments.

Mail: Federal Docket Management System Office, Room 3C843, 1160 Defense Pentagon, Washington, DC 20301–1160.

Instructions: All submissions received must include the agency name and docket number or RIN for this Federal Register document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at http://www.regulations.gov as they are received without change, including any personal identifiers or contact information.

FOR INFORMATION CONTACT: Ann Fazzini, TRICARE Management Activity (TMA), Medical Benefits and Reimbursement Branch, telephone (303) 676-3803.

SUPPLEMENTARY INFORMATION:

I. Executive Summary.

A. Purpose of the Proposed Rule.

The purpose of this proposed rule is to publish proposed TRICARE regulation modifications necessary to implement for LTCHs the statutory requirement that for TRICARE institutional services "payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare]." Medicare pays LTCHs using a LTCH Prospective Payment System (PPS) which classifies Long Term Care (LTC) patients into distinct Diagnosis-Related Groups (DRG). The patient classification system groupings are called Medicare Severity Long Term Care Diagnosis Related Groups (MS-LTC-DRGs), which are the same DRGs used under the hospital inpatient PPS, but that have been weighted to reflect the resources required to treat the medically complex patients treated at LTCHs.

TRICARE pays for most hospital care under the CHAMPUS DRG-based payment system, which is similar to Medicare's, but some hospitals are exempt from the CHAMPUS DRG-based payment system. LTCHs are currently exempt from the CHAMPUS DRG-based payment system; they are paid their billed charges or a discount from their billed charges. Paying billed charges is fiscally imprudent and inconsistent with TRICARE's governing statute. Paying LTCHs under a method similar to Medicare's is prudent, practicable, and harmonious with the statute. Our legal authority for this proposed rule is 10 U.S.C. 1079(j)(2).

B. Summary of the Major Provisions of the Proposed Rule.

1. *Implementation of a Prospective Payment System Methodology for LTCHs.* TRICARE proposes to reimburse LTCHs for inpatient care using a method similar to Medicare's LTCH PPS using MS-LTC-DRGs. Under the proposed TRICARE LTCH reimbursement method, payment for a TRICARE patient will be made at a predetermined, per-discharge amount for each MS-LTC-DRG. The TRICARE LTCH reimbursement method would include payment for all inpatient operating and capital costs of furnishing covered services (including routine and ancillary services), but not certain pass-through costs (e.g. --bad debts, direct medical education, and blood clotting factors).

2. *Transition period.*

In the past when implementing new reimbursement systems, TRICARE has offered a transition or phase-in period to buffer revenue reductions experienced by hospitals. For additional information, we refer the reader to the final rule on Sole Community Hospital (SCH) reimbursement (78 FR 48303). The phase-in period for SCHs was provided, in part, to allow hospitals sufficient time to adjust and budget for these reductions. It also provided an incentive for hospitals to remain in the network by allowing a 5 percent difference in payment reductions

per year. More importantly, the transition was allowed by TRICARE because, by their nature, SCHs were the only hospitals in specific vicinities, so TRICARE patients were dependent on them. In addition, some SCHs rely heavily on TRICARE patients. Neither of these situations is true for LTCHs.

In analyzing TRICARE data for LTCH admissions, we found reasons to forego a transition or phase-in period. First, LTCHs are not financially dependent on TRICARE beneficiaries. Our data show the average LTCH serving TRICARE beneficiaries had less than four admissions in Fiscal Year (FY) 12. Seventeen LTCHs scattered across eight states had 10 or more TRICARE admissions in FY12 and the vast majority of LTCHs had zero or one TRICARE admission in that same fiscal year. Second, out of the 227 LTCHs that had TRICARE admissions in FY12, about 75 percent of these hospitals admitted four or fewer TRICARE beneficiaries. In reviewing the allowed amount paid by TRICARE to LTCHs, allowed charges for non-TRICARE For Life (TFL) beneficiaries were approximately $71 million in FY12. These allowed amounts were equal to 73 percent of billed charges, indicating that there are significant discounts off of the billed charge that are currently being accepted by LTCHs. Considering the low utilization of LTCHs by TRICARE beneficiaries and the discounts LTCHs are offering, we have concluded that implementation of TRICARE LTCH reimbursement methods similar to Medicare will have little financial impact on LTCHs. As a result, we are foregoing a transition period, but invite comments on this approach.

C. Costs and Benefits.

The economic impact of the proposed rule is anticipated to reduce DoD payments to LTCHs, for all TRICARE beneficiaries by approximately $57 million during the first year of implementation.

II. Introduction and Background.

A. TRICARE LTCH Reimbursement

Per 32 Code of Federal Regulations (CFR) 199.14(a)(1)(ii)(D)(4), LTCHs are currently exempt from the TRICARE DRG-based payment system, just as they were exempt from Medicare's Inpatient Prospective Payment System (IPPS) when the Centers for Medicare and Medicaid Services (CMS) initially implemented its DRG-based payment system. Because LTCHs are exempt from the TRICARE DRG-based payment system, and because there is no alternate TRICARE reimbursement mechanism in 32 CFR Part 199 at this time, LTCH inpatient care provided to TRICARE beneficiaries is currently paid on the lower of a negotiated rate (if a network hospital) or billed charges (if a non-network hospital).

Medicare also created a PPS for LTCHs effective with the cost reporting period beginning on or after October 1, 2002. TRICARE often adopts Medicare's reimbursement methods but delays implementation generally until any transition phase is complete for the Medicare program. CMS included a 5-year transition period when it adopted LTCH PPS for Medicare, under which LTCHs could elect to be paid a blended rate for a set period of time. This transition period ended in 2006. Following the transition phase, Medicare adopted an LTCH-specific DRG system, the MS-LTC-DRG, in 2008. The MS-LTC-DRG is still used as the patient classification system for LTCHs. Given TRICARE's statutory requirement to adopt Medicare's reimbursement methods when practicable, TRICARE is proposing to adopt a reimbursement method similar to Medicare's LTCH PPS for our beneficiaries.

Under 10 U.S.C. 1079(j)(2), the amount to be paid to hospitals, skilled nursing facilities, and other institutional providers under TRICARE, "shall be determined to the extent practicable in

accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare."

Patients with clinically complex problems, such as multiple acute or chronic conditions, may need hospital care for an extended period of time. LTCHs represent a relatively small number of hospitals (approximately 425 under Medicare), which treat a critically ill population with complex needs.

The MS-LTC-DRG system under Medicare's LTCH PPS classifies patients into distinct diagnostic groups based on clinical characteristics and expected resource needs. The patient classification groupings, which are the same groupings used under the inpatient acute care hospital groupings (i.e. MS–DRGs) are weighted to reflect the resources required to treat the medically complex patients who are treated in LTCHs. By their nature, LTCHs treat patients with comorbidities requiring long-stay, hospital-level care.

For TRICARE, there were approximately 700 non-TFL and 100 TFL LTCH admissions in FY 12 for which TRICARE was the primary payer. The average LTCH serving non-TFL TRICARE beneficiaries had less than four admissions in FY 12. TRICARE non-TFL LTCH-allowed charges were approximately $71 million in FY 12. These allowed amounts are equal to 73 percent of billed charges, indicating that there are significant discounts at LTCHs. We found that the average allowed amount for non-TFL beneficiaries was almost $101,000 during FY 12, which is significantly more than the estimated amount that Medicare would have paid for these discharges (the average Medicare LTCH PPS payment would have been less than $50,000). Thus, using the Medicare LTCH-PPS system would reduce TRICARE-allowed amounts significantly, reducing TRICARE payments by $40 million per year for non-TFL beneficiaries.

For TFL beneficiaries for whom TRICARE was the primary payer, TRICARE paid approximately $23 million in FY 12. In cases where TRICARE is the primary payer, such as when a Medicare beneficiary exhausts his/her day limits, TRICARE is paying billed charges. Reimbursing using methods similar to Medicare LTCH reimbursement would reduce TRICARE payments for TFL beneficiaries by approximately $17 million per year.

Shifting to methods similar to Medicare LTCH reimbursement would reduce TRICARE payments to LTCHs for non-TFL and TFL beneficiaries by $57 million during the first year of implementation.

TRICARE currently pays LTCHs for inpatient care in one of two ways:

(1) Network hospitals: Payment is an amount equal to billed charges less a negotiated discount. The discounted reimbursement is usually substantially greater than what would be paid using the TRICARE DRG method, which TRICARE generally uses to reimburse hospitals for inpatient care; or

(2) Non-network hospitals: Payment is equal to billed charges.

As discussed above TRICARE's current payment method results in TRICARE reimbursing LTCHs substantially more than Medicare does for equivalent inpatient care. A change is needed to conform to the statute.

Under 32 CFR 199.14(a)(1)(ii)(D)(*4*), LTCHs are currently exempt from the TRICARE DRG-based payment system. Based on 10 U.S.C. 1079(j)(2), TRICARE is proposing to adopt a reimbursement method similar to Medicare's LTCH PPS as the methodology to reimburse TRICARE LTCHs.

Establishing a TRICARE LTCH inpatient reimbursement method similar to Medicare is practicable. Even though the beneficiary populations differ between Medicare and TRICARE,

we have found that the distribution of LTCH cases by diagnosis groups is similar between TRICARE and Medicare. Additionally, TRICARE has a low volume of admissions to LTCHs, so calculating weights and rates for TRICARE admissions to LTCHs is impracticable. We are able to calculate our own weights for admissions to general hospitals on an annual basis because of the volume of TRICARE admissions to general hospitals, however, it would be difficult to determine a new set of weights based on a small admission population. For example, only five MS-LTC-DRGs had 25 or more TRICARE admissions in FY 12 and only 17 had ten or more TRICARE admissions in that year. Consequently, we are proposing to adopt the methods used currently in Medicare's MS-LTC-DRG reimbursement system except for slight differences in calculating short stay outlier payments; and not adopting the 25 percent threshold payment adjustment policy. TRICARE's proposed adoption of Medicare's MS-LTC-DRG reimbursement system includes adoption of Medicare's interrupted stay policy and high-cost outlier payments.

Short Stay Outlier (SSO). For cases with a very short length of stay, Medicare uses an alternate method of payment. For an SSO discharge, the Medicare payment is based on the least of the following:

- 100 percent of the estimated cost of the case.
- 120 percent of the MS–LTC–DRG specific per diem amount multiplied by the covered length of stay of the particular case.
- The full MS–LTC–DRG amount.
- A blend of the IPPS amount for the same type of case and 120 percent of the MS-LTC-DRG per diem amount (for certain cases with relatively short lengths of stay, the blend percentage for the MS-LTC-DRG per diem portion is zero percent and as such the blended payment under this option is 100 percent of the IPPS amount).

To simplify, and because it is not practicable for TRICARE to adopt Medicare's complex four step process considering our low volume of LTCH claims, we are proposing to adopt the methodology of paying short stay outliers at the lesser of: 1) their cost (i.e. 100 percent of the estimated cost of the case) or 2) the full MS-LTC-DRG amount. This approach is fair and ensures that LTCH costs will be covered for short stay outlier cases.

25 Percent Threshold Payment Adjustment. In the FY 2005 Inpatient Prospective Payment System (IPPS) Final Rule, the Centers for Medicare & Medicaid Services (CMS) established a special payment adjustment policy for LTCHs as defined by section 1886(d)(1)(B)(iv)(I) of the Social Security Act. This includes LTCHs that are Hospitals-within-Hospitals (HwHs) or satellites of an LTCH that is co-located with a host hospital or on the campus (any facility within 250 yards of the hospital).

This payment adjustment policy is commonly called the "25 percent rule." The 25 percent transfer rule provides a financial penalty to LTCHs that receive more than 25 percent of their patients from any one acute care hospital. Given the low number of TRICARE admissions, this provision is not practicable, and is unnecessary under TRICARE.

We are also aware the Department of Health and Human Services intends to address implementation of Section 1206(a) of the Pathway for SGR Reform Act of 2013 (Public Law 113-67) in the FY 2016 rulemaking process. Section 1206(a) provides for the establishment of patient criteria for "site neutral" payment rates under the LTCH PPS. The Department of Defense proposes to defer action on this issue pending review of the final Medicare policy.

B. Pediatric Cases

Our analysis found that the TRICARE and Medicare populations have similar diagnoses and that the estimated TRICARE costs in each MS-LTC-DRG group are similar to those in

Medicare. There are very few TRICARE LTCH cases for patients under age 17; however, these pediatric cases have similar diagnoses as other TRICARE LTCH admissions. Therefore, we propose to adopt the same MS-LTC-DRG reimbursement for pediatric patients as we are for all other TRICARE beneficiaries.

We are inviting comments on this proposal and welcome feedback on whether the MS-LTC-DRG weights are appropriate for pediatric cases. We also welcome options and alternative approaches for LTCH reimbursement for pediatric beneficiaries.

III. Regulatory Impact Analysis

A. Overall Impact

DoD has examined the impacts of this proposed rule as required by Executive Orders (E.O.s) 12866 (September 1993, Regulatory Planning and Review) and 13563 (January 18, 2011, Improving Regulation and Regulatory Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and the Congressional Review Act (5 U.S.C. 804(2)).

1. *Executive Order 12866 and Executive Order 13563*

E.O.s 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year).

We estimate that the effects of the LTCH provisions that would be implemented by this rule would not result in LTCH revenue reductions exceeding $100 million in any one year. We estimate that this rulemaking is not “economically significant" as measured by the $100 million threshold. However, we have prepared a Regulatory Impact Analysis that, to the best of our ability, presents the costs and benefits of the rulemaking.

2. *Congressional Review Act. 5 U.S.C. 801*

Under the Congressional Review Act, a major rule may not take effect until at least 60 days after submission to Congress of a report regarding the rule. A major rule is one that would have an annual effect on the economy of $100 million or more or have certain other impacts. This Notice of Proposed Rule Making (NPRM) is not a major rule under the Congressional Review Act.

3. *Regulatory Flexibility Act (RFA)*

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) identification of a small business (having revenues of $34.5 million or less in any one year). For purposes of the RFA, we have determined that all LTCHs would be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity. Therefore, this Rule would have a significant impact on a substantial number of small entities. The Regulatory Impact Analysis, as well as the contents contained in the preamble, also serves as the Regulatory Flexibility Analysis.

4. *Unfunded Mandates*

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $140 million. This Proposed Rule will not mandate any requirements for State, local, or tribal governments or the private sector.

5. *Paperwork Reduction Act*

This rule will not impose significant additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3502-3511). Existing information collection requirements of the TRICARE and Medicare programs will be utilized. We do not anticipate any increased costs to hospitals because of paperwork, billing, or software requirements since we are keeping TRICARE's billing/coding requirements (i.e., hospitals will be coding and filing claims in the same manner as they currently are with TRICARE).

6. *Executive Order 13132, "Federalism*"

This rule has been examined for its impact under E.O. 13132, and it does not contain policies that have federalism implications that would have substantial direct effects on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of Government. Therefore, consultation with State and local officials is not required.

B. Hospitals Included in and Excluded from the proposed TRICARE LTCH reimbursement methodology

The TRICARE LTCH reimbursement system encompasses all TRICARE authorized LTCHs that have inpatient stays for TRICARE beneficiaries except for hospitals in States that are paid

by Medicare and TRICARE under a waiver that exempts them from Medicare's inpatient prospective payment system or the CHAMPUS DRG-based payment system, respectively. Currently, only Maryland hospitals operate under such a waiver.

C. Analysis of the Impact of TRICARE LTCH Payment Reform on LTCHs

1. Methodology

We analyzed the impact of TRICARE implementing a new method of payment for LTCHs. The proposed method is very similar to Medicare's LTCH payment method, which uses the Medicare MS-LTC-DRG system. Our analysis compares the payment impact of the new methodology compared to current TRICARE methodology (where TRICARE pays billed charges or discounts off of these billed charges for all LTCH claims).

The data used in developing the quantitative analyses presented below are taken from TRICARE charge and payment data from October 2011 – September 2012. Our analysis has several qualifications. First, we drew upon various sources for the data used to categorize hospitals in Table 1, below. We attempted to construct these variables using information from Medicare's FY12 Impact file to verify that each provider was in fact a Medicare LTCH. For individual hospitals, however, some miscategorizations are possible. We were unable to match 18 hospital claims from 7 LTCHs to the FY12 Impact file, and therefore excluded them from the analysis. After we removed the excluded claims which we could not assign payment and hospital classification variables for, we used the remaining hospitals and claims as the basis for our analysis. All Maryland LTCHs were also excluded from the analysis.

Using charge data from 2012, the FY12 Medicare MS-LTC-DRG weights, the FY12 Medicare national base payment rate, the FY12 Medicare high cost outlier fixed threshold, and the FY12 wage index adjustment factors, we simulated TRICARE payments using the proposed

LTCH payment method. We focused the analysis on TRICARE claims where TRICARE was the primary payer because only these TRICARE payments will be affected by the proposed reforms.

2. Effect on Hospitals

Table 1, First Year Impact of TRICARE LTCH proposed rule, below, demonstrates the results of our analysis. This table categorizes LTCHs which had TRICARE inpatient stays in FY12 by various geographic and special payment consideration groups to illustrate the varying impacts on different types of LTCHs. The first column represents the number of LTCHs in FY12 in each category which had inpatient stays in which TRICARE was the primary payer. The second column shows the number of TRICARE discharges in each category. The third and fourth columns show the average allowed amount per discharge paid by TRICARE in FY12, and under the proposed LTCH payment method. The fifth column shows the percentage impact of the policy change by showing the percentage reduction in the proposed allowed amounts relative to the current allowed amounts.

The first row in Table 1 shows the overall impact of the 227 LTCHs included in the analysis. The next three rows of the table contain hospitals categorized according to their geographic location (large urban, other urban, and rural). The second major grouping is by bed-size category, followed by a grouping for TRICARE network status. The fourth grouping shows the LTCHs by regional Census divisions while the final grouping is by LTCH ownership status. We estimate that in the first year of implementation, TRICARE payments to LTCHs will decrease by 61 percent under the proposed LTCH payment methodology in comparison to the current TRICARE payment methodology for LTCH claims. For all groups of hospitals, payments under the proposed payment methodology would be reduced.

The following discussion highlights some of the changes in payments among LTCH classifications.

Ninety-eight percent of all TRICARE LTCH admissions were to urban LTCHs. Payments would decrease by 61 percent for large urban, 63 percent for other urban, and 58 percent for rural LTCHs.

Very small LTCHs (1-24 beds) would have the least impact; payments would be reduced by 49 percent. The change in payment methodology would have a slightly greater impact on medium-sized LTCHs (50-124 beds), where payments would be reduced by about 64 percent.

The change in LTCH payment methodology would have a larger impact on TRICARE non-network LTCHs than network LTCHs. Payments to non-network LTCHs would decline by 71 percent, in comparison to 56 percent for in-network hospitals. There is a smaller decline in TRICARE payments for network hospitals because these LTCHs provide discounts to TRICARE, which means that their allowed amounts are already lower. We found that network hospitals on average provide a 29 percent discount off billed charges and that almost 77 percent of all TRICARE LTCH discharges are in-network.

LTCHs in various geographic areas will be affected differently due to this change in payment methodology. The two regions with the largest number of TRICARE claims, the South Atlantic and West South Central region, would have an average decrease of 62 and 61 percent respectively, which are very similar to the overall average of 61 percent. LTCHs in the East North Central and New England regions would have the lowest reductions: 52 and 50 percent. Seventy-eight percent of all TRICARE LTCH discharges in FY12 were in proprietary (for-profit) LTCHs, and these facilities would have their allowed amounts reduced by approximately

63 percent. The decline in allowed amounts for voluntary (not-for-profit) LTCHs would be less than for-profit hospitals (57 percent).

Table 1
First Year Impact of TRICARE LTCH Rule

	Number of Hospitals	Number of Discharges	Allowed per Discharge (Current Policy)	Allowed per Discharge (Medicare Method)	Percent Reduction in Allowed Amounts (Medicare)
All LTCHs	**227**	**799**	**$118,313**	**$45,818**	**61%**
Large Urban	119	452	$130,245	$51,305	61%
Other Urban	99	331	$104,693	$39,254	63%
Rural	9	16	$62,960	$26,583	58%
Beds	**227**	**799**	**$118,313**	**$45,818**	**61%**
1-24	8	15	$70,322	$36,020	49%
25-34	53	133	$110,915	$42,644	62%
35-49	52	158	$102,939	$44,645	57%
50-74	58	241	$122,152	$43,093	65%
75-124	29	129	$128,611	$47,691	63%
125+	27	123	$133,590	$55,324	59%
Network Status	**227**	**799**	**$118,313**	**$45,818**	**61%**
Network	167	615	$98,171	$43,417	56%
Non-Network	60	184	$185,633	$53,841	71%
Region	**227**	**799**	**$118,313**	**$45,818**	**61%**
New England	9	16	$84,165	$42,352	50%
Mid Atlantic	12	17	$174,619	$39,285	78%
South Atlantic	43	225	$143,208	$53,810	62%
East North Central	31	80	$85,300	$40,781	52%
East South Central	19	50	$92,855	$32,717	65%
West North Central	11	26	$120,767	$40,459	66%
West South Central	68	262	$86,930	$34,044	61%
Mountain	22	87	$123,410	$55,947	55%
Pacific	12	36	$274,333	$94,955	65%
Ownership	**227**	**799**	**$118,313**	**$45,818**	**61%**
Proprietary	180	625	$111,926	$41,377	63%
Government Owned	5	12	$60,539	$32,068	47%
Voluntary	42	162	$147,233	$63,968	57%

Note: Excludes 18 LTCH claims from 7 LTCHs where we were unable to match LTCH claims to the FY12 Medicare Impact File

Source: TRICARE FY12 LTCH Claims and the FY12 Medicare Impact File.

3. Review for a Transition Period

We considered whether a transition would be necessary to implement the change in LTCH payment methodology for TRICARE claims. For the following reasons, we have determined, that a transition period is unnecessary.

First, the TRICARE payments to LTCHs will be equal to or, for short stay outlier cases, TRICARE payments may be greater than Medicare's LTCH payments. TRICARE's short-stay outlier payments will be based on costs, which is at least as generous as Medicare's short-stay outlier payments. The Medicare Payment Advisory Committee (MedPAC) is an independent congressional agency to advise the U.S. Congress on issues affecting the Medicare program. MedPAC's most recent research indicates that Medicare LTCHs have a positive margin. Thus, we believe that paying LTCHs amounts that are at least as generous as Medicare do not require a transition.

Second, the number of TRICARE discharges from LTCHs is very small in comparison to the number of Medicare discharges in LTCHs each year. In FY12, there were 799 discharges to LTCHs in which TRICARE was the primary payer. Medicare, in comparison, had approximately 134,700 discharges to LTCHs in 2010. Thus, in aggregate, the TRICARE LTCH claims are a very small percentage of the industry's claims (about one-half of a percent).

Third, we also found that in FY12 there were only 17 LTCHs with 10 or more TRICARE admissions. For these 17 LTCHs, we found that TRICARE admissions accounted for less than 4 percent of the Medicare discharges at those LTCHs. More importantly, at none of the 17 LTCHs did the TRICARE LTCH discharges (where TRICARE was the primary payer) exceed 5 percent of the LTCH's discharges. Because the number of TRICARE discharges at any one LTCH is so small and such a small portion of their LTCH business, a transition period is not required.

Fourth, for the reasons cited above, we do not think that there will be access problems for TRICARE beneficiaries. In addition, we note that MedPAC has concluded that Medicare beneficiaries have continued access to LTCHs as evidenced by an increasing supply of providers and an increasing number of LTCH stays. Given that the TRICARE LTCH rates will equal or exceed Medicare LTCH rates, we do not anticipate access problems for TRICARE beneficiaries. Further, by statute, hospitals that participate under Medicare are required to agree to accept TRICARE reimbursement.

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 proposed to be amended as follows:

PART 199--[AMENDED]

1. The authority citation for Part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55.

2. In § 199.2, amend paragraph (b) by adding a definition of "Long Term Care Hospital" in alphabetical order to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

Long Term Care Hospital (LTCH). A hospital that is designated by the Centers for Medicare and Medicaid Services (CMS) as a LTCH and meets the applicable requirements established by § 199.6(b)(4)(xviii).

* * * * *

3. In § 199.6, add paragraph (b)(4)(xviii) to read as follows:

§ 199.6 TRICARE--authorized providers.

* * * * *

(b) * * *

(4) * * *

(xviii) Long Term Care Hospital (LTCH). LTCHs must meet all the criteria for classification as an LTCH under 42 CFR part 412, subpart O, as well as all of the requirements of this part in order to be considered an authorized LTCH under the TRICARE program.

* * * * *

4. Section 199.14 is amended by revising paragraph (a)(1)(ii)(D)(*4)* and adding paragraph (a)(9) to read as follows:

The revisions and addition read as follows:

§ 199.14 Provider reimbursement methods.

(a) * * *

(1) * * *

(ii) * * *

(D) * * *

(*4*) Long Term Care Hospitals. Prior to implementation of the CHAMPUS reimbursement method described in paragraph (a)(9) of this section, a long term care hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a long term hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as

determined by the Director, DHA, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

* * * * *

(9) *Reimbursement for inpatient services provided by an LTCH.* (i) In accordance with 10 U.S.C. 1079(j)(2), TRICARE payment methods for institutional care shall be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. The CHAMPUS-LTC-DRG reimbursement methodology shall be in accordance with Medicare's Medicare Severity Long Term Care Diagnosis Related Groups (MS-LTC-DRGs) as found in regulation at 42 CFR part 412, subpart O. Inpatient services provided in hospitals subject to the Medicare LTCH reimbursement methodology as specified in 42 CFR parts 412 and 413 will be paid in accordance with the provisions outlined in sections 1886(d)(1)(B)(IV) of the Social Security Act and its implementing Medicare regulation (42 CFR parts 412 and 413) to the extent practicable. Under the above governing provisions, CHAMPUS will recognize, to the extent practicable, in accordance with 10 U.S.C. 1079(j)(2), Medicare's MS-LTC-DRG methodology to include, the relative weights, inpatient operating and capital costs of furnishing covered services (including routine and ancillary services), interrupted stay policy, high cost outlier payments, wage adjustments for variations in labor-related costs across geographical regions, cost-of-living adjustments, and updates to the system.

(ii) While CHAMPUS intends to remain as true as possible to Medicare's MS-LTC-DRG methodology, there will be some deviations required to accommodate CHAMPUS' unique benefit structure and beneficiary population as authorized under the provisions of 10 U.S.C.1079(j)(2).

(A) Due to TRICARE's low claim volume admissions to LTCHs, TRICARE will not adopt the 25 percent threshold rule.

(B) Rather than adopting Medicare's four-step process for short-stay outliers, TRICARE shall pay short-stay outliers at the lesser of:

(*1*) One hundred (100) percent of costs; or

(*2*) The full LTCH DRG amount. The 100 percent of costs will be based on the LTCH's billed charge multiplied by the LTCH's most recent cost-to-charge ratio as determined by the Centers for Medicare and Medicaid Services.

(C) The criteria for adopting, modifying, and/or extending deviations and/or adjustments to the MS-LTC-DRG payments shall be issued through CHAMPUS policies, instructions, procedures and guidelines as deemed appropriate by the Director, DHA, or a designee.

(iii) Exemption. The TRICARE LTCH reimbursement methodology under this paragraph does not apply to hospitals paid in States that are paid by Medicare and TRICARE under a waiver that exempts them from Medicare's inpatient prospective payment system or the CHAMPUS DRG-based payment system, respectively.

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Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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