First and second preferences of meeting time.

Organization for which you work.

Organization you will represent (if different).

*Stakeholder category:* Government, industry, union, trade association, insurance, manufacturers, consultants, or other (if other, please specify).

Electronic copies of this **Federal Register** notice, as well as news releases and other relevant documents, are available on the OSHA Web page at: *http://www.osha.gov*.

**Authority and Signature**

This document was prepared under the direction of David Michaels, PhD, MPH, Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. This action is taken pursuant to sections 4, 6, and 8, Public Law 91–596, 84 STAT. 1590 (29 U.S.C. 653, 655, 657), Secretary of Labor's Order No. 4–2010 (75 FR 55355 (Sept. 10, 2010)), and 29 CFR part 1911.

Signed at Washington, DC, on June 29, 2011.

**David Michaels,**

*Assistant Secretary of Labor for Occupational Safety and Health.*

[FR Doc. 2011–16742 Filed 7–1–11; 8:45 am]

**BILLING CODE 4510–26–P**

## DEPARTMENT OF DEFENSE

### Office of the Secretary

### 32 CFR Part 199

**[Docket ID DoD–2010–HA–0072; RIN 0720–AB41]**

## TRICARE; Reimbursement of Sole Community Hospitals and Adjustment to Reimbursement of Critical Access Hospitals

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

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule is to implement the statutory provision at 10 United States Code (U.S.C.) 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 implements a reimbursement methodology similar to that furnished to Medicare beneficiaries for inpatient services provided by Sole Community Hospitals (SCHs). It will be phased in over a several-year period.

**DATES:** Written comments received at the address indicated below by September 6, 2011 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 FURTHER INFORMATION CONTACT:** Ms. Martha M. Maxey, TRICARE Management Activity (TMA), Medical Benefits and Reimbursement Branch, telephone (303) 676–3627.

**SUPPLEMENTARY INFORMATION:**

### I. Introduction and Background

Hospitals are authorized TRICARE institutional providers under 10 U.S.C. 1079(j)(2) and (4). 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.'' Medicare reimburses SCHs for inpatient care the greatest of these aggregate amounts:

1. What the SCH would have been paid under the Medicare Diagnosis-Related Group (DRG) method for all of that hospital's Medicare discharges.

2. The amount that would have been paid if the SCH were paid the average ''cost'' per discharge at that hospital in Fiscal Year (FY) 1982, 1987, 1996, or 2006, updated to the current year, for all its Medicare discharges.

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

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 Diagnosis-Related Group (DRG) method.

Non-network Hospitals: Payment is equal to billed charges.

TRICARE's current method results in reimbursing SCHs 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)(*6*), SCHs are exempt from the TRICARE DRG-based payment system. Based on the above statutory mandate, TRICARE is proposing to use an approach that approximates The Centers for Medicare and Medicaid Services' (CMS) method for SCHs.

### II. SCH Reimbursement Methodology

Establishing a TRICARE SCH inpatient reimbursement method exactly matching that of Medicare is not practicable. While TRICARE can calculate the aggregate DRG reimbursement for all TRICARE discharges by a SCH during a year, using the Medicare cost per discharge would not be appropriate for TRICARE. Differences in the TRICARE and Medicare beneficiary case mix render the Medicare average cost per discharge not directly applicable for TRICARE purposes.

In addition, basing SCH reimbursement on annual updates to a TRICARE base-year average cost per discharge could result in inappropriate payments to some SCHs. At many SCHs, the number of TRICARE discharges per year is very low. Approximately half of the SCHs had fewer than 20 TRICARE discharges annually. The TRICARE average cost per discharge in 1 year may not be a good predictor of the average cost per discharge in a future year due to significant change in the case mix that can occur between two small sets of patients.

Alternatively, TRICARE could make payments equal to the SCH's specific cost-to-charge ratio (CCR) multiplied by the hospital's billed charges for services. This would avoid making payments unrelated to case mix and would be consistent with the Medicare principle of relating payments for SCHs to cost of services. This is the approach adopted in the proposed rule.

### III. TRICARE's SCH Phase-in Period

In introducing its current SCH reimbursement method, Medicare used a 3-year phase-in period to provide the hospitals time for making business and clinical process adjustments. TRICARE is proposing a phase-in period with a maximum 15 percent per-year reduction from the starting point in TRICARE-allowed amounts for non-network

hospitals and a 10 percent-per-year reduction for network hospitals. This involves calculating a hospital's ratio of TRICARE-allowed to billed charges and reducing that by 15 percentage points each year for non-network hospitals and 10 percentage points each year for network hospitals until it reaches the hospital's CCR. For example, if a non-network hospital currently had a TRICARE-allowed to billed ratio of 100 percent, it would be paid 85 percent of billed charges in year one, 70 percent in year 2, 55 percent in year 3, and 40 percent in year 4. For a network hospital that had a TRICARE-allowed to billed ratio of 98 percent, it would be paid 88 percent in year 1, 78 percent in year two, 68 percent in year 3, and 58 percent in year 4. It should be noted that in no year could the TRICARE payment fall below costs (most hospitals have costs equal to 30 to 50 percent of billed charges). This transition method would approximately follow the CHAMPUS Maximum Allowable Charge physician payment system reform precedent and limit reductions to no more than 15 percent per year during the phase-in period. It also provides an incentive for hospitals to remain in the network by allowing a 5 percent difference in payment reductions per year. Finally, it will buffer the revenue reductions experienced upon initial implementation of TRICARE's SCH payment reform while allowing hospitals sufficient time to adjust and budget for these reductions.

TRICARE will pay a SCH for inpatient services it provides during a FY the greater of two aggregate amounts: (1) What the SCH would have been paid under the DRG method for all of that hospital's TRICARE discharges; or (2) An amount equal to the SCH's specific CCR multiplied by the hospital's billed charges for the TRICARE services. This will be accomplished through a year-end adjustment to the reimbursements provided during the year.

## IV. New SCHs and SCHs With No Inpatient Claims

TRICARE will pay a new SCH using the average CCR for all SCHs calculated in the most recent year until it files a Medicare cost report. For SCHs that had no inpatient claims from TRICARE prior to implementation of the SCH payment reform but do have a claim, TRICARE will pay them based on their Medicare CCR.

## V. SCH General Temporary Military Contingency Payment Adjustment

In addition to the SCH phase-in period outlined in paragraph III. above, the agency is proposing a SCH Temporary Military Contingency Payment Adjustment (TMCPA) for TRICARE network hospitals located within Military Treatment Facility (MTF) Prime Service Areas (PSAs) and deemed essential for military readiness and support during contingency operations. The TMA Director, or designee, may approve a SCH General TMCPA for hospitals that serve a disproportionate share of Active Duty Service members (ADSMs) and Active Duty dependents (ADDs). Procedures for requesting a SCH TMCPA will be outlined in the SCH section of the TRICARE Reimbursement Manual.

## VI. Critical Access Hospital General Temporary Military Contingency Payment Adjustment

On August 31, 2009, we published a final rule (74 FR 44752), which implemented a reimbursement methodology similar to that furnished to Medicare beneficiaries for services provided by critical access hospitals (CAHs), i.e., reimbursing them 101 percent of reasonable costs. It has come to our attention that there may be some CAHs located in MTF PSAs that are deemed essential for military readiness and support during contingency operations. Thus, the agency also is proposing a CAH TMCPA for TRICARE network hospitals located within MTF PSAs and deemed essential for military readiness and support during contingency operations. The TMA Director may approve a CAH TMCPA for hospitals that serve a disproportionate share of ADSMs and ADDs. Procedures for requesting a CAH General TMCPA will be outlined in the CAH section of the TRICARE Reimbursement Manual.

## VII. Regulatory Impact Analysis

### *A. Overall Impact*

The Department of Defense 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

EOs 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 SCH provisions that would be implemented by this rule would result in SCH revenue reductions exceeding $100 million in any one year. We estimate the total reduction (from the proposed changes in this rule) in hospital revenues under the SCH reform for its first year of implementation (assumed for purposes of this RIA to be FY2012), compared to expenditures in that same period without the proposed SCH changes, to be approximately $211 million. However, as discussed below, the proposed transitions will reduce this amount considerably. When the transitions are taken into account, the first year impact will be a reduction in allowed amounts of $31 million.

We estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold and, hence, also a major rule under the Congressional Review Act. Accordingly, 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 a major rule under the Congressional Review Act.

3. Regulatory Flexibility Act

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) definition 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 SCHs 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, the Secretary has determined that this proposed rule would have a significant impact on a substantial number of small entities. We generally prepare a regulatory flexibility analysis that is consistent with the RFA (5 U.S.C. section 604), unless we certify that the rule would not have a significant impact on a substantial number of small entities. The Regulatory Impact Analysis, as well as the contents contained in the preamble, is meant to serve as the Proposed 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. Public Law 96–511, ''Paperwork Reduction Act'' (44 U.S.C. Chapter 35)

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 SCH Reforms*

The SCH reform encompasses all SCHs as defined by Medicare that participate in the TRICARE program that have inpatient stays for TRICARE patients. It will also include SCHs classified by CMS as Essential Access Community Hospitals (EACH) hospitals. However, Maryland hospitals that are paid by Medicare and TRICARE under a cost containment waiver are excluded from the SCH Reform.

*C. Analysis of the Impact of Policy Changes on Payment Under SCH Reform Alternatives Considered*

Alternatives that we considered, the proposed changes that we will make, and the reasons that we have chosen each option are discussed below.

1. Alternatives Considered for Addressing Reduction in SCH Payments

Analysis of the effects of paying SCHs using the computation of either the greater of what the SCH would have been paid under the DRG method for all of that hospital's TRICARE discharges or an amount equal to the SCH's specific CCR multiplied by the hospital's billed charges for the TRICARE services approach would reduce the TRICARE payments to these SCHs by an average of over 50 percent. This approach would pay each SCH the greater of two aggregate amounts: (1) The sum of the TRICARE-allowed amounts if all the TRICARE inpatient admissions over a 12-month period were paid using the TRICARE DRG method; or (2) the TRICARE-allowed amounts if all the TRICARE inpatient admissions over a 12-month period were paid using the CCR approach (in which the TRICARE-allowed amount for each admission is equal to the billed charge for that admission multiplied by the hospital's historical CCR). Table 1 provides our estimate of the impact of this approach without any transitions. We found that there would be large reductions in payments for all types of SCHs (see Table 3).

Because the impact of moving from a charge-based reimbursement to a cost-based reimbursement similar to Medicare's would produce large reductions in the TRICARE-allowed amounts for all types of SCHs, we considered a phase-in of this approach over a 4-year period. Under this option, the CCR portion of the approach would be modified so that the hospital's billed charge on each claim would not be multiplied by the hospital's CCR until the fourth year (when the transition was complete). In the first 3 years, the billed charges for each claim would be multiplied by a ratio so that there was an equal reduction in the ratio used each year over the 4-year transition. For example, if the hospital were receiving 100 percent of its billed charges prior to implementation of the SCH reform and it had a CCR of 0.32, then its billed charges would be multiplied by factors of 0.83, 0.66, and 0.49 in the first 3 years respectively so that each year the payment ratio declined by an equal amount (in this case by a factor of 0.17). In each year, the aggregate level of allowed amounts produced using the CCR approach at each SCH would be compared with the aggregate level of DRG-allowed amounts at the SCH, and the SCH would be paid the greater of the two aggregate amounts. This 4-year transition would allow hospitals to have a phased transition to the cost-based rates. Although this option would provide a multi-year period for SCHs to transition to the cost-based rates, we did not choose this option because it would still result in large reductions for some SCHs over a relatively short period of time.

A second option we considered was to have a transition based on a reduction of 15 percentage points per year in the allowed amounts for each SCH. Under this option, the CCR portion in this approach would be modified. During the transition period, the billed charges on each claim at an SCH would be multiplied by a factor so that the ratio decreased by 15 percentage points each year from the level in the previous year. For example, if the SCH were receiving 100 percent of its billed charges prior to SCH reform and it had a CCR of 0.32, then its billed charges would be multiplied by factors of 0.85, 0.70, 0.55, and 0.40 in the first 4 years respectively, so that each year the ratio declined by 15 percentage points. In the fifth year, the ratio would be set at 0.32, the hospital's CCR. (The actual number of years of transition will depend on the hospital's CCR and could be more or less than the 4 years in this example as the ratio will never be less than the CCR.) In each year, the aggregate level of allowed amounts produced using the CCR approach at each SCH would be compared with the aggregate level of DRG-allowed amounts at the SCH and the SCH would be paid the greater of the two aggregate amounts. This type of transition ensures that there is a manageable reduction in the level of payments each year for each hospital. We selected this option.

2. Alternatives Considered for SCHs in the TRICARE Network

We were concerned there might be access problems at some hospitals with a high concentration of TRICARE patients if their payments were decreased significantly. In particular, we were concerned that some hospitals might leave the TRICARE network if payments were reduced too quickly. This was a particular concern because 24 of the 25 SCHs with the highest levels of TRICARE-allowed amounts in the first 6 months of CY 2010 were in the TRICARE network. Thus, the SCHs that would face the largest reductions in the level of TRICARE-allowed amounts from TRICARE's SCH reform would be network hospitals.

An option we considered, and the one we are proposing in this rule, is to provide a 10 percent-per-year reduction in the allowed amounts for SCHs in the TRICARE network. This option would modify the CCR portion of the approach. During the transition period, the billed charges on each claim at an SCH in the TRICARE network would be multiplied by a factor so that the ratio decreased by 10 percentage points each year from the starting point (in contrast to 15 percentage points for non-network hospitals). For example, if a TRICARE network SCH had allowed amounts equal to 92 percent of its billed charges prior to SCH reform, and it had a CCR of 0.35, then its billed charges would be multiplied by factors of 0.82, 0.72, 0.62, 0.52, and 0.42 in the first 5 years, respectively, to calculate the allowed amounts. Under this approach, each year the ratio for network SCHs would decline by ten percentage points. In the sixth year, the ratio would be set at 0.35, the hospital's CCR (assuming that the hospital's CCR had remained at 0.35). In each year, the aggregate level of allowed amounts produced using the CCR approach at each SCH would be compared with the aggregate level of DRG-allowed amounts at the SCH, and the SCH would be paid the greater of the two aggregate amounts. This type of transition ensures that there is a manageable reduction in the level of payments each year for each hospital. We selected this option. Table 1 shows the results of this option.

*D. Effects on Sole Community Hospitals*

Table 1 shows the impact of revised SCH inpatient reimbursement during FY 2012. Table 2 shows projected TRICARE reduction in reimbursement for top 20 hospitals. Table 3 shows full amount of reduction without a phase-in period and transitional payments.

TABLE 1—ESTIMATED IMPACT OF SCH REFORMS ON TRICARE-ALLOWED AMOUNTS AT SOLE COMMUNITY HOSPITALS DURING THE FY 2012—FIRST YEAR OF PHASE-IN (WITH TRANSITION PAYMENTS)

[In $ millions]

| Estimated allowed amount under current policy | Allowed amounts under SCH reform | Reduction in allowed amounts | SCH Reform allowed amounts as a percentage of current policy allowed amounts |
|---|---|---|---|
| $326 | $295 | $31 | 90 |

**Notes:**

(1) This table presents the impact as modified by the transition mechanisms proposed in this NPRM (the 15 percent-per-year reduction for non-network hospitals and the 10 percent-per-year reduction for TRICARE network SCHs). This table includes the impact of transition payments to SCHs.

(2) Maryland hospitals are excluded.

TABLE 2—IMPACT ($M) OF FIRST YEAR FOR TOP 20 SOLE COMMUNITY HOSPITALS

| Hospital name | City | State | Reduction ($M) in FY2010 if phase-in started in FY2010 |
|---|---|---|---|
| Fairbanks Memorial Hospital | Fairbanks | AK | 0.4 |
| FLagstaff Medical Center | Flagstaff | AZ | 0.5 |
| Sierra Vista Regional Health Center | Sierra Vista | AZ | 1.2 |
| Yuma Regional Medical Center | Yuma | AZ | 1.3 |
| North Colorado Medical Center | Greeley | CO | 0.3 |
| Southeast Georgia Health System Bru | Brunswick | GA | 0.3 |
| Camden Medical Center | Saint Marys | GA | 0.4 |
| Munson Medical Center | Traverse City | MI | 0.3 |
| Phelps Co Reg Med Ctr | Rolla | MO | 0.5 |
| Western Missouri Medical Center | Warrensburg | MO | 0.5 |
| Benefis Healthcare | Great Falls | MT | 1.1 |
| Onslow Memorial Hospital Inc | Jacksonville | NC | 1.6 |
| Carolinaeast Health System | New Bern | NC | 1.4 |
| Altru Health System, dba Altru Hospital | Grand Forks | ND | 0.5 |
| Trinity Hospitals | Minot | ND | 0.9 |
| Gerald Champion Regional Medical Center | Alamogordo | NM | 0.6 |
| Jackson County Memorial Hospital | Altus | OK | 0.3 |
| Beaufort Memorial Hospital | Beaufort | SC | 1.5 |
| Rapid City Regional Hospital—Hospital | Rapid City | SD | 1.2 |
| Cheyenne Regional Medical Center | Cheyenne | WY | 1.3 |

**Note 1:** Top 20 SCHs based on total amount reimbursed during FY2007–FY2010 where TRICARE was primary payer.

**Note 2:** Impact of reduction calculated using FY2010 reimbursed amount.

**Note 3:** Applied reduction of 10% for FY2010 if network provider; 15% for FY2010 if non-network provider until the hospital reaches their cost-to-charge ratio.

**Note 4:** Samaritan Medical Center, Watertown, NY gained SCH status in FY2011. Based on preliminary data, Samaritan Medical Center would most likely be included in the top 20 SCH list.

**Note 5:** Mary Washington Hospital, Fredericksburg, VA lost SCH status in January 2011.

**Note 6:** This data includes all claims received through February 2, 2011 for dates of care beginning in FY2010 and not estimated to completion.

**Note 7:** CMS currently reviewing SCH status of North Colorado Medical Center, Greeley, CO.

TABLE 3—ESTIMATED IMPACT OF COST-BASED REIMBURSEMENT ON TRICARE-ALLOWED AMOUNTS AT SOLE COMMUNITY HOSPITALS WITHOUT TRANSITION PAYMENTS

[In $ millions]

| Current policy | Cost-based reimbursement | Reduction in TRICARE-allowed amounts | Allowed amounts under cost-based reimbursement as a percent of current policy-allowed amounts |
|---|---|---|---|
| $369 | $158 | $211 | 43 |

**Notes:**
(1) This table does not include any transition payments to SCHs.
(2) Maryland hospitals are excluded.

**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, paragraph (b) is amended by adding a definition for ''Sole Community Hospitals'' in alphabetical order to read as follows:

**§ 199.2 Definitions.**

* * * * *

(b) * * *

*Sole community hospitals (SCHs).* Urban or rural hospitals that are the sole source of care in their community and meet the applicable requirements established by § 199.6 (b)(4)(xvii).

* * * * *

3. Section 199.6 is amended by adding new paragraph (b)(4)(xvii) to read as follows:

**§ 199.6 TRICARE—authorized providers.**

* * * * *

(b) * * *

(4) * * *

(xvii) *Sole community hospitals (SCHs).* SCHs must meet all the criteria for classification as a SCH under 42 CFR 412.92 in order to be considered a SCH under the TRICARE program.

* * * * *

4. Section 199.14 is amended by:

a. Revising paragraph (a)(1)(ii)(D)(*6*), paragraph (a)(2)(viii)(D), paragraph (a)(3), the first sentence of paragraph (a)(4), and the first sentence of paragraph (a)(6); and

b. Adding new paragraph (a)(7).

The revisions and additions read as follows:

**§ 199.14 Provider reimbursement methods.**

(a) * * *

(1) * * *

(ii) * * *

(D) * * *

(*6*) *Sole community hospitals.* Prior to Fiscal Year 2012, any hospital that has qualified for special treatment under the Medicare prospective payment system as a SCH (see subpart G of 42 CFR part 412) and has not given up that classification is exempt from the CHAMPUS DRG-based payment system.

* * * * *

(2) * * *

(viii) * * *

(D) *Sole community hospitals.* Prior to Fiscal Year 2012, any hospital that has qualified for special treatment under the Medicare prospective payment system as a SCH and has not given up that classification is exempt.

* * * * *

(3) *Reimbursement for inpatient services provided by a CAH.* (i) For admissions on or after December 1, 2009, inpatient services provided by a CAH, other than services provided in psychiatric and rehabilitation distinct part units, shall be reimbursed at 101 percent of reasonable cost. This does not include any costs of physician services or other professional services provided to CAH inpatients. Inpatient services provided in psychiatric distinct part units would be subject to the CHAMPUS mental health payment system. Inpatient services provided in rehabilitation distinct part units would be subject to billed charges.

(ii) The percentage amount stated in paragraph (a)(3)(i) of this section is subject to possible upward adjustment based on a temporary military contingency payment adjustment (TMCPA) for TRICARE network hospitals located within Military Treatment Facility Prime Service Areas and deemed essential for military readiness and support during contingency operations. The TMA Director may approve a CAH TMCPA for hospitals that serve a disproportionate share of active duty service members (ADSMs) and active duty dependents (ADDs). A TMCPA may be approved by the Director, TMA for a specified period based on a showing that without the TMCPA, DoD's ability to meet military contingency mission requirements will be significantly compromised.

(4) *Billed charges and set rates.* The allowable costs for authorized care in all hospitals not subject to the CHAMPUS DRG-based payment system, the CHAMPUS mental health per-diem system, the reasonable cost method for CAHs, or the reimbursement rules for SCHs shall be determined on the basis of billed charges or set rates. * * *

* * * * *

(6) *Hospital outpatient services.* This paragraph (a)(6) identifies and clarifies payment methods for certain outpatient services, including emergency services, provided by hospitals. * * *

(7) *Reimbursement for inpatient services provided by a SCH.* (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. TRICARE's SCH reimbursements approximate Medicare's for SCHs. Inpatient services provided by a SCH, other than services provided in psychiatric and rehabilitation distinct part units, shall be reimbursed through a two-step process, with an initial payment as step one, and a year-end adjustment as step two.

(ii) The initial payment for a SCH referred to in paragraph (a)(7)(i) of this section will be based on the applicable percentage of the TRICARE-allowed amount. The TRICARE-allowed amount is the lesser of billed charges or the negotiated amount accepted by a network SCH. The applicable percentage is the greater of the SCH's specific historical cost-to-charge ratio (as calculated by CMS), or the following percentage:

(A) In FY 2012, 90 percent for network SCHs or 85 percent for non-network SCHs.

(B) In FY 2013, 80 percent for network SCHs or 70 percent for non-network SCHs.

(C) In FY 2014, 70 percent for network SCHs or 55 percent for non-network SCHs.

(D) In FY 2015, 60 percent for network SCHs or 40 percent for non-network SCHs.

(E) In FY 2016, 50 percent for network SCHs or 25 percent for non-network SCHs.

(F) In FY 2017, 40 percent for network SCHs or 10 percent for non-network SCHs.

(G) In FY 2018, 30 percent for network SCHs or 0 percent for non-network SCHs.

(H) In FY 2019, 20 percent for network SCHs or 0 percent for non-network SCHs.

(I) In FY 2020, 10 percent for network SCHs or 0 percent for non-network SCHs.

(J) In FY 2021, 0 percent for network SCHs or 0 percent for non-network SCHs.

(iii) The second step referred to in paragraph (a)(7)(i) of this section is a year-end adjustment. The year-end adjustment will compare the aggregate amount paid over a 12-month period under paragraph (a)(7)(ii) of this section to the aggregate amount that would have been paid for the same care using the TRICARE DRG-method (under paragraph (a)(1) of this section). In the event that the DRG method amount is the greater, the year-end adjustment will be the amount by which it exceeds the aggregate amount paid. In addition, the year-end adjustment also may incorporate a possible upward adjustment based on a TMCPA for TRICARE network hospitals located within MTF PSAs and deemed essential for military readiness and support during contingency operations. The TMA Director, or designee, may approve a SCH TMCPA for hospitals that serve a disproportionate share of ADSMs and ADDs. A TMCPA may be approved by the Director, TMA, for a specified period based on a showing that, without the TMCPA, DoD's ability to meet military contingency mission requirements will be significantly compromised.

(iv) The SCH reimbursement provisions of paragraphs (a)(7)(i) through (iii) do not apply to any costs of physician services or other professional services provided to SCH inpatients (which are subject to individual provider payment provisions of this section), inpatient services provided in psychiatric distinct part units (which are subject to the CHAMPUS mental health per-diem payment system), or inpatient services provided in rehabilitation distinct part units (which are reimbursed on the basis of billed charges or set rates).

* * * * *

Dated: June 23, 2011.

**Patricia L. Toppings,**

*OSD Federal Register Liaison Officer, Department of Defense.*

[FR Doc. 2011–16629 Filed 7–1–11; 8:45 am]

**BILLING CODE 5001–06–P**

## DEPARTMENT OF THE INTERIOR

## National Park Service

## 36 CFR Part 7

**RIN 1024–AD92**

## Special Regulations; Areas of the National Park System, Yellowstone National Park

**AGENCY:** National Park Service, Interior.

**ACTION:** Proposed rule.

**SUMMARY:** The National Park Service (NPS) is proposing this rule to establish a management framework that allows the public to experience the unique winter resources and values at Yellowstone National Park. The proposed rule would provide a variety of use levels and experiences for visitors by establishing maximum numbers of snowmobiles and snowcoaches permitted in the park on a given day. It also would require that most snowmobiles and snowcoaches operating in the park meet air and sound requirements and be accompanied or operated by a commercial guide.

**DATES:** Comments must be received by September 6, 2011.

**ADDRESSES:** You may submit your comments, identified by Regulation Identifier Number (RIN) 1024–AD92, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Yellowstone National Park, Winter Use Proposed Rule, P.O. Box 168, Yellowstone NP, WY 82190
- *Hand Deliver to:* Management Assistant's Office, Headquarters Building, Mammoth Hot Springs, Yellowstone National Park, Wyoming.

All submissions received must include the agency name and RIN. For additional information see ''Public Participation'' under **SUPPLEMENTARY INFORMATION** below.

**FOR FURTHER INFORMATION CONTACT:** Wade Vagias, Management Assistant's Office, Headquarters Building, Yellowstone National Park, 307–344–2019 or at the address listed in the **ADDRESSES** section.

**SUPPLEMENTARY INFORMATION:**

### Background

The NPS has been managing winter use in Yellowstone National Park for several decades. A detailed history of the winter use issue, past planning efforts, and litigation is provided in the background section of the 2011 Draft Environmental Impact Statement (DEIS). The park has most recently operated under the 2009 interim plan, which was in effect for the past two winter seasons and expired by its own terms on March 15, 2011. With publication of this proposed rule, and the DEIS, the NPS is soliciting public comment on a long-term direction for winter use in Yellowstone National Park.

Additional information, including the DEIS, is available online at: *http://www.nps.gov/yell/parkmgmt/participate.htm.*

### Park Resource Issues

The DEIS analyzes the issues and environmental impacts of seven alternatives for the management of winter use in the park. Major issues analyzed in the DEIS include social and economic issues, human health and safety, wildlife, air quality, natural soundscapes, visitor use and experience, and visitor accessibility. Impacts associated with each of the alternatives are detailed in the DEIS, which is available at the following site: *http://parkplanning.nps.gov.*

### Description of the Proposed Rule

Snowmobile and snowcoach use at Yellowstone National Park is referred to as oversnow vehicle (OSV) use. The proposed regulations are similar in many respects to plans and rules that have been in effect for the last six winter seasons. Thus, many of the regulations regarding operating conditions, designated routes, and restricted hours of operation have been enforced by the NPS for several years. One notable difference, however, is a new proposal in this rule to provide a variety of use levels and experiences for visitors by establishing varying maximum numbers of OSVs permitted in the park for different days throughout the winter season. This would be accomplished by implementing different use levels for OSV use that would vary day-by-day, on a pre-set annual schedule, rather than being fixed for the entire winter season. Authorized snowmobile use would