Billing Code: 5001-06

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 220

[Docket ID: DOD-2016-HA-0107]

RIN 0720-AB68

Collection from Third Party Payers of Reasonable Charges for Healthcare Services

AGENCY: Office of the Assistant Secretary of Defense (Health Affairs), DoD.

ACTION: Proposed rule.

SUMMARY: This rule exercises the Department of Defense's (DoD's) authority to update current regulations to compute reasonable charges for inpatient and ambulatory (outpatient) institutional resources and also for pharmaceuticals, durable medical equipment (DME), supplies, immunizations, injections or other medications administered or furnished by DoD military treatment facilities (MTFs) under their three existing healthcare cost recovery programs – Third Party Collections, Medical Services Account, and Medical Affirmative Claims. Specifically, the rule updates the reasonable charges methodologies for inpatient and ambulatory institutional billing to allow for the use of Itemized Resource Utilization (IRU) based rates – developed from the cost to provide inpatient and ambulatory institutional healthcare resources – in addition to current bundled prospective reimbursement approaches of diagnostic related group (DRG), ambulatory payment classification (APC), ambulatory surgery center (ASC) and ambulatory procedure visit (APV) based rates. It also revises the reasonable charges methodology for pharmaceuticals, DME, supplies, immunizations, injections or medication administered to allow for their calculation using either Civilian Health and Medical Program of

the Uniformed Services (CHAMPUS) prevailing rates or IRU based rates – developed from the cost to provide these healthcare items and resources– regardless of whether CHAMPUS prevailing rates are available. The additional IRU methodology implements an itemized rate and reasonable charges structure that improves collections and operation of DoD's healthcare cost recovery programs by ensuring MTFs receive appropriate reimbursement for institutional healthcare resources as well as for pharmaceuticals, DME, supplies, immunizations, injections or medication provided or administered and is more consistent with civilian health insurance industry practice. The proposed rule also replaces "hospital" with "institutional" throughout most of the regulation to align it with civilian health insurance industry terminology and better promote identification and separate billing of institutional and professional services.

DATES: Comments must be received by [INSERT 60 days from date of publication in the Federal Register].

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

• Federal Rulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

• Mail: Department of Defense, Office of the Deputy Chief Management Officer, Directorate for Oversight and Compliance, 4800 Mark Center Drive, Mailbox #24, Alexandria, VA 22350-1700.

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 FURTHER INFORMATION CONTACT: Ms. DeLisa E. Prater, Program Manager, Defense Health Agency Uniform Business Office, (703) 275-6380.

SUPPLEMENTARY INFORMATION:

A. Executive Summary

1. Purpose of the Proposed Rule. The purpose of this proposed rule is to incorporate new additional statutory authority for calculating reasonable institutional facility charges for: (a) inpatient services and resources provided at DoD (MTFs in addition to the current authorized methodology which uses all-inclusive prospective Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) diagnostic related group (DRG) based payment rates (including professional charges), and (b) ambulatory services provided at DoD MTFs in addition to the current authorized methodologies which use all-inclusive CHAMPUS ambulatory procedure classification (APC) and ambulatory surgery center (ASC) based payment rates and MHS ambulatory procedure visit (APV) based payment rates. As defined in 32 CFR 199.2, the term "facility charges" means the charges, either inpatient or outpatient, made by a MTF to cover the overhead costs of providing the service (e.g., building costs such as depreciation and interest, staffing costs, drugs and supplies; overhead costs such as utilities, housekeeping, maintenance). It also revises the reasonable charges methodology for pharmaceuticals, DME, supplies, immunizations, injections or medication administered or provided to allow for their reasonable charges calculation using either CHAMPUS prevailing or cost based rates regardless of whether CHAMPUS prevailing rates are available. The legal authority for this proposed rule is 10 U.S.C. 1095(f), 1097b(b) and 1079b.

2. Summary of the Major Provisions of the Proposed Rule

a. It would create an additional exception to the general rule that reasonable charges under 32 CFR 220.8(a), 220.8(b), 220.8(f)(5) and 220.8(f)(6) for inpatient and ambulatory institutional resources as well as for pharmaceuticals, DME, supplies, immunizations, injections or medication administered are based on the rates used by CHAMPUS under 32 CFR 199.14 to reimburse authorized providers. Specifically, it authorizes DoD MTFs to use an alternative reasonable charges methodology based on Itemized Resource Utilization (IRU) rates – developed from the cost to provide these resources and items – in addition to the use of aggregated and prospective DRG, APC, ASC and APV and prevailing CHAMPUS based encounter rates.

b. As a ''housekeeping'' change, it would replace "hospital" with "institutional" throughout most of the regulation to align it with civilian health insurance industry terminology and better promote identification and separate billing of institutional and professional services as required by 32 CFR 220.8(b).

B. Background. DoD is authorized to collect "reasonable charges" from third party payers for the cost of inpatient and ambulatory (outpatient) institutional services and also for pharmaceuticals, DME, supplies, immunizations, injections or medication administered or provided at DoD MTFs to military retirees, all dependents, and other eligible beneficiaries who have private health insurance. *See* 10 U.S.C 1095 and 32 CFR 220.2. Also, DoD must collect from nonbeneficiaries (or their insurers) the cost of trauma or other medical care provided to them and from other federal agencies, the average cost of healthcare provided to their beneficiaries at DoD MTFs (10 USC 1079b(a) and 1085). Currently, DoD uses all-inclusive prospective CHAMPUS DRG based payment rates (including professional charges) as the reasonable charges for inpatient care and all-inclusive CHAMPUS APC and ASC based and

MHS APV charges for miscellaneous institutional ambulatory care in its healthcare cost recovery programs – Third Party Collection, Medical Services Account and Medical Affirmative Claims. The MHS APV rate is authorized by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) Policy Memorandum, "Use of CPT Code 99199" (September 14, 2004) because MTFs currently do not have the appropriate software to group encounters into APCs and ASCs. Also, DoD uses the average cost for pharmaceutical rates because CHAMPUS prevailing rates are not available. However, DoD uses CHAMPUS based rates for DME, supplies, immunizations, injections or medication administered.

C. Expected Costs. IRU based rates are more representative of actual costs specific to the institutional resources and also to pharmaceuticals, DME, supplies, immunizations, injections or medication administered or consumed in the provision of care to a patient. Also, IRU based rates provide DoD the ability it does not currently have to bill third party payers in an itemized manner that they are accustomed to. With the availability of this alternative reasonable charges methodology, DoD MTFs can bill for institutional resources and also for pharmaceuticals, DME, supplies, immunizations, injections or medication administered using charge descriptions (i.e., an MTF's comprehensive list of items and services for which it can charge) and individual cost-based rates associated with those descriptions. As a result, institutional bills are much more consistent with the actual resources and services provided to the patient, third party payers who receive MTF claims will have the detailed data needed for reimbursement, and the potential for MTFs to receive appropriate reimbursement improves. MTF claims are frequently returned for additional information or denied because they are not in an itemized format consistent with standard industry health insurance practice. The format of resulting line-item inpatient charges based on IRU rates will more closely resemble the format currently used in the health insurance

industry and promote more efficient claim adjudication. This rule will not affect any payments by TRICARE as this rule does not pertain to purchased care. It specifically applies to rate development for cost recovery in the direct care setting.

In addition, using only the current methodologies for reasonable charges based on bundled prospective DRG/APC/ASC/APV based rates methods and CHAMPUS prevailing rates methods for pharmaceuticals, DME, supplies, immunizations, injections or medication administered limits MTFs' flexibility and ability to effectively accommodate current and new provider reimbursement methodologies and is likely reducing and resulting in missed reimbursement opportunities from third party payers. Third party payers do not uniformly have nor apply payment methods and rates to claims received. Rather, they each have their own distinct set of rules for and levels of payment that are not necessarily DRG/APC/ASC/APV/CHAMPUS rate based. For example, there are multiple versions of groupers, and a payer's reimbursement policy may use a different grouper than DoD or not involve a grouper at all. Moreover, third party payers are increasingly replacing fee-for-service with value-based performance payment portfolios (e.g., pay for performance, bundled payments, shared savings/accountable care organizations) for providers, including DoD MTFs. Itemized billing using IRU based rates provides payers with the detailed data needed for whatever reimbursement process they use yielding fewer requests for additional information and re-processing of claims and increased potential reimbursement.

Additional benefits from allowing for IRU based charges include:

(1) Providing greater transparency of DoD MTFs' financial efficiency and performance through more detailed purchasing, dispensing, and financial billing functions. IRU based charges provide information necessary to complete detailed analyses into what and how a MTF is

purchasing, dispensing, and billing, which will lead to more informed decisions on how to save money, time, and effort at each of those three stages.

(2) Enabling different MTF departments and decision makers to come together to discuss common practices, terminology, and reporting, allowing for the development and analysis of benchmarks evaluating clinical performance, and identifying and implementing the most cost-effective delivery modes available.

(3) Providing the ability to track and monitor resources used to treat patients, thereby allowing MTF staff, management, and leadership to better control and manage costs, and optimize the efficiency of operations to deliver efficient care or prevent unnecessary care.

This IRU based charges approach is consistent with 10 U.S.C 1095(f) and 1097b(b) that authorize the ASD(HA) to calculate all third party payment collections and rates charged to civilians and interagency payers based on any appropriate method. It is the Assistant Secretary's determination that itemized IRU based rates for inpatient and ambulatory resources and also for pharmaceuticals, DME, supplies, immunizations, injections or medication administered or provided better represents the reasonable charges and costs of providing care to all patients in MTFs.

The rule also replaces "hospital" with "institutional" throughout most of the regulation to align it with civilian healthcare insurance industry terminology. The current regulation uses "hospital" interchangeably to mean both: (1) a facility that provides emergency, inpatient, and in some cases outpatient medical care for sick or injured people; and (2) the institutional component of a hospital stay (i.e., overhead and ancillary, diagnostic and treatment services, other than professional services provided by the facility during the inpatient stay such as room and board, laboratory tests and the technical component of radiology services). It is the general rule under

CHAMPUS, 32 CFR 220.8(b) and also industry best practice to identify and charge separately for institutional and inpatient professional services. This nomenclature change helps DoD MTFs reinforce the distinction and better promotes identification and separate billing of institutional and professional services as required by 32 CFR 220.8(b) and in accordance with health insurance industry best practice.

D. Regulatory Procedures

Executive Order 12866, "Regulatory Planning and Review," and Executive Order 13563, "Improving Regulation and Regulatory Review"

Executive Orders 13563 and 12866 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, distribute impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. It has been determined that this rule is not a significant regulatory action. The rule does not: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy; a section of the economy; productivity; competition; jobs; the environment; public health or safety; or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another Agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in these Executive Orders.

Executive Order 13771, "Reducing Regulation and Controlling Regulatory Costs"

There are no cost savings to the public anticipated by amending the current 32 CFR part 220. Consistent with the analysis of transfer payments under OMB Circular A-4, this proposed rule does not involve regulatory costs subject to Executive Order 13771, "Reducing Regulation and Controlling Regulatory Costs."

Unfunded Mandates Reform Act (Sec. 202, Pub. L. 104-4)

Section 202 of Public Law 104–4, "Unfunded Mandates Reform Act," (2 U.S.C. 1532) requires that an analysis be performed to determine whether any federal mandate may result in the expenditure by State, local and tribal governments, in the aggregate, or by the private sector of $100 million in any one year. It has been certified that this proposed rule does not contain a Federal mandate that may result in the expenditure by State, local and tribal governments, in aggregate, or by the private sector, of $100 million or more in any one year, and thus this proposed rule is not subject to this requirement.

Public Law 96-354, "Regulatory Flexibility Act" (5 U.S.C. 601 et seq.)

Public Law 96–354, ''Regulatory Flexibility Act'' (RFA) (5 U.S.C. 601), requires that each Federal agency prepare a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities. This proposed rule is not an economically significant regulatory action, and it has been certified that it will not have a significant impact on a substantial number of small entities. Therefore, this proposed rule is not subject to the requirements of the RFA.

Public Law 96-511, "Paperwork Reduction Act" (44 U.S.C. Chapter 35)

This rule does not contain a "collection of information" requirement and will not impose additional information collection requirements on the public under Public Law 96–511, "Paperwork Reduction Act" (44 U.S.C. Chapter 35).

Executive Order 13132, "Federalism"

E.O. 13132, "Federalism," requires that an impact analysis be performed to determine whether the rule has 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. It has been certified that this proposed rule does not have federalism implications, as set forth in E.O. 13132.

List of Subjects in 32 CFR Part 220

Claims, Health care, Health insurance, and Military personnel.

Accordingly, 32 CFR part 220 is proposed to be amended as follows:

PART 220–[AMENDED]

1. The authority citation for part 220 is revised to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. 1095(f), 1097b(b) and 1079b.

2. Amend **§** 220.8 by:

a. Revising paragraphs (b), (c)(1), (5), (f)(2), (5) and (6),

b. Adding new paragraph (f)(8); and

c. Removing in paragraph (d) the wording "inpatient hospital care" and adding in its place "care."

The revisions and additions read as follows:

§220.8 Reasonable charges.

* * * * *

(b) *Inpatient institutional and professional services on or after October 1, 2017.*

Reasonable charges for inpatient institutional services provided on or after October 1, 2017, are based on either of two methods as determined by the ASD(HA). The first uses the CHAMPUS

Diagnosis Related Group (DRG) payment system rates under 32 CFR 199.14(a)(1). Certain adjustments are made to reflect differences between the CHAMPUS payment system and MHS billing solutions. Among these are to include in the inpatient hospital service charges adjustments related to direct medical education and capital costs (which in the CHAMPUS system are handled as annual pass through payments). Additional adjustments are made for long stay outlier cases. The second method uses Itemized Resource Utilization (IRU) rates based on the cost to provide inpatient institutional resources. Like the CHAMPUS system, inpatient professional services are not included in the inpatient institutional services charges calculated under either methodology, but are billed separately in accordance with paragraph (e) of this section. In lieu of either method described in this paragraph (b), the method in effect prior to April 1, 2003 (described in paragraph (c) of this section), may continue to be used for a period of time after April 1, 2003, if the ASD(HA) determines that effective implementation requires a temporary deferral.

(c) *Inpatient institutional and inpatient professional services before April 1, 2003*. (1) *In general*. Prior to April 1, 2003, the computation of reasonable charges for inpatient institutional and professional services is reasonable costs based on diagnosis related groups (DRGs). Costs shall be based on the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal diagnosis involved. The average charge per case shall be published annually as an inpatient standardized amount. A relative weight for each DRG shall be the same as the DRG weights published annually for hospital reimbursement rates under CHAMPUS pursuant to 32 CFR 199.14(a)(1). The method in effect prior to April 1, 2003 (as described in this paragraph (c)), may continue to be used for a period of time after April 1, 2003, if the

ASD(HA) determines that effective implementation requires a temporary deferral of the method described in paragraph (b) of this section.

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(5) *Identification of professional and institutional charges*. For purposes of billing third party payers other than automobile liability and no-fault insurance carriers, inpatient billings are subdivided into two categories:

(i) Institutional charges (which refer to routine service charges associated with the facility encounter or hospital stay and ancillary charges).

* * * * *

(f) * * *

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(2) With respect to inpatient institutional charges in the Burn Center at Brooke Army Medical Center, the ASD(HA) may establish an adjustment to the rate otherwise applicable under the payment methodologies under this section to reflect unique attributes of the Burn Center.

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(5) The charge for immunizations, allergin extracts, allergic condition tests, and the administration of certain medications when these services are provided by or through a facility of the Uniformed Services or a separate immunizations or shot clinic, are based either on CHAMPUS prevailing rates or on IRU rates based on the cost to provide these items, exclusive of any costs considered for purposes of any outpatient visit. A separate charge shall be made for each immunization, injection or medication administered.

(6) The charges for pharmacy, durable medical equipment and supply resources are based either on CHAMPUS prevailing rates or on IRU rates based on the cost to provide these items, exclusive of any costs considered for purposes of any outpatient visit. A separate charge shall be made for each item provided.

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(8) Ambulatory (outpatient) institutional services on or after October 1, 2017. Reasonable charges for institutional facility charges for ambulatory services provided on or after October 1, 2017, are based on any of three methods as determined by the ASD(HA). The first uses the CHAMPUS Ambulatory Payment Classification (APC) and Ambulatory Surgery Center (ASC) payment system rates under 32 CFR 199.14(a)(1)(ii) and (iii) and 32 CFR 199.14(d) respectively. The second uses a bundled MHS Ambulatory Procedure Visit (APV) payment system rate charge reflected by the average cost of providing an APV exclusive of professional services. The third method uses IRU rates based on the cost to provide ambulatory institutional resources. Like the CHAMPUS system, ambulatory professional services are not included in the ambulatory institutional facility charges calculated under any of the three methodologies, but are billed separately in accordance with paragraph (e) of this section.

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Dated: December 11, 2018.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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