

[FR Doc. 2016-06937 Filed 3-25-16; 8:45 am]

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**DEPARTMENT OF DEFENSE****Office of the Secretary****TRICARE Bundled Payment for Lower Extremity Joint Replacement or Reattachment (LEJR) Surgeries Based on Centers for Medicare and Medicaid Services (CMS) Comprehensive Care for Joint Replacement (CJR) Model****AGENCY:** Department of Defense.**ACTION:** Notice of demonstration.

**SUMMARY:** This notice is to advise interested parties of a Military Health System (MHS) demonstration project under the authority of Title 10, United States Code, Section 1092, entitled TRICARE Bundled Payment for Lower Extremity Joint Replacement or Reattachment (LEJR) Surgeries that will test bundled payment and quality measurement on an “episode of care” basis to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery. This demonstration is being conducted in compliance with Section 726 of the National Defense Authorization Act (NDAA) for 2016. This particular TRICARE demonstration will be based on Centers for Medicare and Medicaid Services’ (CMS) Comprehensive Care for Joint Replacement (CJR) Model, which will be implemented in 67 metropolitan statistical areas (MSAs) beginning April 1, 2016. CMS’s CJR Model is designed to promote better and more efficient care for beneficiaries undergoing LEJR surgery (DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (major joint replacement or reattachment of lower extremity without major complications or comorbidities)). Participant hospitals in the CMS model will be held financially accountable for the quality and cost of the entire episode of care, which begins with hospital admission of a beneficiary and ends 90 days post-discharge in order to cover all related costs for the complete recovery period. This “bundled” episode includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries. The TRICARE demonstration project will test this value-based payment model in the Tampa-St. Petersburg MSA for DRG 470 only (including 90 days of related post-operative care) to assess whether value-driven bundled payment

incentives will result in a reduction in the rate of increase in health care spending and improvements in health care quality, patient experience of care, and overall health of TRICARE beneficiaries. All network and non-network hospitals with at least 20 TRICARE admissions for DRG 470 over the three years of Fiscal Year (FY) 2013, 2014, and 2015 shall be required to participate in the demonstration project (excluding admissions for beneficiaries with primary Other Health Insurance (OHI), Active Duty Service Members (ADSMs), and Medicare-TRICARE dual eligible beneficiaries). Once selected for participation, hospitals will remain in the project throughout the duration of this demonstration (regardless of actual TRICARE utilization) unless the Government directs otherwise.

**DATES: Effective Date:** This demonstration is mandated by Section 726 of the National Defense Authorization Act for Fiscal Year 2016, with an implementation deadline of May 23, 2016. This demonstration authority will remain in effect until December 31, 2019.

**ADDRESSES:** Defense Health Agency, Health Plan Execution and Operations, 7700 Arlington Boulevard, Suite 5101, Falls Church, Virginia 22042.

**FOR FURTHER INFORMATION CONTACT:** For questions pertaining to this demonstration, please contact Ms. Debra Hatzel at (303) 676-3572.

**SUPPLEMENTARY INFORMATION:****A. Background**

Section 726 of the National Defense Authorization Act (NDAA) for Fiscal Year 2016 directed the Department of Defense to conduct a demonstration project on incentives to improve health care provided under the TRICARE program, also known as paying for value rather than for volume or value-based reimbursement. Innovative health care payment models are being tested and implemented by the CMS and a variety of commercial health care programs and insurers. This demonstration will assess whether value-driven incentives will result in a reduction in the rate of increase in health care spending and improvements in health care quality, patient experience of care, and overall health of TRICARE beneficiaries.

This demonstration program is based on the Medicare Program for Comprehensive Care for Joint Replacement (CJR) Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services, under the authority of the Center for Medicare and Medicaid Innovation (CMMI) pursuant to section 1115A of

the Social Security Act, and as implemented by CMS. A copy of the Final Rule published by CMS on November 24, 2015, may be found at <https://www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals>. In general, CMS sought to target high expenditure, high utilization procedures for which there were significant regional variation in spending. Acute care hospitals, as the site of surgery, will be held accountable for spending during the entire episode of care. This model seeks to promote the alignment of financial and other incentives for all health care providers and suppliers caring for a beneficiary during an LEJR episode, thereby improving quality and increasing efficiency in the provision of care. It is also anticipated the CJR model will benefit Medicare beneficiaries by improving coordination and transition of care by incentivizing more efficient service delivery and higher value care across the inpatient and post-acute care spectrum spanning the episode of care. The CMS CJR model will be implemented in 67 metropolitan statistical areas (MSAs) beginning April 1, 2016. Under Medicare, this episode-based payment model is mandatory for all hospitals in the designated MSAs.

The Department of Defense elected to conduct a demonstration project to adapt, in general, and test this value-based incentive program to assess whether a reduction in the rate of increase in health care spending can be achieved while simultaneously improving the experience and quality of health care provided to our beneficiaries by providing financial incentives for high-quality, efficient care. Consistent with the CJR model, TRICARE demonstration hospitals will be held accountable for the costs and quality of the entire episode of care and will be afforded the opportunity to earn performance-based payments by appropriately reducing expenditures and meeting certain quality metrics.

An analysis of LEJR surgeries in the TRICARE beneficiary population was conducted. This analysis revealed some of the Metropolitan Service Areas (MSAs) participating in the CMS Comprehensive Care for Joint Replacement (CJR) model have a substantial number of TRICARE-eligible beneficiaries. These locations include the Killeen-Temple TX MSA, the Seattle-Tacoma WA MSA, and the Tampa-St. Petersburg FL MSA. Both the Killeen-Temple MSA and the Seattle-Tacoma MSA are associated with large inpatient military treatment facilities

(MTFs); however, there are not any inpatient MTFs associated with the Tampa-St. Petersburg MSA. Based on FY 2015 data, there are 74,133 TRICARE eligibles residing in the Tampa-St. Petersburg area, and 128 joint replacement or reattachment surgeries for TRICARE beneficiaries were performed in FY 2015. Due to collocation with CMS's MSA (which makes hospital participation mandatory), the significant number of TRICARE eligible beneficiaries receiving joint replacement or reattachment surgeries, and the lack of MTF inpatient resources, Tampa-St. Petersburg was selected for this demonstration project. Additionally, it was determined only one to two percent of all TRICARE LEJR patients are in DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities). As a result, the TRICARE demonstration project will exclude DRG 469 admissions since there are insufficient volumes for setting target episode prices for these procedures.

### **B. Description of the Demonstration Project**

All network and non-network hospitals in the Tampa-St. Petersburg area will be required to participate in the demonstration if they had at least 20 TRICARE admissions for DRG 470 over the three years of FY 2013, FY 2014, and FY 2015 (excluding admissions for beneficiaries with Other Health Insurance (OHI), Active Duty Service Members (ADSMs), and Medicare-TRICARE dual eligible beneficiaries). Once selected for participation, demonstration hospitals will remain in the program throughout the duration of this NDAA demonstration (regardless of actual TRICARE utilization) unless the Government directs otherwise. Demonstration hospitals will be accountable for quality and cost of care for an inpatient stay that results in DRG 470, along with all related care provided during the 90-day period following discharge.

The Defense Health Agency (DHA) will prospectively establish target episode prices for each demonstration hospital at least 30 days prior to the start of each demonstration year. This target episode price shall be based on TRICARE claims for DRG 470 admissions and associated post-operative care for FY 2013, FY 2014, and FY 2015, and shall be a blend of hospital-specific and market-wide historical episode costs. This historical data period shall be used for the duration of the demonstration, with annual adjustments for inflation. In Demonstration Years one and two, the

blended rate for the target episode price shall be developed with two-thirds hospital-specific data and one-third market-wide data; in Demonstration Year three, the target episode price shall be developed with one-third hospital-specific data and two-thirds market-wide data.

Although the CMS CJR Model incorporates an automatic cost savings of 3 percent into their target episode prices, DHA will not deduct an automatic cost savings amount when developing TRICARE target episode prices. Instead, target episode pricing will take historical network discounts, DRG and CPT pricing adjustments, and annual inflation factors into consideration. Additionally, the value of any care provided in the direct care system will not be considered in developing target prices. This will permit local military treatment facilities to recapture, where appropriate, post-surgery outpatient care under existing TRICARE procedures based on the MTF's capability and capacity without affecting incentive calculations. The target episode price will clearly indicate the cost build-up calculations for each component of care within the episode. These target episode prices will become the basis for calculating any incentive payments or penalties.

For purposes of this demonstration, Demonstration Year one will commence for admissions on May 23, 2016, and will include all completed episodes with an end date continuing through September 30, 2017 (including the full 90 days post-discharge period). Subsequent demonstration years will be conducted on a fiscal year basis (*i.e.*, for episodes ending October 1st through September 30th). The target episode price in effect on the date of hospital admission shall be used for incentive calculation purposes, even if a portion of post-discharge care is delivered in the subsequent demonstration year.

During each demonstration year, all hospital, physician, and post-acute care claims will be paid under the normal TRICARE reimbursement methodologies. At the end of each demonstration year, the total costs of all completed episodes for the year will be compared to the aggregate target episode price for each demonstration hospital to determine whether actual costs were less than, equal to, or greater than the target episode price. In order to ensure all costs are properly attributed to each demonstration hospital, actual cost calculations shall occur no sooner than 90 calendar days following the end of the demonstration year to allow adequate time for claims processing. In order to encourage use of the direct care

system and because the managed care support contractor processing the episode calculations will not have access to direct care cost data, costs for direct care shall be excluded (consistent with the target cost development).

In addition to performing these cost calculations, DHA will utilize the composite quality score (as determined by CMS) for each demonstration hospital as the basis for determining eligibility for gain-sharing. This composite quality score is a hospital-level summary quality score reflecting performance and improvement on the quality measures adopted for the Medicare CJR model (Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)) complications measure and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience survey measure. TRICARE will use Hospital Compare as the source for these data. Hospitals that do not achieve and maintain a favorable CJR composite quality score for the full demonstration year are not eligible for incentive payments, regardless of whether cost savings are achieved. TRICARE is following the same approach as Medicare in order to ensure hospitals are not reducing the quality of care offered to beneficiaries or reducing patients' overall perception of their hospital experience.

Incentive payments will be calculated using the CMS gain/loss sharing model; beginning in Demonstration Year one, positive incentive payments will be made to hospitals who achieve and maintain a favorable CJR composite quality score for the full demonstration year and who demonstrate cost savings as compared to the target episode price. "Downside" risk (negative financial incentives) will not be phased into the payment model until the second demonstration year. Gain/Loss sharing will increase over time, from no loss sharing in Demonstration Year one (only gain sharing), to higher levels in later years (gain sharing of 5 percent in Demonstration Years one and two, and 10 percent in Demonstration Year three). Loss sharing is 0 in Demonstration Year one, 5 percent in Demonstration Year two, and 10 percent in Demonstration Year three.

On a quarterly basis, demonstration hospitals will receive feedback from the MCSCs on their current quality performance (as identified in Hospital Compare), episode of care costs to date, and projected eligibility for incentives (based on TRICARE claims and Medicare's composite quality scores for each hospital). To facilitate effective communication with demonstration

hospitals, these quarterly reports shall mirror the format and detail of CMS's feedback reports to the extent feasible. Active Duty Service Members (ADSMs), Medicare-TRICARE Dual Eligible (TDEFIC) beneficiaries, and beneficiaries with Other Health Insurance (OHI) are excluded from this demonstration.

### C. Communications

The DHA will proactively educate beneficiaries, providers, and other stakeholders about this change.

### D. Evaluation

This demonstration project will assist the Department in evaluating whether value-driven incentives will result in a reduction in the rate of increase in health care spending and improvements in health care quality, patient experience of care, and overall health of TRICARE beneficiaries. Regular status reports and a full analysis of demonstration outcomes will be conducted consistent with the requirements in Section 726 of the 2016 NDAA. Future expansions of the demonstration project to additional locations may be considered based on DHA data analysis for the Tampa-St. Petersburg market. Details of any future expansions will be announced via **Federal Register** notice prior to implementation.

Dated: March 22, 2016.

**Aaron Siegel,**

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

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## DEPARTMENT OF EDUCATION

[Docket No.: ED-2016-ICCD-0009]

### Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Campus Equity in Athletics Disclosure Act (EADA) Survey

**AGENCY:** Office of Postsecondary Education (OPE), Department of Education (ED).

**ACTION:** Notice.

**SUMMARY:** In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 3501 *et seq.*), ED is proposing an extension of an existing information collection.

**DATES:** Interested persons are invited to submit comments on or before April 27, 2016.

**ADDRESSES:** To access and review all the documents related to the information collection listed in this notice, please use <http://www.regulations.gov> by searching the Docket ID number ED-2016-ICCD-0009. Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at <http://www.regulations.gov> by selecting the Docket ID number or via postal mail, commercial delivery, or hand delivery. *Please note that comments submitted by fax or email and those submitted after the comment period will not be accepted.* Written requests for information or comments submitted by postal mail or delivery should be addressed to the Director of the Information Collection Clearance Division, U.S. Department of Education, 400 Maryland Avenue SW., LBJ, Room 2E-103, Washington, DC 20202-4537.

**FOR FURTHER INFORMATION CONTACT:** For specific questions related to collection activities, please contact Ashley Higgins, 202-219-7061.

**SUPPLEMENTARY INFORMATION:** The Department of Education (ED), in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the Department assess the impact of its information collection requirements and minimize the public's reporting burden. It also helps the public understand the Department's information collection requirements and provide the requested data in the desired format. ED is soliciting comments on the proposed information collection request (ICR) that is described below. The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology. Please note that written comments received in response to this notice will be considered public records.

*Title of Collection:* Campus Equity in Athletics Disclosure Act (EADA) Survey.

*OMB Control Number:* 1840-0827.

*Type of Review:* An extension of an existing information collection.

*Respondents/Affected Public:* State, Local, and Tribal Governments; Private Sector.

*Total Estimated Number of Annual Responses:* 2,072.

*Total Estimated Number of Annual Burden Hours:* 11,397.

*Abstract:* The collection of information is necessary under section 485 of the Higher Education Act of 1965, as amended, with the goal of increasing transparency surrounding college athletics for student, prospective students, parents, employees and the general public. The survey is a collection tool to compile the annual data on college athletics. The data collected from the individual institutions by ED and is made available to the public through the Equity in Athletics Data Analysis Cutting Tool as well as the College Navigator.

Dated: March 23, 2016.

**Kate Mullan,**

*Acting Director, Information Collection Clearance Division, Office of the Chief Privacy Officer, Office of Management.*

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## DEPARTMENT OF ENERGY

[FE Docket No. 16-29-LNG]

### Cheniere Marketing, LLC; Application for Blanket Authorization To Export Previously Imported Liquefied Natural Gas on a Short-Term Basis

**AGENCY:** Office of Fossil Energy, DOE.

**ACTION:** Notice of application.

**SUMMARY:** The Office of Fossil Energy (FE) of the Department of Energy (DOE) gives notice of receipt of an application (Application), filed on March 7, 2016, by Cheniere Marketing, LLC (CMI), requesting blanket authorization to export liquefied natural gas (LNG) previously imported into the United States from foreign sources in an amount up to the equivalent of 500 billion cubic feet (Bcf) of natural gas on a short-term or spot market basis for a two-year period commencing on June 7, 2016.<sup>1</sup> CMI seeks authorization to export the LNG from the Sabine Pass LNG terminal owned by Sabine Pass LNG, L.P. located in Cameron Parish, Louisiana, to any country with the capacity to import LNG via ocean-going carrier and with which trade is not

<sup>1</sup> CMI's current blanket authorization to export previously imported LNG, granted in DOE/FE Order No. 3442 on June 6, 2014, extends through June 6, 2016.