

DEPARTMENT OF DEFENSE**Office of the Secretary****32 CFR Part 199**

RIN 0720-AA73

TRICARE; Sub-Acute Care Program; Uniform Skilled Nursing Facility Benefit; Home Health Care Benefit; Adopting Medicare Payment Methods for Skilled Nursing Facilities and Home Health Care Providers**AGENCY:** Office of the Secretary, DoD.**ACTION:** Final rule.

SUMMARY: This rule partially implements the TRICARE “sub-acute and long-term care program reform” enacted by Congress in the National Defense Authorization Act for Fiscal Year 2002, specifically: Establishment of “an effective, efficient, and integrated sub-acute care benefits program,” with skilled nursing facility (SNF) and home health care benefits modeled after those of the Medicare program; adoption of Medicare payment methods for skilled nursing facility, home health care, and certain other institutional health care providers; adoption of Medicare rules on balance billing of beneficiaries, prohibiting it by institutional providers and limiting it by non-institutional providers; and change in the statutory exclusion of coverage for custodial and domiciliary care.

DATES: *Effective Dates:* This rule is effective August 1, 2003, except the amendments to § 199.14(h), which are effective June 1, 2004.

ADDRESSES: Medical Benefits and Reimbursement Systems, TRICARE Management Activity, 16401 East Centretch Parkway, Aurora, Colorado 80011–9066.

FOR FURTHER INFORMATION CONTACT: For payments to Skilled Nursing Facilities and Skilled Nursing Facility (SNF) services, Tariq Shahid, Medical Benefits and Reimbursement Systems, TRICARE Management Activity, telephone (303) 676–3801. For Home Health Care (HHC) benefits and payment methods, David E. Bennett, TRICARE Management Activity, Medical Benefits and Reimbursement Systems, telephone (303) 676–3494. For payments for clinical laboratory and certain other services in hospital outpatient departments and emergency departments and balance billing limits, Stan Regensberg, Medical Benefits and Reimbursement Systems, TRICARE Management Activity, telephone (303) 676–3742. For custodial care issues, Mike Kottyan, Medical Benefits and

Reimbursement Systems, TRICARE Management Activity, telephone (303) 676–3520.

SUPPLEMENTARY INFORMATION:**I. Overview**

In the National Defense Authorization Act for Fiscal Year 2002 (NDAA–02), Pub. L. 107–107 (December 28, 2001), Congress enacted several reforms relating to TRICARE coverage and payment methods for skilled nursing and home health care services. The statutory “Sub-Acute and Long-Term Care Program Reform” under section 701 of this Act added a new 10 U.S.C. 1074j, which provides in pertinent part:

§ 1074j Sub-acute care program.

(a) Establishment.—The Secretary of Defense shall establish an effective, efficient, and integrated sub-acute care benefits program under this chapter. * * *

(b) Benefits.—(1) The program shall include a uniform skilled nursing facility benefit that shall be provided in the same manner and under the conditions described in Section 1861(h) and (i) of the Social Security Act (42 U.S.C. 1395x(h) and (i)), except that the limitation on the number of days of coverage under Section 1812(a) and (b) of such Act (42 U.S.C. 1395d(a) and (b)) shall not be applicable under the program. Skilled nursing facility care for each spell of illness shall continue to be provided for as long as medically necessary and appropriate. * * *

(3) The program shall include a comprehensive, part-time or intermittent home health care benefit that shall be provided in the manner and under the conditions described in Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

In addition to these requirements that TRICARE establish an integrated sub-acute care program consisting of skilled nursing facility and home health care services modeled after the Medicare program, Congress also, in section 707 of NDAA–02, changed the statutory authorization (in 10 U.S.C. 1079(j)(2)) that TRICARE payment methods for institutional care “may be” determined to the extent practicable in accordance with Medicare payment rules to a mandate that TRICARE payment methods “shall be” so determined. This amendment is effective 90 days after the date of enactment.

A third Congressional action in NDAA–02, also in Section 707, is the statutory codification of existing TRICARE policy—modeled after Medicare—that institutional providers are not permitted to balance bill beneficiaries for charges above the TRICARE payment amount and that non-institutional providers may not balance bill in excess of 15 percent over the TRICARE Maximum Allowable Charge.

A fourth component of this reform program (in Section 701(c)) is the narrowing of the regulatory definition of custodial care, which previously was statutorily excluded but not defined, by the adoption of the new statutory definition of “custodial care” that has the effect of eliminating current program restrictions on paying for certain medically necessary custodial care. The new statutory definition of domiciliary care is consistent with the previous regulatory definition, and no changes are required.

This final rule implements these statutory requirements. We are adopting for TRICARE a skilled nursing facility (SNF) benefit similar to Medicare’s, but as specified in the statute, without Medicare’s day limits. We are also adopting Medicare’s prospective payment method for SNF care. Similarly, we are adopting the Medicare benefit structure and payment method for home health care (HHC) services. We are applying to SNF and HHC providers the statutory prohibition against balance billing. In addition, we are incorporating the new statutory definitions of “custodial care” and “domiciliary care.” Finally, this rule also provides clarification of existing payment policies for laboratory services including clinical laboratory; rehabilitation therapy services; radiology services; diagnostic services; ambulance services; durable medical equipment (DME) and supplies; oxygen and related supplies; drugs administered other than oral method; all professional provider services that are provided in an emergency room, clinic, hospital outpatient departments, etc.; and routine venipuncture in hospital outpatient and emergency departments that were adopted under the allowable charge methodology under 32 CFR 199.14.

We note that the series of sub-acute and long-term care program reforms adopted by Congress in NDAA–02 included several parts that are not a part of implementation in this final rule. Most significant are: repeal of the Case Management Program under 10 U.S.C. 1079(a)(17) (repealed—along with several other related enactments—by Section 701(g)(2) of NDAA–02); continuation of the Case Management Program for certain beneficiaries currently covered by it (Section 701(d)); and establishment of a new program of extended benefits for disabled family members of active duty service members (Section 701(b)). These and several other related statutory changes are being implemented through separate regulatory changes.

Finally, we note that Congress included as Section 8101 of the DoD 2002 Appropriations Act, a general provision identical to a provision included in the 2000 (Section 8118) and 2001 (Section 8100) Appropriations Acts concerning implementation of the case management program under 10 U.S.C. 1079(a)(17). Although Sections 8118 and 8100 of the 2000 and 2001 Appropriations Acts were repealed by Section 701(g)(1)(B) and (C) of NDAA-02, the same provision was reenacted in the 2002 Appropriations Act. By its terms, Section 8101 of the DoD 2002 Appropriations Act, exclusively addresses implementation of a program (the case management program under 10 U.S.C. 1079(a)(17)) that has now been repealed. Thus, we consider Section 8101 as not affecting implementation of the sub-acute and long-term care reform program adopted by Congress in NDAA-02.

The program reforms adopted by Congress and implemented in this final rule take major steps toward achieving the Congressional objective of an effective, efficient, and integrated sub-acute care benefits program.

II. Skilled Nursing Facility Benefits

As noted above, 10 U.S.C. 1074j requires TRICARE to include a skilled nursing facility benefit that shall for the most part be provided in the manner and under the conditions described under Medicare. As a result, TRICARE is adopting Medicare's three-day prior-hospitalization requirement for coverage of a SNF admission. Accordingly, for a SNF admission to be covered under TRICARE, the beneficiary must have a qualifying hospital stay (meaning an inpatient hospital stay), of not less than three consecutive days before the beneficiary is discharged from the hospital. The beneficiary must enter the SNF within 30 days after discharge from the hospital or within such time as it would be medically appropriate to begin an active course of treatment where the individual's condition is such that SNF care would not be medically appropriate within 30 days after discharge from a hospital. The skilled services must be for a medical condition that was either treated during the qualifying three-day hospital stay, or started while the beneficiary was already receiving covered SNF care. Additionally, an individual shall be deemed not to have been discharged from a SNF, if within 30 days after discharge from a SNF, the individual is again admitted to the same or a different SNF. These coverage requirements are the same as applied under Medicare. We are not, however, adopting Medicare's 100-day limit on

SNF services. Consistent with the statute, SNF coverage for each spell of illness shall continue to be provided for as long as medically necessary and appropriate.

III. Payments for Skilled Nursing Facility Services

TRICARE had not reformed payment methods applicable to SNFs due to the very small volume of SNF services paid for by TRICARE. The volume of such services is now expected to increase significantly because of the Congressional action in 2000 reinstating TRICARE coverage secondary to Medicare for Medicare-eligible DoD health care beneficiaries (Section 712 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, Pub. L. 106-398). Coincident with Congressional action in directing adoption of Medicare payment methods for institutional providers, we have undertaken a review of the Medicare payment method and rates for SNF care under Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy) and 42 CFR Part 413, subpart J. That review and assessment have convinced us that adoption of Medicare SNF payment methods and rates is not only required by law, but also fair, feasible, practicable, and appropriate.

Medicare implemented its per diem Prospective Payment System (PPS) for SNF care covering all costs (routine, ancillary and capital) of Medicare-covered SNF services as of July 1, 1998. The Medicare payment rates are based upon resident assessments. All Medicare-certified SNFs are required to conduct assessments on residents using a standardized assessment tool, called the Minimum Data Set (MDS). Medicare then uses information from this assessment to categorize SNF patients into major categories, such as: (1) Rehabilitation; (2) Extensive Services; (3) Special Care; (4) Clinically Complex; (5) Impaired Cognition; (6) Behavior Problems; and (7) Reduced Physical Function. This is done using the Resource Utilization Group (RUG)-III grouper. The RUG-III grouper is a computer program that converts resident specific assessment data into a case-mix classification. In classifying patients into groups based upon their clinical and functional characteristics, the grouper further subdivides each of these major categories resulting in specific patient RUGs.

For each RUG, the Medicare SNF per diem payment is calculated as the sum of three parts—the nursing component, the therapy component and the non-case-mix component. Under the nursing and therapy components of the payment

rate, each of RUG carries a uniquely assigned relative weight factor. This relative weight factor, or case mix index, represents a relative index or resource consumption. Resource-intensive patients are assigned to a RUG that carries a higher relative weight factor. This RUG-specific relative weight factor is multiplied by the applicable nursing and therapy base rates (which vary depending on whether the SNF is urban or rural) to develop the nursing and therapy components of the per diem payment rate. These two components are then added to the non-case-mix adjusted component resulting in the PPS per diem payment rate.

A key part of the Medicare SNF payment system is the use of the MDS to classify SNF residents into one of the RUG groups. An important issue is whether the RUG-III classification system used by Medicare to classify patients into the RUG groups would be practicable for the TRICARE SNF benefit. We think that it would be practicable. Much of the SNF care for which TRICARE will be paying is as second payer to Medicare for the same patient. Even for non-Medicare-eligible patients (e.g., most patients under age 65), the characteristics recognized by the RUG-III system would be equally applicable. In this regard, we note that more than ten states have decided to use the RUG-III system to classify Medicaid patients into RUGs and several other states are currently in the developmental stages of implementing the RUG-III system. This reflects a broad view that the MDS and RUGs are appropriate for non-Medicare SNF residents. In our review and discussions, we could not identify any significant barriers to the use of the RUG-III system to classify TRICARE patients.

One implementation issue that we have identified related to classification concerns the timing of resident assessments. The Medicare SNF payment system requires periodic patient assessments. The Centers for Medicare and Medicaid Services (CMS) requires that SNF patients be assessed on days 5, 14, 30, 60, and 90, as well as to be reassessed if there are status changes between these periodic assessments. We have considered the level of assessment required after 100 days when TRICARE becomes primary payer for patients whose SNF care must continue beyond the Medicare benefit limit. We believe continuing to assess patients every 30 days would be consistent with Medicare's practice of skilled authorization.

A second implementation issue concerns the use of MDS for neonates

and very young children. The MDS was not designed for very young children. As a result, we believe that children under ten should not be assessed using the MDS. We will review the methods used by Medicaid programs and may adopt one of their assessment methods at a later time. Until then, the allowed charge for children under age ten in a SNF will continue to be the billed charge or negotiated rates.

We have also considered whether the Medicare SNF payment rates and weights are appropriate for TRICARE. We believe they are. For some of the payment methods TRICARE has adopted for non-SNF providers that are based on the Medicare's system, we have developed DoD-specific weights and rates. In some, such as for physician payments, we implemented our own phase-in process, but have now reached comparability with Medicare. In the case of SNF PPS, the Medicare weights and rates were developed to be used nationally—like TRICARE—thus, we have no special State considerations that some Medicaid programs would have. In addition, the TRICARE population group that will be the primary user of SNF services and the Medicare population group are quite similar. Thus, we believe that there is no reason why the Medicare weights and rates would not be appropriate to use. However, we will carefully monitor the TRICARE SNF patient characteristics to ensure that the weights and rates are appropriate. If necessary, the weights and rates could be modified after one or more years of experience.

Based on all of these considerations and the statutory requirements, the Department is adopting for TRICARE the Medicare payment methods and rates, including MDS assessments, RUG-III classifications, and Medicare weights and per diem rates. For patient stays longer than 90 days, MDS assessments would be required every 30 days.

In adopting the Medicare's SNF payment methodology, we are also incorporating into our rule a provision that has been in the TRICARE Operations Manual requiring that TRICARE-eligible SNFs are required to be Medicare-certified institutions. We believe this policy facilitates assurance of quality of care and is consistent with the payment approach we are adopting. For pediatric SNFs, TRICARE will accept Medicaid certification in lieu of the Medicare certification as the pediatric SNFs might choose not to apply for Medicare certification and the Medicaid certification standards are

quite similar to the Medicare certification standards.

For overseas, the SNF PPS will be applicable to those areas as it applies under Medicare.

On July 7, 2003, DoD published a notice (68 FR 40251) to announce the effective and implementation date for the new SNF benefit provisions and SNF PPS. The notice established that the new SNF benefit provisions and SNF PPS is effective for SNF admissions on or after August 1, 2003.

IV. Home Health Care Benefits

Home health agencies (HHAs) are recognized as authorized providers under TRICARE, but payment only extended to services rendered by otherwise authorized TRICARE individual professional providers, such as registered nurses, physical and occupational therapists, and speech pathologists. Coverage of services provided by home health aides and medical social workers were not allowed except under case management and the hospice benefit. Payment is also extended under the TRICARE-allowable charge methodology for medical supplies that are essential in enabling HHA professional staff to effectively carry out physician ordered treatment of the beneficiary's illness or injury. Unlike Medicare, TRICARE required HHAs to have either Community Health Accreditation Program or Joint Commission on the Accreditation of Healthcare Organizations accreditation to qualify as network providers. These certification requirements have been changed to make them consistent with those of Medicare in order to effectively accommodate adoption of the new HHA prospective payment system, i.e., to require Medicare certification/approval for provider authorization status under TRICARE.

Medicare's home health benefit structure and conditions for coverage are being adopted coincident with implementation of the new prospective payment system including those provisions under Sections 1861(m), 1861(o), and 1891 of the Social Security Act and 42 CFR part 484. In general, coverage extends to part-time or intermittent skilled nursing care and home health aide services from qualified providers. The specific benefit structure and conditions for coverage are set forth in the new Section 199.4(e)(21) of the regulation.

In adopting this new benefit structure for TRICARE, we note the potential need for some transition time or other accommodation for some patients currently receiving home health services under present program coverage rules.

Our regulation (Section 199.1(n)) allows the recognition of special circumstance and authority of the Director to address them.

V. Payment Method for Home Health Care Services

TRICARE is adopting Medicare's benefit structure and prospective payment system for reimbursement of HHAs that are currently in effect for the Medicare program under Section 4603 of the Balanced Budget Act of 1997, as amended by Section 5101 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999, and by Sections 302, 305, and 306 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. This includes adoption of the comprehensive Outcome and Assessment Information Set (OASIS) and consolidated billing requirements.

The adoption of the Medicare HHA prospective payment system replaces the retrospective physician-oriented fee-for-service model used for payment of home health services under TRICARE. Under the new prospective payment system, TRICARE will reimburse HHAs a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and non-routine medical supplies provided under the beneficiary's plan of care. Durable medical equipment and osteoporosis drugs receive a separate payment amount in addition to the prospective payment system amount for home health care services.

The variation in reimbursement among beneficiaries receiving home health care under this newly adopted prospective payment system will be dependent on the severity of the beneficiary's condition and expected resource consumption over a 60-day episode-of-care, with special reimbursement provisions for major intervening events, significant changes in condition, and low or high resource utilization. The resource consumption of these beneficiaries will be assessed using OASIS selected data elements. The score values obtained from these selected data elements will be used to classify home health beneficiaries into one of 80 Home Health Resource Groups (HHRGs) based on their average expected resource costs relative to other home health care patients.

The HHRG classification determines the cost weight, i.e., the appropriate case-mix weight adjustment factor that indicates the relative resources used and costliness of treating different patients. The cost weight for a particular HHRG is then multiplied by a standard average

prospective payment amount for a 60-day episode of home health care. The case-mix adjusted standard prospective payment amount is then adjusted to reflect the geographic variation in wages to come up with the final HHA payment amount. As indicated above, the ordinary unit of payment is based on a 60-day episode of care. Payment covers the entire episode of care regardless of the number of days of care actually provided during the 60-day period. There are exceptions to this standard payment period under certain conditions that will result in reduced or additional amounts being paid. If the beneficiary is still in treatment at the end of the initial 60-day episode of care, a physician must re-certify the beneficiary's continuing need for home health services and the homebound status of the patient, and a new episode of care may begin. There is currently no limit on the number of medically necessary consecutive 60-day episodes that beneficiaries may receive under the HHA prospective payment system.

As noted above, the variation in reimbursement among beneficiaries receiving HHC under this newly adopted prospective payment system will be dependent on the severity of the beneficiary's condition and expected resource consumption over a 60-day episode-of-care, with special reimbursement provisions for major intervening events, significant changes in condition, and low or high resource utilization. A case mix system has been developed to measure the severity and projected resource utilization of beneficiaries receiving home health services using selected data elements off of the OASIS assessment instrument (i.e., the assessment document submitted by HHAs for reimbursement) and an additional element measuring receipt of at least ten visits for therapy services. These key data elements are organized and assigned a score value in order to measure the impact of clinical, functional and services utilization dimensions on total resource use. The resulting summed scores are used to assign a beneficiary to a particular severity level within each of the following dimensions:

- *Clinical Dimension*—The clinical dimension has four severity levels (0–3) and takes into account the beneficiary's primary diagnosis and prevalent medical conditions.

- *Functional Dimension*—The functional dimension assesses the beneficiary's ability to perform various activities of daily living (e.g., the beneficiary's ability to dress and bathe) and consists of five severity levels (0–4).

- *Services Utilization Dimension*—The services utilization dimension has four severity levels (0–3) and indicates whether the beneficiary was discharged from a skilled nursing facility or rehabilitation hospital within the past 14 days and whether the patient is expected to receive ten or more occupational, physical and/or speech therapy visits.

A case-mix grouper is used for assigning a severity level within each of the above dimensions and for classifying the beneficiary into one of 80 HHRGs. The HHRG indicates the extent and severity of the beneficiary's home health needs reflected in its relative case-mix weight (cost weight). The case-mix weight indicates the group's relative resource use and cost of treating different patients. The case-mix weights for Fiscal Year 2001 ranged from 0.5265 to 2.8113. The standardized prospective payment rate is multiplied by the beneficiary's assigned HHRG case-mix weight to come up with the 60-day episode payment.

On March 30, 2004, DoD published a notice (69 FR 16531) to announce the phased-in implementation of the HHA prospective payment system with the start health care delivery date under each of the TRICARE Next Generation of Contracts (T–Nex). The implementation date for the regional groupings of states under each of the T–Nex contracts is provided in that notice. This implementation began on June 1, 2004, and was fully phased-in on November 1, 2004.

VI. Balance Billing Limitations

Consistent with the Congressional action discussed above, we are revising Section 199.6 of the regulation to specify that institutional providers, including SNFs and HHAs, are required, in order to be TRICARE-authorized providers, to be participating providers on all claims. They must accept, except for any required beneficiary deductible and co-payment amounts, the TRICARE payment as payment in full. Medicare and TRICARE payment rates are designed to fully reimburse the institutions and are required by Medicare and TRICARE to be accepted as full reimbursement. TRICARE eligible hospitals, SNFs, and HHAs must enter into a participation agreement.

VII. Definitions of “Custodial Care” and “Domiciliary Care”

As noted above, Congress adopted definitions of “custodial care” and “domiciliary care” that we are incorporating into the TRICARE regulation. Custodial and domiciliary care continue to be excluded by the

statute and regulation. However, the new definition for custodial care narrows the exclusion, resulting in increasing coverage of medically necessary custodial care. This is also consistent with the Congressional effort largely to standardize TRICARE and Medicare sub-acute care coverage and payment policies. As a corollary to these definitions, we are also adopting a definition of the term “activities of daily living.”

VIII. Payment Methods for Hospital Outpatient Services

Medicare implemented a new Outpatient Prospective Payment System (OPPS) on August 1, 2000, as a payment methodology for facility charges in hospital outpatient departments and emergency departments. This system replaced Medicare's prior payment methodology for such services, which was largely based on provider cost reports, but included some fee schedules. The Medicare OPPS is in process of being phased in, with a series of transitional payment adjustments that were based partly upon the prior Medicare cost reports and Medicare's prior cost-based methodology. Consistent with the TRICARE payment reform statutory authority and general policy, we plan to follow the Medicare approach. However, because of complexities of the Medicare transition process and the lack of TRICARE cost report data comparable to Medicare's, it is not practicable for the Department to adopt Medicare OPPS for hospital outpatient services at this time. A separate regulatory initiative will address hospital outpatient services not covered by this regulation. We anticipate eventual adoption of the Medicare OPPS for most TRICARE hospital outpatient services covered by the Medicare OPPS.

This rule clarifies payments for hospital based outpatient services that have established allowable TRICARE charges. These services would include laboratory services including clinical laboratory; rehabilitation therapy services; radiology services; diagnostic services; ambulance services; durable medical equipment (DME) and supplies; oxygen and related supplies; drugs administered other than oral method; all professional provider services that are provided in an emergency room, clinic, or hospital outpatient department, etc.; and routine venipuncture. For these services, payments are based on the TRICARE-allowable cost method in effect for professional providers or the CHAMPUS Maximum Allowable Charge (CMAC). Some services have a professional and a technical component

such as laboratory, radiology, and diagnostic services. If only the technical component is billed by the hospital, the technical component of the TRICARE allowable charge will be applied to the TRICARE payment. If the professional outpatient hospital services are billed by a professional provider group, not by the hospital, no payment shall be made to the hospital for these services. All other outpatient hospital services, except for ambulatory surgery services, shall be paid as billed such as facility charges. Ambulatory surgery services shall be paid in accordance with Section 199.14(d) of the regulation.

IX. Public Comments

We published the interim final rule on June 13, 2002, and provided a 60-day comment period. We received public comments from several commentors. These comments and the Department's responses are summarized below.

Comment. One commentor felt that it would be preferable to adopt Medicare standards for coverage and payment through references to applicable Medicare statutory and regulatory provisions rather than incorporating the actual regulatory language itself. The commentor felt that inclusion of language beyond these references could result in the loss of uniformity; i.e., that the Department may not be able to keep current with changes in Medicare standards.

Response. The Department believes that incorporation of actual regulatory language, in addition to applicable cross references to Medicare statutes and regulations, will only tend to strengthen the uniformity between the programs. The conditions for participation, along with a general overview of the prospective payment methodology, will ensure a basic understanding of the benefit coverage and payments among managed care support contractors, providers and eligible beneficiary groups. As with other adopted Medicare reimbursement systems (e.g., those Medicare reimbursement systems for hospice and acute inpatient hospitalization), uniformity is maintained through annual policy manual updates. These routine changes ensure compliance with existing Medicare regulations and internal Program Memoranda (i.e., Medicare internal procedural guidelines for the processing and payment of home health services). The updating process also ensures that the most current rates and wage indexes are being used in reimbursement of home health services. We also believe that the Medicare cross references (i.e., the statutory and regulatory provisions) cited in the

interim final rule are sufficient to maintain uniformity in benefit structure and reimbursement between the programs (i.e., consistency in benefit coverage and reimbursement between the Medicare and TRICARE programs). The cross referenced regulatory provisions implement key sections of the Social Security Act relating to covered services, conditions of participation and the prospective payment of home health services.

Comment. One commentor felt that the Department had exceeded the statutory authority granted it under the National Defense Authorization Act for Fiscal Year 2002 (NDAA-02), Pub. L. 107-107 for home health services through the adoption of conditions of coverage and participation prescribed under Sections 1861(o) and 1891 of the Social Security Act and 42 CFR Part 484. The commentor also expressed the view that restricting eligibility to home care based on a "qualifying service," would limit an effective way to decrease aide visits, while at the same time provide compensatory strategies needed to increase beneficiary safety and independence.

Response. The Department does not believe it has exceeded the statutory authority granted to it under the NDAA-02, Pub. L. 107-107, given the fact that the conditions of coverage and participation prescribed under 1861(o) and 1891 of the Social Security Act and 42 CFR Part 484 are an integral part of the Medicare home health benefit from which HHA PPS rates were extrapolated; i.e., the national mean utilization for each of the six home health disciplines was used in calculating the initial unadjusted national 60-day episode payment. Since the conditions of coverage/participation determine the mix and level of services (e.g., the beneficiary must need skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology services, or have continued need for occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services have ceased, on which the prospective payment rates were based), it is illogical to believe that it was Congress' intent to exclude their adoption under the TRICARE program. A shift in the mix and level of services (e.g., the substitution of occupational services for home health aide services) resulting from elimination of the Medicare conditions of coverage/participation would deviate from the resource allocation used in establishing the prospective payment rates.

Comments. Two commentors expressed concern over the weakness of

Medicare's Outcome and Assessment Information Set (OASIS) instrument as a payment setting mechanism for maternity patients and individuals under the age of 18. The commentors felt that, while an abbreviated OASIS format (i.e., a core of 23 elements used to determine the reimbursement amount) might be workable, it would not accurately reflect the needs of a younger TRICARE population, or generate an appropriate payment for home health services.

Response. A fixed case-mix and wage adjusted 60-day episode payment will be paid to Medicare-certified home health agencies providing home health services to beneficiaries who are under the age of 18 and/or receiving maternity care. However, this prospective payment amount will be determined through the manual completion and scoring of an abbreviated assessment form (Home Health Resource Group Worksheet). The 23 items in this assessment will provide the minimal amount of data necessary for generating a Health Insurance Prospective Payment System (HIPPS) code for reimbursement under the HHA PPS. While an abbreviated assessment may facilitate payment under the HHA PPS, it does not adequately reflect the management oversight required to ensure quality of care for beneficiaries under the age of 18, and obstetrical patients. As a result, TRICARE contractors will have to continue to case manage these beneficiary categories through the use of appropriate evaluation criteria as required under the specific terms of their contract to ensure the quality and appropriateness of home health services (e.g., the use of Interqual criteria for managing the appropriateness of home health services).

The program intends to conduct a follow-up analysis after at least a year's worth of accumulated data to evaluate the appropriateness of Medicare weights and rates in reimbursement of these specialty provider categories.

If a Medicare-certified HHA is not available within the service area, the TRICARE contractor may authorize care in a non-Medicare certified HHA (e.g., a HHA which has not sought Medicare certification/approval due to the specialized beneficiary categories it services—patients receiving maternity care and/or patients under the age of 18) that qualifies for corporate services provider status under TRICARE. The freestanding corporate entity will be reimbursed for otherwise covered professional services under the TRICARE Maximum Allowable Charge (TMAC) reimbursement system, subject to any restrictions and limitations as

may be prescribed under existing TRICARE policy. Payment will also be allowed for supplies used by a TRICARE authorized individual provider employed by or under contract with a corporate services provider in the direct treatment of a TRICARE eligible beneficiary. Allowable supplies will be reimbursed in accordance with TRICARE allowable charge methodology. There are also regulatory and contractual provisions currently in place that grant contractors the authority to establish alternative network reimbursement systems as long as they do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies.

Comment. One commentator wanted to know how children under the age of ten would be reimbursed given the fact that they are exempt from the HHA PPS.

Response. The exemption has been removed for children under the age of ten. A fixed case-mix and wage adjusted 60-day episode payment will be paid to Medicare-certified home health agencies providing home health services to beneficiaries who are under the age of 18. This prospective payment amount will be determined through the manual completion and scoring of an abbreviated assessment form (Home Health Resource Group Worksheet). The 23 items in this assessment will provide the minimal amount of data necessary for generating a Health Insurance Prospective Payment System (HIPPS) code for reimbursement under the HHA PPS.

Comment. Another commentator requested that the requirement for physician certification of the correctness of the Home Health Resource Group (HHRG) referenced in the **SUPPLEMENTARY INFORMATION** section of the interim final rule be removed and implementation monitored to ensure that the requirement is not enforced. The commentator felt that a physician was in no position to oversee the reimbursement methodology or to maintain the expertise necessary to offer such certification.

Response. The Department agrees that a physician does not have the necessary expertise to certify the correctness of the Home Health Resource Group (HHRG). As a result, the requirement has been removed from the **SUPPLEMENTARY INFORMATION** section of the final rule. Contractor enforcement of the deleted requirement is not anticipated since it does not appear in any of the implementing instructions (*i.e.*, TRICARE Policy Manual issuances). The physician's fundamental role is to certify the continuing need for home health services and the homebound

status of the patient through the development and maintenance of a formal Plan of Care (POC). The POC must specify the medical treatments/services to be furnished, the type of home health disciplines that will furnish the ordered services, and the frequency of the services furnished.

Comment. One commentator felt that the absence of a definitive effective date would cause confusion for TRICARE beneficiaries and providers of home health services. It was recommended that a **Federal Register** notice be issued at least 60 days prior to the actual implementation date in order to give both patients and providers the opportunity to take appropriate steps to transition into the new benefit.

Response. On March 30, 2004, DoD published a notice (69 FR 16531) to announce the phased-in implementation of the HHA prospective payment system with the start health care delivery date under each of the TRICARE Next Generation of Contracts (T-Nex). The implementation date for the regional groupings of states under each of the T-Nex contracts was provided in that notice. This implementation began on June 1, 2004, and was fully phased-in on November 1, 2004. There were also provisions within the implementing guidelines which gave both patients and providers the necessary time to transition into the new benefit. Under those provisions, TRICARE contractors were responsible for identifying all beneficiaries receiving home health care services 60 days prior to implementation of the HHA PPS, and for notifying them and the HHA of any change in their benefit.

Comment. Another commentator suggested that "Activities of Daily Living" as defined in 32 CFR 199.2(b) be modified to include the phrase "that reasonably can be performed by an untrained adult with minimum structure or supervision," since many of the listed activities can rise to the level of skilled nursing or therapy services in complicated or abnormal circumstances.

Response. Similar language already appears in the definition.

Comment. One commentator recommended that "Home Health Discipline" as defined in 32 CFR 199.2(b) be modified to include "home health aide services" since only 5 of the 6 disciplines appeared in the original rule.

Response. The definition of "Home Health Discipline" has been modified to include "home health aide services".

Comment. One commentator recommended that decisions on policy changes remain solely with TRICARE Management Activity and not with

individual contractors. The commentator felt that variations in contractor policies could lead to lingering confusion between patients, providers and regulatory officials regarding actual policy interpretation.

Response. TRICARE Management Activity will be responsible for issuing all policy decisions and/or changes pertaining to the coverage and reimbursement of home health services.

Comment. Another commentator requested further clarification regarding the circumstances in which TRICARE would consider care "custodial."

Response. "Custodial Care" is treatment or services that can be rendered safely and reasonably by a person who is not medically skilled, and is designed mainly to help the patient with the activities of daily living. The activities of daily care consist of providing food (including special diets), clothing, and shelter; personal hygiene services, observation and general monitoring; bowel training or management (unless abnormalities in bowel function are of a severity to result in a need for medical or surgical intervention in the absence of skilled services); safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and such other elements of personal care that reasonably can be performed by an untrained adult with minimal instruction or supervision.

Comment. Another commentator felt that the reference to "all services" in paragraph 199.6(b)(4)(xv)(F)(1) might be confusing, as it is intended to apply to all home health services. The commentator recommended that "home health" be added prior to "services."

Response. The commentator's recommendation has been adopted. "All services" in paragraph 199.6(b)(4)(xv)(F)(1) has been further clarified in this final rule by adding "home health" prior to "services."

Comment. A commentator recommended that "Custodial Care" as defined in 32 CFR 199.2(b) be modified to indicate that its application in the context of the home health benefit be limited to circumstances where the overall plan of care does not include any skilled nursing or therapy services. It was felt that additional guidance was necessary to avoid misapplication of the custodial care exclusion given the fact that home health aide services by their very nature are: (1) Services that can be rendered safely and reasonably by a person who is not medically skilled, or (2) designed to help a patient with the activities of daily living.

Response. The definition contained in the interim final rule is statutory, that is, the language was contained in the National Defense Authorization Act for Fiscal Year 2002 (NDAA-02), Public Law 107-107, Section 701(c). Custodial care remains excluded.

Comment. A beneficiary advocacy organization expressed concern that (1) not all NDAA-02 reforms are addressed in the interim final rule; (2) family members may experience breaks in coverage for services allowed pre-NDAA-02 until all NDAA-02 reforms are implemented; and (3) a desire that active-duty family members are provided all services authorized by NDAA-02.

Response. (1) Because of the complexity of developing the proposed programs, including significant agency decisions regarding the discretionary elements of NDAA-02, and the requirement to follow the prescribed rule-making process, the Agency has determined it is more timely and fiscally prudent to implement certain NDAA-02 authorized programs separate from those covered by this rule; (2) there are no pre-NDAA-02 benefits which require implementation of NDAA-02 benefits in order to be allowed; and (3) those services required by NDAA-02 to be provided to active-duty family members are available through existing programs; discretionary NDAA-02 elements will be implemented following the rule-making process and incorporation into the managed care support contracts.

Comment. The same organization wanted to know how the new home health benefit and reimbursement methodology was going to be transitioned into the program since the existing coverage is more robust than that being implemented through statute.

Response. The new home health benefit and reimbursement system has been transitioned into the program as part of the next generation of TRICARE contracts. There were provisions within the implementing guidelines which gave both patients and providers the necessary time to transition into the new benefit. Under these provisions, TRICARE contractors were responsible for identifying all beneficiaries receiving home health care services 60 days prior to implementation of the HHA PPS, and for notifying them and the HHA of any change in their benefit.

Comment. The same organization also wanted to know how the cases of beneficiaries who are already getting a benefit and who did not have a three-day qualifying hospital stay (required for a skilled nursing facility (SNF) benefit) be handled. The commentor

raised concerns about the education for providers treating non-Medicare eligible beneficiaries and wanted to know how providers will know that the three-day Medicare rule will also apply to these TRICARE beneficiaries.

Response. The three-day qualifying hospital stay and the SNF prospective payment system (PPS) requirements apply to those cases that have an SNF admission date of August 1, 2003, or after. This implementation date allowed for the education of providers. Under the new requirements, SNFs are required to enter into a participation agreement with TRICARE. Along with this participation agreement, the Managed Care Support (MCS) contractors are required to send a letter to SNFs explaining the new requirements. This letter specifically states that the new requirements also apply to those TRICARE beneficiaries who are not Medicare-eligible. Prior to the implementation of SNF PPS, MCS contractors spent considerable effort in educating the providers regarding the new SNF benefit and PPS requirements and entered into a participation agreement with SNFs.

Comment. The same organization suggested that guidelines regarding benefits available to active-duty family members versus non-active-duty family members be incorporated into this rule.

Response. As mentioned above, the benefits authorized by NDAA-02 for active-duty family members are either currently available or will be so as a result of separate rule-making and implementation in the T-Nex contracts, therefore, suggested guidelines are not necessary in this rule.

Comment. That organization commented that the Resource Utilization Groups (RUG-III) used to calculate SNF payments and the Minimum Data Set (MDS) assessments may not be designed to reflect coverage of conditions affecting children and supported the Department's proposal not to use the MDS for children under age ten. They believed it appropriate that the "billed charge" for the care of these children will be deemed the "allowed charge." The organization also commented that it is concerned about the transition for care of children as they get older and that there may be a period where coverage for slightly more home care will allow the family to have the child with them at home before having to place the child in an institutional setting. It suggested that the procedures allow for some flexibility to meet the needs and wishes of the family where cost effective.

Response. For the benefits authorized by section 701(b) of NDAA-02, the

allowed charges will be the "billed charges" or "negotiated rates" for children under age 10. As stated in the rule, the MDS will not be used for assessment of these children until further review by the Department is completed. Currently, the applicability of MDS will be determined based on the child's age (10 years) on the date of his/her SNF admission. We believe the medical necessity and medical appropriateness should determine the most cost effective level and setting of care. In certain cases, home health care may be the most cost effective and appropriate care based upon the medical necessity and medical need of a child's condition.

Comment. The same commentor was also concerned that the definition of "homebound" may be too restrictive for families with children. The commentor believed this definition needed to be modified to reflect the characteristics of the entire TRICARE beneficiary population, and not just the Medicare-eligible segment.

Response. An exception is being made to the definitional homebound criteria for beneficiaries under the age of 18 and those receiving maternity care. The only homebound requirement for these special beneficiary categories is written certification from a physician attesting to the fact that leaving the home would place the beneficiary at medical risk.

Comment. Two commentors recommended elimination of the significant change in condition (SCIC) adjustment in 32 CFR 199.14(h)(4), as it creates an unnecessary administrative burden and unfairly reimburses providers when patients' conditions deteriorate.

Response. Section 707 of National Defense Authorization Act for Fiscal Year 2002 (NDAA-02) was quite specific in its intent that TRICARE home health payment amounts be determined to the extent practicable in accordance with the same reimbursement rates as apply to payments to providers of services of the same type under title XVIII of the Social Security Act (42 U.S.C. 1295). Elimination of the significant change in condition (SCIC) adjustment would represent a major deviation from the Medicare HHA PPS methodology, and as such, would be contrary to the statutorily mandated reimbursement provisions under Section 707 of NDAA-02.

Comment. Another commentor wanted to know if TRICARE would be adopting changes to the OASIS data collection instrument as a result of upcoming Center for Medicare and

Medicaid Services (CMS) Technical Expert Panel (TEP) assessments.

Response. TRICARE will be adopting all upcoming Center for Medicare and Medicaid Services (CMS) changes to the OASIS data collection instrument.

Comment. Two commentors felt that the requirement for TMA Director approval of home health aide training programs, as specified in 32 CFR 199.4(e)(21)(i)(D), would impose an additional standard beyond that set out in the Medicare conditions of participation for home health agencies. It was recommended that the requirement for home health aide training programs be modified to reflect the current Conditions of Participation under the Medicare Program.

Response. The requirement for home health aide training programs has been modified to reflect the current condition of participation under the Medicare program; i.e., the home health aide must have successfully completed a state-established or other training program that meets the requirements of 42 CFR 484.36 Condition of participation: Home health aide services.

Comment. One commentor wanted to know if the concept of "TRICARE-authorized physician" was more restrictive than that of Medicare's—as it relates to general supervision/direction of "skilled nursing services" as defined in 32 CFR 199.2(b). The commentor recommended that "TRICARE-authorized physician" either be defined, or the reference eliminated from the definition of "skilled nursing services."

Response. Physician as defined in 32 CFR 199.2(b) is a person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority. Based on this definition, it appears that the concept of "TRICARE-authorized physician" is comparable to that of Medicare's—as it relates to general supervision/direction of "skilled nursing services."

Comment. One commentor recommended adding the phrase "subject to appropriate adjustments" at the end of the second and fourth sentences of subparagraph 32 CFR 199.14(h)(1), since residual final payment depends upon the actual HHRG and the impact of other payment adjustments that cannot be made prior to final claim submission.

Response. The phrase "subject to appropriate adjustments" is being added to the recommended sentences in subparagraph 32 CFR 199.14(h)(1), since it is agreed that residual final payments are impacted by other payment adjustments that cannot be made prior to final claim submission.

Comment. Several commentors felt that the OASIS was an unsuitable data collection tool for active duty dependents since it was developed primarily for the elderly with very different health care needs. The commentor recommended development of an assessment tool which would more closely correlate with a younger, healthier TRICARE population.

Response. The program intends to conduct a follow-up analysis after at least a year's worth of accumulated data to evaluate the appropriateness of Medicare weights and rates in reimbursement of TRICARE beneficiaries.

Comment. Another commentor recommended adding the phrase "to another home health agency" following "transfer" in subparagraph 32 CFR 199.14(h)(3), since transfer is limited to a transfer to another home health agency for continuation of receiving the home health benefit.

Response. The commentor's recommendation has been adopted by adding the phrase "to another home health agency" following "transfer" in subparagraph 32 CFR 199.14(h)(3) of the final rule.

Comment. One commentor recommended modification of the citation references in 32 CFR 199.4(e)(21)(ii)(I). The commentor felt that the existing citations were related solely to Medicare conditions of participation for home health agencies rather than conditions of coverage for home health services.

Response. The citation reference 42 CFR 409, Subpart E, has been added to subparagraph 32 CFR 199.4(e)(21)(ii)(I). This subpart implements Sections 1814(a)(2)(C), 1835(a)(2)(A), and 1861(m) of the Social Security Act with respect to the requirements that must be met for Medicare payment to be made for home health services furnished to eligible beneficiaries.

Comment. Another commentor felt that a description of the outlier payment methodology was warranted in the regulatory text.

Response. A description of the outlier payment methodology has been incorporated into the final rule.

Comment. Another commentor felt that the Medicare qualifying condition for payment definition of "intermittent skilled nursing services" be included in 32 CFR 199.2(b), since it is distinct from the scope of coverage standards available under the home health benefit (i.e., the definitions of "intermittent home health aide and skilled nursing services" and "part time home health aide and skilled nursing services").

Response. The definitions of intermittent or part-time skilled nursing and home health aide services have been consolidated and revised to reflect the statutory definition under § 1861 of the Social Security Act (42 U.S.C. 1395x(m)).

Comment. One commentor felt that the new definitions of custodial care, domiciliary care and activities of daily living combined with the anticipated "significant increase" in patient volume and the elimination of Medicare day limits require careful administration and oversight that can best be provided through case management and suggested to include operational guidelines for the Managed Care Support Contractors.

Response. The Department will administer the provisions consistent with the statutory requirements. Detailed operational guidelines have been developed for the Managed Care Support contractors.

Comment. The same commenter stated that the Medicare payment system was not designed for an active duty population and misses the mark completely with respect to children.

Response. These issues have been addressed above and the Department plans to carefully monitor and evaluate the issues pertaining to children.

Comment. The commenter stated that there is some concern as to how well the rule will serve the needs of those living outside the continental United States.

Response. The SNF PPS will be applicable to those areas outside the continental United States as it is applicable under Medicare.

Comment. The commentor felt that there was a gap in the level of nursing care afforded under the new home health benefit.

Response. 32 CFR 199.4(e)(21) "Home health services," provides the broad range of services available under the new home health benefit structure.

Comment. The commentor pointed out that home health aide and medical social worker services were currently being covered under case management as well as under the hospice benefit.

Response. Section IV of the **SUPPLEMENTARY INFORMATION** portion of the rule has been modified to reflect this additional coverage.

Comment. The same commentor suggested that the rule specify what, if any, benefit exclusions remain following the change in the definitions of "custodial care" and "domiciliary care."

Response. The existing regulatory language provides the benefit exclusions; relevant TRICARE policies have been or will be modified as

necessary to reflect the revised definitions.
Comment. The commentor also suggested adding a regulatory definition for “medically necessary care.”

Response. That term is consistent with the existing regulatory definitions of “appropriate medical care” and “medically or psychologically necessary”; a separate definition is not necessary.

Comment. The same commentor recommended that the case manager’s involvement in the plan of care be recognized in the final rule.

Response. The regulatory provisions for establishment of a plan of care are consistent with those provided under the Medicare program.

X. Regulatory Procedures

We have examined the impacts of the Final Rule under Executive Order 12866. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year).

We originally thought that this final rule was a major one because it had an impact of more than \$100 million per year. However, we now believe that the impact will be significantly less. We had

originally projected that the skilled nursing facility (SNF) benefit change and the reduced TRICARE payments to SNFs would reduce SNF payments by more than \$100 million per year. However, analysis of actual SNF payments that have been made since the benefit changes and payment system were implemented in August 2003 indicate that the impact has been much less than expected. Based on the analysis of actual SNF payments and other benefit changes, we have determined that this rule is not economically significant under Executive Order 12866.

SNF Changes

The objective of the SNF benefit change and the revised SNF payment system is to make TRICARE’s SNF benefit consistent with Medicare, which satisfies a Congressional goal. A second objective is to increase the quality of care by requiring a more detailed review of SNF cases and more appropriate placement of SNF patients. There will also be an increase in payment efficiency because SNF payments will cease when SNF care is no longer necessary.

We assessed the quantitative impact of the SNF change by comparing TRICARE’s payments for SNF care prior to the changes with payments after the changes were implemented in August 2003. These payment trends capture

both the impact of the SNF benefit changes and reimbursement changes.
We examined SNF payments for beneficiaries under age 65 and age 65 and over separately. Table 1 shows that the level of government payments for SNF services for beneficiaries under age 65 declined by about 48 percent from the quarter immediately prior to implementation of the new rules to the quarter immediately after their implementation (we did not use data from August 2003 because some persons were in SNFs under the old rules and some were there under the new rules). We believe that most of this impact is due to TRICARE’s shift from paying billed charges for SNF services to using the SNF PPS method. The percentage reduction in government SNF payments was less for persons age 65 and over: we found an 11 percent decline in SNF payments for these beneficiaries. We believe that the impact is less for beneficiaries age 65 and over because TRICARE is second payer to Medicare. Because Medicare’s payments for these beneficiaries have been based on Medicare’s SNF-PPS payment system for a number of years, TRICARE’s introduction of the new payment system had a very small impact. In aggregate, the benefit changes and the new SNF payment system reduced TRICARE government payments to SNFs by 18 percent, which is equal to about \$4.2 million per quarter or about \$17 million per year.

TABLE 1.—CHANGE IN GOVERNMENT PAYMENTS FOR SNF CARE FOR TRICARE BENEFICIARIES
[In thousands]

	Under age 65	Age 65 and above	Total
May–July 2003	\$4,790	\$18,051	\$22,841
Sep–Nov 2003	\$2,571	\$16,048	\$18,619
% Change	– 48	– 11	– 18

Home Health

The objective of the home health (HH) benefit change and the revised HH payment system is to make TRICARE’s HH benefit consistent with Medicare, which satisfies a Congressional goal. A second objective is to increase the quality of care by requiring a more detailed review of HH cases and more appropriate placement of HH patients. The HH payment system also increases efficiency because its per-episode method of payment discourages unnecessary utilization.

For home health claims, the benefit and reimbursement changes have just gone into effect and the data have not developed as of yet. Therefore, the

retrospective method of analysis we used for SNF services is not possible for home health claims. We analyzed recent HH payments under TRICARE and found that TRICARE paid about \$21 million per year in home health allowed amounts in the 2002–2003 period. We estimate that the new HH system will decrease HH payments by approximately 20 percent. Thus, we estimate that TRICARE payments for HH care will be reduced by approximately \$4 million per year. We estimate an impact of less than \$1 million per year for beneficiaries age 65 and over because TRICARE is secondary payer to Medicare and Medicare has been using

the HH PPS method to pay HH services for a number of years.

Change in Definition of Custodial Care

The narrowing of the definition of custodial care expanded the benefits available to certain TRICARE beneficiaries. This satisfied the Congressional goal of revising TRICARE’s definition of custodial care and expanding TRICARE’s benefits.

We assessed the quantitative impact of the change by examining the level of additional benefits that TRICARE paid for persons who received benefits under the expanded program. We were able to identify the TRICARE beneficiaries who received services due to the expanded TRICARE benefits. We found that

TRICARE payments were approximately \$6.9 million in FY 2003 for these beneficiaries. All of these benefit payments represented additional government payments due to the change in the definition of custodial care. The payments were \$6.2 million in the first six months of FY 2004. Reliable data are not available beyond the first six months of FY04. We believe that the FY04 impact is more appropriate and believe that the annual impact of the change in the definition of custodial care is about \$12.4 million.

Summary

The quantitative impact of the three changes consists of \$17 million in savings for the SNF change, \$4 million in savings for the HH change, and \$12 million in costs for the change in the definition of custodial care.

Paperwork Reduction Act

This rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511). Existing information collection requirements of the TRICARE and Medicare programs will be utilized. Comments on information collection requirements should be submitted to Kim Frazier, 5111 Leesburg Pike, Suite 810, Falls Church, VA 22041–3206, telephone 703–681–3636.

Implementation

This rule implements specific statutory requirements with specific statutory effective dates. The implementation of new SNF benefit requirements and SNF prospective payment system is effective for admissions on or after August 1, 2003. The implementation of the other benefit requirements and the home health care prospective payment system is effective with the start health care delivery date under each of the TRICARE Next Generation of Contracts (T-Nex). The implementation of T-Nex contracts was fully phased-in on November 1, 2004. These other benefit requirements and the home health care prospective payment system are part of the contractual requirements of the T-Nex contracts, and were not negotiated or directed as a change to the previous contracts.

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—[AMENDED]

■ 1. The authority citation for Part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. Chapter 55.

■ 2. Section 199.2(b) is amended by adding the definitions of “facility charge” and “part-time or intermittent home health aide and skilled nursing services” in alphabetical order, by revising the definitions of “homebound” and “home health discipline”, by removing the definitions of “intermittent home health aide and skilled nursing services” and “part-time home health aide and skilled nursing services”, to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

Facility charge. The term “facility charge” means the charge, either inpatient or outpatient, made by a hospital or other institutional provider to cover the overhead costs of providing the service. These costs would include building costs, *i.e.* depreciation and interest; staffing costs; drugs and supplies; and overhead costs, *i.e.*, utilities, housekeeping, maintenance, etc.

* * * * *

Homebound. A beneficiary’s condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment—including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in the—state shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary’s homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. An exception is made to the above homebound definitional criteria for

beneficiaries under the age of 18 and those receiving maternity care. The only homebound criteria for these special beneficiary categories is written certification from a physician attesting to the fact that leaving the home would place the beneficiary at medical risk.

Home health discipline. One of six home health disciplines covered under the home health benefit (skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech-language pathology services, and medical social services).

* * * * *

Part-time or intermittent home health aide and skilled nursing services. Part-time or intermittent means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week).

* * * * *

■ 3. Section 199.4 is amended by revising the second sentence in paragraph (b)(3)(xiv), by removing and reserving paragraph (e)(12), by revising paragraphs (e)(21)(i)(D), (e)(21)(ii)(I), by revising “§ 199.14(i)” to read “§ 199.14(e)” in paragraphs (f)(8)(i) and (f)(8)(ii)(A), and by revising paragraphs (g)(7) and (g)(8) to read as follows:

§ 199.4 Basic program benefits.

(b) * * *

(3) * * *

(xiv) * * * Skilled nursing facility care for each spell of illness shall continue to be provided for as long as medically necessary and appropriate.

* * *

* * * * *

(e) * * *

(21) * * *

(i) * * *

(D) Part-time or intermittent services of a home health aide who has successfully completed a state-established or other training program that meets the requirements of 42 CFR Part 484;

* * * * *

(ii) * * *

(I) Any other conditions of coverage/participation that may be required under Medicare’s HHA benefit; *i.e.*, coverage guidelines as prescribed under Sections 1861(o) and 1891 of the Social Security Act (42 U.S.C. 1395x(o) and 1395bbb), 42 CFR Part 409, Subpart E and 42 CFR Part 484.

* * * * *

(g) * * *

(7) *Custodial care*. Custodial care as defined in § 199.2.

(8) *Domiciliary care*. Domiciliary care as defined in § 199.2.

* * * * *

■ 4. Section 199.6 is amended by revising paragraph (a)(8)(i)(B), by adding a note in paragraph (b)(4)(vi)(K), and by revising paragraph (b)(4)(xv)(F)(1), to read as follows:

§ 199.6 TRICARE authorized providers.

(a) * * *

(8) * * *

(i) * * *

(B) A SNF or a HHA, in order to be an authorized provider under TRICARE, must enter into a participation agreement with TRICARE for all claims.

* * * * *

(b) * * *

(4) * * *

(vi) * * *

(K) * * *

Note: If a pediatric SNF is certified by Medicaid, it will be considered to meet the Medicare certification requirement in order to be an authorized provider under TRICARE.

* * * * *

(xv) * * *

(F) * * *

(1) The HHA must submit all TRICARE claims for all home health services, excluding durable medical equipment (DME), while the beneficiary is under the home health plan without regard to whether or not the item or service was furnished by the HHA, by others under arrangement with the HHA, or under any other contracting or consulting arrangement.

* * * * *

■ 5. Section 199.14 is amended as follows:

■ a. Amend paragraph (a)(4) by revising “paragraph (i)” to read “paragraph (l)”;

■ b. Revise paragraphs (a)(5) introductory text and (a)(5)(i);

■ c. Amend paragraphs (a)(5)(ii) and (a)(5)(iii) by revising “paragraph (h)(1)” to read “paragraph (j)(1)” in both places;

■ d. Revise paragraph (a)(5)(iv);

■ e. Add paragraphs (a)(5)(v) through (a)(5)(xii);

■ f. Revise paragraphs (h) introductory text; (h)(1), (h)(3), and (h)(5);

■ g. Amend paragraph (j)(1)(i)(B) by revising “paragraph (g)(1)(iv)” to read “paragraph (j)(1)(iv)”;

■ h. Amend paragraph (j)(1)(i)(D) by revising “paragraph (h)(1)(i)(B)” to read “paragraph (j)(1)(i)(B)” and by revising “paragraph (h)(1)(i)(C)” to read “paragraph (j)(1)(i)(C)”;

■ i. Amend paragraph (j)(1)(ii)(B) by revising “paragraph (g)(1)(ii)(A)” to read “paragraph (j)(1)(ii)(A)”

■ j. Amend paragraph (j)(1)(ii)(C) by revising “paragraph (g)(1)(ii)(B)” to read “paragraph (j)(1)(ii)(B)”;

■ k. Amend paragraph (j)(1)(iii) introductory text by revising “paragraphs (g)(1)(iii)(A) and (B)” to read “paragraphs (j)(1)(iii)(A) and (B)”;

■ l. Amend paragraph (j)(1)(iii)(D) by revising “paragraphs (h)(1)(i) through (iii)” to read “paragraphs (j)(1)(i) through (iii)” and by revising “paragraph (h)(1)(iii)(B)” to read “(j)(1)(iii)(B)”;

■ m. Amend paragraph (j)(1)(iv)(B)(2) by revising “paragraph (g)(1)(iv)(B)(1)” to read “paragraph (j)(1)(iv)(B)(1)”;

■ n. Amend paragraph (j)(1)(iv)(C) by revising “paragraph (g)(1)(iii)(A)(1)” to read “paragraph (j)(1)(iii)(A)(1)”, by revising “paragraphs (g)(1)(iii) and (g)(1)(iv)” to read “paragraphs (j)(1)(iii) and (j)(1)(iv)”, and by revising “paragraph (g)(1)(iii)(C)” to read “paragraph (j)(1)(iii)(C)”;

■ o. Amend paragraph (j)(1)(iv)(C)(1) by revising “paragraph (g)(1)(iv)(C)(2)” to read “paragraph (j)(1)(iv)(C)(2)”;

■ p. Amend paragraph (j)(1)(ii)(C)(2) by revising “paragraph (g)(1)(iv)(C)(1)” to read “paragraph (j)(1)(iv)(C)(1)”, and by revising “paragraph (g)(1)(iv)(C)(3)” to read “paragraph (j)(1)(iv)(C)(3)”;

■ q. Amend paragraph (j)(1)(iv)(D) introductory text by revising “paragraph (h)(1)(iv)(C)” to read “paragraph (j)(1)(iv)(C)”, and by revising “paragraph (h)(1)” to read “paragraph (j)(1)”;

■ r. Amend paragraph (j)(1)(iv)(D)(2)(i) by revising “paragraph (h)(1)” to read “paragraph (j)(1)”;

■ s. Amend paragraph (j)(1)(iv)(D)(2)(ii) by revising “paragraph (h)(1)(ii)” to read “paragraph (j)(1)(ii)” and by revising “paragraph (h)(1)(iv)(A)” to read “paragraph (j)(1)(iv)(A)”;

■ t. Amend paragraph (j)(1)(iv)(D)(3) by revising “paragraph (h)(1)(iv)(D)” to read “paragraph (j)(1)(iv)(D)”;

■ u. Amend paragraph (j)(1)(iv)(E) introductory text by revising “paragraph (h)(1)” to read “paragraph (j)(1)”, and by revising “paragraph (h)(1)(iv)(E)” to read “paragraph (j)(1)(iv)(E)”;

■ v. Amend paragraph (j)(1)(iv)(E)(2) by revising “paragraph (h)(1)” to read “paragraph (j)(1)”;

■ w. Amend paragraph (j)(1)(v)(A) by revising “paragraph (g)(1)(v)” to read “paragraph (j)(1)(v)”;

■ x. Amend paragraph (j)(1)(v)(B) by revising “(g)(1)(v)(B)(1) through (3)” to read “paragraphs (j)(1)(v)(B)(1) through (3)”;

■ y. Amend paragraph (j)(1)(v)(C) introductory text by revising “paragraph (g)(1)(v)” to read “paragraph (j)(1)(v)”;

■ z. Amend paragraph (j)(1)(vi)(A) by revising “paragraph (g)(1)(ii)(B)” to read “paragraph (j)(1)(ii)(B)” and by revising

“paragraph (g)(1)(v)” to read “paragraph (j)(1)(v)”;

■ aa. Amend paragraph (j)(1)(vi)(B) introductory text by revising “paragraph (g)(1)(vi)(A)” to read “paragraph (j)(1)(vi)(A)”;

■ bb. Amend paragraph (j)(1)(vi)(B)(1) by revising “paragraph (g)(1)(vi)(B)(2)” to read “paragraph (j)(1)(vi)(B)(2)”, and by revising “paragraph (g)(1)(v)” to read “paragraph (j)(1)(v)”;

■ cc. Amend paragraph (j)(1)(vi)(B)(2) by revising “paragraph (g)(1)(v)” to read “paragraph (j)(1)(v)” and by revising “paragraph (g)(1)(v)(B)(2)” to read “(j)(1)(v)(B)(2)”;

■ dd. Amend paragraph (j)(1)(vii)(A) by revising “paragraphs (g)(1)(iii) and (g)(1)(v)” to read “paragraphs (j)(1)(iii) and (j)(1)(v)”;

■ ee. Amend paragraph (j)(1)(viii) introductory text by revising “paragraphs (g)(1)(i) through (g)(1)(iv)” to read “paragraphs (j)(1)(i) through (j)(1)(iv)”;

■ ff. Amend paragraph (j)(1)(viii)(A) by revising “paragraph (g)(1)(viii)” to read “paragraph (j)(1)(viii)”;

■ gg. Amend paragraph (j)(1)(viii)(B) by revising “paragraph (g)(1)(iii)” to read “paragraph (j)(1)(iii)”;

■ hh. Amend paragraph (j)(1)(viii)(C) by revising “paragraph (g)(1)(iv)” to read “paragraph (j)(1)(iv)”;

■ ii. Amend paragraph (j)(1)(viii)(D) by revising “paragraph (g)(1)(iv)(B)” to read “paragraph (j)(1)(iv)(B)”;

■ jj. Amend paragraph (l)(2) introductory text by revising “paragraph (g)” to read “paragraph (j)”;

■ kk. Amend paragraph (l)(2) by revising “paragraph (g)” to read “paragraph (j)”.

§ 199.14 Provider reimbursement methods.

(a) * * *

(5) *Hospital outpatient services*. This paragraph (a)(5) identifies and clarifies payment methods for certain outpatient services, including emergency services, provided by hospitals.

(i) *Laboratory services*. TRICARE payments for hospital outpatient laboratory services including clinical laboratory services are based on the allowable charge method under paragraph (j)(1) of the section. In the case of laboratory services for which the CMAC rates are established under that paragraph, a payment rate for the technical component of the laboratory services is provided. Hospital charges for an outpatient laboratory service are reimbursed using the CMAC technical component rate.

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(iv) *Radiology services*. TRICARE payments for hospital outpatient

radiology services are based on the allowable charge method under paragraph (j)(1) of the section. In the case of radiology services for which the CMAC rates are established under that paragraph, a payment rate for the technical component of the radiology services is provided. Hospital charges for an outpatient radiology service are reimbursed using the CMAC technical component rate.

(v) *Diagnostic services.* TRICARE payments for hospital outpatient diagnostic services are based on the allowable charge method under paragraph (j)(1) of the section. In the case of diagnostic services for which the CMAC rates are established under that paragraph, a payment rate for the technical component of the diagnostic services is provided. Hospital charges for an outpatient diagnostic service are reimbursed using the CMAC technical component rate.

(vi) *Ambulance services.* Ambulance services provided on an outpatient basis by hospitals are paid on the same basis as ambulance services covered by the allowable charge method under paragraph (j)(1) of this section.

(vii) *Durable medical equipment (DME) and supplies.* Durable medical equipment and supplies provided on an outpatient basis by hospitals are paid on the same basis as durable medical equipment and supplies covered by the allowable charge method under paragraph (j)(1) of this section.

(viii) *Oxygen and related supplies.* Oxygen and related supplies provided on an outpatient basis by hospitals are paid on the same basis as oxygen and related supplies covered by the allowable charge method under paragraph (j)(1) of this section.

(ix) *Drugs administered other than oral method.* Drugs administered other than oral method provided on an outpatient basis by hospitals are paid on the same basis as drugs administered other than oral method covered by the allowable charge method under paragraph (j)(1) of this section. The allowable charge for drugs administered other than oral method is established from a schedule of allowable charges based on a formulary of the average wholesale price.

(x) *Professional provider services.* TRICARE payments for hospital outpatient professional provider services rendered in an emergency room, clinic, or hospital outpatient department, etc., are based on the allowable charge method under paragraph (j)(1) of the section. In the case of professional services for which the CMAC rates are established under that paragraph, a payment rate for the

professional component of the services is provided. Hospital charges for an outpatient professional service are reimbursed using the CMAC professional component rate. If the professional outpatient hospital services are billed by a professional provider group, not by the hospital, no payment shall be made to the hospital for these services.

(xi) *Facility charges.* TRICARE payments for hospital outpatient facility charges that would include the overhead costs of providing the outpatient service would be paid as billed. For the definition of facility charge, see § 199.2(b).

(xii) *Ambulatory surgery services.* Hospital outpatient ambulatory surgery services shall be paid in accordance with § 199.14(d).

(h) *Reimbursement of Home Health Agencies (HHAs).* HHAs will be reimbursed using the same methods and rates as used under the Medicare HHA prospective payment system under Section 1895 of the Social Security Act (42 U.S.C. 1395fff) and 42 CFR Part 484, Subpart E except as otherwise necessary to recognize distinct characteristics of TRICARE beneficiaries and as described in instructions issued by the Director, TMA. Under this methodology, an HHA will receive a fixed case-mix and wage-adjusted national 60-day episode payment amount as payment in full for all costs associated with furnishing home health services to TRICARE-eligible beneficiaries with the exception of osteoporosis drugs and DME. The full case-mix and wage-adjusted 60-day episode amount will be payment in full subject to the following adjustments and additional payments:

(1) *Split percentage payments.* The initial percentage payment for initial episodes is paid to an HHA at 60 percent of the case-mix and wage adjusted 60-day episode rate. The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage adjusted 60-day episode rate subject to appropriate adjustments. The initial percentage payment for subsequent episodes is paid at 50 percent of the case-mix and wage-adjusted 60-day episode rate. The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage-adjusted 60-day episode rate subject to appropriate adjustments.

(3) *Partial episode payment (PEP).* A PEP adjustment is used for payment of an episode of less than 60 days resulting from a beneficiary's elected transfer to

another HHA prior to the end of the 60-day episode or discharge and readmission of a beneficiary to the same HHA before the end of the 60-day episode. The PEP payment is calculated by multiplying the proportion of the 60-day episode during which the beneficiary remained under the care of the original HHA by the beneficiary's assigned 60-day episode payment.

* * * * *

(5) *Outlier payment.* Outlier payments are allowed in addition to regular 60-day episode payments for beneficiaries generating excessively high treatment costs. The following methodology is used for calculation of the outlier payment:

(i) TRICARE makes an outlier payment for an episode whose estimated cost exceeds a threshold amount for each case-mix group.

(ii) The outlier threshold for each case-mix group is the episode payment amount for that group, the PEP adjustment amount for the episode or the total significant change in condition adjustment amount for the episode plus a fixed dollar loss amount that is the same for all case-mix groups.

(iii) The outlier payment is a proportion of the amount of estimated cost beyond the threshold.

(iv) TRICARE imputes the cost for each episode by multiplying the national per-visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines.

(v) The fixed dollar loss amount and the loss sharing proportion are chosen so that the estimated total outlier payment is no more than the predetermined percentage of total payment under the home health PPS as set by the Centers for Medicare & Medicaid Services (CMS).

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Dated: October 5, 2005.

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