

Accomplishment Instructions of Boeing Alert Service Bulletin 757-27A0157, dated December 18, 2017.

(2) For airplanes in Configuration 2 in Groups 1, 2, and 3, as defined in Boeing Alert Service Bulletin 757-27A0157, dated December 18, 2017: No work is required by this paragraph.

(h) Prohibited Modification

As of the effective date of this AD, do not accomplish the actions specified in Boeing Service Bulletin 757-27A0152 on any airplane.

(i) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Los Angeles ACO Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the certification office, send it to the attention of the person identified in paragraph (j) of this AD. Information may be emailed to 9-ANM-LAACO-AMOC-Requests@faa.gov.

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(3) An AMOC that provides an acceptable level of safety may be used for any repair, modification, or alteration required by this AD if it is approved by the Boeing Commercial Airplanes Organization Designation Authorization (ODA) that has been authorized by the Manager, Los Angeles ACO Branch, to make those findings. To be approved, the repair method, modification deviation, or alteration deviation must meet the certification basis of the airplane, and the approval must specifically refer to this AD.

(4) AMOCs approved previously for AD 2015-08-01 are not approved as AMOCs for any provision in this AD.

(5) For service information that contains steps that are labeled as RC, the provisions of paragraphs (i)(5)(i) and (i)(5)(ii) of this AD apply.

(i) The steps labeled as RC, including substeps under an RC step and any figures identified in an RC step, must be done to comply with the AD. If a step or substep is labeled "RC Exempt," then the RC requirement is removed from that step or substep. An AMOC is required for any deviations to RC steps, including substeps and identified figures.

(ii) Steps not labeled as RC may be deviated from using accepted methods in accordance with the operator's maintenance or inspection program without obtaining approval of an AMOC, provided the RC steps, including substeps and identified figures, can still be done as specified, and the airplane can be put back in an airworthy condition.

(j) Related Information

For more information about this AD, contact Myra Kuck, Aerospace Engineer, Cabin Safety, Mechanical & Environmental Systems Section, FAA, Los Angeles ACO Branch, 3960 Paramount Boulevard,

Lakewood, CA 90712-4137; phone: 562-627-5316; fax: 562-627-5210; email: Myra.J.Kuck@faa.gov.

(k) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the service information listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this service information as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) Boeing Alert Service Bulletin 757-27A0157, dated December 18, 2017.

(ii) Reserved.

(3) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Contractual & Data Services (C&DS), 2600 Westminister Blvd., MC 110-SK57, Seal Beach, CA 90740-5600; telephone 562-797-1717; internet <https://www.myboeingfleet.com>.

(4) You may view this service information at the FAA, Transport Standards Branch, 1601 Lind Avenue SW, Renton, WA. For information on the availability of this material at the FAA, call 425-227-1221.

(5) You may view this service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to <http://www.archives.gov/federal-register/cfr/ibr-locations.html>.

Issued in Renton, Washington, on December 22, 2017.

John P. Piccola, Jr.,

Acting Director, System Oversight Division, Aircraft Certification Service.

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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[Docket ID: DOD-2012-HA-0146]

RIN 0720-AB47

TRICARE; Reimbursement of Long Term Care Hospitals and Inpatient Rehabilitation Facilities

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

ACTION: Final rule.

SUMMARY: This final rule establishes reimbursement rates for Long Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs) in accordance with the statutory requirement that TRICARE inpatient care "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." This final rule adopts Medicare's reimbursement methodologies for inpatient services provided by LTCHs and IRFs. Each reimbursement methodology will be phased in over a 3-year period. This final rule also removes the definitions for "hospital, long-term (tuberculosis, chronic care, or rehabilitation)" and "long-term hospital care," and creates separate definitions for "Long Term Care Hospital" and "Inpatient Rehabilitation Facility" adopting Centers for Medicare & Medicaid Services (CMS) classification criteria. This final rule also includes authority for a year-end, discretionary General Temporary Military Contingency Payment Adjustment (GTMCPA) for inpatient services in TRICARE network IRFs when deemed essential to meet military contingency requirements.

DATES: This rule is effective March 5, 2018.

Applicability Date: The regulations setting forth the revised reimbursement systems shall be applicable for all admissions to Long Term Care Hospitals and Inpatient Rehabilitation Facilities, respectively, commencing on or after the first day of the month which is at least 120 days after the date of publication of this rule in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Sharon Seelmeyer, Defense Health Agency (DHA), Medical Benefits and Reimbursement Branch, telephone (303) 676-3690.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose of the Final Rule

1. Long Term Care Hospitals (LTCHs)

The purpose of this final rule is to establish a reimbursement system for LTCHs in accordance with the statutory provision at title 10, United States Code (U.S.C.), section 1079(i)(2). This statute requires that TRICARE payment for institutional care be determined, to the extent practicable, in accordance with the same rules as those that 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 LTCH patients into distinct Diagnosis-Related Groups (DRGs). The patient classification system groupings are called Medicare Severity Long Term Care Diagnosis Related Groups (MS-LTC-DRGs), which are the same DRG groupings used under the Medicare acute hospital inpatient prospective payment system (IPPS), but that have

been weighted to reflect the resources required to treat the medically complex patients treated at LTCHs.

On January 26, 2015, a TRICARE proposed rule was published in the **Federal Register** [79 FR 51127], proposing to adopt a TRICARE LTCH PPS similar to the Center for Medicare and Medicaid Service's (CMS) reimbursement system for LTCHs, with the exception of not adopting Medicare's LTCH 25 percent rule. This TRICARE proposed rule was subsequently withdrawn and replaced by the proposed rule published August 31, 2016 [81 FR 59934]. We refer the reader to the August 31, 2016, proposed rule for additional information.

TRICARE pays for most hospital care under the TRICARE DRG-based payment system, which is similar to Medicare's, but some hospitals are exempt by current regulation from the TRICARE DRG-based payment system. LTCHs were exempted from the TRICARE DRG-based payment system and were paid by TRICARE at the lower of a negotiated rate or billed charges. Paying billed charges is fiscally imprudent and inconsistent with TRICARE's governing statute. Paying LTCHs under Medicare's methods is prudent, because it reduces government costs without affecting beneficiary access to services or quality; it is practicable, because it can be implemented without major costs; and, it is harmonious with the statute because the statute states that TRICARE shall determine its payments for institutional services to the extent practicable in accordance with Medicare's payment rates. The final rule creates a gradual transition from TRICARE's current policy of authorizing LTCHs 100 percent of allowable charges (which is either the billed charge or a voluntarily negotiated rate) by phasing-in Medicare's LTCH reimbursement rates as follows: Allowing 135 percent of Medicare LTCH PPS amounts in the first 12-month period after implementation, 115 percent in the second 12-month period after implementation, and 100 percent in the third 12-month period after implementation and follows Medicare policies during subsequent Fiscal Years (FY). Our legal authority for this portion of the final rule is 10 U.S.C. 1079(i)(2).

2. Inpatient Rehabilitation Facilities (IRFs)

The purpose of this rule is to also adopt Medicare's reimbursement system for inpatient care for IRFs in accordance with the statutory requirement at 10 U.S.C. 1079 (i)(2) that TRICARE "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 IRFs using an IRF Prospective Payment System (PPS) which classifies IRF patients into one of 92 case-mix groups (CMGs).

Similar to LTCHs, IRFs (both freestanding rehabilitation hospitals and rehabilitation hospital units) are currently exempted from the TRICARE DRG-based payment system and paid by TRICARE at the lower of a negotiated rate or billed charges. As discussed earlier, paying billed charges is fiscally imprudent and inconsistent with TRICARE's governing statute. Paying IRFs under a method similar to Medicare's is prudent, practicable, and harmonious with the statute. The final rule creates a gradual transition from TRICARE's current policy of authorizing IRFs 100 percent of allowable charges (which is either the billed charge or a voluntarily negotiated rate) by phasing-in Medicare's IRF PPS as follows: Allowing 135 percent of Medicare IRF PPS amounts in the first 12-month period after implementation, 115 percent in the second 12-month period after implementation, and 100 percent in the third 12-month period after implementation and follow Medicare's policies during subsequent FYs. Our legal authority for this portion of the final rule is 10 U.S.C. 1079(i)(2).

B. Summary of the Major Provisions of the Final Rule

1. Payment Method for LTCHs

TRICARE shall reimburse LTCHs for inpatient care using Medicare's LTCH PPS using Medicare's MS-LTC-DRGs. TRICARE is creating a 3-year transition period as described below. Payment for a TRICARE patient will be made at a predetermined, per-discharge amount for each Medicare Severity (MS)-LTC-DRG under the TRICARE LTCH PPS reimbursement methodology. The TRICARE LTCH PPS reimbursement methodology includes 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). When the Medicare hospital day limit is exhausted for TRICARE beneficiaries, who are also eligible for Medicare (i.e., TRICARE For Life (TFL) beneficiaries), TRICARE is the primary payer for medically necessary services, the beneficiary will be responsible for the appropriate TRICARE inpatient cost share. The beneficiary's out-of-pocket

costs will be limited by the respective statutory catastrophic cap.

2. LTCH Transition Period

In response to public comments, we agree that a transition period is appropriate in order to prepare LTCHs for changes in reimbursement. TRICARE will allow LTCHs 135 percent of the Medicare LTCH PPS amounts in the first 12-month period after implementation, 115 percent in the second 12-month period after implementation, and 100 percent in the third 12-month period after implementation and follow Medicare's policies during subsequent fiscal years.

CMS has established two different types of LTCH PPS payment rates based on the Pathway for Sustainable Growth Rate Reform Act of 2013: (1) Standard LTCH PPS payment rates; and (2) lower site-neutral LTCH PPS payment rates that are paid at the lower of the IPPS comparable per diem amount, or the estimated cost of the case. Site-neutral patients include LTCH patients who do not use prolonged mechanical ventilation during their LTCH stay or who did not spend three or more days in the intensive care unit (ICU) during their prior acute care hospital stay. Medicare transitioned to the site-neutral payment rate reductions in FY 2016 and FY 2017 by requiring payment based on a 50/50 blend of the standard LTCH PPS rate and the site-neutral LTCH PPS rate for site-neutral patients in those years. Beginning at the individual hospital's cost reporting period beginning in FY 2018, all Medicare LTCH payments for site-neutral patients are calculated using the site-neutral payment methodology (without a 50/50 blend in payments).

TRICARE will adopt the Medicare LTCH PPS in its entirety except for the Medicare 25 percent threshold rule, including both the full LTCH PPS Standard Federal Payment Rate and site-neutral LTCH PPS methodology for qualifying LTCH cases. TRICARE will have a 3-year transition period which will start at the applicability date of this final rule. We will apply the FY 2019 LTCH PPS for the purposes of the 12-month period beginning on October 1, 2018, and follow any changes adopted by Medicare LTCH PPS for subsequent years. For example, if FY 2019 is the first year of the TRICARE transition period, TRICARE would follow Medicare and all TRICARE LTCHs would receive 135 percent of the full site-neutral payment for TRICARE site-neutral patients. TRICARE will also consider military treatment facilities (MTF) and Veterans Administration (VA) hospitals as Subsection (d)

hospitals for the purposes of the site-neutral policy.

3. Children's Hospitals and Pediatric Patients in LTCHs

Children's hospitals will be exempt from the TRICARE LTCH PPS and will be paid under the TRICARE DRG-based payment system. Pediatric patients who receive care in TRICARE authorized LTCHs will be paid under the TRICARE LTCH PPS. This final rule edits the regulatory language to include this provision.

4. Payment Method for IRFs

TRICARE shall reimburse IRFs for inpatient care using Medicare's IRF PPS. TRICARE is creating a 3-year transition period as described below. Payment for a TRICARE patient will be made at a prospectively-set, fixed payment per discharge based on a patient's classification into one of 92 CMGs. Each CMG has a national relative weight reflecting the expected relative costliness of treatment for patients in that category compared with that for the average Medicare inpatient rehabilitation patient. The relative weight for each CMG is multiplied by a standardized Medicare IRF base payment amount to calculate the case-mix adjusted prospective payment rate. The TRICARE IRF PPS payment rates will cover all inpatient operating and capital costs that IRFs are expected to incur in furnishing inpatient rehabilitation services. When the Medicare hospital day limit is exhausted for TRICARE beneficiaries who are also eligible for Medicare (*i.e.*, TRICARE For Life (TFL) beneficiaries), TRICARE will then be the primary payer for medically necessary services and the beneficiary will be responsible for the appropriate TRICARE inpatient cost share. The beneficiary's out-of-pocket costs will be limited by the respective statutory catastrophic cap.

5. IRF Transition Period

In response to public comments, we agree that a transition period is appropriate in order to prepare IRFs for changes in reimbursement. To protect IRFs from sudden significant reductions, the final rule creates a gradual transition from TRICARE's current policy of allowing 100 percent of allowable charges (which is either the

billed charge or a voluntarily negotiated rate) by phasing-in the Medicare IRF PPS rates as follows: allowing 135 percent of Medicare IRF PPS amounts in the first 12-month period after implementation, 115 percent in the second 12-month period after implementation, and 100 percent in the third 12-month period after implementation. We will apply the FY 2019 IRF PPS for purposes of the 12-month period beginning on October 1, 2018, and follow any changes adopted by the Medicare IRF PPS for subsequent years.

6. Children's Hospitals and Pediatric Patients in IRFs

As stated in the supplementary language of the proposed rule published on August 31, 2016, Children's hospitals will be exempt from the TRICARE IRF PPS and will be paid under the TRICARE DRG-based payment system. Pediatric patients who receive care in TRICARE authorized IRFs will be paid under the TRICARE IRF PPS.

7. IRF Low Income Payment (LIP) Adjustment

TRICARE is including the LIP adjustment in the TRICARE IRF PPS.

8. Removal of Outdated Terms

This final rule removes outdated definitions in Title 32, Code of Federal Regulations (CFR), Part 199.2 for "[h]ospital, long-term (tuberculosis, chronic care, or rehabilitation)" and "[l]ong-term hospital care" and adds a new definition for "Long-Term Care Hospital (LTCH)" as well as adding a new definition for "Inpatient Rehabilitation Facility (IRF)." The new definitions adopt CMS' LTCH and IRF classifications. The TRICARE requirements for both LTCHs and IRFs to be authorized institutional providers have been added to 32 CFR 199.6.

9. General Temporary Military Contingency Payment Adjustment (GTMCPA) For IRFs

One of the purposes of the TRICARE program is to support military members and their families during periods of war or contingency operations, when military facility capability may be diverted or insufficient to meet military readiness priorities. To preserve the availability of IRFs during such periods, the final rule includes authority for a

year-end discretionary, temporary adjustment that the Director, DHA may approve in extraordinary economic circumstances for a network IRF that serves a disproportionate share of Active Duty Service members (ADSMs) and Active Duty dependents (ADDs). TRICARE is in the process of developing policy and procedural instructions for exercising the discretionary authority under the qualifying criteria for the GTMCPAs for inpatient services provided in IRFs. The policy and procedural instructions will be available within three to six months following the applicability date of the new inpatient reimbursement methodology for IRFs. Network IRFs will be able to request a GTMCPA approximately 14 months from the applicability date of the new reimbursement method as any GTMCPA will be based on twelve months of claims payment data under the new method. Once finalized, the policy and procedural instructions will be available in the TRICARE Reimbursement Manual at <http://manuals.tricare.osd.mil>. As with any discretionary authority exercised under the regulation, a determination approving or denying a GTMCPA for an IRF is not subject to the appeal and hearing procedures set forth in 32 CFR 199.10, and Section 199.14(a)(10) of this final rule has been revised to clarify this point.

C. Costs and Benefits

Consistent with OMB Circular A-4, the effect of this rule is a transfer caused by a Federal budget action; it does not impose costs, including private expenditures. The final rule is anticipated to reduce DoD allowed amounts to LTCHs by approximately \$73M in the first year of the transition, if implemented in FY 2019 when TRICARE site-neutral LTCH cases will be paid at the full applicable LTCH PPS payment amount (see Table 1). DoD allowed amounts to LTCHs would be reduced by \$86M in the second year, and \$98M in the third and final year of the transition.

This final rule is also anticipated to reduce DoD allowed amounts to IRFs by approximately \$24M in FY 2019, which is anticipated to be the first year of the transition period, \$41M in the second year, and \$57M in the final year of transition.

Table 1
Reductions in TRICARE Allowed Amounts Under Proposed Policy During Transition Period

	Transition Schedule - Percent of Medicare Allowed Payments	Reductions Under Proposed Policy (Millions)	
		LTCH	IRF
FY19	135%	\$73	\$24
FY20	115%	\$86	\$41
FY21	100%	\$98	\$57

Source: FY 2015 TRICARE IRF claims data and FY 2016 Medicare IRF rate setting file. Assumes Rule is implemented at the start of FY 2019.

II. Discussion of Final Rule

A. Introduction and Background

In the **Federal Register** of August 31, 2016 [81 FR 59934], DoD published for public comment a rule proposing to revise its reimbursement methodologies for LTCHs and IRFs. Under 10 U.S.C. 1079(i)(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.”

B. TRICARE LTCH PPS Reimbursement Methodology

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 and long lengths of stay. Per 32 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 IPPS when the CMS initially implemented its DRG-based payment system. 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 the lower of a negotiated rate or billed charges, which is usually substantially greater than what would be paid using the TRICARE DRG method.

Medicare created a PPS for LTCHs effective with the cost reporting period beginning on or after October 1, 2002. The MS–LTC–DRG system under

Medicare’s LTCH PPS classifies patients into distinct diagnostic groups based on their 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.

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, in 2008 Medicare adopted an LTCH-specific DRG system, which uses MS–LTC–DRGs, as the patient classification method for LTCHs. In FY 2016, Medicare began its adoption of a site-neutral payment system for LTCHs. Beginning in FY 2016 and continuing in FY 2017 and 2018, CMS has been phasing in the site-neutral payment methodology; during that time, 50 percent of the allowed amount for site-neutral patients was calculated using the site-neutral payment methodology (IPPS comparable amount) and 50 percent was calculated using the current full LTCH PPS standard federal payment rate methodology. Beginning in cost reporting periods that start in FY 2018, all Medicare payments for qualifying LTCH site-neutral patients are calculated using the Medicare site-neutral payment methodology. All other LTCH patients meeting the Medicare

criteria for a full LTCH PPS Standard Payment will be paid using the standard LTCH PPS payment methodology.

Under 10 U.S.C. 1079(i)(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].” Based on 10 U.S.C. 1079(i)(2), TRICARE is adopting Medicare’s LTCH PPS, to include Medicare’s MS–LTC–DRG weights and rates, and Medicare’s site-neutral payment methodology for TRICARE authorized LTCHs. TRICARE will adopt the Medicare payment methodology that is in place at the time of TRICARE’s implementation and TRICARE will adopt any additional updates or changes to Medicare’s LTCH PPS payment methodology as they are adopted by Medicare. TRICARE is also adopting Medicare’s adjustments for short-stay outliers, site-neutral payments, interrupted stay policy, the method of payment for preadmission services, and high-cost outlier payments. TRICARE is not adopting Medicare’s 25 percent rule because there are too few TRICARE discharges at individual LTCHs to have a threshold policy based on TRICARE admissions. In FY15, only 15 of the 200 LTCHs with TRICARE discharges had 10 or more TRICARE admissions and over 70 percent of the 200 LTCH discharges were from LTCHs with 1–3 TRICARE discharges. As a result, TRICARE has too few discharges at all but a very small number of LTCHs to calculate and apply the 25 percent test using TRICARE discharges. TRICARE could not apply the results of the Medicare 25 percent rule to TRICARE LTCH discharges

because the results of Medicare's test are not known until the LTCH's Medicare cost report is settled after the end of the year. Even if DHA knew which LTCHs had failed the 25 percent rule and could identify the specific acute care hospitals that had exceeded the 25 percent rule, it would not be appropriate to apply an adjustment to the TRICARE LTCH discharges from that acute care hospital because DHA would not know which specific TRICARE LTCH discharges from that acute care hospital should have payment reductions and it would be inconsistent with Medicare's policy to reduce the payments for all TRICARE LTCH discharges from that hospital. As a result, DoD is not adopting Medicare's 25 percent rule. TRICARE will also incorporate Medicare's LTCH Quality Reporting (QR) payment adjustments for TRICARE LTCHs that are reflected Medicare's annual payment update for that facility. TRICARE is not establishing a separate reporting requirement for hospitals, but will utilize Medicare's payment adjustments resulting from their LTCH QR Program. Please see Medicare's final rule published on August 22, 2016 [81 FR 56761] for more detail about that program.

TRICARE will have a three-year phase-in period to prepare LTCHs for these changes in TRICARE reimbursement. TRICARE will allow LTCHs 135 percent of the Medicare LTCH PPS amounts in the first 12-month period after implementation, 115 percent in the second 12-month period after implementation, and 100 percent in the third 12-month period after implementation and follow Medicare's LTCH PPS policies during subsequent FYs.

C. TRICARE IRF PPS Reimbursement Methodology

IRFs are free standing rehabilitation hospitals and rehabilitation units in acute care hospitals that provide an intensive rehabilitation program. Per 32 CFR 199.14(a)(1)(ii)(D)(2) and (3), IRFs are currently exempt from the TRICARE DRG-based payment system, just as they were exempt from Medicare's IPPS when the CMS initially implemented its DRG-based payment system. Per 42 CFR 412.1(a)(3), an inpatient rehabilitation hospital or rehabilitation unit of an acute care hospital must meet the requirement for classification as an IRF stipulated in 42 CFR 412.604. In order to qualify as a Medicare-certified IRF, Medicare requires that a certain percentage (currently 60 percent) of the IRF's total inpatient population must meet at least one of 13 medical conditions listed in 42 CFR 412.29(b)(2).

Because there is no alternate TRICARE reimbursement mechanism in 32 CFR part 199 at this time, IRF care provided to TRICARE beneficiaries in this setting is currently paid the lower of a negotiated rate, or billed charges. We are adopting Medicare's 60 percent requirement for IRFs.

Medicare created a PPS for IRFs effective with the cost reporting period beginning in January 2002. Section 4421 of the Balanced Budget Act of 1997 (Pub. L. 105-33) modified how Medicare payment for IRF services is to be made by creating Section 1886(j) of the Social Security Act, which authorized the implementation of a per-discharge prospective payment system for inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals—referred to as IRFs. As required by Section 1886(j) of the Act, the Federal rates reflect all costs of furnishing IRF services (routine, ancillary, and capital related). CMS included a 9-month transition period when it adopted the IRF PPS for Medicare, under which IRFs could elect to be paid a blended rate. The transition period ended October 1, 2002. Following the transition period, payment to all IRFs was based entirely on the prospective payment.

TRICARE will also have a three-year phase-in to protect IRFs from sudden significant reductions. The final rule creates a gradual transition to full implementation of the Medicare IRF PPS by allowing 135 percent of Medicare IRF PPS amounts in the first 12-month period after implementation, 115 percent in the second 12-month period after implementation, and 100 percent in the third 12-month period after implementation and follow Medicare's IRF PPS policies during subsequent FYs.

Under 10 U.S.C. 1079(i)(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]." Based on 10 U.S.C. 1079(i)(2), TRICARE is adopting Medicare's IRF reimbursement methodology for TRICARE authorized IRFs.

TRICARE is also adopting Medicare's IRF adjustments for interrupted stays, short stays of less than three days, short-stay transfers (defined as transfers to another institutional setting with an IRF length of stay less than the average length for the CMG), high-cost outliers, and the LIP adjustment. Further, TRICARE is adopting Medicare's

Inpatient Rehabilitation Hospital Quality Reporting (IRFQR) payment adjustments for TRICARE authorized IRFs that reflect Medicare's annual payment update for that facility. TRICARE is not establishing a separate reporting requirement for hospitals, but will utilize Medicare's payment adjustments resulting from their IRFQR Program. Please see Medicare's final rule [CMS-1632-F; CMS-1632-CN2] RIN 0938-AS41.

D. Pediatric Cases in TRICARE Authorized LTCHs and IRFs

1. LTCH

Our analysis found that in FY 2015, there were five pediatric TRICARE patients treated at TRICARE LTCHs. We found that TRICARE LTCH patients had similar diagnoses as Medicare LTCH patients and that the few pediatric LTCH patients had similar diagnoses as TRICARE patients. Therefore, we are also adopting Medicare's LTCH PPS methodology for pediatric patients treated in TRICARE authorized LTCHs. Some TRICARE patients are treated at Children's hospitals and these hospitals will be exempt from the LTCH PPS and will be paid under the TRICARE DRG-based payment system.

2. IRF

Approximately 50 TRICARE beneficiaries under the age of 17 received treatment at TRICARE IRFs in FY 2015. We are adopting Medicare's IRF PPS for pediatric patients treated at TRICARE authorized IRFs. Some TRICARE patients are treated at Children's hospitals and these hospitals will be exempt from the IRF PPS, and will be paid under the TRICARE DRG-based payment system.

E. Veterans Administration (VA) Hospitals

VA hospitals specialize in treating injured veterans and provide access to rehabilitative care.

1. LTCH

VA hospitals are not Medicare-authorized LTCHs (because they are Federal hospitals) and they are not reimbursed using Medicare's LTCH PPS method.

2. IRF

VA hospitals are not Medicare-authorized IRFs (because they are Federal hospitals) and they are not reimbursed using Medicare's IRF PPS method. TRICARE allows VA hospitals to provide inpatient rehabilitation care to TRICARE beneficiaries, and VA hospitals provide care for over 200 TRICARE patients each year (mostly

ADSMs). VA hospitals will continue to be paid under existing payment methodologies.

F. IRF General Temporary Military Contingency Payment Adjustment (GTMCPA)

In response to the public comments, the final rule includes authority for a year-end, discretionary, GTMCPA that the Director, DHA, may approve in extraordinary economic circumstances for inpatient services from TRICARE network IRFs deemed to be essential for military readiness and support during contingency operations. The Director, DHA, or designee, may approve a GTMCPA for network IRFs that serve a disproportionate share of ADSMs and ADDs. Specific procedures for requesting an IRF GTMCPA will be outlined in the TRICARE Reimbursement Manual.

G. Additional Revisions to the Regulations

In reviewing the proposed rule, we realized that the current regulation regarding the reimbursement of facilities and services that exempt from the DRG-based payment system (32 CFR 199.14(a)(1)(ii)(C)) contains an incorrect cross-reference to paragraph (a)(3) vice (a)(4). The new paragraph (a)(3) was added as part of TRICARE; Reimbursement of Critical Access Hospitals final rule (74 FR 44752, August 31, 2009). The old paragraph (a)(3) regarding billed charges and set rates was renumbered as (a)(4), which is now the correct reference. Consequently, we have included this correction in the final rule,

III. Public Comments

The TRICARE LTCH and IRF proposed rule [81 FR 59934] published on August 31, 2016, provided a 60-day comment period. Following is a summary of the public comments and our responses.

A. LTCH

Comment: One commenter stated that DHA should have a transition period for the LTCH rule because LTCHs are already experiencing financial instability due to the implementation of Medicare's site-neutral payments. The commenter further stated that because of this instability, LTCHs may temporarily suspend all care to TRICARE beneficiaries upon implementation of the LTCH-PPS. The commenter believes this would be less likely to occur if DHA implements a two-year transition period.

Response: In response to this comment, we have considered whether

we should modify our approach to include a transition period. We analyzed our options and as a result, we are including a 3-year phase in to full adoption of Medicare's LTCH PPS rates. TRICARE LTCHs will be allowed 135 percent of Medicare LTCH PPS amounts in the first 12-month period after implementation, 115 percent in the second 12-month period after implementation, and 100 percent in the third 12-month period after implementation and subsequent FYs.

Comment: Two commenters stated that DHA should do additional analysis on TRICARE LTCH beneficiaries to understand whether the LTCH payment reform will limit beneficiary access to needed care. These commenters believe that analyses should be done to ensure that the LTCH-PPS rates would adequately cover the cost of care for the TRICARE population. They opined that DHA should delay implementation of the LTCH-PPS to do these analyses.

Response: DHA analyzed FY 2015 TRICARE LTCH claims data to understand the differences between the LTCH payment rates for TRICARE patients under the current TRICARE method and proposed adoption of Medicare methods. We note that: (1) TRICARE's proposed LTCH payment rates would be no less than Medicare rates; (2) Medicare LTCH rates are higher than LTCH costs; (3) during the transition period the TRICARE rates would be much higher than the Medicare rates; and (4) that in studying Medicare beneficiary access to LTCHs, Medicare Payment Advisory Commission (MedPAC) has found that LTCH access has been maintained for Medicare beneficiaries (MedPAC, 2016 Report to Congress, Chapter 10). Thus, for the reasons stated above, DHA believes it is reasonable to assume that TRICARE beneficiaries will not have access problems for LTCH care.

Comment: One commenter stated DHA should not implement a TRICARE-specific 25-percent policy for LTCHs because the 25-percent rule would penalize many TRICARE LTCHs that admit less than four TRICARE patients annually. If implemented, the 25-percent rule would reduce TRICARE payments by far more than 67 percent.

Response: We agree with the commenter that DHA should not include a TRICARE-specific 25-percent policy for LTCHs. Our intent was not to have a TRICARE-specific 25-percent policy for LTCHs. We have also decided it is not practicable for TRICARE to adopt Medicare's 25-percent policy adjustments for TRICARE LTCHs because there are too few TRICARE discharges to have a threshold policy

based on TRICARE admissions, and it would be unfair to adjust all of an LTCH's payments if the LTCH failed the Medicare threshold (and this would also be inconsistent with Medicare's policy).

Comment: One commenter stated that DHA should modify its LTCH-PPS short stay outlier policy for LTCHs to cap payments at the cost of the case. The commenter believed the Medicare Short Stay Outlier (SSO) policy would encourage perverse incentives for LTCHs who may discharge patients at certain points of their stay based on what outlier payment they would receive. A capped policy would also be easier to implement.

Response: We disagree that the Medicare LTCH SSO policy should be modified for TRICARE. DHA aims to follow Medicare policy as closely as possible, and for this reason, using Medicare's exact outlier methodology is appropriate.

Comment: Two commenters stated that TRICARE should treat military treatment facilities and VA hospitals as "subsection (d)" hospitals for the purposes of determining whether a case meets the clinical patient-level criteria used to determine eligibility for the LTCH-PPS standard reimbursement rate.

Response: We thank the commenters for bringing to our attention that due to the site neutral criteria, patients may potentially be rejected from admission to Long Term Care Hospitals because the preceding stay was not at a subsection (d) hospital. In order to eliminate a potential rejection, DHA agrees that TRICARE should treat military treatment facilities and VA hospitals as "subsection (d)" hospitals for the purposes of LTCH admission and qualification for the LTCH-PPS payment. It is important to ensure that Military Treatment Facility (MTF) and VA discharged TRICARE beneficiaries do not have LTCH access issues. We would also note that this approach is consistent with the guidance issued by CMS. Specifically, for patients who may have used their VA benefit or received inpatient care at a MTF that qualified as an "immediately preceding" stay, applicable criteria for exclusion from the site neutral payment rate are met. (See MLN Matters® Number: SE1627 released October 18, 2016.)

Comment: One commenter stated that few TRICARE patients go to LTCHs so the TRICARE LTCH payment change is irrelevant.

Response: We disagree with the commenter on their statement that few TRICARE patients go to LTCHs, and that changes to the TRICARE LTCH payment system would be irrelevant. In FY 2015,

over 700 TRICARE patients were admitted to approximately 200 LTCHs, with allowed amounts of over \$90M. As a result, LTCH payment changes would not be irrelevant.

Comment: One commenter stated the SSO policy proposed would be different than Medicare's reimbursement system.

Response: This comment was in response to the withdrawn TRICARE proposed rule published in the **Federal Register** on January 26, 2015 [79 FR 51127]. The proposed rule has since been withdrawn. We published a new proposed rule in the **Federal Register** on August 31, 2016 [81 FR 59934], stating we would adopt Medicare's short stay outlier policy in its entirety.

Comment: One commenter agreed with our proposed definition changes.

Response: We thank the commenter for their review and observations.

B. IRF

Comment: One commenter stated the proposed timeline date of the beginning FY 2017 for implementation was incorrect.

Response: We agree that the timeline cannot begin at the beginning of FY 2017 and have modified the projected implementation date to FY 2019 for both LTCHs and IRFs.

Comment: One commenter stated that DHA should reduce IRF administrative burdens such as the repetitive authorization process.

Response: This comment does not appear to be contingent on the proposed rule, and is instead commenting on TRICARE IRF current practice. We invite the commenter to contact their regional Managed Care Support Contractor to work with them and make them aware of the issue.

Comment: Two commenters stated that TRICARE should have a transition period for the IRF rule. Providers should be given adequate advance notice of any changes to their reimbursement and should have the flexibility to transition to the new system.

Response: In response to this comment, we have considered whether we should modify our approach to include a transition period. We are including a 3-year transition period for adopting Medicare's IRF PPS rates. TRICARE will allow 135 percent of Medicare IRF PPS amounts in the first 12-month period after implementation, 115 percent in the second 12-month period after implementation, and 100 percent in the third 12-month period after implementation, and follow Medicare's IRF PPS policies during subsequent FYs.

Comment: One commenter, noting that TRICARE beneficiaries are

substantially younger than Medicare beneficiaries, stated Medicare's CMG system and weights are not appropriate for TRICARE patients because TRICARE IRF patient characteristics are much different than Medicare IRF patient characteristics. This commenter also suggested that TRICARE should increase CMG weights for key TRICARE categories in order to account for TRICARE patients' different needs.

Response: We believe that the Medicare CMG system and weight structure is appropriate for TRICARE patients because although TRICARE may have a different case mix of IRF patients than Medicare, TRICARE IRF patients require similar rehabilitation services in IRFs as Medicare patients. Although in aggregate TRICARE patients do stay longer in the IRF setting (15 days in FY 2015, in comparison to the Medicare average length-of-stay of 13 days in FY 2014 (MedPAC, March 2016 Report to Congress, Table 9–5, Chapter 9)), we think the factors that are built into the Medicare CMGs are appropriate for TRICARE patients because they require similar rehabilitation services. IRF patients are grouped into one of 92 CMGs based on a number of characteristics such as the diagnosis requiring rehabilitation, functional status, cognitive status, age, and comorbidities. We think CMGs are appropriate for both Medicare and TRICARE patients. With respect to the age difference between Medicare and TRICARE beneficiaries, the Medicare CMG system is also currently used for the reimbursement of patients under the age of 65 who are entitled to Medicare. Further, in examining FY 2015 TRICARE IRF claims, three-quarters of IRF claims and about half of all allowed amounts were for retirees and their dependents.

Comment: One commenter suggested that a closer review of the legislative history shows that Congress did not intend to require DoD to adopt Medicare reimbursement rules for IRF care.

Response: We disagree. The pertinent statutory provision (10 U.S.C. 1079(i)(2)) states, "payments may 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 Title XVIII of the Social Security Act." The commenter argues that it was not Congress' intent to adopt Medicare rates to TRICARE IRF beneficiaries because the above statutory language was enacted before Medicare's PPS reimbursement system for IRFs went into effect. The commenter would like to read this statutory authority as being limited to only those types of care for

which Medicare had a reimbursement methodology in place at the time of enactment of the statute. We see no justification that allows DoD to disregard the unambiguous requirement in the statute to adopt Medicare reimbursement methodologies to the extent practicable. We believe for the reasons stated in the proposed rule that using the IRF-PPS for TRICARE patients is practicable, and therefore, is in accordance with DoD's statutory obligation.

Comment: One commenter stated that if TRICARE implements the Medicare IRF-PPS, more TRICARE patients will be discharged from IRFs to other post-acute care settings (like Skilled Nursing Facilities (SNFs)). Because TRICARE does not have a limit on the number of medically necessary SNF days, the commenter opines that TRICARE patients may stay indefinitely at SNFs. The commenter asserted that TRICARE's projected savings from adopting the Medicare IRF PPS would be reduced because of the increased use of post-acute care.

Response: First, we would note that the commenter assumes there will be a reduction in the amount of care provided in an IRF setting which will then cause TRICARE beneficiaries to take greater advantage of other post-acute care. We do not believe this will occur. We agree with the commenter that if there is an increase in the number of TRICARE patients who are discharged from IRFs and then admitted to SNFs, it would reduce the estimated level of TRICARE savings. However, we think that the impact of this effect would be small. For example, even under the very unrealistic assumption that every TRICARE patient discharged from an IRF would have an additional 7-day stay at a SNF that otherwise would not occur, it would increase TRICARE costs by less than \$10M, which is much less than the anticipated TRICARE payment reduction of almost \$60M in FY 2020. Further, we disagree with the commenter that TRICARE patients who transfer to SNFs would stay at SNFs indefinitely. Only patients who require medically necessary care will be admitted to SNFs, and the stays must continue to be medically necessary. Based upon the experience of other TRICARE SNF patients who have an average length of stay of 22 days, we do not think that TRICARE SNF stays will be indefinite.

Comment: One commenter stated that TRICARE can retain contractual relationships with in-network providers, and negotiate with out-of-network providers on a case by case basis.

Response: The managed care support contractors are responsible for negotiating discounts from providers, and have strong incentives to do this today. We found that about 37 percent of out-of-network TRICARE IRFs were reimbursed at a discount off of billed charges in FY 2015 and that over 60 percent were paid at 100 percent of billed charges. Relying on the managed care support contractors to negotiate rates with network providers, however, is not a substitute for establishing an applicable reimbursement methodology. Further, negotiating rates with out-of-network providers on a case-by-case basis does not ensure compliance with statutory obligations not to pay more than Medicare rates when practicable.

Comment: One commenter stated that TRICARE could adopt Medicare rules for certain TRICARE patients like retirees who may have more similar characteristics to Medicare beneficiaries, and maintain current payment policy for other family members and active duty service members. This will ensure that ADSMs and their families will continue to receive the full scope of IRF services.

Response: We have reviewed the beneficiary population data, and we agree that a discretionary adjustment should be considered to ensure that there is sufficient access for ADSMs and their families. Those network IRFs with a high proportion of ADSM/ADD admissions may be eligible to receive a GTMCPA.

Comment: One commenter stated that TRICARE should make outlier payments based on a marginal cost factor equal to 100% of the costs in excess of the fixed-loss threshold, rather than 80% as provided by Medicare, since this practice is inconsistent with the ordinary practices of the insurance industry. TRICARE should use individual hospital cost-to-charge ratios rather than a national cost-to-charge ratio. This will help ensure payment for care provided to Service members and their families.

Response: We disagree that using Medicare's outlier methodology would be inappropriate for TRICARE patients. Under 10 U.S.C. 1079(i)(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]." Given the statutory language, TRICARE is adopting Medicare's IRF PPS reimbursement method for our beneficiaries. Medicare does use

facility-specific cost-to-charge ratios (please see Medicare's final rule published on August 6, 2015 [80 FR 47036]), and DHA plans on doing the same.

Comment: One commenter stated that DHA should do additional analysis on TRICARE IRF beneficiaries to understand whether the IRF payment reform will limit beneficiary access to needed care. Additionally, analyses should be done to ensure that the IRF-PPS rates would adequately cover the cost of care for the TRICARE population.

Response: DHA disagrees that there will be access problems because TRICARE will pay no less than Medicare does for IRF care and because MedPAC has found that there do not appear to be capacity constraints on IRF care for Medicare patients (MedPAC, 2016 Report to Congress, Chapter 9). MedPAC has also found that Medicare IRF payments exceed IRF costs.

Comment: One commenter stated that they do not agree that the agency is compelled to adopt the Medicare IRF PPS.

Response: 10 U.S.C. 1079(i)(2) states that "payments may 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 Title XVIII of the Social Security Act." We believe that it is practicable to adopt the Medicare system, and that adopting the IRF-PPS more closely aligns TRICARE to Medicare payment methods and rules.

Comment: One commenter stated that DHA should implement the LIP adjustment in IRF-PPS method, and revert back to policy from the original proposed rule because it is a fundamental part of the Medicare program and critical to providers serving vulnerable populations, and should not be excluded from the TRICARE rate.

Response: We agree with the commenter that the LIP adjustment should be included in the TRICARE IRF PPS. This will allow for the same payment to LIP adjusted hospitals as Medicare, and will also provide additional reimbursement to IRFs serving vulnerable TRICARE populations.

Comment: One commenter stated that TRICARE patients to IRFs should not complicate the compliance methodology for satisfying the 60 Percent Rule and that the 60 Percent Rule is not a component of payment policy.

Response: We believe that the statement in the proposed rule has confused the commenter regarding

TRICARE and Medicare's 60 percent rule. It was the intent of the policy to note that TRICARE would honor the Medicare adjustments based on fulfilling the criteria of the 60 percent rule with Medicare patients, and not that TRICARE would require a 60 percent rule for its own patients. In other words, if Medicare penalizes an IRF because the IRF did not meet the 60 percent rule criteria with Medicare patients, TRICARE would also penalize the hospital. This is because TRICARE would use the same grouping software as Medicare, which already includes the 60-percent rule adjustments.

Comment: One commenter requested that we confirm that the majority of out-of-network IRF reimbursement is being reimbursed at 100 percent of billed charges.

Response: Using FY 2015 data, we found that about 63 percent of TRICARE non-network IRFs were reimbursed at 100 percent of billed charges. On average, out-of-network providers were reimbursed at 87 percent of billed charges.

IV. Regulatory Impact Analyses for LTCHs and IRFs

A. Overall Impact

DoD has examined the impacts of this final 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), the Congressional Review Act (5 U.S.C. 804(2)), and E.O. 13771, Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

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 (\$100M or more in any one year).

We estimate that the effects of the LTCH and IRF provisions that would be implemented by this rule would not

result in LTCH or IRF revenue reductions exceeding \$100 million in any one year individually, however, when combined revenue reductions would exceed \$100 million, making this rulemaking “economically significant” as measured by the \$100 million threshold. We have prepared a Regulatory Impact Analyses that, to the best of our ability, presents the costs and benefits of the rulemaking. This final rule is anticipated to reduce DoD allowed amounts to LTCHs by \$73M and to IRFs by \$24M in FY 2019 during the first year of transition.

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 \$100M or more or have certain other impacts. This final rule 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) identification of a small business (having revenues of \$34.5M or less in any one year). For purposes of the RFA, we have determined that the majority of LTCHs and IRFs 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 Analyses, 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 \$100M in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$140M. This final 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.

7. Executive Order (E.O.) 13771, “Reducing Regulation and Controlling Regulatory Costs”

E.O. 13771 seeks to control costs associated with the government imposition of private expenditures required to comply with Federal regulations and to reduce regulations that impose such costs. This rule is not subject to the requirements of E.O. 13771 because this rule results in no more than *de minimis* costs.

B. Hospitals Included In and Excluded From the Proposed LTCH and IRF PPS Reimbursement Methodologies

The TRICARE LTCH PPS and the TRICARE IRF PPS encompass all Medicare-classified LTCHs and IRFs that are also authorized by TRICARE and 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 Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) DRG-based payment system, respectively. Neoplastic Disease Care Hospitals would also be exempt from the TRICARE LTCH PPS, while Veterans Administration (VA) hospitals would be exempt from the TRICARE IRF PPS. Children’s hospitals would be

exempt from the TRICARE LTCH PPS and IRF PPS.

C. Analysis of the Impact of Policy Changes on Payment for LTCH and IRF Alternatives Considered

The alternatives that were considered, the changes that we are proposing, and the reasons that we have chosen these options are discussed below.

1. Alternatives Considered for Addressing Reduction in LTCH Payments

Under the method discussed here, TRICARE’s LTCH payments per discharge would decrease by 50–80 percent for most LTCHs once the LTCH PPS rates were adopted. Because the impact of moving from a charge-based reimbursement method to Medicare’s method would produce such large reductions in the TRICARE allowed amounts for LTCH care, we initially considered a 4-year phase-in of this approach. Under this option, one portion of the payment would continue to be paid as the billed charge and the remaining portion would be paid under the Medicare approach. In the first year, 75 percent of the payment would be based on billed charges and in each subsequent year this portion would be reduced by 25 percentage points so that by the fourth year the billed charge portion would not be used.

As stated in our proposed rule, we believed this transition approach was not appropriate for four main reasons: (1) Medicare-based payments for TRICARE patients would have a minimal impact on overall LTCH payments, (2) LTCHs admit few TRICARE patients each year, (3) TRICARE payments would be equal to Medicare payments, and (4) there are not likely to be access issues as a result of the reimbursement change (MedPAC, 2015 Report to Congress, Chapter 11).

After careful review of the comments on the proposed rule, however, we agree that TRICARE should adopt a transition. During the transition, TRICARE would pay more than Medicare (135 percent of Medicare LTCH PPS payments in year 1 and 115 percent of Medicare LTCH PPS payments in year 2), and 100 percent of Medicare LTCH PPS payments in the final year of the transition. This transition will offer a gradual transition to full Medicare rates. Given that the TRICARE LTCH rates will equal Medicare LTCH rates in the final year of the transition, and because TRICARE payments will have a limited impact on overall LTCH payments, we do not anticipate access problems for TRICARE beneficiaries under this transition. Further, by statute, hospitals that

participate under Medicare are required to agree to accept TRICARE reimbursement.

2. Alternatives Considered for Addressing Reduction in IRF Payments

Under the method discussed here, TRICARE's IRF payments per discharge would decrease by almost 30 percent for the median TRICARE IRF and about one-third of TRICARE IRFs would have a reduction of 50 percent or more in allowed amounts. Because the impact of moving from a charge-based reimbursement method to Medicare's method would produce such large reductions in the TRICARE allowed amounts for IRF care, we considered a 3-year phase-in of this approach. Under this option, one portion of the payment would continue to be paid as the billed charge while the remaining portion would be paid under the Medicare approach. In the first year, two-thirds of the payment would be based on billed charges and in each subsequent year this portion would be reduced by one-third so that by the third year the billed charge portion would not be used.

As stated in our proposed rule, we believed this transition approach was not appropriate for four main reasons: (1) Medicare payments for TRICARE patients would have a minimal impact on overall IRF payments, (2) IRFs admit few TRICARE patients each year, (3) TRICARE payments will be equal to Medicare payments, and (4) access issues as a result of the reimbursement change are unlikely because MedPAC reports IRFs paid by Medicare have positive margins (MedPAC, 2015 Report to Congress, Chapter 10).

After careful review of the comments on the proposed rule, however, we agree that TRICARE should adopt a transition that allows a percentage of Medicare payments in the first two years (135 percent of Medicare IRF PPS payments in year 1 and 115 percent of Medicare IRF PPS payments in year 2), and 100 percent of Medicare IRF PPS payments in the final year of the transition. This transition will protect IRFs from sudden significant reductions, offering a gradual transition to full Medicare rates. Given that the TRICARE IRF rates will equal Medicare IRF rates in the final year of the transition and will have a limited impact on overall IRF payments, we do not anticipate access problems for TRICARE beneficiaries using the 3-year transition period. Further, by statute, hospitals that participate under Medicare are required to agree to accept TRICARE reimbursement.

D. Analysis of the Impact of TRICARE LTCH and IRF Payment Reform

1. LTCH Methodology

We analyzed the impact of TRICARE implementing a new method of payment for LTCHs. The proposed method is Medicare's LTCH PPS payment method, which uses the Medicare MS-LTC-DRG system for cases that meet specific clinical criteria to qualify for the standard LTCH PPS payment rates and, as of FY 2018, the Medicare IPPS MS-DRG system for all non-standard payment (site-neutral) patients. Our analysis compares the impact on allowed charges 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 allowed charge data from October 2014 to September 2015. We drew upon various sources for the data used to categorize hospitals in Table 2, below. We attempted to construct these variables using information from Medicare's FY 2015 Impact file to verify that each provider was in fact a Medicare LTCH. One limitation is that for individual hospitals, some mis-categorizations are possible. We were unable to match 3 LTCHs with 4 hospital claims to the FY 2015 Impact file, and as a result, these 4 claims were excluded from the analysis. We also excluded 32 hospital claims where the DRG on the claim was unclassifiable. All Neoplastic Disease Care Hospitals (1 hospital, 1 claim) and Children's Hospital claims (2 hospitals, 46 claims) were also excluded from the analysis, and there were no TRICARE beneficiaries who were treated in Maryland LTCHs in FY 2015. After we removed the excluded claims for which we could not assign charge and hospital classification variables, we used the remaining hospitals and claims as the basis for our analysis. 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.

Using allowed charge data from FY 2015, the FY 2015 Medicare MS-LTC-DRG and MS-DRG weights, the FY 2015 Medicare LTCH and IPPS national base payment rates, the FY 2015 Medicare high cost outlier fixed thresholds, and the FY 2015 wage index adjustment factors, we simulated TRICARE allowed amounts in FY 2015 using the proposed LTCH prospective payment method. Under "current policy" we assumed

that TRICARE LTCH costs would increase by 7 percent per year from FY 2015 to FY 2020 to reflect increases in billed charges. We then projected the costs under the proposed policy, assuming that under the Medicare LTCH-PPS, costs would increase by 3 percent per year from FY 2015 to FY 2020. Under the Medicare LTCH-PPS, the percentage annual increase of 3 percent in TRICARE allowed amounts is less than the percentage increase under current policy due to slower increases in Medicare LTCH reimbursement rates (in comparison to TRICARE billed charges). The difference between the current and the proposed policy assuming full implementation of the transition period would have been \$65M if fully implemented in FY 2015.

2. IRF Methodology

We analyzed the impact of TRICARE implementing a new method of payment for IRFs. The proposed method is Medicare's IRF prospective payment system (PPS) method, which pays a prospectively-set fixed payment per discharge based on a patient's classification into one of 92 case-mix groups (CMGs). Our analysis compares the impact on allowed charges of the new methodology compared to current TRICARE methodology (where TRICARE pays billed charges or discounts off of these billed charges for all IRF claims).

The data used in developing the quantitative analyses presented below are taken from TRICARE allowed charge data from October 2014 to September 2015. We drew upon various sources for the data used to categorize hospitals in Table 3, below. We attempted to construct these variables using information from Medicare's FY 2016 IRF rate setting file and the Medicare Provider file to verify that each TRICARE IRF provider was in fact a Medicare IRF. One limitation is that for individual hospitals, some mis-categorizations are possible. We were unable to match 8 IRF claims from 4 IRFs to Medicare provider numbers within the FY 2016 IRF rate setting file, and therefore had to exclude them from the analysis, even though these 4 IRFs were confirmed to be Medicare-certified IRFs in the October 2016 Medicare IRF Provider Specific file. We also excluded all Children's Hospital (2 hospitals, 11 discharges) and all Veterans hospital (12 hospitals, 239 discharges) claims because these hospitals are not paid under the Medicare IRF PPS. After we removed the excluded claims for which we could not assign charge and hospital classification variables, we used the remaining hospitals and claims as the

basis for our analysis. 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.

The impact of adopting the Medicare IRF-PPS is difficult to estimate because there is insufficient diagnosis information on the TRICARE claims to classify TRICARE patients into a CMG. Because we were unable to classify TRICARE discharges into one of the 92 Medicare CMGs, we took an alternative approach to estimate the costs of adopting the Medicare IRF-PPS system. Our approach is based on first calculating the facility-specific "Medicare" costs for TRICARE IRF discharges at each IRF using the FY 2015 TRICARE billed charges at that IRF and the 2015 Medicare cost-to-charge ratio (CCR) for that IRF. We then used Medicare payment and cost data from the FY 2016 Medicare IRF rate setting file to calculate the Medicare margin at each IRF. In a third step of our approach we multiplied the estimated cost of each TRICARE discharge calculated in the first step by the IRF-specific margin to get an estimate of the allowed amount that would be paid by TRICARE under the Medicare IRF-PPS for each discharge.

Under "current policy" we assumed that TRICARE IRF costs would increase by 6 percent per year from FY 2015 to FY 2020 to reflect increases in billed charges. We then projected the costs under the proposed policy, assuming that under the Medicare IRF-PPS, costs would increase by 2.5 percent per year from FY 2015 to FY 2020. Under the Medicare IRF-PPS, the percentage annual increase of 2.5 percent in TRICARE allowed amounts is less than the percentage increase under current policy due to slower increases in Medicare IRF reimbursement rates (in comparison to TRICARE billed charges).

As a result, this approach allows us to estimate the change in allowed amounts under the Medicare method without having CMG data on TRICARE patients. The difference between the current and the proposed policy, assuming full implementation of the transition period

would have been \$33M if fully implemented in FY 2015.

3. Effect of Payment Policy Change on LTCHs

Table 2, Impact of TRICARE LTCH Rule in FY 2015, presents the results of our analysis of FY 2015 TRICARE claims data. This table categorizes LTCHs which had TRICARE inpatient stays in FY 2015 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 FY 2015 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 column shows the average TRICARE allowed amount per discharge in FY 2015. The fourth column shows the simulated average allowed amount per discharge under the Medicare LTCH payment method, assuming full implementation of both the TRICARE transition and the Medicare site-neutral payment policy. The fifth column shows the percentage reduction in the allowed amounts under the full implementation of the Medicare site-neutral method relative to the current allowed amounts.

The first row in Table 2 shows the overall impact on the 207 LTCHs included in the analysis. The next three rows of the table contain hospitals categorized according to their urban/rural status in FY 2015 (large urban, other urban, and rural). The second major grouping is by LTCH bed-size category, followed by TRICARE network status of the LTCH. The fourth grouping shows the LTCHs by regional divisions while the final grouping is by LTCH ownership status.

Upon full implementation of the Medicare site-neutral payment policy and after the TRICARE transition is complete, TRICARE allowed amounts to LTCHs would have decreased by 70 percent in comparison to allowed amounts paid to LTCHs under the current TRICARE policy (in FY 2015 dollars). For all the LTCH groups shown in Table 2, allowed amounts under the proposed payment methodology would be reduced.

The following discussion highlights some of the changes in allowed amounts among LTCH classifications. 99 percent of all TRICARE LTCH admissions were to urban LTCHs. Allowed amounts would have decreased by 69 percent for large urban, 71 percent for other urban and 67 percent for rural LTCHs.

Very small LTCHs (1–24 beds) would have had the least impact; allowed amounts would have been reduced by 53 percent. The change in payment methodology would have had the greatest impacts on large LTCHs (125 or more beds), where allowed amounts would have been reduced by about 73 percent.

The change in LTCH payment methodology would have a larger impact on TRICARE non-network LTCHs than network LTCHs because almost all network LTCHs currently offer a discount off billed charges while the majority of non-network LTCHs do not. Allowed charges to non-network LTCHs would have declined by 74 percent, in comparison to 67 percent for in-network hospitals. We found that network hospitals on average provide a 32 percent discount off billed charges for non-TFL TRICARE beneficiaries and that 70 percent of all TRICARE LTCH discharges were in-network in FY 2015.

LTCHs in various geographic areas would have been 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 had an average decrease of 69 and 71 percent in allowed charges respectively, which are very similar to the overall average of 70 percent. LTCHs in the New England and West North Central regions would have had the lowest reductions in allowed charges: 39 and 50 percent, respectively.

77 percent of all TRICARE LTCH discharges in FY 2015 were in proprietary (for-profit) LTCHs, and these facilities would have had their allowed amounts reduced by approximately 71 percent. The decline in allowed amounts for voluntary (not-for-profit) LTCHs would have been less than for-profit hospitals (61 percent).

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Table 2
Impact of TRICARE LTCH Rule in FY 2015

	Number of Hospitals	Number of Discharges	Allowed per Discharge Under Current Policy	Allowed per Discharge Under LTCH PPS	Percent Reduction in Allowed Amounts
All LTCHs	207	781	\$119,434	\$36,159	70%
Large Urban	105	469	\$127,074	\$39,481	69%
Other Urban	98	307	\$108,665	\$31,333	71%
Rural	4	5	\$64,006	\$20,815	67%
Beds	207	781	\$119,434	\$36,159	70%
1-24	3	5	\$47,190	\$22,054	53%
25-34	38	91	\$115,102	\$35,002	70%
35-49	52	172	\$102,288	\$31,505	69%
50-74	62	246	\$120,171	\$37,614	69%
75-124	31	149	\$108,677	\$33,800	69%
125+	21	118	\$162,876	\$44,375	73%
Network Status	207	781	\$119,434	\$36,159	70%
Network	147	549	\$103,620	\$34,528	67%
Non-Network	60	232	\$156,855	\$40,018	74%
Region	207	781	\$119,434	\$36,159	70%
New England	2	3	\$36,269	\$22,213	39%
Mid Atlantic	14	29	\$184,906	\$49,451	73%
South Atlantic	42	264	\$123,577	\$37,767	69%
East North Central	33	65	\$102,139	\$34,667	66%
East South Central	18	70	\$89,630	\$31,008	65%
West North Central	10	30	\$73,097	\$36,742	50%
West South Central	64	242	\$98,605	\$28,164	71%
Mountain	13	46	\$213,907	\$62,625	71%
Pacific	11	32	\$199,204	\$48,316	76%
Ownership	207	781	\$119,434	\$36,159	70%
Proprietary	171	605	\$121,844	\$34,940	71%
Government Owned	5	19	\$124,053	\$24,828	80%
Voluntary	31	157	\$109,588	\$42,227	61%

Note: Impact of rule shown in FY15 dollars, after the end of the transition period (TRICARE payments would be equal to 100 percent of Medicare LTCH PPS payments) and assuming full implementation of the Medicare site-neutral payment policy.

Source: FY15 TRICARE LTCH Claims and FY15 Medicare Impact File. Excludes claims with other health insurance.

Excludes 32 claims where the LTCH DRG on the TRICARE claim as unclassifiable. Excludes claims for Neoplastic Disease Care Hospitals and Children's Hospitals.

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4. Effect of Payment Policy Change on IRFs

Table 3, Impact of TRICARE IRF Rule in FY 2015, presents the results of our analysis of FY 2015 TRICARE claims data. This table categorizes IRFs which had TRICARE inpatient stays in FY 2015 by various geographic and special payment consideration groups to illustrate the varying impacts of different types of IRFs. The first column represents the number of IRFs in FY 2015 in each category which had inpatient stays in which TRICARE was the primary payer. The second column shows the simulated number of TRICARE discharges in each category. The third column shows the average TRICARE allowed amount per discharge in FY 2015. The fourth column shows the average allowed amount per discharge under the Medicare IRF payment method, assuming full implementation of the TRICARE transition, and including the LIP adjustment. The fifth column shows the percentage reduction in the allowed amounts under the Medicare payment method relative to the current TRICARE allowed amounts.

The first row in Table 3 shows the overall impact on the 493 IRFs included in the analysis. The next two rows of the table categorize hospitals according to their geographic location in FY 2015 (urban and rural). The second major

grouping is by IRF bed-size category, followed by whether the IRF is a freestanding facility or a part of a hospital unit. The fourth grouping shows IRFs by TRICARE network status and fifth by teaching status. The sixth grouping is by regional divisions and the final grouping is by IRF ownership status.

The following discussion highlights some of the changes in allowed amounts among IRF classifications. 96 percent of all TRICARE IRF admissions were to urban IRFs. Allowed amounts would have decreased by 36 percent for urban IRFs and 11 percent for rural IRFs.

Very small IRFs (1–24 beds) would have had the most impact; allowed amounts would have been reduced by 50 percent. The change in payment methodology would have had the least impact on medium to large IRFs (75 to 124 beds), where allowed amounts would have been reduced by about 8 percent.

The change in IRF payment methodology would have resulted in a 49 percent reduction in the allowed amounts for IRFs that are part of a hospital unit. In comparison, freestanding IRF payments would have been reduced by 18 percent. The change in IRF payment methodology would have also had a larger impact on TRICARE non-network IRFs than network IRFs because network IRFs currently offer a discount off billed charges while non-network IRFs

typically do not. Allowed charges to non-network IRFs would have declined by 55 percent, in comparison to 30 percent for in-network hospitals. We found that network hospitals on average provide a 34 percent discount off billed charges for TRICARE beneficiaries without other health insurance, and that 85 percent of all TRICARE IRF discharges were in-network in FY 2015.

We also found that the change in IRF payment methodology would have a larger impact on teaching hospitals, where payments would have been reduced by 41 percent, in comparison to non-teaching hospitals, where payments would have been reduced by 34 percent. Approximately 81 percent of all TRICARE IRF discharges were from non-teaching IRF facilities.

IRFs in various geographic areas will be affected differently by this change in payment methodology. The two regions with the largest number of TRICARE IRF claims, the South Atlantic (803 discharges) and West South Central (668 discharges), would have had an average decrease of 35 and 33 percent in allowed charges respectively. IRFs in New England and the Middle Atlantic would have had the lowest reductions in allowed charges of 13 percent. The Mountain, West South Central, and Pacific regions would have had the highest reductions (between 33 and 49 percent).

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Table 3

Impact of TRICARE IRF Rule in FY 2015

	Number of Facilities	Number of TRICARE Discharges	Allowed per Discharge Under Current Policy	Proposed Allowed per Discharge Under IRF PPS	Percent Reduction in Allowed Amounts
All IRFs	493	2,582	\$35,813	\$23,020	36%
Urban	457	2,489	\$36,338	\$23,156	36%
Rural	36	93	\$21,753	\$19,375	11%
Beds	493	2,582	\$35,813	\$23,020	36%
1-24	176	564	\$44,469	\$22,177	50%
25-34	71	214	\$35,337	\$21,508	39%
35-49	82	326	\$34,010	\$21,891	36%
50-74	96	755	\$30,037	\$22,507	25%
75-124	51	372	\$25,132	\$23,214	8%
125+	17	351	\$47,611	\$27,244	43%
Type	493	2,582	\$35,813	\$23,020	36%
Hospital Unit	314	1,179	\$44,892	\$23,008	49%
Freestanding	179	1,403	\$28,183	\$23,030	18%
Network Status	493	2,582	\$35,813	\$23,020	36%
Network	354	2,191	\$33,005	\$22,967	30%
Non-Network	139	391	\$51,546	\$23,314	55%
Teaching Status	493	2,582	\$35,813	\$23,020	36%
Teaching	50	481	\$45,572	\$26,740	41%
Non-Teaching	443	2,101	\$33,578	\$22,168	34%
Region	493	2,582	\$35,813	\$23,020	36%
New England and Middle Atlantic	72	179	\$60,802	\$52,598	13%
South Atlantic	104	803	\$31,011	\$20,302	35%
East North Central	64	154	\$34,186	\$22,629	34%
East South Central	36	258	\$29,581	\$20,498	31%
West North Central	39	152	\$47,777	\$30,876	35%
West South Central	99	668	\$32,611	\$21,870	33%
Mountain	41	173	\$40,192	\$22,603	44%
Pacific	38	195	\$65,615	\$33,478	49%
Ownership	493	2,582	\$35,813	\$23,020	36%
Proprietary	186	1,200	\$29,570	\$21,092	29%
Government Owned	56	307	\$36,902	\$22,990	38%
Voluntary	251	1,075	\$42,470	\$25,181	41%

Note: Impact of rule shown in FY15 dollars, after the end of the transition period (TRICARE payments would be equal to 100 percent of Medicare LTCH PPS payments).

Source: FY15 TRICARE IRF Claims and FY16 and FY17 Medicare Rate Setting File. Excludes claims with other health insurance.

Excludes claims from 12 VA Hospitals (239 discharges), 2 Children's Hospitals (11 discharges), and 4 IRFs (8 discharges) where we could not identify enough information to include in the estimate. We have combined the North East and Middle Atlantic states for the purpose of this impact analysis due to small sample size in the North East region.

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46 percent of all TRICARE IRF discharges in FY 2015 were in proprietary (for-profit) IRFs, and these facilities would have had their allowed amounts reduced by approximately 29 percent. The decline in allowed amounts for voluntary (not-for-profit) and government-owned IRFs would have been slightly more than proprietary hospitals (41 and 38 percent).

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 amended as follows:

PART 199—CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

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:

- a. Removing the definition of "Hospital, long-term (tuberculosis, chronic care, or rehabilitation).";
b. Adding the definition of "Inpatient Rehabilitation Facility (IRF)" in alphabetical order.
c. Adding the definition of "Long Term Care Hospital (LTCH)" in alphabetical order.
d. Removing the definition of "Long-term hospital care."

The additions read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

Inpatient Rehabilitation Facility (IRF). A facility classified by CMS as an IRF and meets the applicable requirements established by § 199.6(b)(4)(xx) (which includes the requirement to be a Medicare participating provider).

* * * * *

Long Term Care Hospital (LTCH). A hospital that is classified by the Centers for Medicare and Medicaid Services (CMS) as an LTCH and meets the applicable requirements established by § 199.6(b)(4)(v) (which includes the requirement to be a Medicare participating provider).

* * * * *

3. In § 199.6, revise paragraphs (b)(4)(v) and (xvi), and add paragraph (b)(4)(xx) to read as follows:

§ 199.6 TRICARE—authorized providers.

* * * * *

(b) * * *

(4) * * *

(v) 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.

(A) In order for the services of LTCHs to be covered, the hospitals must comply with the provisions outlined in paragraph (b)(4)(i) of this section. In addition, in order for services provided by such hospitals to be covered by TRICARE, they must be primarily for the treatment of the presenting illness.

(B) Custodial or domiciliary care is not coverable under TRICARE, even if rendered in an otherwise authorized LTCH.

(C) The controlling factor in determining whether a beneficiary's stay in a LTCH is coverable by TRICARE is the level of professional care, supervision, and skilled nursing care that the beneficiary requires, in addition to the diagnosis, type of condition, or degree of functional limitations. The type and level of medical services required or rendered is controlling for purposes of extending TRICARE benefits; not the type of provider or condition of the beneficiary.

* * * * *

(xvi) Critical Access Hospitals (CAHs). CAHs must meet all conditions of participation under 42 CFR 485.601 through 485.645 in relation to TRICARE beneficiaries in order to receive payment under the TRICARE program. If a CAH provides inpatient psychiatric services or inpatient rehabilitation services in a distinct part unit, the distinct part unit must meet the conditions of participation in 42 CFR 485.647, with the exception of being paid under the inpatient prospective payment system for psychiatric facilities as specified in 42 CFR 412.1(a)(2) or the inpatient prospective payment system for rehabilitation hospitals or rehabilitation units as specified in 42 CFR 412.1(a)(3). Upon implementation of TRICARE's IRF PPS in § 199.14(a)(10), if a CAH provides inpatient rehabilitation services in a distinct part unit, the distinct part unit shall be paid under TRICARE's IRF PPS.

* * * * *

(xx) Inpatient Rehabilitation Facility (IRF). IRFs must meet all the criteria for classification as an IRF under 42 CFR part 412, subpart B, and meet all applicable requirements established in this part in order to be considered an authorized IRF under the TRICARE program.

(A) In order for the services of inpatient rehabilitation facilities to be covered, the facility must comply with the provisions outlined in paragraph (b)(4)(i) of this section. In addition, in order for services provided by these facilities to be covered by TRICARE, they must be primarily for the treatment of the presenting illness.

(B) Custodial or domiciliary care is not coverable under TRICARE, even if rendered in an otherwise authorized inpatient rehabilitation facility.

(C) The controlling factor in determining whether a beneficiary's stay in an inpatient rehabilitation facility is coverable by TRICARE is the level of professional care, supervision, and skilled nursing care that the beneficiary requires, in addition to the diagnosis, type of condition, or degree of functional limitations. The type and level of medical services required or rendered is controlling for purposes of extending TRICARE benefits; not the type of provider or condition of the beneficiary.

* * * * *

4. Section 199.14 is amended by:

- a. Revising paragraph (a)(1)(ii)(C) introductory text;
b. Revising paragraphs (a)(1)(ii)(D)(2), (3) and (4), and (a)(1)(ii)(E);
c. Revising paragraph (a)(3)(i);
d. Revising paragraph (a)(4) introductory text; and
e. Adding paragraphs (a)(9) and (10).

The revisions read as follows:

§ 199.14 Provider reimbursement methods.

(a) * * *

(1) * * *

(ii) * * *

(C) Services exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the CHAMPUS DRG-based payment system, are exempt from the CHAMPUS DRG-based payment system. The services in paragraphs (a)(1)(ii)(C)(1) through (a)(1)(ii)(C)(4) and (a)(1)(ii)(C)(7) through (a)(1)(ii)(C)(9) of this section shall be reimbursed under the procedures in paragraph (a)(4) of this section, and the services in paragraphs (a)(1)(ii)(C)(5) and (a)(1)(ii)(C)(6) of this section shall be reimbursed under the procedures in paragraph (j) of this section.

* * * * *

(D) * * *

(2) Inpatient Rehabilitation Facilities (IRF). Prior to implementation of the IRF PPS methodology described in paragraph (a)(10) of this section, an inpatient rehabilitation facility which is

exempt from the Medicare prospective payment system is also exempt from the TRICARE DRG-based payment system.

(3) *Psychiatric and rehabilitation units (distinct parts)*. Prior to implementation of the IRF PPS methodology described in paragraph (a)(10) of this section, a rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the TRICARE DRG-based payment system. A psychiatric unit which is exempt from the Medicare prospective payment system is also exempt from the TRICARE DRG-based payment system.

(4) *Long Term Care Hospitals*. Prior to implementation of the LTCH PPS methodology 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.

(E) *Hospitals which do not participate in Medicare*. Any hospital which is subject to the CHAMPUS DRG-based payment system and which otherwise meets CHAMPUS requirements but which is not a Medicare-participating provider (having completed a form HCA-1514, Hospital Request for Certification in the Medicare/Medicaid Program and a form HCFA-1561, Health Insurance Benefit Agreement) must complete a participation agreement with TRICARE. By completing the participation agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and to accept the CHAMPUS-determined allowable amount as payment in full for these claims. Any hospital which does not participate in Medicare and does not complete a participation agreement with TRICARE will not be authorized to provide services to TRICARE beneficiaries.

* * * * *

(3) * * *

(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 allowable cost (*i.e.*, 101 percent of reasonable cost) under procedures, guidelines, and instructions issued by the Director, DHA, or designee. This does not include any costs of physicians' services or other professional services provided to CAH inpatients. Inpatient services provided in psychiatric distinct part units would be subject to the TRICARE mental health payment system. Inpatient services provided in rehabilitation

distinct part units would be subject to billed charges. Upon implementation of TRICARE's IRF PPS, inpatient services provided in rehabilitation distinct part units would be subject to the TRICARE IRF PPS methodology in paragraph (a)(10) of this section.

* * * * *

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

* * * * *

(9) *Reimbursement for inpatient services provided by a Long Term Care Hospital (LTCH)*. (i) In accordance with 10 U.S.C. 1079(i)(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 TRICARE-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 Prospective Payment System (PPS) and classified as LTCHs and also 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) and 1886(m)(6) of the Social Security Act and its implementing Medicare regulation (42 CFR parts 412, 413, and 170) to the extent practicable. Under the above governing provisions, TRICARE will recognize, to the extent practicable, in accordance with 10 U.S.C. 1079(i)(2), Medicare's LTCH PPS methodology to include the relative weights, inpatient operating and capital costs of furnishing covered services (including routine and ancillary services), interrupted stay policy, short-stay and high cost outlier payments, site-neutral payments, wage adjustments for variations in labor-related costs across geographical regions, cost-of-living adjustments, payment adjustments associated with the quality reporting program, method of payment for preadmission services, and updates to the system. TRICARE will not be adopting Medicare's 25 percent threshold payment adjustment.

(ii) Implementation of the TRICARE LTCH PPS will include a gradual

transition to full implementation of the Medicare LTCH PPS rates as follows:

(A) For the first 12 months following implementation, the TRICARE LTCH PPS allowable cost will be 135 percent of Medicare LTCH PPS amounts.

(B) For the second 12 months of implementation, TRICARE LTCH PPS allowable cost will be 115 percent of the Medicare LTCH PPS amounts.

(C) For the third 12 months of implementation, and subsequent years, TRICARE LTCH PPS allowable cost will be 100 percent of the Medicare LTCH PPS amounts.

(iii) *Exemption*. The TRICARE LTCH PPS methodology under this paragraph does not apply to hospitals in States that are reimbursed by Medicare and TRICARE under a waiver that exempts them from Medicare's inpatient prospective payment system or the TRICARE DRG-based payment system, to Children's Hospitals, or to Neoplastic Disease Care Hospitals, respectively.

(10) *Reimbursement for inpatient services provided by Inpatient Rehabilitation Facilities (IRF)*. (i) In accordance with 10 U.S.C. 1079(i)(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 TRICARE IRF PPS reimbursement methodology shall be in accordance with Medicare's IRF PPS as found in 42 CFR part 412. Inpatient services provided in IRFs subject to the Medicare IRF prospective payment system (PPS) and classified as IRFs and also as specified in 42 CFR 412.604 will be paid in accordance with the provisions outlined in section 1886(j) of the Social Security Act and its implementing Medicare regulation found at 42 CFR part 412, subpart P to the extent practicable. Under the above governing provisions, TRICARE will recognize, to the extent practicable, in accordance with 10 U.S.C. 1079(i)(2), Medicare's IRF PPS methodology to include the relative weights, payment rates covering all operating and capitals costs of furnishing rehabilitative services adjusted for wage variations in labor-related costs across geographical regions, adjustments for the 60 percent compliance threshold, teaching adjustment, rural adjustment, high-cost outlier payments, low income payment adjustment, payment adjustments associated with the quality reporting program, and updates to the system.

(ii) Implementation of the TRICARE IRF PPS will include a gradual transition to full implementation of the Medicare IRF PPS rates as follows:

(A) For the first 12 months of implementation, the TRICARE IRF PPS allowable cost will be 135 percent of Medicare IRF PPS amounts.

(B) For the second 12 months of implementation, the TRICARE IRF PPS allowable cost will be 115 percent of the Medicare IRF PPS amounts.

(C) For the third 12 months of implementation, and subsequent years, the TRICARE IRF PPS allowable cost will be 100 percent of the Medicare IRF PPS amounts.

(iii) The IRF PPS allowable cost in paragraph (a)(10)(ii) of this section may be supplemented by an inpatient general temporary military contingency payment adjustment (GTMCPA) for TRICARE authorized IRFs.

(A) This is a year-end discretionary, temporary adjustment that the Director, DHA (or designee) may approve based on the following criteria:

(1) The IRF serves a disproportionate share of ADSMs and ADDs;

(2) The IRF is a TRICARE network hospital;

(3) The IRF's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and

(4) Without the GTMCPA, DoD's ability to meet military contingency mission requirements will be significantly compromised.

(B) Policy and procedural instructions implementing the GTMCPA will be issued as deemed appropriate by the Director, DHA (or designee). As with other discretionary authority under this part, a decision to allow or deny a GTMCPA to an IRF is not subject to the appeal and hearing procedures of § 199.10.

(iv) *Exemption.* The TRICARE IRF PPS methodology under this paragraph does not apply to hospitals in States that are reimbursed by Medicare and TRICARE under a waiver that exempts them from Medicare's inpatient prospective payment system or the TRICARE DRG-based payment system, to Children's hospitals, or to VA hospitals, respectively.

* * * * *

Dated: December 22, 2017.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2017-28022 Filed 12-28-17; 8:45 am]

BILLING CODE 5001-06-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG-2017-1077]

RIN 1625-AA00

Safety Zone; Mississippi River, Baton Rouge, LA

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone for all navigable waters from mile marker (MM) 229.5 to MM 230.5 Above Head of Passes on the Lower Mississippi River. This temporary safety zone is necessary to provide for the safety of life on these navigable waters near downtown, Baton Rouge, LA, during a fireworks display on December 31, 2017. Entry of vessels or persons into this zone is prohibited unless specifically authorized by the Captain of the Port Sector New Orleans or a designated representative.

DATES: This rule is effective from 11:30 p.m. on December 31, 2017, through 1 a.m. on January 1, 2018.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to <http://www.regulations.gov>, type USCG-2017-1077 in the "SEARCH" box and click "SEARCH." Click on Open Docket Folder on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Lieutenant Raymond Wagner, Marine Safety Unit Baton Rouge, U.S. Coast Guard; telephone 225-298-5400 ext. 230, email *Raymond.W.Wagner@uscg.mil*.

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

- AHP Above Head of Passes
- CFR Code of Federal Regulations
- COTP Captain of the Port Sector New Orleans
- DHS Department of Homeland Security
- FR Federal Register
- NPRM Notice of proposed rulemaking § Section
- U.S.C. United States Code

II. Background Information and Regulatory History

The Coast Guard is issuing this temporary rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5

U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are "impracticable, unnecessary, or contrary to the public interest." Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because it is impractical and contrary to public interest. We must establish this safety zone by December 31, 2017. It is impracticable to publish an NPRM because we lack sufficient time to provide a reasonable comment period and then consider those comments before issuing the rule. It is also contrary to public interest as it would delay the safety measures necessary to protect life and property from the possible hazards associated with the display.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making it effective less than 30 days after publication in the **Federal Register**. Waiting a full 30 days after publication in the **Federal Register** is contrary to the public interest as that would delay the effectiveness of the safety zone until after the planned fireworks event. Immediate action is needed to protect vessels and mariners from the safety hazards associated with an aerial fireworks display over the waterway. The Coast Guard will notify the public and maritime community that the safety zone will be in effect and of the enforcement periods via broadcast notices to mariners.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority in 33 U.S.C. 1231. The Captain of the Port Sector New Orleans (COTP) has determined that potential hazards associated with the fireworks display on December 31, 2017 will be a safety concern for any vessels or persons in the vicinity of the launch area between mile marker (MM) 229.5 and MM 230.5 Above Head of Passes (AHP) on the Lower Mississippi River. This rule is needed to protect personnel, vessels, and the marine environment in the navigable waters within the safety zone during the fireworks display.

IV. Discussion of the Rule

The Coast Guard is establishing a temporary safety zone on the Lower Mississippi River for 1 hour and 30 minutes on the night of December 31, 2017. The safety zone will include all navigable waters of the Lower Mississippi River in Baton Rouge, LA, from mile marker (MM) 229.5 to MM