

**List of Subjects in 21 CFR Part 1308**

Administrative practice and procedure, Drug traffic control, Reporting and recordkeeping requirements.

For the reasons set out above, the DEA proposes to amend 21 CFR part 1308 as follows:

**PART 1308—SCHEDULES OF CONTROLLED SUBSTANCES**

■ 1. The authority citation for part 1308 continues to read as follows:

**Authority:** 21 U.S.C. 811, 812, 871(b), unless otherwise noted.

■ 2. In § 1308.11, add paragraphs (h)(28) and (29) to read as follows:

**§ 1308.11 Schedule I**

\* \* \* \* \*

(h) \* \* \*

(28) Mitragynine (to include synthetic equivalents as well as mitragynine naturally contained in the plant of the genus and species name: *Mitragyna speciosa* Korth, also known as kratom) its isomers, esters, ethers, salts and salts of isomers, esters and ethers . . . (9823)

(29) 7-Hydroxymitragynine (to include synthetic equivalents as well as 7-hydroxymitragynine naturally contained in the plant of the genus and species name: *Mitragyna speciosa* Korth, also known as kratom) its isomers, esters, ethers, salts and salts of isomers, esters and ethers . . . (9838)

Dated: August 25, 2016.

**Chuck Rosenberg,**

*Acting Administrator.*

[FR Doc. 2016–20803 Filed 8–30–16; 8:45 am]

**BILLING CODE 4410–09–P**

**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:** Proposed rule.

**SUMMARY:** The Department of Defense, Defense Health Agency, is proposing to revise its reimbursement of Long Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs). Proposed revisions are in accordance with the statutory provision at title 10,

United States Code (U.S.C.), section 1079(i)(2) that requires TRICARE payment methods for institutional care 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. Our regulation includes a definition for “Hospital, long-term (tuberculosis, chronic care, or rehabilitation).” This rule proposes to delete this definition and create separate definitions for “Long Term Care Hospital” and “Inpatient Rehabilitation Facility” in accordance with Centers for Medicare & Medicaid Services (CMS) classification criteria. Under TRICARE, LTCHs and IRFs (both freestanding rehabilitation hospitals and rehabilitation hospital units) are currently paid the lower of a negotiated rate (if they are a network provider) or billed charges (if they are a non-network provider). Although Medicare’s reimbursement methods for LTCHs and IRFs are different, it is prudent to propose adopting both the Medicare LTCH and IRF Prospective Payment System (PPS) methods simultaneously to align with our statutory requirement to utilize the same reimbursement system as Medicare. This proposed rule sets forth the proposed regulation modifications necessary for TRICARE to adopt Medicare’s LTCH and IRF Prospective Payment Systems and rates applicable for inpatient services provided by LTCHs and IRFs to TRICARE beneficiaries.

**DATES:** Written comments received at the address indicated below by October 31, 2016 will be accepted.

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

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

*Mail:* Department of Defense, Deputy Chief Management Officer, Directorate for Oversight and Compliance, 4800 Mark Center Drive, ATTN: Box 24, Alexandria, VA 22350–1700.

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

**FOR FURTHER INFORMATION CONTACT:**

Sharon Seelmeyer, Defense Health Agency (DHA), Medical Benefits and Reimbursement Section, telephone (303) 676–3690.

**SUPPLEMENTARY INFORMATION:****I. Executive Summary***A. Purpose of the Proposed Rule***1. Long Term Care Hospitals (LTCHs)**

This rule publishes TRICARE’s proposed modifications to our regulation that are necessary to adopt the Medicare LTCH Prospective Payment System and rates. This is in accordance with the statutory requirement that for TRICARE institutional services “payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare].” Medicare pays LTCHs using a LTCH Prospective Payment System (PPS) which classifies 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 CMS’ reimbursement system for LTCHs, with the exception of not adopting Medicare’s LTCH 25 percent rule. However, that proposed rule acknowledged that the Department of Health and Human Services intended to address implementation of Section 1206(a) of the Pathway for Sustainable Growth Rate (SGR) Reform Act of 2013 (Pub. L. 113–67) in their FY 2016 rulemaking process. As a result, the TRICARE proposed rule included a statement that DoD would “defer action on this issue pending review of the final Medicare policy.” This review has been completed and we have changed our approach regarding implementation of the TRICARE LTCH PPS. Consequently, we are withdrawing the proposed rule published in the **Federal Register** on January 26, 2015, and publishing this new proposed rule to inform the public of our intent to adopt the CMS LTCH PPS system with no modifications or exceptions. We have determined that it is practicable to adopt Medicare’s LTCH

PPS reimbursement methodology in its entirety without deviations.

On August 22, 2014, the CMS final rule on updating the annual payment rates for the Medicare PPS for inpatient hospital services provided by LTCHs was published in the **Federal Register** [79 FR 49853]. As part of its final rule, CMS discussed the need for future policy changes that would be required to carry out the provisions under section 1206 of the Pathway for SGR Reform Act of 2013, to include section 1206(a), which provides for the establishment of an alternate “site-neutral” payment rate for Medicare LTCH patients that fail to meet certain statutorily defined criteria, such as having been discharged by an IPPS hospital immediately preceding the LTCH admission, having 3 or more days in an ICU during the immediately preceding IPPS stay or having received at least 96 hours of respiratory ventilation services. If the above statutorily defined criteria is not met, the LTCH will receive a “site-neutral” payment rate. As mentioned earlier, as a result of the unspecified potential changes that might be required to Medicare’s LTCH reimbursement system, a statement was added to TRICARE’s proposed rule that DoD would defer action on adopting Medicare’s potential changes relating to “site-neutral” payments until DoD could review the final Medicare policy. Upon review of Medicare’s final rule published on August 17, 2015, we learned that significant changes had been made to Medicare’s previous LTCH reimbursement system, specifically the precise details about the creation of Medicare’s “site-neutral” payments beginning in FY 2016. This proposed rule explains our new reimbursement approach for LTCHs based on CMS’ changes.

TRICARE pays for most hospital care under the TRICARE DRG-based payment system, which is similar to Medicare’s, but some hospitals are exempt from the TRICARE DRG-based payment system. LTCHs are currently exempt from the TRICARE DRG-based payment system and are paid by TRICARE at the lower of a negotiated rate (if they are a network provider) or billed charges (if they are a non-network provider). 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. Our legal authority for this portion of the proposed rule is 10 U.S.C. 1079(i)(2).

## *2. Inpatient Rehabilitation Facilities (IRFs)*

This rule also publishes proposed TRICARE regulation modifications necessary to adopt the Medicare IRF Prospective Payment System (PPS) and rates. This is in accordance with the statutory requirement that for TRICARE institutional services “payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare].” Medicare pays IRFs using an IRF Prospective Payment System (PPS) which classifies IRF patients into one of 92 case-mix groups (CMGs).

Similarly to LTCHs, IRFs, (both freestanding rehabilitation hospital and rehabilitation hospital units) are currently exempt from the TRICARE DRG-based payment system and are paid by TRICARE at the lower of a negotiated rate (if they are a network provider) or billed charges (if they are a non-network provider). 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. Our legal authority for this portion of the proposed rule is 10 U.S.C. 1079(i)(2).

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

### *1. Adoption of Medicare’s Prospective Payment System Methodology for LTCHs*

TRICARE proposes to reimburse LTCHs for inpatient care using Medicare’s LTCH PPS using Medicare’s MS–LTC–DRGs. Under the proposed TRICARE LTCH PPS reimbursement methodology, payment for a TRICARE patient will be made at a predetermined, per-discharge amount for each MS–LTC–DRG. The TRICARE LTCH PPS reimbursement methodology would include payment for all inpatient operating and capital costs of furnishing covered services (including routine and ancillary services), but not certain pass-through costs (e.g., bad debts, direct medical education, and blood clotting factors). When the Medicare day limit is exhausted for TRICARE beneficiaries who are also eligible for Medicare (i.e., TRICARE For Life (TFL) beneficiaries),

TRICARE will be the primary payer for medically necessary services and the beneficiary will be responsible for the appropriate TRICARE inpatient cost share. We anticipate the beneficiary’s out-of-pocket costs will be limited by the statutory catastrophic cap of \$1,000 per family, per fiscal year for active duty family members and reserve select beneficiaries and \$3,000 cap per family, per fiscal year for all other beneficiaries.

### *2. Transition Period*

The Pathway for SGR Reform Act of 2013 directed CMS to make significant changes to the payment system for LTCHs. The law directs CMS to establish two different types of LTCH PPS payment rates depending on whether or not the patient meets certain clinical criteria: (1) Standard LTCH PPS payment rates; and (2) lower site-neutral LTCH PPS payment rates that are generally based on the Medicare acute hospital IPPS rates. 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. The law transitions the payment reductions in FY16 and FY17 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 FY17, when we anticipate implementing the TRICARE LTCH PPS payment changes, we propose that TRICARE adopt Medicare’s FY17 LTCH PPS payment policies, which will include Medicare’s payment of site-neutral cases with Medicare’s 50/50 blended payment for site-neutral patients. Medicare has not yet set the payment for site neutral cases for FY 2018, however, we will follow that payment rate once it is determined. For example, if the blended payment rate ends by FY18, we would also follow Medicare and all TRICARE site-neutral LTCH patients would receive the site-neutral payment (without a blend with the standard LTCH PPS rate). If implementation of the TRICARE LTCH PPS is delayed beyond FY17, there will be no transition period for site-neutral patients. Rather, TRICARE will adopt the Medicare LTCH PPS methodology applicable at the time of TRICARE implementation.

### *3. Adoption of Medicare’s Prospective Payment System Methodology for IRFs*

TRICARE proposes to reimburse IRFs for inpatient care using Medicare’s IRF PPS which pays a prospectively-set, fixed payment per discharge based on a patient’s classification into one of 92

case-mix groups (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 would cover all inpatient operating and capital costs that IRFs are expected to incur in furnishing intensive rehabilitation services. When the Medicare day limit is exhausted for TRICARE beneficiaries who are also eligible for Medicare (*i.e.*, TFL beneficiaries), TRICARE will be the primary payer for medically necessary services and the beneficiary will be responsible for the appropriate TRICARE inpatient cost share. We anticipate the beneficiary's out-of-pocket costs will be limited by the statutory catastrophic cap of \$1,000 per family, per fiscal year for active duty family members and reserve select beneficiaries and \$3,000 cap per family, per fiscal year for all other beneficiaries.

#### 4. Removal of Outdated Terms

This proposed rule removes outdated definitions in 32 CFR 199.2 for "Hospital, long-term (tuberculosis, chronic care, or rehabilitation)" and "Long-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 are based on CMS' LTCH and IRF classifications. Our review of the data shows that there were no facilities reimbursed under our existing LTCH or IRF reimbursement methodologies that will not meet the new proposed definitions. The TRICARE requirements for both LTCHs and IRFs to be authorized institutional providers have been added to 32 CFR 199.6.

#### C. Costs and Benefits

The economic impact of the proposed rule is anticipated to reduce DoD allowed amounts to LTCHs by approximately \$77 million during implementation if that occurs as planned in FY17, when TRICARE site-neutral cases will be paid based on a transitional 50/50 blended payment and \$87 million if implemented in FY18 when site-neutral payments are fully phased-in. If implementation is delayed beyond FY17, TRICARE will use the Medicare fully phased in site-neutral payments for site-neutral patients. This proposed rule is also anticipated to

reduce DoD allowed amounts to IRFs by approximately \$53 million in FY17.

## II. Introduction and Background

### A. Reimbursement

#### 1. TRICARE LTCH PPS Reimbursement

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 424 under Medicare), which treat a critically ill population with complex needs and long lengths of stay. Per 32 Code of Federal Regulations (CFR) 199.14(a)(1)(ii)(D)(4), LTCHs are currently exempt from the TRICARE DRG-based payment system, just as they were exempt from Medicare's Inpatient Prospective Payment System (IPPS) when the 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 if a network LTCH, which is usually substantially greater than what would be paid using the TRICARE DRG method, or billed charges if a non-network LTCH.

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 FY16, Medicare will begin its adoption of a site-neutral payment system for LTCHs. Beginning in FY16 and continuing in FY17, CMS

is phasing in a site-neutral payment methodology; during the transition period in FY16 and FY17, for site-neutral patients, 50 percent of the allowed amount will be calculated using the site-neutral payment methodology and 50 percent will be calculated using the current full LTCH PPS standard federal payment rate methodology. Beginning in FY18, all Medicare payments for site-neutral patients will be calculated using the site-neutral payment methodology. Given TRICARE's statutory requirement to adopt Medicare's reimbursement methods when practicable, TRICARE is proposing to adopt Medicare's LTCH PPS reimbursement method for our beneficiaries, including the Medicare site-neutral payment methodology. TRICARE will adopt the Medicare payment methodology that is in place at the time of TRICARE's implementation. For example, for an FY17 implementation, we will follow Medicare and use a 50/50 blend of the site-neutral method and the full LTCH PPS payments for site-neutral patients use a 50/50 blend. If implementation is delayed beyond FY17, TRICARE will use the Medicare site-neutral payments for site-neutral 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]." Based on 1079(i)(2), TRICARE is proposing to adopt Medicare's LTCH PPS as the methodology to reimburse TRICARE authorized LTCHs. A change is needed to conform to the statute.

For TRICARE, we were able to identify complete claims information for 678 patients who were Active Duty Service Members (ADSMs), their dependents, or retirees and their dependents who were not eligible for the TRICARE For Life program (referred to as non-TFL), and 56 TFL LTCH admissions in FY14, for which TRICARE was the primary payer for patients with no other health insurance (referred to as non-Other Health Insurance (OHI)). We also identified 27 non-TFL and 3 TFL non-OHI LTCH admissions in FY14 with incomplete claims data, and excluded these claims from the analysis. TRICARE allowed charges for non-TFL beneficiaries were approximately \$73 million in FY14. We found that the average TRICARE allowed amount for non-TFL beneficiaries was approximately \$107,000 in FY14, which is significantly

more than the estimated amount that Medicare would have paid for these discharges (the average Medicare LTCH PPS payment would have been approximately \$42,000). Using the Medicare LTCH PPS system would have reduced TRICARE-allowed amounts by almost \$45 million in FY14 for non-TFL beneficiaries.

For TFL beneficiaries for whom TRICARE was the primary payer, TRICARE paid approximately \$19 million in allowed charges in FY14. In cases where TRICARE is the primary payer for LTCH care of TFL beneficiaries, such as when a Medicare beneficiary exhausts his/her day limits, TRICARE is paying billed charges. Reimbursing using methods similar to the Medicare LTCH PPS methodology would have reduced TRICARE allowed charges for TFL beneficiaries by approximately \$15 million in FY14.

Shifting to methods similar to the Medicare LTCH PPS methodology would have reduced TRICARE allowed charges to LTCHs for non-TFL and TFL beneficiaries by \$60 million in FY14 and is expected to reduce allowed charges by \$77 million in FY17, assuming that site-neutral payments will be based on a 50/50 blend of the standard LTCH PPS rate and the site-neutral LTCH PPS rate. We projected savings in FY17 by first projecting costs under TRICARE's current policy for reimbursing LTCHs. We assumed that the costs would increase by 7 percent per year from FY14 to 17 reflecting increases in both TRICARE admissions to LTCHs under current policy and increases in TRICARE billed charges. We then projected the costs under the proposed policy assuming that under the Medicare LTCH-PPS the combination of admissions and higher reimbursement rates would increase costs by 3 percent per year. This percentage annual increase in TRICARE allowed amounts using the LTCH-PPS is less than the current policy percentage increase to reflect lower rates of increases in LTCH reimbursement rates under the LTCH-PPS (in comparison to TRICARE billed charges) and fewer LTCH admissions due to the phased in implementation of the Medicare LTCH site-neutral policy. The difference between the current policy and proposed policy amounts was equal to savings of \$77 million in FY17, assuming partial phase-in of site-neutral payments.

As discussed above, TRICARE's current payment method results in TRICARE reimbursing LTCHs substantially more than Medicare does for equivalent inpatient care. Adopting Medicare's LTCH PPS methodology is

practicable. Even though the beneficiary populations differ between Medicare and TRICARE non-TFL beneficiaries, we have found that the distribution of LTCH cases by diagnosis groups is similar between the two populations. To adjust for the differences in use by the TRICARE and Medicare populations, we considered developing TRICARE-specific weights and rates. However, TRICARE has a low volume of admissions to LTCHs, so calculating weights and rates for TRICARE admissions to LTCHs is impracticable. We are able to calculate our own weights for admissions to general hospitals on an annual basis because of the volume of TRICARE admissions to general hospitals; however, it would be difficult to determine a new set of TRICARE LTCH weights because of the small number of TRICARE admissions. For example, there were only about 700 TRICARE admissions in FY14 in the approximately 750 MS-LTC-DRG groups. Only four MS-LTC-DRGs had 25 or more TRICARE admissions in FY14 and only 14 had ten or more TRICARE admissions in that year. Approximately 600 MS-LTC-DRGs had no TRICARE LTCH admissions. Consequently, we are proposing to adopt the weights and rates used currently in Medicare's MS-LTC-DRGs.

Further, TRICARE proposes to adopt Medicare's LTCH PPS to include short-stay outliers, the 25 percent threshold payment adjustment, site-neutral payments, interrupted stay policy, the method of payment for preadmission services, and high-cost outlier payments. TRICARE also proposes to incorporate Medicare's Long Term Care Hospital Quality Reporting (LTCHQR) payment adjustments for TRICARE LTCHs 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 LTCHQR Program. Please see Medicare's final rule [CMS-1632-F; CMS-1632-CN2] RIN 0938-AS41.

## 2. TRICARE IRF PPS Reimbursement

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)(1), an inpatient rehabilitation hospital or rehabilitation unit of an acute care hospital must meet the

requirement for classification as an IRF stipulated in subpart B of 42 CFR part 412. One criterion specified at 42 CFR 412.29(b)(1) that Medicare uses for classifying a hospital or unit of a hospital as an IRF is that a minimum percentage (currently 60 percent) of a facility'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 if a network IRF, or billed charges if a non-network IRF.

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.

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 1079(i)(2), TRICARE is proposing to adopt Medicare's reimbursement methodology to reimburse TRICARE authorized IRFs. A change is needed to conform to the statute.

For TRICARE, we were able to identify complete claims information for 2,929 TRICARE beneficiaries discharged from IRFs in FY14 where TRICARE was the primary payer. TRICARE allowed charges for these beneficiaries was approximately \$121 million in FY14. These allowed amounts were equal to 74 percent of billed charges, indicating that there were significant discounts offered by IRFs. Excluding Children's and Veterans (VA) hospital claims, which are not paid under the IRF-PPS,

TRICARE allowed amounts were \$89 million in FY14. We found that the average allowed amount per IRF stay (excluding Children's and VA hospital claims) was \$34,300 in FY14, which is significantly more than the estimated amount that Medicare would have paid for these discharges (the average Medicare IRF PPS payment was approximately \$18,600 in 2014). The 2014 Medicare payment amount per case was reported in the 2016 Medicare Payment Advisory Commission (MedPAC) report. Using the Medicare IRF PPS system would have reduced TRICARE allowed amounts by approximately \$41 million in FY14.

Given TRICARE's statutory requirement to adopt Medicare's reimbursement methods when practicable, TRICARE is proposing to adopt Medicare's IRF PPS reimbursement method for its beneficiaries who receive rehabilitative care in IRFs. TRICARE proposes to adopt Medicare's IRF PPS and include Medicare's adjustments for interrupted stays, short stays of less than three days, short-stays transfers (defined as transfers to another institutional setting with an IRF length of stay less than the average length for the CMG), and high-cost outliers. TRICARE proposes to not adopt Medicare's low-income payment (LIP) adjustment for IRFs, because TRICARE does not adjust for Disproportionate Share in acute care hospitals under the TRICARE DRG system. TRICARE also proposes to incorporate Medicare's Inpatient Rehabilitation Hospital Quality Reporting (IRFQR) payment adjustments for TRICARE 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.

## B. Pediatric Cases

### 1. LTCH

Our analysis found that the TRICARE pediatric LTCH patients and Medicare populations have similar diagnoses and that the estimated TRICARE costs in each MS–LTC–DRG group are similar to those in Medicare. There are very few TRICARE LTCH cases for patients under age 17; however, these pediatric cases have similar diagnoses as other TRICARE LTCH admissions. Therefore, we propose to adopt the same LTCH PPS methodology for pediatric patients

in LTCHs as we are for all other TRICARE beneficiaries.

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

### 2. IRF

In 2014, approximately 50 patients under the age of 17 received IRF care under TRICARE. Approximately 38 percent of those TRICARE pediatric IRF cases were treated at Children's hospitals, which are exempt from Medicare's IRF PPS. TRICARE is proposing that pediatric rehabilitation cases at Children's hospitals would also be exempt under the TRICARE IRF PPS and instead paid under the TRICARE DRG system. Pediatric cases treated at TRICARE IRFs would be paid under the TRICARE IRF PPS.

### C. Veterans (VA) Hospitals

VA hospitals specialize in treating injured veterans and provide access to rehabilitative care. VA hospitals are not Medicare authorized IRFs (because they are Federal hospitals) and they do not use 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 Active Duty Service Members (ADSMs)). VA hospitals will continue to be paid under existing methodologies.

## III. Regulatory Impact Analyses for LTCHs and IRFs

### A. Overall Impact

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

#### 1. Executive Order 12866 and Executive Order 13563

E.O.s 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts,

and equity). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year).

We estimate that the effects of the LTCH 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 Regulatory Impact Analyses that, to the best of our ability, presents the costs and benefits of the rulemaking. This proposed rule is anticipated to reduce DoD allowed amounts to LTCHs by \$77 million and to IRFs by \$53 million in FY17.

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

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

#### 3. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) identification of a small business (having revenues of \$34.5 million or less in any one year). For purposes of the RFA, we have determined that the majority of LTCHs and all 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 \$100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$140 million. This Proposed Rule will not mandate any requirements for State, local, or tribal governments or the private sector.

#### 5. Paperwork Reduction Act

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

#### 6. Executive Order 13132, "Federalism"

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

#### *B. Hospitals Included in and Excluded From the Proposed 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 CHAMPUS DRG-based payment system, respectively. Currently, only Maryland hospitals operate under such a waiver.

#### *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 an average of 45–75 percent for most LTCHs. 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 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 be zero points.

For the following reasons, we have determined that a transition period is unnecessary because the Medicare-based payment amounts will have a minimal impact on overall LTCH payments and to any particular LTCH under TRICARE. First, the TRICARE payments to LTCHs will be equal to Medicare's LTCH payments. The Medicare Payment Advisory Committee (MedPAC) is an independent congressional agency which advises the U.S. Congress on issues affecting the Medicare program. MedPAC's most recent research indicates that Medicare LTCHs have a positive Medicare margin. Second, the number of TRICARE discharges from LTCHs is very small in comparison to the number of Medicare discharges in LTCHs each year. In FY14, there were 764 discharges to LTCHs in which TRICARE was the primary payer (including the 30 discharges with incomplete data). Medicare, in comparison, had approximately 138,000 discharges to LTCHs in 2013. Thus, in aggregate, the TRICARE LTCH claims are a very small percentage of the industry's claims (about one-half of one percent). Third, we found that in FY14 there were only 5 LTCHs with 15 or more TRICARE admissions. For all but two TRICARE LTCHs, we found that TRICARE admissions accounted for less than six percent of the number of Medicare discharges. Of the 212 LTCHs with TRICARE discharges, we found that 154 had 3 or fewer discharges in FY14 and that 208 Medicare LTCHs had no admissions in FY14 where TRICARE was the primary payer. Thus, the number of TRICARE discharges at any

one LTCH is small and TRICARE is a small portion of LTCH revenues. Fourth, we do not think that there will be access problems for TRICARE beneficiaries. MedPAC has analyzed LTCH access for Medicare patients and concluded that Medicare beneficiaries have continued access to LTCHs under the Medicare payment methodology proposed here as evidenced by an increasing supply of providers and an increasing number of LTCH stays. Given that the TRICARE LTCH rates will equal Medicare LTCH rates and will have a limited impact on overall LTCH payments, we do not anticipate access problems for TRICARE beneficiaries. Further, by statute, hospitals that participate under Medicare are required to agree to accept TRICARE reimbursement. In summary, for these four reasons we do not think that a transition period is necessary, but we invite comments on this approach.

#### 2. Alternatives Considered for Addressing Reduction in IRF Payments

Under the method discussed here, TRICARE's IRF payments per discharge would decrease by 30–40 percent for most IRFs. 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 and 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 be zero points.

For the following reasons, we have determined that a transition period is unnecessary because the Medicare-based payment amounts will have a minimal impact on overall LTCH payments and to any particular LTCH under TRICARE. First, the TRICARE payments to IRFs will be equal to Medicare's IRF payments. The Medicare Payment Advisory Committee (MedPAC) is an independent congressional agency which advises the U.S. Congress on issues affecting the Medicare program. MedPAC's most recent research from March 2015 indicates that Medicare IRFs generally have positive Medicare margins. Thus, we think that IRFs will earn a positive margin from TRICARE. Second, the number of TRICARE discharges from IRFs is very small in comparison to the number of Medicare IRF discharges each year. In FY14, there were 2,681 IRF

discharges in which TRICARE was the primary payer (including the 78 discharges with incomplete data and excluding discharges from Children's and VA hospitals). Medicare, in comparison, had approximately 376,000 IRF stays in 2014. Thus, in aggregate, the TRICARE IRF claims account for less than one percent of the industry's claims. Third, we found that in FY14 there were only 24 IRFs with 20 or more TRICARE admissions. For all but nine TRICARE IRFs, we found that TRICARE admissions accounted for less than ten percent of the number of Medicare discharges. Of the 591 IRFs with TRICARE discharges (including the 23 with incomplete data), we found that 408 had 3 or fewer discharges in FY14 and that 771 Medicare IRFs had no TRICARE admissions in FY14 where TRICARE was the primary payer. Thus, the number of TRICARE discharges at any one IRF is small and TRICARE accounts for a small portion of IRF revenues. Fourth, we do not think that there will be access problems for TRICARE beneficiaries. MedPAC has analyzed IRF access for Medicare patients and concluded that Medicare beneficiaries have continued access to IRFs. MedPAC reports the number of providers and volume of services in IRFs has remained stable between 2012 and 2013. Because the TRICARE IRF rates will equal Medicare IRF rates and will have a limited impact on overall LTCH payments, we do not anticipate access problems for TRICARE beneficiaries. Further, by statute, hospitals that participate under Medicare are required to agree to accept TRICARE reimbursement. In summary, for these four reasons we do not think that a transition period is necessary, but we invite comments on this approach.

#### *D. Analysis of the Impact of TRICARE LTCH and IRF Payment Reform on LTCHs and IRFs*

##### *1. LTCH Methodology*

We analyzed the impact of TRICARE implementing a new method of payment for LTCHs. The proposed method is Medicare's LTCH 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 FY17, the Medicare IPPS MS-DRG system for all other (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 2013 to September 2014. We drew upon various sources for the data used to categorize hospitals in Table 1, below. We attempted to construct these variables using information from Medicare's FY14 Impact file to verify that each provider was in fact a Medicare LTCH. One limitation is that for individual hospitals, some miscategorizations are possible. We were unable to match 30 hospital claims from 6 LTCHs to the FY14 Impact file, and as a result, these claims were excluded from the analysis. All Maryland LTCHs were also excluded from the analysis. After we removed the excluded claims which we could not assign charge and hospital classification variables for, we used the remaining hospitals and claims as the basis for our analysis.

Using allowed charge data from 2014, the FY14 Medicare MS-LTC-DRG and MS-DRG weights, the FY14 Medicare LTCH and IPPS national base payment rates, the FY14 Medicare high cost outlier fixed thresholds, and the FY14 wage index adjustment factors, we simulated TRICARE allowed amounts in FY14 using the proposed LTCH prospective payment method. We focused the analysis on TRICARE claims where TRICARE was the primary payer because only these TRICARE payments will be affected by the proposed reforms.

##### *2. 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 2013 to September 2014. We drew upon various sources for the data used to categorize hospitals in Table 1, below. We attempted to construct these variables using information from Medicare's FY16 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 miscategorizations are possible. We were unable to match 78 IRF claims from 23 IRFs to Medicare provider numbers within the FY16 IRF rate setting file or the October 2015 Medicare IRF PSF file, and as a result, these claims were excluded from the analysis. We also excluded all Children's Hospital (4 hospitals, 22 discharges) and all Veterans hospital (12 Veterans hospitals, 226 discharges) claims because these hospitals are not paid under the Medicare IRF-PPS. After we removed the excluded claims which we could not assign charge and hospital classification variables for, we used the remaining hospitals and claims as the basis for our analysis.

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 FY14 TRICARE billed charges at that IRF and the Medicare cost-to-charge ratio (CCR) for that IRF. We then used Medicare payment and cost data from the FY16 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 FY14 to FY17 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 FY14 to FY17. 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). The difference between the current and the proposed policy was equal to \$53 million in FY17. 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. 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.

### 3. Effect on Hospitals

Table 1, Impact of TRICARE LTCH Rule in FY14, Assuming Full Implementation of the Medicare Site-Neutral Payment Policy, below, presents the results of our analysis of FY14 TRICARE claims data. This table categorizes LTCHs which had TRICARE inpatient stays in FY14 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 FY14 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 FY14. The fourth column shows the simulated average allowed amount per discharge under the Medicare LTCH payment method, assuming full implementation of 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 1 shows the overall impact on the 222 LTCHs

included in the analysis. The next three rows of the table contain hospitals categorized according to their urban/rural status in FY14 (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.

We estimate that in FY14, assuming full implementation of the Medicare site-neutral payment policy, TRICARE allowed amounts to LTCHs would have decreased by 67 percent in comparison to allowed amounts paid to LTCHs under the current TRICARE policy. For all groups of LTCHs, allowed amounts under the proposed payment methodology would have been reduced.

The following discussion highlights some of the changes in allowed amounts among LTCH classifications. Ninety-six percent of all TRICARE LTCH admissions were to urban LTCHs. Allowed amounts would have decreased by 69 percent for large urban, 64 percent for other urban, and 71 percent for rural LTCHs.

Very small LTCHs (1–24 beds) would have had the least impact; allowed amounts would have been reduced by 49 percent. The change in payment methodology would have had the greatest impact on large LTCHs (125 or more beds), where allowed amounts would have been reduced by about 72 percent.

The change in LTCH payment methodology would have a larger impact on TRICARE non-network LTCHs than network LTCHs because network LTCHs currently offer a discount off billed charges while non-network LTCHs do not. Allowed charges to non-network LTCHs would have declined by 74 percent, in comparison to 64 percent for in-network hospitals. We found that network hospitals on average provide a 30 percent discount off billed charges for non-TFL TRICARE beneficiaries and that 79 percent of all TRICARE LTCH discharges were in-network in FY14.

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 68 and 69 percent in allowed charges respectively, which are very similar to the overall average of 67 percent. LTCHs in the East North Central and West North Central regions would have had the lowest reductions in allowed charges: 59 and 45 percent, respectively.

Seventy-nine percent of all TRICARE LTCH discharges in FY14 were in proprietary (for-profit) LTCHs, and these facilities would have had their allowed amounts reduced by approximately 68 percent. The decline in allowed amounts for voluntary (not-for-profit) LTCHs would have been less than for-profit hospitals (63 percent).

TABLE 1—IMPACT OF TRICARE LTCH RULE IN FY14, ASSUMING FULL IMPLEMENTATION OF THE MEDICARE SITE-NEUTRAL PAYMENT POLICY

	Number of LTCHs with TRICARE stays	Number of TRICARE discharges	Allowed per discharge (current policy)	Allowed per discharge (Medicare method)	Percent reduction in allowed amounts
All LTCHs .....	222	734	\$125,235	\$41,071	67
Large Urban .....	110	405	148,099	46,255	69
Other Urban .....	103	312	96,193	34,787	64
Rural .....	9	17	113,576	32,880	71
Beds .....	222	734	125,235	41,071	67
1–24 .....	7	13	53,921	27,635	49
25–34 .....	42	103	107,786	38,029	65
35–49 .....	55	164	114,849	39,252	66
50–74 .....	63	205	108,308	36,920	66
75–124 .....	35	151	137,763	44,779	67
125+ .....	20	98	186,523	52,064	72
Network Status .....	222	734	125,235	41,071	67
Network .....	160	580	110,147	39,461	64
Non-Network .....	62	154	182,062	47,133	74
Region .....	222	734	125,235	41,071	67
New England .....	5	15	74,012	24,186	67
Mid Atlantic .....	11	22	121,182	29,631	76
South Atlantic .....	39	238	131,922	41,939	68
East North Central .....	32	71	93,975	38,786	59
East South Central .....	19	54	146,180	46,381	68
West North Central .....	13	27	87,161	48,098	45
West South Central .....	68	214	104,033	31,831	69



TABLE 1—IMPACT OF TRICARE LTCH RULE IN FY14, ASSUMING FULL IMPLEMENTATION OF THE MEDICARE SITE-NEUTRAL PAYMENT POLICY—Continued

	Number of LTCHs with TRICARE stays	Number of TRICARE discharges	Allowed per discharge (current policy)	Allowed per discharge (Medicare method)	Percent reduction in allowed amounts
Mountain .....	18	56	166,254	60,533	64
Pacific .....	17	37	223,154	64,625	71
Ownership .....	222	734	125,235	41,071	67
Proprietary .....	175	567	127,929	40,763	68
Government Owned .....	10	29	108,139	32,452	70
Voluntary .....	37	138	117,760	44,147	63

Source: FY14 TRICARE LTCH claims and FY14 Medicare Impact File. Excludes claims with other health insurance (OHI). Amounts adjusted for FY14 Wage Index and FY14 COLA.

**Note:** Excludes 30 claims from 6 TRICARE LTCHs that did not have a cost-to-charge ratio (CCR) in the FY14 Medicare Impact File.

Table 2, Impact of TRICARE IRF Rule in FY14, presents the results of our analysis of FY14 TRICARE claims data. This table categorizes IRFs which had TRICARE inpatient stays in FY14 by various geographic and special payment consideration groups to illustrate the varying impacts on different types of IRFs. The first column represents the number of IRFs in FY14 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 FY14. The fourth column shows the average allowed amount per discharge under the Medicare IRF payment method, excluding 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 2 shows the overall impact on the 568 IRFs included in the analysis. The next two rows of the table categorize hospitals according to their geographic location in FY14 (urban and rural). The second major grouping is whether the IRF is a freestanding

facility or a part of a hospital unit, followed by a grouping for TRICARE network status. The fourth grouping is whether the IRF is a teaching facility and the fifth groups IRFs by Census division. The final grouping is by IRF ownership status.

The following discussion highlights some of the changes in allowed amounts among IRF classifications. Ninety-five percent of all TRICARE IRF admissions were to urban IRFs. Allowed amounts would have decreased by 45 percent for urban IRFs and 21 percent for rural IRFs.

TABLE 2—IMPACT OF TRICARE IRF RULE IN FY14

	Number of IRFs with TRICARE stays	Number of TRICARE discharges	Allowed per discharge (current policy)	Proposed policy allowed per discharge (medicare method)	Percent reduction in allowed amounts
All IRFs .....	568	2,603	\$34,260	\$19,129	44
Urban .....	523	2,473	34,944	19,257	45
Rural .....	45	130	21,248	16,687	21
Type .....	568	2,603	34,260	19,129	44
Freestanding .....	181	1,191	26,852	19,661	27
Hospital Unit .....	387	1,412	40,508	18,680	54
Network Status .....	568	2,603	34,260	19,129	44
Network .....	433	2,323	32,806	19,169	42
Non-Network .....	135	280	46,318	18,800	59
Teaching Status .....	568	2,603	34,260	19,129	44
Teaching .....	56	444	43,861	22,195	49
Non-Teaching .....	512	2,159	32,285	18,498	43
Region .....	568	2,603	34,260	19,129	44
North East and Middle Atlantic .....	78	184	27,964	22,299	20
South Atlantic .....	47	242	27,730	16,486	41
East North Central .....	112	787	32,048	19,076	40
East South Central .....	44	122	33,838	15,707	54
West North Central .....	72	185	33,972	19,093	44
West South Central .....	109	611	33,749	18,714	45
Mountain .....	56	242	38,008	17,603	54
Pacific .....	50	230	51,600	24,108	53
Ownership .....	568	2,603	34,260	19,129	44
Proprietary .....	196	1,099	30,601	18,709	39
Government Owned .....	73	350	36,075	18,835	48
Voluntary .....	299	1,154	37,193	19,618	47

Source: FY14 TRICARE IRF Claims and FY16 Medicare Rate Setting File. Excludes claims with other health insurance (OHI).

**Note:** Excludes claims from 12 VA Hospitals (226 discharges), 4 Children's Hospitals (22 discharges), and 28 IRFs where we were unable to identify Medicare certification or sufficient Medicare data (78 discharges). 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.

The change in payment methodology would have resulted in a 54 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 27 percent.

The change in IRF payment methodology would have 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 do not. Allowed charges to non-network IRFs would have declined by 59 percent, in comparison to 42 percent for in-network hospitals. We found that network hospitals on average provide a 32 percent discount off billed charges for non-OHI TRICARE beneficiaries and that 89 percent of all TRICARE IRF discharges were in-network in FY14.

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 49 percent, in comparison to non-teaching hospitals, where payments would have been reduced by 43 percent. Approximately 83 percent of all TRICARE IRF discharges were from non-teaching IRF facilities.

IRFs in various geographic areas will be affected differently due to this change in payment methodology. The two regions with the largest number of TRICARE claims, the East North Central (787 discharges) and West South Central (611 discharges), would have had an average decrease of 40 and 45 percent in allowed charges respectively. IRFs in the North East and Middle Atlantic would have had the lowest reductions in allowed charges of 20 percent. The Mountain, East South Central, and Pacific regions would have had the highest reductions of between 53 and 54 percent.

Forty-two percent of all TRICARE IRF discharges in FY14 were in proprietary (for-profit) IRFs, and these facilities would have had their allowed amounts reduced by approximately 39 percent. The decline in allowed amounts for voluntary (not-for-profit) and government-owned IRFs would have been slightly more than proprietary hospitals (47 and 48 percent respectively).

#### List of Subjects in 32 CFR Part 199

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, Military personnel.

Accordingly, 32 CFR part 199 is proposed to be amended as follows:

### PART 199—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 definitions of “Hospital, long-term (tuberculosis, chronic care, or rehabilitation)” and “Long-term hospital care”; and
- b. Adding the definitions of “Long Term Care Hospital (*LTCH*)” and “Inpatient Rehabilitation Facility (*IRF*)” in alphabetical order.

The additions read as follows:

#### § 199.2 Definitions.

\* \* \* \* \*

(b) \* \* \*

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

\* \* \* \* \*

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

\* \* \* \* \*

■ 3. In § 199.6, revise paragraphs (b)(4)(v) and (xvi), and add paragraph (xviii) 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 hospital 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.

\* \* \* \* \*

(xviii) *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 paragraphs (a)(1)(ii)(D)(2), (3) and (4), and (ii)(E);

■ b. Revising paragraph (a)(3)(i) introductory text; and

■ c. Adding new paragraphs (a)(9) and (10).

The revisions and additions read as follows:

**§ 199.14 Provider reimbursement methods.**

(a) \* \* \*

(1) \* \* \*

(ii) \* \* \*

(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.

(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. With the exceptions of CAHs, in addition to LTCHs and IRFs which must be Medicare-participating providers upon implementation of TRICARE's LTCH and IRF PPS, it is not required that a hospital be a Medicare-participating provider in order to be an authorized TRICARE provider.

However, 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 DHA Director, 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 (a)(10) of this section.

\* \* \* \* \*

(9) Reimbursement for inpatient services provided by an 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, the 25 percent threshold payment adjustment, 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.

(ii) 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, respectively.

(10) Reimbursement for inpatient services provided by Inpatient Rehabilitation Facilities. (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 Subpart B of 42 CFR part 412 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 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 60 percent compliance threshold, teaching adjustment, rural adjustment, high-cost outlier payments, payment adjustments associated with the quality reporting program, and updates to the system. TRICARE will not adopt Medicare's low-income payment adjustment under TRICARE's IRF PPS.

(ii) 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, respectively.

\* \* \* \* \*

Dated: August 24, 2016.

Aaron Siegel,

Alternate OSD Federal Register Liaison  
Officer, Department of Defense.

[FR Doc. 2016-20660 Filed 8-30-16; 8:45 am]

BILLING CODE 5001-06-P

## DEPARTMENT OF HOMELAND SECURITY

### Coast Guard

#### 33 CFR Part 165

[Docket Number USCG-2016-0715]

RIN 1625-AA00

#### Safety Zone; Blasting, Delaware River

**AGENCY:** Coast Guard, DHS.

**ACTION:** Notice of proposed rulemaking.

**SUMMARY:** The Coast Guard proposes to establish a temporary safety zone on the waters of the Tinicum Range, Eddystone Range, Chester Range, and Marcus Hook Range, in the Delaware River from December 1, 2016 to March 15, 2016. The safety zone would temporarily restrict vessel traffic from transiting or anchoring in a portion of the Delaware River while rock blasting, dredging, and rock removal operations are being conducted to facilitate the Delaware River Main Channel Deepening project for the main navigational channel of the Delaware River. This action is needed to protect personnel, vessels, and the marine environment from potential hazards created by rock blasting, dredging, and rock removal operations. We invite your comments on this proposed rulemaking.

**DATES:** Comments and related material must be received by the Coast Guard on or before September 30, 2016.

**ADDRESSES:** You may submit comments identified by docket number USCG-2016-0715 using the Federal eRulemaking Portal at <http://www.regulations.gov>. See the "Public Participation and Request for Comments" portion of the **SUPPLEMENTARY INFORMATION** section for further instructions on submitting comments.

**FOR FURTHER INFORMATION CONTACT:** If you have questions about this

rulemaking, call or email MST1 Thomas Simkins, Sector Delaware Bay Waterways Management Division, U.S. Coast Guard; telephone 215-271-4889, email [Tom.J.Simkins@uscg.mil](mailto:Tom.J.Simkins@uscg.mil).

#### SUPPLEMENTARY INFORMATION:

##### I. Table of Abbreviations

CFR Code of Federal Regulations  
DHS Department of Homeland Security  
FR Federal Register  
NPRM Notice of proposed rulemaking  
§ Section  
U.S.C. United States Code  
COTP Captain of the Port

##### II. Background, Purpose, and Legal Basis

The Army Corps of Engineers (ACOE) is sponsoring a project, termed "The Deepening," in which dredging operations are taking place in the Delaware River and Bay navigational channel deepening the channel to 45 feet. The project goal is to maintain a minimum depth of 45 feet to accommodate larger vessel traffic entering the Sector Delaware Bay Zone. The upcoming portion of the project requires the deepening of the Delaware River from Tinicum Range, south, through Marcus Hook Rang, in which the topography consist of mostly rock bottom. To satisfy the minimum project depth of 45 feet the ACOE has hired Great Lakes Dredging Company to perform rock blasting operations, dredging, and removal of rock in Tinicum Range, Eddystone Range, Chester Range, and Marcus Hook Range, in the Delaware River from December 1, 2016, to March 15, 2017. The Captain of the Port, Delaware Bay, has determined that potential hazards associated with rock blasting, dredging, and rock removal operations, will be a safety concern for anyone within 500 yards of rock blasting, dredging, and rock removal operations. This proposed rule is needed to protect personnel, vessels, and the marine environment in the navigable waters within the operational area.

The purpose of this rulemaking is to ensure the safety of vessels and the navigable waters within a 500-yard radius of rock blasting, dredging, and rock removal operations. The Coast Guard proposes this rulemaking under authority in 33 U.S.C. 1231; 33 CFR 1.05-1 and 160.5; and Department of Homeland Security Delegation No. 0170.1.

##### III. Discussion of Proposed Rule

This proposed rule would establish a safety zone from December 1, 2016, through March 15, 2017. The safety zone would cover all navigable waters

in the Delaware River within 500 yards of vessels and machinery being used by personnel to conduct rock blasting, dredging, and rock removal. The duration of the zone is intended to protect personnel, vessels, and the marine environment in these navigable waters while operations are being conducted.

For the duration of the project, in the vicinity of the rock blasting, rock removal, and dredging operation, one side of the main navigational channel will be closed due to the drill boat APACHE being unable to relocate for vessel traffic while conducting rock blasting and removal operations. Additionally there is a potential for blasted rock to be within the navigational channel causing a navigational safety hazard for vessels transiting the safety zone. Vessels wishing to transit the safety zone in the main navigational channel may do so if they can make satisfactory passing arrangements with drill boat APACHE, dredge TEXAS, or dredge NEW YORK in accordance with the navigational rules in 33 CFR subchapter E via VHF-FM channel 13 at least 30 minutes prior to arrival. If vessels are unable to make satisfactory passing arrangements with the drill boat APACHE, dredge TEXAS, or dredge NEW YORK they may request permission from the Captain of the Port, or his designated representative, on VHF-FM channel 16. All vessels must operate at the minimum safe speed necessary to maintain steerage and reduce wake.

No vessels may transit through the safety zone during times of explosives detonation. During rock blasting detonation, vessels would be required to maintain a 500 yard distance from the drill boat APACHE. The drill boat APACHE will make broadcasts, via VHF-FM channels 13 and 16, at 15 minutes, 5 minutes, and 1 minute prior to detonation, as well as a countdown to detonation on VHF-FM channel 16. The drill boat APACHE will also raise a red flag signifying when a detonation is occurring. The 500 yard radius will be secured by a contracted security vessel on either side of the blast area. Security vessels will ensure the blasting area is clear prior to explosive detonation. Sector Delaware Bay will ensure significant notice is given to the maritime community of dates and times of blasting via broadcast notice to mariners on VHF-FM channel 16. After every explosive detonation, a survey will be conducted to ensure the navigational channel is clear for vessels to transit. The drill boat APACHE will broadcast, via VHF-FM channels 13 and 16, when the survey has been completed