Executive Order 13211—Regulations That Significantly Affect The Supply, Distribution, or Use of Energy

On May 18, 2001, the President issued Executive Order 13211 which requires agencies to prepare a Statement of Energy Effects for a rule that is (1) considered significant under Executive Order 12866, and (2) likely to have a significant adverse effect on the supply, distribution, or use of energy. Because this rule is exempt from review under Executive Order 12866 and is not expected to have a significant adverse effect on the supply, distribution, or use of energy, a Statement of Energy Effects is not required.

National Environmental Policy Act

This rule does not require an environmental impact statement because section 702(d) of SMCRA (30 U.S.C. 1292(d)) provides that agency decisions on proposed State regulatory program provisions do not constitute major Federal actions within the meaning of section 102(2)(C) of the National Environmental Policy Act (42 U.S.C. 4332(2)(C)).

Paperwork Reduction Act

This rule does not contain information collection requirements that require approval by OMB under the Paperwork Reduction Act (44 U.S.C. 3507 *et seq.*).

Regulatory Flexibility Act

The Department of the Interior certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). The State submittal, which is the subject of this rule, is based upon counterpart Federal regulations for which an economic analysis was prepared and certification made that such regulations would not have a significant economic effect upon a substantial number of small entities. In making the determination as to whether this rule would have a significant economic impact, the Department relied upon the data and assumptions for the counterpart Federal regulations.

Small Business Regulatory Enforcement Fairness Act

This rule is not a major rule under 5 U.S.C. 804(2), the Small Business Regulatory Enforcement Fairness Act. This rule: (a) Does not have an annual effect on the economy of $100 million; (b) Will not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; and (c) Does not have significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of U.S.-based enterprises to compete with foreign-based enterprises. This determination is based upon the fact that the State submittal, which is the subject of this rule, is based upon counterpart Federal regulations for which an analysis was prepared and a determination made that the Federal regulation was not considered a major rule.

Unfunded Mandates

This rule will not impose an unfunded mandate on State, local, or tribal governments or the private sector of $100 million or more in any given year. This determination is based upon the fact that the State submittal, which is the subject of this rule, is based upon counterpart Federal regulations for which an analysis was prepared and a determination made that the Federal regulation did not impose an unfunded mandate.

List of Subjects in 30 CFR Part 924

Intergovernmental relations, Surface mining, Underground mining.

Dated: November 20, 2008.

William L. Joseph,

Acting Mid-Continent Regional Director.

■ For the reasons set out in the preamble, 30 CFR part 924 is amended as set forth below:

PART 924—MISSISSIPPI

■ 1. The authority citation for part 924 continues to read as follows:

Authority: 30 U.S.C. 1201 *et seq.*

■ 2. Section 924.15 is amended in the table by adding a new entry in chronological order by ''Date of final publication'' to read as follows:

§ 924.15 Approval of Mississippi regulatory program amendments.

* * * * *

Original amendment submission date	Date of final publication	Citation/description
* * *	* *	* *
April 5, 2006	December 10, 2008	MSCMR 53–9–71(4) Sections: 105, 1101, and 1105.

[FR Doc. E8–29206 Filed 12–9–08; 8:45 am]

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DEPARTMENT OF DEFENSE

Office of the Secretary

[DOD–2007–HA–0048; RIN 0720–AB19]

32 CFR Part 199

TRICARE; Hospital Outpatient Prospective Payment System (OPPS)

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: This final rule implements a prospective payment system for hospital outpatient services similar to that furnished to Medicare beneficiaries, as set forth in Section 1833(t) of the Social Security Act. The rule also recognizes applicable statutory requirements and changes arising from Medicare's continuing experience with this system including certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Department is publishing this rule to implement an existing statutory requirement for adoption of Medicare payment methods for institutional care which will ultimately provide incentives for hospitals to furnish outpatient services in an efficient and effective manner.

DATES: *Effective Date:* February 9, 2009.

FOR FURTHER INFORMATION CONTACT: David E. Bennett or Martha M. Maxey, TRICARE Management Activity, Medical Benefits and Reimbursement Branch, telephone (303) 676–3494 or (303) 676–3627.

SUPPLEMENTARY INFORMATION:

I. Introduction and Background

The Medicare OPPS evolved out of Congressional mandates for replacement of Medicare's cost-based payment methodology with a prospective payment system (PPS). Medicare implemented OPPS for services furnished on or after August 1, 2000, with temporary transitional provisions to buffer the financial impact of the new prospective payment system (*e.g.*,

incorporating transitional pass-through adjustments and proportional reductions in beneficiary cost-sharing to lessen potential payment reductions experienced under the new OPPS).

Congress likewise established enabling legislation under section 707 of the National Defense Authorization Act of Fiscal Year 2002 (NDAA–02), Public Law 107–107 (December 28, 2001) changing the statutory authorization [in 10 U.S.C. 1079(j)(2)] that TRICARE payment methods for institutional care shall be determined, to the extent practicable, in accordance with the same reimbursement rules used by Medicare. Similarly, under 10 U.S.C. 1079(h), the amount to be paid to healthcare professional and other non-institutional healthcare providers ''shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules used by Medicare''. Based on these statutory mandates, TRICARE is adopting Medicare's prospective payment system for reimbursement of hospital outpatient services currently in effect for the Medicare program as required under the Balanced Budget Act of 1997 (BBA 1997), (Pub. L. 105–33) which added section 1833(t) of the Social Security Act providing comprehensive provisions for establishment of a Medicare hospital OPPS. The Act required development of a classification system for covered outpatient services that consisted of groups arranged so that the services within each group were comparable clinically and with respect to the use of resources. The Act also described the method for determining the Medicare payment amount and beneficiary coinsurance amount for services covered under the outpatient PPS. This included the formula for calculating the conversion factor and data requirements for establishing relative payment weights.

Centers for Medicare & Medicaid Services (CMS) published a proposed rule in the **Federal Register** on September 8, 1998 (63 FR 47552) setting forth the proposed PPS for hospital outpatient services. On June 30, 1999, a correction notice was published (64 FR 35258) to correct a number of technical and typographical errors contained in the September 8, 1998 proposed rule.

Subsequent to publication of the proposed rule, the Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA 1999) (Pub. L. 106–133) enacted on November 29, 1999, made major changes that affected the proposed Medicare OPPS. The following BBRA 1999 provisions were implemented in a final rule (65 FR 18434) published on April 7, 2000.

- Made adjustments for covered services whose costs exceed a given threshold (i.e., an outlier payment).
- Established transitional pass-through payments for certain medical devices, drugs, and biologicals.
- Placed limitations on judicial review for determining outlier payments and the determination of additional payments for certain medical devices, drugs, and biologicals.
- Included as covered outpatient services implantable prosthetics and durable medical equipment and diagnostic x-ray, laboratory, and other tests associated with those implantable items.
- Limited the variation of costs of services within each payment classification group.
- Required at least annual review of the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, the addition of new services, new cost data, and other relevant information or factors.
- Established transitional corridors that would limit payment reductions under the hospital outpatient PPS.
- Established hold harmless provisions for rural and cancer hospitals.
- Provided that the coinsurance amount for a procedure performed in a year could not exceed the hospital inpatient deductible for the year.

Section 1833(t) of the Social Security Act was subsequently amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) and the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173) making additional changes in the OPPS.

As a prelude to implementation of the Medicare OPPS, Congress enacted the Omnibus Budget Reconciliation Act of 1986 (OBRA) (Pub. L. 99–509) which paved the way for development of a PPS for hospital outpatient services by prohibiting payment for non-physician services furnished to hospital patients (inpatients and outpatients), unless the services were furnished either directly or under arrangement with the hospital, except for services of physician assistants, nurse practitioners and clinical nurse specialists. Exceptions were also made for clinical diagnostic procedures, the payment of which may only be made to the person or entity that performed, or supervised the performance of, the test; and for exceptionally intensive hospital outpatient services provided to Skilled Nursing Facility (SNF) residents that lie well beyond the scope of the care that SNFs would ordinarily furnish, and thus beyond the ordinary scope of the SNF care plan. Consolidated billing facilitated the payment of services included within the scope of each ambulatory payment classification (APC). The OBRA also mandated hospitals to report claims for services under the Healthcare Common Procedure Coding System (HCPCS) which enabled the identification of specific procedures and services used in the development of outpatient PPS rates.

Ongoing changes and refinement to the Medicare OPPS have been accomplished through annual proposed and final rulemaking, along with interim transmittals and program memoranda taking into consideration changes in medical practice, addition of new services, new cost data, and other relevant information and factors. TRICARE will recognize to the extent practicable all applicable statutory requirements and changes arising from Medicare's continuing experience with this prospective payment system, including changes to the amounts and factors used to determine the payment rates for hospital outpatient services paid under the prospective payment system [e.g., annual recalibration (updating) of group weights and conversion factors and adjustments for area wage differences (wage index updates)]. The Department of Defense (DoD), otherwise referred to as the agency for purposes of this rule, will adopt all of Medicare's CY 2008 OPPS changes published in the **Federal Register** on November 27, 2007, (72 FR 66580); e.g., extending the current packaging to include guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents, and observation services; and reduction of payments in cases where a hospital receives a substantial partial credit from the manufacturer toward the cost of a replacement device implanted in a procedure.

While TRICARE intends to remain as true as possible to Medicare's basic OPPS methodology (i.e., adoption and updating of the Medicare data elements used to calculate the prospective payment amounts), there will be some deviations required to accommodate the uniqueness of the TRICARE program. These deviations have been designed to accommodate existing TRICARE benefit structure and claims processing procedures/systems implemented under

the TRICARE Next Generation Contracts (T–NEX), while at the same time eliminating any undue financial burden to TRICARE Prime, Extra, and Standard beneficiary populations. Following is a brief discussion of each of these deviations:

➢ *Outpatient Code Editor (OCE)*—The Medicare Outpatient Code Editor with APC program edits data to help identify possible errors in coding and assigns Ambulatory Payment Classification numbers based on HCPCS codes for payment under the OPPS. The Medicare OPPS APC is an outpatient equivalent of the inpatient Diagnosis Related Group (DRG)-based PPS. Like the inpatient system based on DRGs, each APC has a pre-established prospective payment amount associated with it. However, unlike the inpatient system that assigns a patient to a single DRG, multiple APCs can be assigned to one outpatient claim. If a patient has multiple outpatient services during a single visit, the total payment for the visit is computed as the sum of the individual payments for each service. Medicare provides updated versions of the OCE, along with installation and user manuals, to its fiscal intermediaries on a quarterly basis. The updated OCE reflects all new coding and editing changes during that quarter.

It was found upon initial testing of the OCE that it could not be used in its present form given the fact that the extensive editing embedded in its software program was specific to Medicare's benefit structure and internal claims processing requirements. As a result, the Agency has developed a TRICARE-specific OCE which will better accommodate the benefit structure and claims processing systems currently in place under the T–NEX contracts. This modified software package will edit claims data for errors and indicate actions to be taken and reasons why the actions are necessary. This expanded functionality will facilitate the linkage between the action being taken, the reasons for the action, and the information on the claim that caused the action. The edits will be specific for TRICARE, ensuring compliance with current claims processing criteria. The OCE will also assign an APC number for each service covered under the TRICARE OPPS and return information to be used as input to the TRICARE PRICER program.

Like Medicare's OCE, the TRICARE-specific OCE will be updated on a quarterly basis incorporating, to the extent practicable, all Medicare changes/updates (i.e., those changes initiated through rulemaking and transmittals/program memoranda). Periodic updating of the TRICARE-specific OCE will ensure consistency and accuracy of claims processing and payment under the TRICARE OPPS.

➢ *Deductible and Cost Sharing*—Medicare's OPPS coinsurance was initially frozen at 20 percent of the national median charge for the services within each APC (wage adjusted for the provider's geographic area) or 20 percent of the APC payment rate, whichever was greater (i.e., the coinsurance for an APC could not fall below 20 percent of the APC payment rate). This was designed so that, as the total payment to the provider increased each year based on market basket updates, the present or frozen coinsurance amount would become a smaller portion of the total payment until the coinsurance represented 20 percent of the total. Once the coinsurance became 20 percent of the payment amount, annual updates would be applied to the coinsurance so that it would continue to account for 20 percent of the total charge. Wage adjusted coinsurance amounts were further limited by the Medicare inpatient deductible. Subsequent legislation has accelerated the reduction of beneficiary copayment amounts by imposing prescribed percentage limitations off of the APC payment rate. For example, for all services paid under the Medicare OPPS in CY 2005, the national unadjusted copayment amount cannot exceed 45 percent of the APC rate. Accelerated reductions were imposed specifically for those APC groups for which coinsurance represented a relatively high proportion of the total payment.

A program payment percentage is calculated for each APC by subtracting the unadjusted national coinsurance amount for the APC from the unadjusted payment rate and dividing the result by the unadjusted payment rate. The payment rate for each APC group is the basis for determining the total payment (subject to wage-index adjustment) that a hospital will receive from the beneficiary and the Medicare program.

Since imposition of Medicare's unadjusted national coinsurance amounts would have an adverse financial impact on TRICARE beneficiaries (i.e., imposition of significantly higher cost-sharing for Prime beneficiaries), the Agency has opted to use the following hospital outpatient deductible and cost-sharing/copayments currently being applied in Tables 1 and 2 below for Prime, Extra, and Standard TRICARE programs for hospital outpatient services:

TABLE 1—HOSPITAL OUTPATIENT DEDUCTIBLES

TRICARE programs	Active duty family members		Retirees, their family members & survivors
	E1–E4	E5 & above	
Prime	None	None	None.
Extra	$50 per Individual	$150 per Individual	$150 per Individual.
	$100 Maximum per family	$300 Maximum per family	$300 Maximum per family.
Standard	$50 per Individual	$150 per Individual	$150 per Individual.
	$100 Maximum per family	$300 Maximum per family	$300 Maximum per family.

TABLE 2—HOSPITAL OUTPATIENT COPAYMENTS/COST-SHARING

Type of service	TRICARE prime program			TRICARE extra program	TRICARE standard program
	Active duty family member		Retirees, their family members & survivors		
	E1–E4	E5 & above			
Hospital Outpatient Departments *clinic visits; therapy visits; treatment rooms, etc.*	$0 copayment per visit.	$0 copayment per visit.	$12 copayment per visit.	Active Duty Family Members: Cost-share—15% of fee negotiated by contractor.	Active Duty Family Members: Cost-share—20% of the allowable charge.

TABLE 2—HOSPITAL OUTPATIENT COPAYMENTS/COST-SHARING—Continued

Type of service	TRICARE prime program			TRICARE extra program	TRICARE standard program
	Active duty family member		Retirees, their family members & survivors		
	E1–E4	E5 & above			
				Retirees, Their Family Members & Survivors: Cost-share—20% of the fee negotiated by the contractor.	Retirees, Their Family Members & Survivors: Cost-share—25% of the allowable charge.
Emergency Services *Emergency and urgently needed care obtained in hospital emergency room.*	$0 copayment per visit.	$0 copayment per visit.	$30 copayment per emergency room visit.		
Ambulatory Surgery (same day) Hospital-based ambulatory surgical center.	$0 copayment per visit.	$0 copayment per visit.	$25 copayment ..	ADFMs: Cost-share—$25	ADFMs: Cost-share—$25.
			No separate copayment/cost-share for separately billed professional charges.	Retirees, Their Family Members & Survivors: Cost-share—20% of the institutional fee negotiated by the contractor.	Retirees, Their Family Members & Survivors: Lesser of 25% of group rate or 25% of billed charge.
Birthing Centers *Prenatal care, outpatient delivery, and postnatal care provided in hospital-based birthing center.*	$0 copayment per visit.	$0 copayment per visit.	$25 copayment.		
Partial Hospitalization Programs (PHPs) *Mental health services provided in authorized hospital-based PHP.*	$0 copayment per visit.	$0 copayment per visit.	$40 per diem charge.	ADFMs: $20 per diem charge.	ADFMs: $20 per diem charge.
			No separate copayment/cost-share for separately billed professional charges.	Retirees, Their Family Members & Survivors: Cost-share—20% of the TRICARE allowed amount.	Retirees, Their Family Members & Survivors: Cost-share—25% of the TRICARE allowed amount.

➢ *Hold-Harmless Protection*—At the inception of the Medicare OPPS, providers were eligible to receive additional transitional outpatient payments (TOPs) if the payments they received under the OPPS were less than the payments they could have received for the same services under the payment system in effect before the OPPS. Prior to January 1, 2004, most hospitals that realized lower payments under OPPS received transitional corridor payments based on a percent of the decreased payments, with the exception of cancer hospitals, children's hospitals and rural hospitals having 100 or fewer beds, which were held harmless under this provision and paid the full amount of the decrease in payment under the OPPS. Since transitional corridor payments were intended to be temporary payments to ease the provider's transition from a prior cost-based payment system to a prospective payments system, they were terminated as of January 1, 2004, with the exception of cancer and children's hospitals, which were held harmless permanently under transitional corridor provisions of the statute (section 1833(t)(7) of the Social Security Act). The authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 Public Law 108–173, expired for rural hospitals having 100 or fewer beds, and sole community hospitals (SCHs) located in rural areas as of December 31, 2005. However, subsequent legislation (section 5105 of Pub. L. 109–171) reinstituted the hold-harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 1, 2006, and before January 1, 2010, for rural hospitals having 100 or fewer beds and SCHs. This provision provided an increased payment for such hospitals for outpatient services if the Medicare OPPS payment they received was less than the pre-BBA payment amount (i.e., the amount that was received prior to implementation of OPPS) that they would have received for the same covered service. When the OPPS payment is less than the payment the provider would have received prior to OPPS implementation, the amount of payment is increased by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of the difference for CY 2008. The amount of payment under section 1833(t)(13)(B) of the Act, as amended by section 411 of Pub. L. 108–73, also provided a payment increase for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy seeds and services paid under pass-through payments effective January 1, 2006, if justified by a study of the difference in costs for rural SCHs, which include Medicare essential access community hospitals or EACHs.

While the Agency adopted the hold-harmless TOPs for rural hospitals having 100 or fewer beds and SCHs, it opted to totally exempt cancer and children's hospitals from the TRICARE OPPS in lieu of imposing the hold-harmless provision, given the administrative complexity of capturing the data required for payment of

monthly interim TOP amounts. TOPs would require a comparison of what would have been paid [i.e., billed charges and CHAMPUS Maximum Allowable Charge (CMAC) amounts] prior to implementation of the OPPS for hospital outpatient services to those amounts actually paid under the OPPS for the same services. A TOP would be allowed in addition to the OPPS amount if payment to a cancer or children's hospital was lower than the amount that would have been paid prior to implementation of the OPPS. Since transitional corridor payments were specifically designed to supplement the losses experienced under the OPPS (i.e., to pay for services at the full amount that would have been allowed prior to implementation of the OPPS), and most, if not all, outpatient services paid at billed charges or CMAC would exceed the OPPS amount, the program cannot justify the administrative burden/expense of maintaining the hold-harmless provisions for cancer and children's hospitals. As a result, TRICARE will continue to reimburse cancer and children's hospitals on a fee-for-services basis using billed charges and CMAC rates; i.e., they will be excluded altogether from the OPPS.

Adoption of the Medicare OPPS has also highlighted other policy considerations which must be addressed in order to accommodate preexisting authorization criteria and reimbursement systems. Following are these identified policy considerations and prescribed resolutions:

➢ *Partial Hospitalization Programs (PHP)*—The TRICARE criteria under which PHP services may be rendered are different than Medicare's—both with regard to the need for PHP services and facility requirements. Currently, Medicare OPPS partial hospitalization services may be provided to patients in lieu of inpatient psychiatric care in hospital outpatient departments or Medicare-certified community mental health centers (CMHCs). The Agency has opted to retain the existing mental health review criteria under 32 CFR 199.4(b)(10) in order to ensure the continued level and quality of mental healthcare afforded under the basic program. Following are the TRICARE review criteria for determining the medical necessity of psychiatric partial hospitalization services:

- The patient is suffering significant impairment from a mental disorder (as defined in § 199.2) which interferes with age appropriate functioning.
- The patient is unable to maintain himself or herself in the community, with appropriate support, at a sufficient level of functioning to permit an adequate course of therapy exclusively on an outpatient basis (but is able, with appropriate support, to maintain a basic level of functioning to permit partial hospitalization services and presents no substantial imminent risk of harm to self or others).
- The patient is in need of crisis stabilization, treatment of partially stabilized mental health disorders, or services as a transition from an inpatient program.
- The admission into the partial hospitalization program is based on the development of an individualized diagnosis and treatment plan expected to be effective for the patient and permit treatment at a less intensive level.

Based on existing mental health review criteria under 32 CFR 199.4(b)(10) and certification requirements prescribed under 32 CFR 199.6(b)(4)(xii)(A), including accreditation by the Joint Commission, under the current edition of the Standards for Behavioral Healthcare, not all hospital-based PHPs will be assured of receiving payment under the OPPS unless they meet the above prescribed certification requirements and enter into a participation agreement with TRICARE. CMHC PHPs have been excluded from payment under the TRICARE OPPS since CMHCs are not recognized as authorized providers under the TRICARE program.

While the authorization standards under 32 CFR 199.6(b)(4)(xii)(A) through (D) will be retained/applied for both hospital-based and freestanding PHPs currently recognized under the Program, including the requirement for a written participation agreement with TRICARE, freestanding PHPs will be exempt from TRICARE OPPS and will continue to be reimbursed under the existing TRICARE PHP per diem system as prescribed under 32 CFR 199.14(a)(2)(ix), subject to their own unique mental health copayment/cost-sharing provisions.

➢ Ambulatory Surgery Procedures—Currently, ambulatory surgery procedures provided in both freestanding ambulatory surgery centers (ASCs) and hospital outpatient departments or emergency rooms are paid using prospectively determined rates established on a cost basis and divided into eleven groups as prescribed under 32 CFR 199.14(d). These payment groups are further adjusted for area labor costs based on Metropolitan Statistical Areas (MSAs). The payment rates established under this system apply only to facility charges for ambulatory surgery (e.g., standard overhead amounts that include, but are not limited to, nursing and technician services, use of the facility and supplies and equipment directly related to the surgical procedure) and do not include such items as physician's fees, laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure), prosthetics and durable medical equipment for use in the patient's home. Ambulatory surgery procedures (both provided in hospital-based and freestanding ambulatory surgery centers) are subject to their own unique copayment/cost-sharing provisions under the current TRICARE ambulatory surgery benefit.

With implementation of the TRICARE OPPS, hospital-based ambulatory surgery procedures will no longer be reimbursed under the original eleven tier payment system, but will instead be paid on a rate-per-service basis that varies according to the APC group to which the surgical procedure is assigned. The relative weight of the APC group will represent the median hospital cost of the services included in the APC relative to the median cost of services included in APC 0606, Level 3 Clinic Visit. The prospective payment rate for each APC will be calculated by multiplying the APC's relative weight by a nationally established conversion factor and adjusting it for geographic wage differences. The APC payment will be subject to the deductible and cost-sharing/copayment amounts currently being applied under Prime, Extra, and Standard TRICARE programs for hospital outpatient services. Denial of Medicare inpatient procedures will also be adhered to under the TRICARE OPPS (i.e., denial of inpatient surgical procedures performed in a hospital outpatient setting) except for those inpatient procedures, which upon medical review, could be safely and efficaciously rendered in an outpatient setting due to TRICARE's younger, healthier beneficiary population. Exceptions to Medicare's inpatient surgical procedure listing were based on major part to standardized utilization management review criteria, (i.e., Interqual and Milliman), used by TRICARE Managed Care Support Contractors' medical review staff. TRICARE-specific APCs will be developed for these designated inpatient procedures based on median costs from the most recent 12 months of claims history. TRICARE OPPS reimbursement will also be extended for an inpatient procedure performed to resuscitate or stabilize a patient with an emergent, life-threatening condition who dies before being admitted as a patient,

which in this case, will be paid under a new technology APC.

Freestanding ASCs will be exempt from TRICARE OPPS and will continue to be paid under the existing eleven tier payment system. ASC procedures will be placed into one of ten groups by their median per procedure cost, starting with $0 to $299 for Group 1, and ending with $1,000 to $1,299 for Group 9 and $1,300 and above for Group 10, subject to their own unique copayment/cost-sharing provisions under the TRICARE freestanding ambulatory surgery benefit. The eleventh payment tier/group was added to the ASC reimbursement system as of November 1, 1998, for extracorporeal shock wave lithotripsy, with a rate established off of the inpatient Diagnostic Related Group (DRG) 323 which is currently $3,289.

➢ Birthing Centers—As described in 32 CFR 199.6(b)(4)(xi), a birthing center is a freestanding or institution-affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth services limited to low-risk pregnancies. These all-inclusive maternity and childbirth services are currently being reimbursed in accordance with 32 CFR 199.14(e) at the lower of the TRICARE established all-inclusive rate or the billed charge. The all-inclusive rate includes laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility to the extent that they are usually associated with a normal pregnancy and childbirth. Since institutional-affiliated maternity centers will continue to be reimbursed under the TRICARE maximum allowable birthing center all-inclusive rate methodology as prescribed under 32 CFR 199.14(e), payment will be equal to the sum of the Class 3 CMAC for total obstetrical care for a normal pregnancy and delivery (CPT code 59400) and the TMA supplied non-professional component amount, which includes both the technical and professional components of tests usually associated with a normal pregnancy and childbirth. As a result, hospital-based birthing centers will continue to be reimbursed the same as freestanding birthing centers except that updating of the hospital-based all inclusive rate, consisting of the CMAC for procedure code 59400 (Birthing Center, all-inclusive charge, complete) and the state specific non-professional component, will lag two months behind the freestanding birthing center all-inclusive update; i.e., the freestanding birthing center all-inclusive rate components will usually be updated on February 1 of each year to coincide with the annual CMAC file update, followed by the hospital-based birthing center all-inclusive rate component updates on April 1 of the same year.

➢ *Observation Stays*—Observation Services are those services furnished on a hospital's premises, including the use of a bed and periodic monitoring by a hospital's staff, which are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient. While observation services reported with HCPCS code G0378 (hospital observation service, per hour) have been packaged into other independent separately payable hospital outpatient services since January 1, 2008, maternity observation claims that have a maternity diagnosis, a minimum of four hours per observation stay and not primary surgical procedure on the day of observation will still be identified using HCPCS code G0378 and reimbursed separately under APC T0002. Under the TRICARE OPPS, additional hospital services (e.g., separate emergency room visit or clinic visit) will not be required on a claim with a maternity diagnosis in order to receive separate payment for an observation stay.

➢ *End-Stage Renal Disease (ESRD) Dialysis Services*—In accordance with sections 1881(b)(2) and (b)(7) of the Social Security Act, a facility that furnishes dialysis services to Medicare patients with ESRD is paid a prospectively determined rate for each dialysis treatment furnished. The rate is a composite that includes all costs associated with furnishing dialysis services except for the costs of physician services and certain laboratory tests and drugs that are billed separately. CMS has exercised the authority granted under section 1833(t)(1)(B)(i) to exclude from the outpatient PPS those services for patients with ESRD that are paid under the ESRD composite rate. Since TRICARE does not have a comparable composite rate in effect for payment of ESRD services, they will be reimbursed under TRICARE's OPPS.

II. Treatment Settings Subject to Outpatient Prospective Payment System

The outpatient prospective payment system applies to any hospital participating in the Medicare program in the 50 United States, the District of Columbia, and Puerto Rico, except for Critical Access Hospitals (CAHs), Indian Health Service hospitals, certain hospitals in Maryland that qualify for payment under the state's cost containment waiver, and specialty care providers which include: (1) Cancer and children's hospitals; (2) freestanding ASCs; (3) freestanding Partial Hospitalization Programs (PHPs); (4) freestanding psychiatric and Substance Use Disorder Rehabilitation Facilities (SUDRFs); (5) Home Health Agencies (HHAs); (6) hospice programs; (7) other corporate services providers (e.g., comprehensive outpatient rehab facilities, freestanding cardiac catheterization centers, freestanding sleep diagnostic centers, and freestanding hyperbaric oxygen treatment centers); (8) freestanding birthing centers; (9) Veterans Administration (VA) hospitals; and (10) freestanding ESRD centers. Due to their inability to meet the more stringent requirements imposed for hospital-based and freestanding PHPs under the Program, CMHCs have also been excluded from payment under TRICARE's OPPS for partial hospitalization program (PHP) services since they are not recognized as authorized providers under the TRICARE program.

An outpatient department, remote location hospital, satellite facility, or other provider-based entity must also be either created by, or acquired by, a main provider (hospital qualifying for payment under TRICARE OPPS) for the purpose of furnishing healthcare services of the same type as those furnished by the main provider under the name, ownership, and financial administrative control of the main provider, in accordance with the following requirements under 42 CFR 413.65 (Medicare Regulation) in order to qualify for payment under the OPPS:

• *Licensure*—The outpatient department, remote location hospital, or the satellite facility and the main hospital are operated under the same license, except in areas where the State requires a separate license for the department of the provider.

• *Clinical Integration*—Professional staff of the outpatient department, remote location hospital or satellite facility are monitored by, and have clinical privileges at the main hospital. The medical director of the outpatient facility must also maintain a reporting relationship with the chief medical officer at the main hospital that has the same frequency, intensity and level of accountability that exists in the relationship between other departmental medical directors and the chief medical officer of the main hospital. Medical records for patients

treated in the facility or organization must be integrated into a unified retrieval system (or cross reference) of the main hospital and there must be full access to all services provided at the main hospital for patients treated in the outpatient facility requiring further care.

• *Financial integration.* The financial operation of the outpatient facility must be fully integrated within the financial system of the main hospital, as evidenced by shared income and expenses between the main hospital and outpatient facility.

• *Public awareness.* The outpatient department, remote location hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the outpatient facility they are aware that they are entering the main provider and are billed accordingly.

Having clear criteria for provider-based status is important because this designation can result in additional TRICARE payments for services at the provider-based facility (i.e., the incorporation of additional facility costs for covered outpatient services/procedures). TRICARE will accept the providers' determination on whether they meet the regulatory criteria for provider-based status for purposes of seeking reimbursement under the TRICARE OPPS.

III. Application of Ambulatory Payment Classification (APC) Model

Payment for services under the TRICARE OPPS is based on grouping outpatient services into APC groups in accordance with provisions outlined in section 1833(t) of the Social Security Act and its implementing regulation 42 CFR Part 419. This grouping is accommodated through the reporting of HCPCS codes and descriptors that are used to group homogenous services (both clinically and in terms of resource consumption) into their respective APC groups.

During the development of the TRICARE hospital OPPS it was recognized that certain hospital outpatient services were being paid based on fee schedules or other prospectively determined rates that were being applied across other ambulatory care settings. As a result, the following services were excluded from the OPPS in order to achieve consistency of payment across different service delivery sites: (1) Physician services; (2) nurse practitioner and clinical nurse specialist services; (3) physician assistant services; (4) certified nurse-midwife services; (5) services of a qualified psychologist; (6) clinical social worker services, except under half- and full-day partial hospitalization programs in which the services are included within the per diem payment amount; (7) services of an anesthetist; (8) screening and diagnostic mammographies; (9) clinical diagnostic services; (10) non-implantable durable medical equipment (DME), orthotics, prosthetics, and prosthetic devices and supplies; (11) hospital outpatient services furnished to SNF inpatients as part of their comprehensive care plan; (12) physical therapy; (13) speech-language pathology; (14) occupational therapy; (15) influenza and pneumococcal pneumonia vaccines; (16) take-home surgical dressings; (17) services and procedures designated as requiring inpatient care; and (18) ambulance services. These services will continue to be reimbursed under the current CMAC fee schedule or other TRICARE-recognized allowable charge methodology (e.g., statewide prevailings).

The remaining outpatient procedures which were not being paid under current fee schedules or other prospectively determined rates were grouped under an APC based on the following criteria:

• *Resource Homogeneity*—The amount and type of facility resources (for example, operating room, medical supplies, and equipment) that are used to furnish or perform the individual procedures or services within each APC group should be homogeneous. That is, the resources used are relatively constant across all procedures or services even though resources used may vary somewhat among individual patients.

• *Clinical Homogeneity*—The definition of each APC should be "clinically meaningful." That is, the procedures or services included within the APC group relate generally to a common organ system or etiology, have the same degree of extensiveness, and utilize the same method of treatment.

• *Provider Concentration*—The degree of provider concentration associated with the individual services that comprise the APC is considered. If a particular service is offered only in a limited number of hospitals, then the impact of payment for the services is concentrated in a subset of hospitals. Therefore, it is important to have an accurate payment level for services with a high degree of provider concentration. Conversely, the accuracy of payment levels for services that are routinely offered by most hospitals does not bias the payment system against any subset of hospitals.

• *Frequency of Service*—Unless there is a high degree of provider concentration, creating separate APC groups for services that are infrequently performed is avoided. Since it is difficult to establish reliable payment rates for low-volume groups, HCPCS codes are assigned to an APC that is most similar in terms of resource use and clinical coherence.

• *Minimal Opportunities for Upcoding and Code Fragmentation*—The APC system is intended to discourage using a code in a higher paying group to define the care. That is, putting two related codes such as the codes for excising a lesion for 1.1 cm and one of 1.0 cm, in different APC groups may create an incentive to exaggerate the size of the lesions in order to justify the incrementally higher payment. APC groups based on subtle distinctions would be susceptible to this kind of coding. Therefore, APC groups were kept as broad and inclusive as possible without sacrificing resource or clinical homogeneity.

These procedures, along with their specific HCPCS coding and descriptors, were used to identify and group services within each established APC group. They included: (1) Surgical procedures (including hospital-based ASC procedures currently being paid under the eleven tier ASC payment methodology); (2) radiology, including radiation therapy; (3) clinic visits; (4) emergency department visits; (5) diagnostic services and other diagnostic tests; 6) partial hospitalization for the mentally ill; (7) surgical pathology; (8) cancer therapy; (9) implantable medical items (e.g., prosthetic implants, implantable DME and implantable items used in performing diagnostic x-rays and laboratory tests); (10) specific hospital outpatient services furnished to a beneficiary who is admitted to a SNF, but in which case the services are beyond the scope of SNF comprehensive care plans; (11) certain preventive services, such as colorectal cancer screening; (12) acute dialysis (e.g., dialysis for poisoning); and (13) ESRD services. These hospital outpatient procedures will be paid on a rate-per-service basis that varies according to the APC group to which they are assigned.

In accordance with section 1833(t)(2) of the Social Security Act, services and items within an APC group cannot be considered comparable with respect to the use of resources in the APC group if the highest median cost is more than 2 times the lowest median cost for an item or service within the same group (referred to a the "2 times rule"). Exceptions may be granted in unusual cases, such as low-volume items and services.

IV. Public Comments

The TRICARE OPPS proposed rule (72 FR 17271) was published on April 1, 2008, providing a 60-day public comment period. Ten timely items of correspondence were received containing multiple comments on the proposed rule which resulted in a substantive change in hospital-based PHP reimbursement (i.e., reimbursement of a single per diem based on a minimum of three service units and payment of PHP professional services outside the per diem) and provided clarification regarding the temporary transitional payment adjustment (TTPA) and temporary military contingency payment adjustment (TMCPA) available under the TRICARE OPPS which will provide hospitals sufficient time to adjust and budget for potential revenue reductions and to ensure network adequacy deemed essential for military readiness and support during contingency operations. Following is a summary of the public comments and our responses:

Comment: Several commentors expressed support for the first option outlined in the proposed rule to provide an implementation plan involving three-year transitional payment adjustments for TRICARE network hospitals, but took exception to the proposal that the transitional adjustments only apply to hospitals that are in close proximity to military bases and treat a disproportionate share of military family members and/or hospitals that provide essential network specialty care. The commentors further supported the three-year transition to set higher payment percentages for the ten APCs (five clinic visits and five emergency room (ER) visits) during the first year, with reductions in each of the transition years. Several commentors also recommended a stop-loss system such as the one used in the implementation of the Medicare OPPS.

Response: We appreciate the commentor's concerns regarding the temporary transitional payment process and have modified it to include all hospitals, both network and non-network. For network hospitals, the temporary transitional payment adjustments (TTPAs) will cover a four-year period. The four-year transition will set higher payment percentages for the ten Ambulatory Payment Classification (APC) codes 604–609 and 613–616, with reductions in each of the transition years. For non-network hospitals, the adjustments will cover a three-year period, with reductions in each of the transition years.

For network hospitals, under the TTPAs, the APC payment level for the five clinic visit APCs would be set at 175 percent of the Medicare APC level, while the five ER visit APCs would be increased by 200 percent in the first year of TRICARE OPPS implementation. In the second year, the APC payment levels would be set at 150 percent of the Medicare APC level for clinic visits and 175 percent for ER APCs. In the third year, the APC visit amounts would be set at 130 percent of the Medicare APC level for clinic visits and 150 percent for ER APCs. In the fourth year, the APC visit amounts would be set at 115 percent of the Medicare APC level for clinic visits and 130 per cent for ER APCs. In the fifth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

For non-network hospitals, under the TTPAs, the APC payment level for the five clinic and ER visit APCs would be set at 140 percent of the Medicare APC level in the first year of TRICARE OPPS implementation. In the second year, the APC payment levels would be set at 125 percent of the Medicare APC level for clinic and ER visits. In the third year, the APC visit amounts would be set at 110 percent of the Medicare APC level for clinic and ER visits. In the fourth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

The transitional payment adjustments have been increased from those percentage amounts appearing in the proposed rule (73 FR 17271) to further buffer the decrease in revenues that hospitals will be experiencing during initial implementation of TRICARE OPPS. TTPA adjustments will also be extended to non-network providers, although they will be lower than for network hospitals to provide incentives for network participation. TRICARE will not utilize a stop-loss system such as the one used in the implementation of Medicare OPPS as it is not administratively feasible to adopt this type of transition under TRICARE. As stated in the proposed rule, these TTPAs will buffer the initial revenue reductions which will be experienced upon implementation of TRICARE's OPPS, providing hospitals with sufficient time to adjust and budget for potential revenue reductions for hospitals most vulnerable to implementation of OPPS.

Based on our discussions with the TRICARE Regional Offices (TROs), in regard to the second option to adopt, modify, and/or extend temporary adjustments to TRICARE's OPPS payments for TRICARE network hospitals deemed essential for military readiness and support during contingency operations, it was decided the policy for determining network waivers under the CHAMPUS Maximum Allowable Charge (CMAC) methodology should be used as a model to determine whether a temporary military contingency payment adjustment (TMCPA) under OPPS is warranted. This does not mean that network hospitals will be exempt from OPPS or that the 115% locality based waiver ceiling applies. Under the TMCPAs, this final rule will allow the reimbursement of higher payment rates for hospital-based outpatient healthcare services, if it is determined necessary to ensure adequate Preferred Provider networks. It might be determined that the initial TTPA of 200% for ER visits in a particular network hospital is not sufficient to ensure network adequacy and as a result, an additional TMCPA of 25 percent, (i.e., 225 percent of the OPPS rate for ER visits) would be necessary to support military contingency operations. The higher rate will be authorized only if all reasonable efforts have been exhausted in attempting to create an adequate network and that it is cost-effective and appropriate to pay the higher rate to ensure an appropriate mix of primary care and specialists in the network. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the mix of primary/specialty providers needed to meet patient access standards, the number of TRICARE beneficiaries in the locality, and the availability of Military Treatment Facility providers and any other factors the TMA Director, or designee determines relevant. If it is determined that the availability of an adequate number and mix of qualified healthcare providers in a network is not found, the Director TRO (DTRO) shall conduct a thorough analysis and forward recommendations with a cost estimate for approval to the TMA Director or designee through the TMA Contracting Officer (CO) for coordination. Those who can apply for the TMCPAs are: The DTRO; providers through the DTRO; Managed Care Support Contractors (MCSCs) through the DTRO; and Military Treatment Facilities (MTFs) through the DTRO. The TMA Director or designee is the final approval authority for TMCPAs. The procedures that are to be followed when submitting a TMCPA request will be outlined in the TRICARE Reimbursement Manual.

Comment: One commentor recommended the final rule include a

definition of the term ''close proximity'' and what constitutes a ''disproportionate share of military family members'' and ''essential network specialty care'' for future reference.

Response: Since these terms will not be used in determining whether TMCPAs will be authorized, there is no need to add a definition for ''close proximity'' and explain what constitutes a ''disproportionate share of military family members'' and ''essential network specialty care.''

Comment: Another commentor expressed concern that certain TRICARE dependent hospitals will be negatively impacted to the point that ongoing service capability to military personnel and their families will be severely limited. This commentor states a reasonable solution would be to create criteria for alternative reimbursement methodologies that would reflect an institution's dependence upon TRICARE. These provisions would include an exemption for network hospitals serving a disproportionate number of TRICARE patients and the continuation of TRICARE Maximum Allowable Charge rates for network hospitals entitled to an exemption.

Response: Under the governing statutory provisions implementing TRICARE's OPPS, TMA cannot exempt hospitals from TRICARE's OPPS on a case-by-case basis; however, see above response on the establishment of higher rates under TRICARE's OPPS using the TTPAs and TMCPAs.

Comment: Another commentor requested the requirement of ''military readiness or contingency operations'' be clarified or interpreted to allow exceptions at any time, to assure the military is prepared to perform its mission at any time and not only at times of ongoing operations. The commentor also believes the Director should be allowed to grant not just a ''temporary deviation'' but also be allowed to grant a more permanent exclusion from OPPS, if it is determined that a hospital's participation in TRICARE is required to support military readiness. The commentor further states that it is a major financial commitment for a hospital to participate in TRICARE and if the participation is only allowed on a temporary basis, this makes it problematic for the hospital to participate. They feel that allowing a more permanent exclusion from OPPS would be helpful in allowing a hospital to remain a part of the TRICARE network.

Response: As stated above, the statutory provisions implementing TRICARE's OPPS, does not allow TMA to permanently exclude hospitals from TRICARE's OPPS; however, there is latitude under these statutory provisions for the adoption of temporary transitional payment adjustments (TTPAs). These TTPAs will buffer the initial revenue reductions which will be experienced upon implementation of TRICARE's OPPS, providing hospitals with sufficient time to adjust and budget for potential revenue reductions for hospitals most vulnerable to implementation of OPPS. In addition, OPPS will ensure consistency of hospital outpatient payments throughout the United States, thus reducing the denial and return of claims to providers for coding errors. Providers will have access to OCE/Pricer software that will facilitate the filing and payment of outpatient claims with their TRICARE claims processors. This will reduce overall administrative costs for both providers and TRICARE contractors. Also, there are additional transitional adjustments, (i.e., TMCPAs) that will ensure network adequacy during military contingency operations. A change in troop deployment, the mix of primary/specialty providers needed to meet patient access standards, and base realignment and/or closures could impact whether a military contingency payment adjustment is warranted. Therefore, it would not be fiscally responsible to make these adjustments permanent.

Comment: Another commentor suggests that if DoD adopts a fully Medicare-based OPPS system for TRICARE, it will have a substantially negative effect upon the financial conditions of community hospitals closest to military installations that military personnel, retirees and their families depend upon for important medical services. The commentor further states that if DoD pegs outpatient hospital reimbursement rates to insufficient Medicare reimbursement, they believe that hospitals in California and elsewhere would consider not performing outpatient procedures on TRICARE members, or withdrawing from TRICARE contracts due to poor reimbursement. This could, in turn, harm access to enrollee outpatient care. This commentor recommends that: (1) DoD should, apart from the congressionally altered market basket update factor, separately calculate TRICARE OPPS rates based on the actual market basket update factor, which they believe more accurately reflects hospitals' costs. Doing so would ensure that more TRICARE network hospitals would retain their affiliation with the program and that hospitals closest to large military installations would not be adversely affected; (2) DoD should adopt a 15 percent ''glide path'' methodology that is similar to its prior rate adjustment methodologies enshrined at 32 CFR 199.14. Under this methodology, TRICARE-participating hospitals may not have their TRICARE outpatient rate reduced by more than 15 percent per year. For example, under this proposal, for the first year of the TRICARE transition OPPS period, TRICARE-contracting facilities would receive the TRICARE outpatient contracted rate, reduced by the lesser of: (a) The amount the contract rate exceeds the TRICARE OPPS rate for the same service or procedure; or (b) 15 percent off the contract rate. This amount becomes the contract rate for each subsequent year's calculation, until the difference between the TRICARE outpatient contracted amount and the TRICARE OPPS amount have equilibrated.

Response: In section 707 of NDAA–02, Congress 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'' determined in accordance with Medicare payment rules. Based on this statutory mandate, TRICARE is adopting Medicare's prospective payment system for reimbursement of hospital outpatient services currently in effect for the Medicare program. As stated above, to minimize the potential negative impact OPPS may have on hospitals (both network and non-network), TRICARE has developed the TTPAs and TMCPAs.

Comment: One commentor requested clarification on whether there were other hospital outpatient services that were excluded from the TRICARE OPPS other than the eighteen (18) listed in 63 FR Pages 17276 and 27277.

Response: There are no other hospital outpatient services that are excluded under TRICARE's OPPS other than those listed in the proposed rule.

Comment: One commentor strongly recommended that the Final Rule establish an implementation date that is at least 90 days from the date of the publication of the Final Rule to allow adequate time for education and system changes to ensure a smooth transition to this new payment methodology.

Response: The agency will attempt to provide as much time as possible to ensure a smooth transition to this new payment methodology.

Comment: This same commentor urges TRICARE to release the updated

TRICARE specific OCE each quarter at the same time the updated Medicare OCE is released.

Response: TRICARE will release its updated OCE each quarter to coincide with Medicare's release of its OCE.

Comment: This same commentor seeks clarification of the statement ''upon medical review'' for those inpatient procedures that the Agency believes can be safely and efficaciously rendered in an outpatient setting due to TRICARE's younger, healthier beneficiary population. The commenter also seeks clarification on how the medical review process will take place, specifically if the medical review process will be conducted for an individual beneficiary claim based upon the review criteria or on advantages to a methodology that applies criteria to an individual beneficiary claim because of the diversity of the population which TRICARE serves.

Response: The current TRICARE exceptions to Medicare's inpatient surgical procedure listing was a result of a review of those inpatient procedures that the Agency determined could be safely and efficaciously rendered in an outpatient setting for TRICARE beneficiaries, based on standardized utilization management review criteria used by the TRICARE Managed Care Support Contractors' medical review staff. TRICARE's determination of whether a procedure is removed from Medicare's inpatient only list is not based on medical review of individual beneficiary claims but on generally accepted medical standards of practice as substantiated by standardized utilization management review criteria.

Comment: This same commentor suggests clarifying the payment rate of ''TRICARE standard allowable charge methodology'' for nonpass-through drugs, biologicals and radiopharmaceuticals with HCPCS codes, but without claims data, to be ''the same as the payment methodology under Medicare OPPS, i.e., separate payment based upon the payment rate for nonpass-through drugs and biologicals, in accordance with the ASP methodology.''

Response: TRICARE is adopting the same payment methodology as the Medicare OPPS effective January 1, 2008, in that the updated payment rates for drugs and biologicals will be based on average sale prices.

Comment: One commentor states the statement in the proposed rule appears vague on whether the Trauma Activation HCPCS G code will be paid in addition to the Critical Care CPT codes reported on the same date of service. The commentor is requesting that TRICARE clarify in the final rule that HCPCS code G0390 will be paid in addition to CPT critical care codes 99291 and 99292 when reported on the same date of service.

Response: TRICARE confirms if trauma activation occurs, HCPCS code G0390 will be paid in addition to CPT critical care codes 99291 or 99292 when reported on the same date of service.

Comment: One commentor had concerns about the requirement that hospitals must use procedure code 58260, which will be assigned to APC 0202, when billing for vaginal hysterectomies. The commentor states that while CPT code 58260 is appropriate for vaginal hysterectomies for uterus 250g or less, it would be inappropriate if performed in conjunction with other procedures such as with removal of tube(s) and or ovarie(s) and other combinations of vaginal hysterectomies because a more specific CPT code (58262) describes these services. The commentor states that proposing to submit a specific code for all vaginal hysterectomies when another CPT code is more appropriate conflicts with the standard set forth by the Department of Health and Human Services and HIPAA. The commentor recommends that TRICARE instruct providers to report the appropriate CPT code representative of the procedure being performed from the CPT code range of 58260–58294, rather than to report CPT code 58260 for all vaginal hysterectomies.

Response: TRICARE will instruct providers to report the appropriate CPT code for vaginal hysterectomies rather than to report CPT code 58260 for all vaginal hysterectomies.

Comment: We received multiple comments expressing concern over the differences in Medicare's PHP reimbursement under OPPS and TRICARE's proposed PHP reimbursement.

Response: Upon further review, TRICARE has decided to adopt Medicare's PHP reimbursement methodology for hospital-based PHPs. For CY 2009, we are adopting CMS' two separate APC payment rates for PHP: One for days with three services (APC 0172) and one for days with four or more services (APC 0173). In addition, TRICARE will allow services of physicians, clinical psychologists, Clinical Nurse Specialists (CNS's), Nurse Practitioners (NPs) and Physician Assistants (PAs) to bill separately for their professional services delivered in a PHP. The only professional services which will be included in the per diem are those furnished by Clinical Social Workers (CSWs), Occupational Therapists (OTs), and alcohol and addiction counselors.

Comment: This commentor also states the Medicare PHP reimbursement methodology does not have a provision for recognizing the costs for proving such specialized partial hospitalization services to children. They believe the use of a Medicare methodology, without accounting for the additional costs of providing care for children in these programs is not reasonable and will further weaken already limited access to community services for TRICARE beneficiaries.

Response: We appreciate the comment. TMA currently is reviewing all aspects of its PHPs and will take this under consideration. In the interim, the Medicare PHP reimbursement methodology will be applied to all hospital-based PHP services.

Comment: One commentor requested a full financial impact analysis be done to determine the impact a move to Medicare reimbursement rates will have on the ability of certified providers to stay in the TRICARE program and provide adequate access to PHP services for TRICARE beneficiaries.

Response: With our adoption of the Medicare full day rate for partial hospitalization and allowing payment of professional services outside the per diem rate, except for CSWs, OTs, and alcohol and addiction counselors, we feel the overall PHP payment (i.e., the TRICARE OPPS per diem plus payment for those professional services identified above) is comparable to the per diem rates currently in effect under TRICARE policy. In addition, the TMCPAs would also apply to ensure adequate access to PHP services.

Comment: Another commentor requested a thorough, detailed impact analysis be made available so that providers could better assess and anticipate the economic ramifications of this major change in TRICARE policy. They state that while the net reported impact of this rule does not exceed the $100 million threshold that would require ''certain regulatory assessments and procedures (73 FR 17287),'' the gross impact is more than twice the $100 million threshold and it is obvious from the reconciliation provided that this rule has some component parts with large impacts. The commentor states it would be helpful and informative if the Agency could share information that would illuminate the redistributive and/or economic impact of this proposed rule.

Response: Based on revised claims data (i.e., charge and payment data from January 2007–June 2007) it has been estimated that this rulemaking is

''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, a Regulatory Impact Analysis has been incorporated into the final rule presenting the costs and benefits associated with implementation of the TRICARE OPPS. Refer to the Regulatory Impact Analysis below for a detailed overview of the economic effects of this final rulemaking.

Comment: One commentor stated the Medicare PHP rate is established based on inclusion of Community Mental Health Centers. TRICARE does not permit CMHCs to be certified providers. The commentor goes on to state that because of this, the Medicare rate calculation is not a good proxy for TRICARE partial hospitalization programs because TRICARE does not include CMHCs as providers, but Medicare median costs rely very heavily on the cost structure of CMHCs.

Response: We agree with the commentor that historically the median per diem cost for CMHCs greatly exceeded the median per diem cost for hospital-based PHPs and fluctuated significantly from year to year while the median per diem cost for hospital-based PHPs remained relatively constant. However, CMS noted that for CY 2006 the hospital-based PHPs per diem median cost was $177 and for CMHCs, the per diem median cost was $172. CMS reports it has observed a stabilizing trend in CMHCs data and similar per diem costs between hospital-based and CMHC PHPs.

Comment: One commentor stated that TRICARE requires compliance with a set of standards (including potential on-site surveys) intended to assure the Department of Defense that the quality of care of certified programs exceeds minimal standards. Medicare does not have a like set of standards. The commentor states that additional resources are required to assure compliance with these standards both in the initial certification process and in the ongoing monitoring of compliance. These additional requirements should be taken into consideration in any rate-setting methodology. The commentor states compliance with these standards imposes additional duties on certified providers.

Response: The Agency will take these comments into consideration as we continue to monitor the applicability of OPPS reimbursement rates to PHP programs that are subject to TRICARE's more stringent certification standards.

Comment: One commentor states that in the event a TRICARE network hospital qualifies for deviations and/or temporary adjustment to OPPS payments for a period of two (2) years or greater (i.e., a ''TRICARE Adjusted Network Hospital''), then in order to support such TRICARE Adjusted Network Hospital's effort to recruit and maintain an adequate physician active medical staff, the Director, TMA or a designee can provide reimbursement to TRICARE participating active medical staff physicians of a TRICARE Adjusted Network Hospital reimbursement equal to the prevailing TRICARE maximum Allowable Charge schedule (TMAC) plus an additional fifteen percent (15%) of such TMAC.

Response: The professional reimbursement is subject to its own waiver process as outlined in 32 CFR Part 199.14(j)(1)(iv)(D) and (E). The two waivers recognized under the TRICARE Program for increased professional provider payments are as follows:

- *Locality Waivers:* If it is determined that access to specific health care services is severely impaired, higher payment rates could be applied to all similar services performed in a locality. Payment rates could be established through the addition of a percentage factor to an otherwise applicable payment amount, or by calculating a prevailing charge, or by using another government payment rate.
- *Network Waiver:* If it is determined that higher rates are necessary to ensure availability of an adequate number and mix of qualified network providers then the amount of reimbursement would be limited to the lesser of (a) an amount equal to the local fee for service charge; or (b) up to 115 percent of the CMAC.

Comment: The same commentor provided recommendations relating to OPPS coding guidelines and updates.

Response: Providers will have access to commercial OCE/Pricer software that will facilitate the filing and payment of outpatient claims with their TRICARE claims processors. In addition, the following data elements are available on TMA's OPPS Web site at *http://www.tricare.mil/opps/* and are updated quarterly and/or annually to coincide with the quarterly OPPS updates: (1) Ambulatory Payment Classifications (APCs) with Status Indicators (SIs) and Payment Rates; (2) Payment Status by HCPCS Code; (3) Payment Status Indicator Descriptions; (4) Statewide Cost-to-Charge Ratios; and (5) OPPS Provider File.

The following data elements are also available under TRICARE's Rates and Reimbursement Web site at *http://tricare.mil/tma/Rates.aspx* and are updated quarterly to coincide with Medicare's quarterly OPPS updates: (1) Age and Gender Restrictions Lists; (2) Inpatient Procedures List; (3) No Government Pay Procedure Code List; and (4) Questionable Covered Services List.

Comment: The same commentor provided recommendations relating to authorization of healthcare services.

Response: We appreciate the comments; however, the healthcare authorization process is outside the scope of the TRICARE OPPS implementing guidelines.

Comment: This same commentor expressed concern about TRICARE's departure from the requirement that ''TRICARE payment methods for institutional care be determined, to the extent practicable, in accordance with the same reimbursement rules used by Medicare,'' by replacing Medicare specific coding and claims payment guidelines with TRICARE specific coding and claims payment guidelines. The commentor further states that TRICARE contractors be required to follow Medicare specific coding and claims payment guidelines as required under the Balanced Budget Act of 1997 and as adopted by Medicare's prospective payment system for reimbursement of hospital inpatient and outpatient services. Only in the event that Medicare does not have guidelines shall guidelines specific to TRICARE be developed and utilized.

Response: While TRICARE intends to remain as true as possible to Medicare's coding guidelines, there will be some deviations required to accommodate the uniqueness of the TRICARE program. These deviations have been designed to accommodate existing TRICARE benefit structure and claims processing procedures/systems and the unique characteristics of the TRICARE beneficiary population.

V. TRICARE OPPS Reimbursement Methodology

➢ *General Overview.* Under the TRICARE OPPS, hospital outpatient services are paid on a rate-per-services basis that varies according to the APC group to which the service is assigned. The APC classification system is composed of groups of services that are comparable clinically and with respect to the use of resources. Level 1 (CPT) and Level II HCPCS codes and descriptors are used to identify and group the services within each APC. Costs associated with items or services that are directly related and integral to performing a procedure or furnishing a service have been packaged into each procedure or service within an APC group with the exception of: (1) New temporary technology APCs for certain approved services that are structured

based on cost rather than clinical homogeneity; and (2) separate APCs for certain medical devices, drugs, biologicals, radiopharmaceuticals and devices of brachytherapy under transitional pass-through provisions. TRICARE is adopting Medicare's classification system, along with its nationally established APC payment amounts as prescribed in section 1833(t) of the Social Security Act and in its accompanying Medicare regulation (42 CFR Part 419) for reimbursement of hospital outpatient services, to the extent practicable, in accordance with 10 U.S.C. 1079(j)(2), with the realization that there will be subtle differences occurring between the TRICARE and Medicare OPPS methodologies based on differences in the age and general health of the populations they serve (i.e., it can be assumed that the TRICARE population is younger and healthier than the population being served by Medicare). For example, TRICARE has already found it necessary to develop a new TRICARE specific APC for maternity observation stays (T0002) to accommodate its unique benefit structure and beneficiary population. There may also be subtle differences in the inpatient only procedure listings being maintained by the two programs since some of the Medicare inpatient only procedures may be determined by TRICARE, upon medical review, to be safe for administration in an outpatient setting due to its younger, healthier population. This may require the development of additional APC groups, along with nationally established payment amounts based on their median costs from the previous year's claims history.

The payment rate for each APC is calculated by multiplying the APC's relative weight by the conversions factor. Weights are derived based on median hospital costs for services/procedures assigned to the hospital outpatient APC groups. Billed charges for items integral to performing the major procedure or visit, which include packaged HCPCS codes (i.e., codes with SI = ''N'') and revenue codes appearing on the same claim, are converted to costs by multiplying each revenue center charge by the appropriate hospital-specific CCR. Centers for Medicare and Medicaid Services (CMS) currently use a four-tiered hierarchy of cost center CCRs to match a cost center to every possible revenue code appearing in the outpatient claims, with the top tier being the most common cost center and the lowest tier being the default CCR. If a hospital's cost center CCR was deleted by trimming, another cost center CCR in the revenue hierarchy can be applied. If no other department CCR can be applied to the revenue code on the claim, CMS uses the hospital's overall CCR for the revenue code.

The costs of the above services/procedures are then standardized for geographic wage variations by dividing the labor-related portion of the operating and capital costs (currently estimated at 60 percent on the average for each billed item) by the hospital inpatient prospective payment system (IPPS) wage index. The standardized labor-related cost and the nonlabor-related cost component for each billed item are summed to derive the total standardized cost for each separately payable HCPCS code. Extreme costs outside three standard deviations from the geometric mean will be eliminated prior to calculating the median cost for each separately payable HCPCS code. The median costs of these procedures will then be mapped to their assigned APCs, and the median costs of those assigned procedures will be used in establishing the overall APC median cost.

The relative payment weights are calculated for each APC by dividing the median cost of each APC by the median cost for APC 0606 (Level 3 Clinic Visit), which is $83.21 for CY 2008, as a reconfiguration of the visit APCs. APC 0606 was chosen in order to maintain consistency in using a median for calculating unscaled weights representing the median cost of some of the most frequently provided services. The relative payment weights were further adjusted by 1.3226 for budget neutrality, based on a comparison of aggregate payments using CY 2007 relative weights to aggregate payments using the CY 2008 final relative weights.

The other component used in establishing national APC payment amounts is the conversion factor, updated on an annual basis in accordance with section 1833(t)(3)(C)(iv) of the Social Security Act, which provides for CY 2008 an updated amount equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act. The market basket increase update factor of 3.3 percent for CY 2008, along with the required wage index budget neutrality adjustment of approximately 1.0019, the adjustment of 0.12 percent for the difference in the pass-through set-aside resulted in a final standard conversion factor for CY 2008 of $63.694.

The national unadjusted APC payment rates that were calculated by multiplying the CY 2008 scaled weight for each APC by the final CY 2008 conversion factor apply to all the services that are classified within the APC group. These national rates (i.e., the unadjusted national rates for both APCs and the HCPCS to which TRICARE OPPS payment was assigned) are listed on TMA's OPPS Web site at *http://www.tricare.mil/opps.*

➢ *Determination of Payment.* A payment status indicator (SI) is provided for every code in the HCPCS to identify how the service or procedure described by the code would be paid under TRICARE's hospital outpatient prospective payment system (OPPS); i.e., it indicates if a service represented by a HCPCS code is payable under the OPPS or another payment system, and also which particular OPPS payment policies apply. One, and only one, SI is assigned to each APC and to each HCPCS code. Following are the CY 2008 payment status indicators, along with a description of the particular services each indicator identifies.

TABLE 8—CY 2008 PAYMENT STATUS INDICATORS FOR TRICARE'S OUTPATIENT HOSPITAL OPPS

Indicator	Description	OPPS payment status
A	Services paid under some payment method other than OPPS (e.g., payment for non-implantable prosthetic and orthotic devices, DME, ambulance services, and individual professional services).	Not paid under OPPS. Paid by contractors under a fee schedule or payment system other than OPPS.
B	More appropriate code required for TRICARE OPPS	Not paid under OPPS.
C	Inpatient procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
E	Items or services not covered by TRICARE	Not paid under OPPS.
F	Acquisition of corneal tissue, certain CRNA services, and Hepatitis B vaccines.	Not paid under OPPS. Paid on allowable charge basis.
G	Pass-through drugs and biologicals	Paid separate APCs under OPPS.

TABLE 8—CY 2008 PAYMENT STATUS INDICATORS FOR TRICARE'S OUTPATIENT HOSPITAL OPPS—Continued

Indicator	Description	OPPS payment status
H	Pass-through device categories allowed on a cost basis	Separate cost-based pass-through payment; not subject to cost-share/co-payment.
K	Non-pass-through drugs and biologicals, therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products.	Paid separate APCs under OPPS.
N	Packaged incidental items and services	Packaged into the primary procedure APC payment amount to which the incidental item or service is normally associated.
P	Partial hospitalization	Per diem APC payments for partial hospitalization programs.
Q	Services either separately payable or packaged	Paid under OPPS; services either packaged or separately payable depending on the specific circumstances of the HCPCS billing. OCE logic will be applied in determining if the services will be packaged or separately payable.
S	Significant procedures allowed under the OPPS for which multiple procedure reduction does not apply.	Paid under OPPS; separate APC payment.
T	Surgical services allowed under OPPS with multiple procedure payment reduction.	Paid under OPPS; separate APC payment.
V	Medical visits (including clinic or emergency department visits)	Paid under OPPS; separate APC payment.
W	Invalid HCPCS or invalid revenue code with blank HCPCS	Not paid under OPPS.
X	Ancillary services	Paid under OPPS; separate APC payment.
Z	Valid revenue code with blank HCPCS and no other SI assigned.	Not paid under OPPS.
TB	Reimbursement not allowed for CPT/HCPCS code submitted	Not paid under OPPS.

➢ *Adjustments for Specific Hospital Payment.* The hospital DRG wage adjustment factor will be used to adjust the portion of the payment rate that is attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions, with the exception of APCs with SIs ''K'' and ''G'' because of the inseparable, subordinate status of the outpatient department within the overall hospital setting. The TRICARE OPPS will also adhere to the same wage index changes as the TRICARE–DRG based payment system, except the effective date for changes will be January 1 of each year instead of October 1. This way only one wage index file will have to be maintained for both the OPPS and DRG-based payment systems. Following are the steps taken in achieving this adjustment for APCs in which multiple procedure discounting is not applied:

Step 1. Calculate 60 percent (labor-related portion) of the national unadjusted payment rate.

Step 2. Determine the wage index area in which the hospital is located and identify the wage index that applies to the specified hospital. The wage index values assigned to each hospital area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals are assigned for FY 2008 under the IPPS.

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined in Step 1 that represents the labor-related portion of the national unadjusted payment rate.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add the amount to the resulting product in step 4. The result is the wage index adjusted payment rate for the relevant wage index area in which the hospital is located.

Step 6. If the provider is a Sole Community Hospital (SCH), multiply the wage adjusted payment rate by 1.071 to calculate the total payment. This adjustment will apply to all services and procedures paid under the TRICARE OPPS (i.e., SIs ''P,'' ''S,'' ''T,'' ''V,'' and ''X''), excluding drugs, biologicals and services paid subject to pass-through payment (i.e., SIs ''G,'' ''H,'' and ''K'').

Applicable deductibles and/or cost-sharing/copayment amounts will be subtracted from the wage adjusted APC payment rate based on the eligibility status of the beneficiary at the time outpatient services were rendered (i.e., those deductibles and cost-sharing/copayment amounts applicable to Prime, Extra, and Standard beneficiary categories). TRICARE will retain its current hospital outpatient deductibles, cost-sharing/copayment amounts (refer to Tables 1 and 2 above) and catastrophic loss protection under the TRICARE OPPS. The ASC cost-sharing provision (i.e., assessment of a single copayment for both the professional and facility charge for a Prime beneficiary) will be adopted as long as it is administratively feasible. This will not apply to Extra and Standard beneficiaries since their cost-sharing is based on a percentage of the total allowed amount.

➢ *Additional APC Payment Adjustments.* TRICARE OPPS payment amounts are discounted when more than one surgical procedure (SI = T) is performed during a single operative session. Under these circumstances, TRICARE will reimburse the full payment and the beneficiary will pay the full cost-share/copayment for the procedure having the highest payment rate, while the remaining surgical procedure payments will be reduced by 50 percent, along with the beneficiary associated cost-share/copayment to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures. A 50 percent discount will also be applied to the OPPS payment amounts and beneficiary copayments/cost-shares for procedures terminated before anesthesia is induced, as identified by modifiers ·73 (Discounted Outpatient Procedure Prior to Anesthesia Administration) and ·52 (Reduced Services). Full payment will be received for a procedure that is started but discontinued after the induction of anesthesia as reported by modifier ·74 (Discounted Procedure). In this case, payment would recognize the costs incurred by the hospital to

prepare the patient for surgery and the resources expended in the operating room and recovery room of the hospital. Discounting will also be applied to conditional, inherent, and independent bilateral procedures.

An additional payment is provided for outpatient services for which a hospital's charges, adjusted to cost, exceed the sum of the wage adjusted APC rate plus a fixed dollar threshold and a fixed multiple of the wage adjusted APC rate. Only line item services with SIs ''P,'' ''S,'' ''T'', ''V,'' or ''X'' will be eligible for outlier payment under TRICARE's OPPS. No outlier payments will be calculated for line item services with SIs ''G,'' ''H,'' ''K,'' and ''N,'' with the exception of blood and blood products.

For CY 2008, the outlier threshold is met when the cost of furnishing a service or procedure exceeds 1.75 times the APC payment amount *and* exceeds the APC payment rate plus the $1,575 fixed-dollar threshold. The fixed-dollar threshold was added to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If a provider meets both of these conditions (i.e., the multiple threshold and the fixed-dollar threshold), the outlier payment is calculated at 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate. The hospital would receive the normal APC payment rate along with the additional outlier amount. For example, suppose a hospital charges $26,000 for a procedure for which the APC adjusted amount is $3,000 and the overall facility CCR is 0.30. The estimated cost to the hospital is $7,800 (0.30 × $26,000). In order to determine whether the procedure is eligible for outlier payment, it first must be determined whether the cost for the service exceeds both the APC multiple outlier cost threshold of $5,250 (1.75 × $3,000) and the fixed-dollar threshold of $4,575 ($3,000 + $1,575). Since the estimated cost to the hospital ($7,800) exceeds both threshold amounts, the hospital would be eligible for 50 percent of the difference, which in this case would be $1,275 ($7,800 − $5,250/2).

➢ *TRICARE's Payment Hierarchy for Non-OPPS Procedures.* If the outpatient procedure is not assigned an APC payment amount (i.e., is not assigned SI ''G,'' ''H,'' ''K,'' ''P,'' ''S,'' ''T,'' ''V,'' or ''X''), but may be reimbursed under an existing TRICARE fee schedule or other prospectively determined rate (i.e., procedures assigned to SI ''A''), the following hierarchy will be used in pricing the procedure. The PRICER will first look to see if there is an appropriate CMAC available for pricing. If a CMAC cannot be found, it will then look to the Durable Medical Equipment Claims: Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule for pricing. If a DMEPOS fee schedule rate is not available for pricing, it will turn to statewide prevailings. If a statewide prevailing cannot be found, the PRICER will reimburse the procedure at the billed charge.

VI. TRICARE's OPPS Transitional Adjustments

Temporary transitional payment adjustments (TTPAs) will be in place for all hospitals, both network and non-network in order to buffer the initial decline in payments upon implementation of TRICARE's OPPS. This is consistent with the stop loss transitional period over which CMS fully implemented its OPPS rate structure, providing hospitals with sufficient time to adjust and budget for potential revenue reductions. It will also provide additional incentives for TRICARE network participation.

For network hospitals, the temporary transitional payment adjustments (TTPAs) will cover a four-year period. The four-year transition will set higher payment percentages for the ten Ambulatory Payment Classification (APC) codes 604–609 and 613–616, with reductions in each of the transition years. For non-network hospitals, the adjustments will cover a three year period, with reductions in each of the transition years. For network hospitals, under the TTPAs, the APC payment level for the five clinic visit APCs would be set at 175 percent of the Medicare APC level, while the five ER visit APCs would be increased by 200 percent in the first year of OPPS implementation. In the second year, the APC payment levels would be set at 150 percent of the Medicare APC level for clinic visits and 175 percent for ER APCs. In the third year, the APC visit amounts would be set at 130 percent of the Medicare APC level for clinic visits and 150 percent for ER APCs. In the fourth year, the APC visit amounts would be set at 115 percent of the Medicare APC level for clinic visits and 130 percent for ER APCs. In the fifth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

For non-network hospitals, under the TTPAs, the APC payment level for the five clinic and ER visit APCs would be set at 140 percent of the Medicare APC level in the first year of OPPS implementation. In the second year, the APC payment levels would be set at 125 percent of the Medicare APC level for clinic and ER visits. In the third year, the APC visit amounts would be set at 110 percent of the Medicare APC level for clinic and ER visits. In the fourth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

Two sets of adjustment factors (i.e., one for clinic visits and the other for ER visits) are being used since revenue cuts for ER visits are generally greater than those associated with clinic visits. Transitional payment adjustments for these 10 visit codes will buffer the initial revenue reductions which will be experienced upon implementation of TRICARE's OPPS, providing hospitals with sufficient time to adjust and budget for potential revenue reductions for hospitals most vulnerable to implementation of OPPS.

An additional temporary military contingency payment adjustment (TMCPA) will also be available at the discretion of the Director, TRICARE Management Activity, or a designee, under provisions of this rule to adopt, modify, and/or extend temporary adjustments to OPPS payments for TRICARE network hospitals deemed essential for military readiness and support during contingency operations. If at any time following implementation it is determined by the TMA Director, or designee, that it is impracticable to support military readiness or contingency operations by making TRICARE's OPPS payments in accordance with the same reimbursement rules implemented by Medicare, a temporary deviation may be granted. This will ensure the availability of adequate civilian healthcare resources necessary to meet all ongoing military readiness and contingencies. The locality-based reimbursement rate waiver process under the CHAMPUS Maximum Allowable Charge (CMAC) methodology will be used as a model for considering TMCPA. This will allow for reimbursement of higher payment rates for healthcare services that would otherwise be allowable, if it is determined necessary to ensure adequate provider networks essential for military readiness and contingency operations. For example, it might be determined that the initial TTPA of 200 percent for ER visits in a particular hospital is not sufficient to ensure network adequacy and as a result, an additional TMCPA of 25 percent, (i.e., 225 percent of the OPPS rate for ER visits) would be necessary to support military contingency operations. The higher rate will be authorized only if all reasonable efforts have been exhausted in attempting to create an adequate network, and it is cost-effective and

appropriate to pay the higher rate to ensure an appropriate mix of primary care and specialists in the network. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the mix of primary/specialty providers needed to meet patient access standards, the number of TRICARE beneficiaries in the locality, and the availability of Military Treatment Facility providers and any other factors the TMA Director, or designee determines relevant. If it is determined that the availability of an adequate number and mix of qualified healthcare providers in a network is not found, the Director TRO (DTRO) shall conduct a thorough analysis and forward recommendations with a cost estimate for approval to the TMA Director, or designee, through the TMA Contracting Officer (CO) for coordination. Those who can apply for the TMCPAs are: The DTRO; providers through the DTRO; Managed Care Support Contractors (MCSCs) through the DTRO; and Military Treatment Facilities (MTFs) through the DTRO. The TMA Director or designee is the final approval authority for TMCPAs. TMCPAs will generally be granted for up to 3 years, after which time hospitals may reapply for subsequent 3-year periods based on current utilization and access data. It is anticipated that the duration between publication of the final rule and TRICARE OPPS implementation will provide sufficient time for hospital's to apply and receive a final approval determination by the Director, TMA or designee. The procedures that are to be followed when submitting a TMCPA request will be outlined in the TRICARE Reimbursement Manual.

TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that the procedures cannot be obtained timely enough from a network hospital. For such case-by-case extensions, ''Temporary'' might be less than three years at the discretion of the TMA Director, or designee.

VII. Regulatory Impact Analysis

A. Overall Impact

The Department of Defense has examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and 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

Executive Order 12866 (as amended by Executive Order 13258) 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 (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate that the effects of the TRICARE OPPS provisions that would be implemented by this rule would result in hospital revenue reductions exceeding $100 million in any 1 year. We estimate the total reduction (from the proposed changes in this rule) in hospital revenue under the OPPS for its first year of implementation (assumed for purposes of this RIA to be April 1, 2009–March 31, 2010) from revenue in the same period without the proposed OPPS changes to be approximately $460 million.

We estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that, to the best of our ability, presents the costs and benefits of the rulemaking.

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

Under the Congressional Review Act, a major rule may not take effect until at least 60 days after submission to Congress of a report regarding the rule. A major rule is one that would have an annual effect on the economy of $100 million or more or have certain other impacts. This final rule is a major rule under the Congressional Review Act. As noted above, the estimated total reduction in hospital revenue under the OPPS for its first year of implementation from revenue in the same period without the proposed OPPS changes is approximately $460 million.

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, other providers, ASCs, and other suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of $31.5 million or less in any 1 year). For purposes of the RFA, we have determined that all hospitals would be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity. Therefore, the Secretary has determined that this final rule would have a significant impact on a substantial number of small entities. We generally prepare a final regulatory flexibility analysis that is consistent with the RFA (5 U.S.C. section 604), unless we certify that the final rule would not have a significant impact on a substantial number of small entities. The Regulatory Impact Analysis as well as the contents contained in the preamble is meant to serve as the Final Regulatory Flexibility Analysis.

Public comments were received during the proposed rule (73 FR 17271) comment period which resulted in substantive changes in hospital-based PHP reimbursement (i.e., reimbursement of a single per diem based on a minimum of three service units and payment of PHP professional services outside the per diem) and provided clarification regarding the Agency's revised transitional plan. Under this revised plan, temporary transitional payment adjustments will now apply to both network and non-network hospitals even though the transitional percentage adjustments for non-network hospitals will be less than those for network hospitals thereby continuing to ensure incentives for network participation. The duration of the temporary transitional payment adjustments (TTPAs) has also been extended for an additional year (four years for network hospitals and 3 years for non-network hospitals). The TTPA process will be administratively practicable while at the same time ensuring the stop-loss protection to allow hospitals the necessary time to adjust and budget for potential revenue reductions. Clarification was also provided regarding temporary contingency payment adjustments (TMPCAs) available under the TRICARE OPPS which will ensure network adequacy deemed essential for military readiness and support during contingency operations. Since all hospitals were considered small entities as part of the Regulatory Impact Analysis the above revisions and clarifications will have a significant

impact on a substantial number of small entities.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $130 million. This final rule will not mandate any requirements for State, local, or tribal governments.

5. Public Law 96–511, ''Paperwork Reduction Act'' (44 U.S.C. Chapter 35)

This rule will not impose significant additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511). Existing information collection requirements of the TRICARE and Medicare programs will be utilized. We don't anticipate any increased costs to hospitals because of paperwork, billing or software requirements since we are adopting Medicare's billing/coding requirements; i.e., hospitals will be coding and filing claims in the same manner as they currently are with Medicare.

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 TRICARE's OPPS

The outpatient prospective payment system encompasses nearly all hospitals that participate in the TRICARE program. However, Maryland hospitals that are paid under a cost containment waiver are excluded from the OPPS. In addition, Critical Access Hospitals (CAHs), Children's hospitals, Inpatient Rehabilitation Facilities (IRFs), Long Term Care hospitals (LTCHs), and Cancer hospitals are excluded from the OPPS.

C. Analysis of the Impact of Policy Changes on Payment Under TRICARE's OPPS

1. Alternatives Considered

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

(a) Alternatives Considered for Addressing Reduction in Payments for ER Visits

Analysis of the effects of the proposed OPPS policies indicate that by type of service, the greatest reductions in hospital payments would occur for the facility charges associated with ER visits and other visits. Table 1 provides our projection of the effect of OPPS on hospital payments by type of service without any transition payments. It shows that of the projected $598 million reduction in hospital payments (before transition payments), over one-half of that reduction would come from reduced payments for the facility charges associated with ER visits and other hospital clinic visits. This reduction far exceeds the reductions for all other services. In reviewing the other types of services affected by OPPS, with four exceptions there are either increases in payments under OPPS (surgeries) or very small decreases in aggregate payments (defined as less than 1 percent of projected current policy allowed amounts—equal to $18 million—which is the case for J-codes and other HCPCS codes). The four exceptions are: (1) Radiology/pathology services, for which the OPPS payments are projected to equal over 80 percent of current policy allowed amounts; (2) other medical services (non-visits, including cardiology tests) for which the OPPS payments are projected to equal two-thirds of current policy allowed amounts; (3) supplies, which under OPPS will be bundled into other APCs or be coded for payment; and (4) ''facility dump codes'', which are services that TRICARE has reimbursed under TRICARE code 99088 (this code is used by claims processors to represent services that are either billed without a CPT code or have revenue codes that the claims processor has coded as 99088). We project that 87 percent of current policy allowed amounts for these facility ''dump codes'' will be reimbursed under OPPS.

Because the majority of the impact of OPPS on hospital payments will occur for facility charges for visits (ER and hospital clinic visits), we examined options to phase in the impact of OPPS for these services. Primary care and emergency room visits to hospital outpatient departments are categorized into 10 main codes (APC codes 604–609 and 613–616). For most hospitals, the largest reductions under OPPS occur for these 10 codes, especially the ER visit codes. We considered a number of alternatives to address this impact as part of the transition to the Medicare APC level. One alternative was to set the TRICARE APC levels at a higher level than the Medicare APCs during a three-year transition period (in the fourth year all TRICARE APC payments would be at the Medicare APC level). Because of TRICARE's interest in establishing and preserving a network of hospitals, this option would apply to only hospitals in the TRICARE network. Under this option, we set the first-year TRICARE APC levels at 150 percent of the Medicare APC levels for the ER codes (APCs 609, 613, 614, 615, and 616) and at 130 percent of the Medicare APC levels for the hospital clinic visit codes (APCs 604–608). These percentages would apply to the first year of implementation and lower percentages would apply to the second and third years of implementation. By year four, the TRICARE APC levels would be equal to the Medicare APC levels. Even though this option increased the level of hospital payments, we did not choose this option because it would still result in a reduction in hospital payments for ER and hospital clinic visits of over 50 percent.

A second option we considered was identical to the first with two exceptions. First, it would increase the year-one level of the TRICARE APC payments for the 10 ER visits and clinic visits codes identified above (APCs 604–609 and 613–616) to 200 percent of the Medicare APC values for the five ER visit codes and to 175 percent of the Medicare APC values for the five hospital clinic visit codes. A second difference is that the transition would be lengthened from three years to four years (i.e., the Medicare APC levels would not be reached for these 10 codes until the start of the fifth year of implementation). Although this option would result in higher hospital payments than the first option, we did not choose this option because it would still represent over a 40 percent reduction in ER and clinic visit payments in the first year of implementation.

A third option we considered and the one we are proposing in this OPPS rule is identical to the second option except that it would extend transition payments for the 10 ER and hospital clinic visit codes to non-network hospitals. Thus, all hospitals would receive higher payments for the 10 visit

codes. As shown in Table 2, this option would set the TRICARE APC levels in the first year of implementation at 140 percent of the Medicare APC level for non-network hospitals for all 10 codes. Even though the transition payments are lower for non-network hospitals than network hospitals, this option provides increased payments for all hospitals with ER and/or hospital clinic visits. We selected this option because we found that it reduced the overall impact of OPPS to about 25 percent of current-policy allowed amounts, because it led to a reduction in hospital payments for ER and clinic visit in the first year of less than 40 percent, and because it would relieve the impact on all hospitals with ER and/or hospital clinic visits. We refer to these payments as temporary transitional payment adjustments (TTPAs). The impact is shown in Table 3.

(b) Alternatives Considered for Addressing Hospitals With a High Concentration of TRICARE Patients

We were concerned there might be access problems at some hospitals with a high concentration of TRICARE patients if their HOPD payments were decreased significantly. In particular, we were concerned that some hospitals might leave the TRICARE network if HOPD payments were reduced too quickly. Under this option, network hospitals which rely on TRICARE for 20 percent or more of their HOPD revenues would be paid APC amounts that are above the Medicare APC levels. We focussed on network hospitals because many of the hospitals with a high level of TRICARE patients are network hospitals. Under this option, each network hospital would provide documentation to TRICARE that they were reliant on TRICARE for 20 percent or more of their HOPD revenues and the TRICARE fiscal intermediaries would then increase their APC payment by a percentage amount (we assumed by 7 percent).

This option would potentially affect the roughly 1,700 TRICARE network hospitals. We estimate that about one-third of the largest 200 TRICARE network hospitals would meet the criteria that the TRICARE allowed amounts under current policy be greater than or equal to 20 percent or more of their total HOPD revenues. If OPPS payments were increased by 7 percent for these hospitals, it would increase TRICARE payments by about $20 million per year. There would also be administrative costs associated with verifying that hospitals relied on TRICARE for more than 20 percent of their revenue. We did not choose this option because we did not think it was sufficiently targeted to access problems. In addition, many of these TRICARE-reliant hospitals may be benefited significantly by the increase in ER payments under the TTPAs.

A second option we considered and the one we are proposing in this OPPS rule is to provide three-year transitional payments adjustments for TRICARE network hospitals if they are deemed essential for military readiness and support during contingency operations. Under this option, temporary military contingency payment adjustments (TMCPAs) would be granted if TRICARE determines that it is necessary to ensure adequate Preferred Provider networks. It might be determined that the initial TTPA of 200 percent for ER visits in a particular hospital is not sufficient to ensure network adequacy and as a result, an additional TMCPA of 25 percent, (i.e., 225 percent of the OPPS rate for ER visits) would be necessary to support military contingency operations. The higher rate will be authorized only if all reasonable efforts have been exhausted in attempting to create an adequate network and TRICARE determines that it is cost-effective and appropriate to pay the higher rate to ensure an appropriate mix of primary care and specialists in the network. For this purpose, such evidence many include consideration of the number of providers in the locality who provide the affected services, the mix of primary/specialty providers needed to meet patient access standards, the number of TRICARE beneficiaries in the locality, and the availability of Military Treatment Facility providers and any other factors the TMA Director, or designee determines relevant.

(c) Alternatives Considered for Addressing All Services

We also considered options for increasing all APC payments above the Medicare APC levels. Under this option, TMA would have a four-year phase-in of OPPS. In the first year, hospitals would have their HOPD payments based on 25 percent of the OPPS amount and 75 percent of the amount that they would have been reimbursed under current policy. In the second, third, and fourth years, the percentage paid according to OPPS would increase to 50 percent, 75 percent, and 100 percent, respectively.

We did not select this option for two reasons. First, we think that for many services, this option would provide little benefit to hospital providers. For example, for surgeries, which would be paid more under OPPS than under current policy, this option would be administratively complex and not provide relief to hospitals (in fact, it would lower their payments). In addition, this option would be administratively cumbersome and costly, because it would require the FIs to process each claim twice. We think it would increase administrative claims processing costs by over $15 million per year.

2. Methodology

We analyzed the impact of OPPS on hospital outpatient payments. Our analysis compares the payment impact of OPPS compared to current law. Current law reflects pre-OPPS payment methodologies in effect in October 2008 and assumed to continue prior to April 1, 2009 (the assumed date of implementation of OPPS for purposes of this RIA).

The data used in developing the quantitative analyses presented below are taken from charge and payment data from January 2007–June 2007 and the current TRICARE hospital provider file (prepared in September 2008). Our analysis has several qualifications. First, we draw upon various sources for the data used to categorize hospitals in Table 4, below. In some cases, there is a degree of variation in the data from the different sources. We have attempted to construct these variables with the best available source overall having information from TMA's provider file, as well as Medicare's POS and PSF provider files. For individual hospitals, however, some miscategorizations are possible. In addition, we were unable to match some hospital claims data to the provider file.

Using charge data from 2007, we simulated payments using the pre-OPPS and OPPS payment methodologies. Both pre-OPPS and OPPS payment estimates include operating and capital costs. The excluded Maryland hospitals and the other excluded hospital types (CAHs, IRFs, LTCHs, and Cancer hospitals) were not included in the simulations.

We also trimmed extremely low charges per unit (under $10) from the impact analysis because we believe the data to be unreliable. Inclusion of claims with billed and allowed charges under $10 would not allow us to assess the impacts among the various classes of hospitals accurately, as they likely have errors in dollar amounts or units.

After we removed the excluded Maryland hospitals, the claims with low payments, and hospitals for which we could not assign payment and hospital classification variables, we used the remaining hospitals as the basis for our analysis.

3. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the proposed policy changes on various hospital groups. We present results only for hospitals whose claims were used for modeling the impacts shown in Table 4 below. We do not show proposed hospital-specific impacts for hospitals whose claims we were unable to use or hospital claims that could not be matched to the provider file. As discussed in this rule, LTCHs, IRFs, CAHs, Children's hospitals, Cancer hospitals and hospitals in Maryland are exempt from this rule and are excluded from Table 4.

We estimate the effects of the proposed policy changes by estimating the effects on payments per service, while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our proposed policy changes, with one exception: We assumed that 25 percent of supply services would not be bundled into other APC payments and that hospitals would likely recode these supplies into CPT codes that would be reimbursed separately. Although we make projections of the change in payments per service (to reflect inflation in billed charges and APC amounts) we do not make adjustments for future changes in variables such as service volume, service-mix, or number of encounters.

One behavioral change that we did not model is the change in hospital discounts. We know that many network hospitals currently provide discounts for both inpatient and outpatient services. For this RIA, we assumed that all the outpatient discounts would be eliminated. We also know that many of the inpatient discounts will also be eliminated, although we did not include that impact in the RIA. Thus, the RIA overstates the impact on hospital payments, especially for these network hospitals that will reduce or eliminate their inpatient discounts in order to reduce the impact of the OPPS change on their revenues.

A second impact that is not included in this RIA is the impact of the TMCPA payments. We did not attempt to estimate which hospitals would receive these payments or the level of the payments. Thus, the RIA overstates the impact on hospital payments, particularly for hospitals that would receive TMCPA payments.

4. Effects on Hospitals

Table 4, Impact of TRICARE Hospital Outpatient Prospective Payment System (OPPS), below, demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The first column represents the number of hospitals in each category. The second column shows the impact of the OPPS excluding the transition payments. It shows the percentage of the projected current policy allowed amounts for HOPD facility charges that would be paid under OPPS without transition payments. The third column shows the impact of the OPPS including the transition payments.

The first row of Table 4 shows the overall impact on the 3,754 hospitals included in the analysis. We included as much data as possible to the extent that we were able to capture all the provider information necessary to determine payment. Our estimates include the same set of services for both pre-OPPS (current policy) and OPPS payments so that we could determine the impact of the OPPS as accurately as possible. Because payment under OPPS can only be determined if bills are accurately coded, the data upon which the impacts were developed do not reflect all hospital outpatient services from January 2007 to June 2007, but only those that were coded using valid HCPCS codes.

The next three rows of the table contain hospitals categorized according to their geographic location (urban and rural). We include 2,469 hospitals located in urban areas (MSAs) in our analysis. In addition, we include 1,285 hospitals located in rural areas in our analysis. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals.

We then show the distribution by the TRICARE-network status of hospitals, as of the date of the service (January–June 2007). We then show the distribution of urban and rural hospitals by regional census divisions. The final category groups hospitals according to whether or not they have residency programs (teaching hospitals that receive an indirect medical education (IME) adjustment).

Column 2 of Table 4 compares our estimate of OPPS payments without application of the transition payments, but incorporating policy changes, to our estimate of payments under the current system. It shows the percentage of allowed amounts for HOPD services paid under OPPS as a percentage of the allowed amounts for HOPD services paid under current policy. The impact is shown for the period from April 1, 2009–March 31, 2010.

Column 3 presents the percentage of allowed amounts paid under OPPS after application of the transition payments to our estimate of allowed amounts under the pre-OPPS system (current policy). The differences between the pre-OPPS and the OPPS payment reflect the combined impact of the transition payment adjustments and distributional differences attributable to variation in charge structures among hospitals. It also presents our assumption about the growth in payments prior to OPPS (billed charges for services subject to the OPPS are assumed to increase by 7 percent per year) and in APC payments (assumed to increase by 3.3 percent per year).

We estimate that in the April 2009–March 2010 period, payments to hospitals for their HOPD facility charges will decrease by 25 percent under the OPPS compared to the pre-OPPS payments. This includes the impact of the transition payments. The values in Table 4 differ slightly from those in Table 3 because not all hospital payments are included in Table 4 due to the issues discussed above.

For all groups of hospitals, payments under the OPPS without the transition payments are below current policy payments for HOPD facility charges. For all of these hospital groups, the transition payments mitigate this impact. The following discussion highlights some of the changes in payments among hospital classifications.

Payment to urban and rural hospitals would decrease substantially without the transition payments (24 percent for rural and 35 percent for urban hospitals). These hospitals experience a decline in payments even with the transition payments (11 percent and 24 percent for rural and urban hospitals, respectively).

Teaching hospitals, whose payments would decrease by 33 percent without the transition payments, have much of these losses offset by the transition payments.

The transition payments have a major impact on TRICARE networks hospitals. It increases the percentage of current policy allowed amounts paid for HOPD facility charges from 67 percent without the transition payments to 80 percent with the transition payments. The transition payments also increase the percentage of current policy allowed amounts paid under OPPS to small and rural hospitals. Under OPPS with the transition payments sole community hospitals will receive over 90 percent of the current policy amounts. Small rural hospitals will also receive over 90 percent of current policy amounts.

If the effect of the transition payments were removed, differences between pre-OPPS payments and OPPS payments among hospitals would still exist. These distributional differences are the result of many factors. First, charge structure variations result in differences between pre-OPPS payments and OPPS payments. Hospitals whose charges are low relative to payment would gain under the OPPS even without the transition payments.

TABLE 1—ESTIMATED IMPACT OF TRICARE OPPS ON HOSPITALS DURING THE APRIL 1, 2009–MARCH 31, 2010 PERIOD

(Assuming no transition payments (In $ millions))

Category of hospital outpatient service	(1) Estimated allowed amounts under current policy	(2) OPPS allowed amounts as a percent of current policy allowed amounts	(3) OPPS allowed amounts	(4) Reduction in allowed amounts (1)–(3)
Surgeries	$406	102%	$413	($7)
Radiology/Pathology	298	82%	245	53
Visits (ER and Other)	516	35%	180	336
Other Medical (non-visits)	192	66%	127	65
J-codes	34	81%	27	7
Other HCPCS codes	20	43%	8	12
Supplies	146	25%	37	109
Facility ''Dump Codes''	177	87%	154	23
Total	1,789	67%	1,191	598

Note: (1) This table does not include any transition payments to hospitals.
(2) This table does not include the impact of reduced hospital discounts for inpatient services.
(3) 75 percent of supplies are assumed to be bundled into other APC payments. We assume that providers will recode the other 25 percent of supply costs (such as J-codes, A-codes, etc.) and will be paid.
(4) Excluded hospitals such as Maryland hospitals, Children's, LTCH, IRFs, and CAHs are excluded from this table. Services not affected by OPPS (like clinical laboratory and rehab therapy) are not included.
(5) Facility ''dump codes'' are services that have been reimbursed by TRICARE under CPT 99088.

TABLE 2—TRANSITION SCHEDULE FOR 10 VISIT CODES, BY TYPE OF VISIT CODE AND NETWORK STATUS OF HOSPITAL

(TRICARE APC as a percent of Medicare APC)

	Network		Non-network	
	ER	Hospital clinic	ER	Hospital clinic
Yr 1	200%	175%	140%	140%
Yr 2	175%	150%	125%	125%
Yr 3	150%	130%	110%	110%
Yr 4	130%	115%	100%	100%
Yr 5	100%	100%	100%	100%

Note: 10 codes are APC codes 604–609 and 613–616.

TABLE 3—ESTIMATED IMPACT OF TRICARE OPPS ON HOSPITALS DURING THE APRIL 1, 2009–MARCH 31, 2010 PERIOD

(With transition payments (in $ millions))

Category of hospital outpatient service	(1) Estimated allowed amounts under current policy	(2) OPPS allowed amounts as a percent of current policy allowed amounts	(3) OPPS allowed amounts	(4) OPPS allowed amounts with transition payment	(5) Reduction in allowed amounts (1)–(4)
Surgeries	$406	102%	$413	$413	($7)
Radiology/Pathology	298	82%	245	245	53
Visits (ER and Other)	516	35%	180	320	196
Other Medical (non-visits)	192	66%	127	127	65
J-codes	34	81%	27	27	7
Other HCPCS codes	20	43%	8	8	12
Supplies	146	25%	37	37	109
Facility ''Dump Codes''	177	87%	154	154	23
Total	1,789	67%	1,191	1,331	458

Note: (1) This table includes the impact of the TTPA payments to hospitals.
(2) This table does not include the impact of reduced hospital discounts for inpatient services.
(3) 75 percent of supplies are assumed to be bundled into other APC payments. We assume that providers will recode the other 25 percent of supply costs (such as J-codes, A-codes, etc.) and will be paid.

(4) Excluded hospitals such as Maryland hospitals, Children's, LTCH's, IRFs, and CAHs are excluded from this table. Services not affected by OPPS (like clinical laboratory and rehab therapy) are not included.

(5) Facility ''dump codes'' are services that have been reimbursed by TRICARE under CPT 99088.

(6) First-year transition for network hospitals is equal to 200% of Medicare APC for 5 ER visit codes and 175% of Medicare APC amounts for 5 hospital clinic visit codes. For non-network hospitals, the first-year transition is 140% of Medicare amounts for both the 5 ER and the 5 hospital clinic visit codes.

TABLE 4—FIRST-YEAR IMPACT OF TRICARE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

[Percentage of current policy allowed amounts paid under OPPS]

	(1) Number of hospitals	(2) OPPS Effect on OP payments (Without transition payments) (percent)	(3) OPPS Effect on OP payments (with transition payments) (percent)
ALL HOSPITALS	3,754	66.2	77.2
URBAN HOSPITALS	2,469	64.7	75.5
RURAL HOSPITALS			
Sole Community	646	79.3	91.5
Other Rural	639	72.7	86.6
BEDS (URBAN)			
0–99 Beds	630	71.5	83.1
100–199 Beds	804	63.0	77.1
200–299 Beds	458	63.8	74.0
300–499 Beds	395	65.5	74.7
500+ Beds	182	64.2	71.3
BEDS (RURAL)			
0–49 Beds	595	76.6	91.3
50–100 Beds	438	75.6	87.6
101+ Beds	252	75.9	89.1
NETWORK STATUS			
Network	1,671	66.6	79.9
Non-Network	2,083	64.7	67.7
REGION (URBAN)			
New England	116	76.7	101.0
Middle Atlantic	341	63.1	75.9
South Atlantic	359	59.4	73.6
East North Cent	409	70.0	83.8
East South Cent	160	63.4	75.1
West North Cent	159	76.3	78.5
West South Cent	360	60.4	74.0
Mountain	153	72.8	74.1
Pacific	363	70.8	71.9
Puerto Rico	49	71.8	74.7
REGION (RURAL)			
New England	41	81.9	97.1
Middle Atlantic	75	80.3	105.3
South Atlantic	185	73.5	89.9
East North Cent	181	78.3	89.1
East South Cent	200	69.8	87.7
West North Cent	207	87.0	92.5
West South Cent	219	69.5	86.8
Mountain	116	75.1	76.5
Pacific	61	78.6	83.1
TEACHING STATUS			
Non-Teaching	2,719	65.6	77.5
Teaching	1,035	66.9	76.7

List of Subjects in 32 CFR Part 199

Claims, Dental health, Healthcare, 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. Paragraph 199.2(b) is amended by adding definitions for ''Ambulatory Payment Classifications (APCs)'' and ''TRICARE Hospital Outpatient Prospective Payment System (OPPS)'' and placing them in alphabetical order to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

Ambulatory Payment Classifications (APCs). Payment of services under the TRICARE OPPS is based on grouping outpatient procedures and services into ambulatory payment classification groups based on clinical and resource homogeneity, provider concentration, frequency of service and minimal

opportunities for upcoding and code fragmentation. Nationally established rates for each APC are calculated by multiplying the APC's relative weight derived from median costs for procedures assigned to the APC group, scaled to the median cost of the APC group representing the most frequently provided services, by the conversion factor.

* * * * *

TRICARE Hospital Outpatient Prospective Payment System (OPPS). OPPS is a hospital outpatient prospective payment system, based on nationally established APC payment amounts and standardized for geographic wage differences that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service in a hospital outpatient department.

* * * * *

§ 199.4 [Amended]

■ 3. Section 199.4 is amended by removing paragraph (c)(3)(i)(C)(*1*) and redesignating paragraphs (c)(3)(i)(C)(*2*) and (c)(3)(i)(C)(*3*) as (c)(3)(i)(C)(*1*) and (c)(3)(i)(C)(*2*).

■ 4. Section 199.14 is amended by revising paragraphs (a)(2)(ix)(A); redesignating paragraphs (a)(5)(i) through (a)(5)(xii) as (a)(5)(i)(A) through (a)(5)(i)(L); adding the following new paragraphs (a)(5)(i) and (a)(5)(ii); and revising paragraph (d)(1) to read as follows:

§ 199.14 Provider reimbursement methods.

(a) * * *

(2) * * *

(ix) * * *

(A) *In general.* Psychiatric and substance use disorder rehabilitation partial hospitalization services authorized by § 199.4(b)(10) and (e)(4) and provided by institutional providers authorized under § 199.6 (b)(4)(xii) and (b)(4)(xiv) are reimbursed on the basis of prospectively determined, all-inclusive per diem rates pursuant to the provisions of paragraph (a)(2)(ix)(C) of this section, with the exception of hospital-based psychiatric and substance use disorder rehabilitation partial hospitalization services which are reimbursed in accordance with provisions of paragraph (a)(5)(ii) of this section. The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, routine nursing service, ancillary services (includes music, dance, occupational and other such therapies), psychological testing and assessment, overhead and any other services for which the customary practice among similar providers is included as part of the institutional charges.

* * * * *

(5) * * *

(i) *Outpatient Services Not Subject to Hospital Outpatient Prospective Payment System (OPPS).* The following are payment methods for outpatient services that are either provided in an OPPS exempt hospital or paid outside the OPPS payment methodology under existing fee schedules or other prospectively determined rates in a hospital subject to OPPS reimbursement.

* * * * *

(ii) *Outpatient Services Subject to OPPS.* Outpatient services provided in hospitals subject to Medicare OPPS as specified in 42 CFR 413.65 and 42 CFR § 419.20 will be paid in accordance with the provisions outlined in sections 1833(t) of the Social Security Act and its implementing Medicare regulation (42 CFR Part 419) subject to exceptions as authorized by § 199.14(a)(5)(ii). Under the above governing provisions, CHAMPUS will recognize to the extent practicable, in accordance with 10 U.S.C. 1079(j)(2), Medicare's OPPS reimbursement methodology to include specific coding requirements, ambulatory payment classifications (APCs), nationally established APC amounts and associated adjustments (e.g., discounting for multiple surgery procedures, wage adjustments for variations in labor-related costs across geographical regions and outlier calculations). While CHAMPUS intends to remain as true as possible to Medicare's basic OPPS methodology, there will be some deviations required to accommodate CHAMPUS' unique benefit structure and beneficiary population as authorized under the provisions of 10 U.S.C. 1079(j)(2). Temporary transitional payment adjustments (TTPAs) will be in place for all hospitals, both network and non-network in order to buffer the initial decline in payments upon implementation of TRICARE's OPPS. For network hospitals, the temporary transitional payment adjustments (TTPAs) will cover a four-year period. The four-year transition will set higher payment percentages for the ten Ambulatory Payment Classification (APC) codes 604–609 and 613–616, with reductions in each of the transition years. For non-network hospitals, the adjustments will cover a three year period, with reductions in each of the transition years. For network hospitals, under the TTPAs, the APC payment level for the five clinic visit APCs would be set at 175 percent of the Medicare APC level, while the five ER visit APCs would be increased by 200 percent in the first year of OPPS implementation. In the second year, the APC payment levels would be set at 150 percent of the Medicare APC level for clinic visits and 175 percent for ER APCs. In the third year, the APC visit amounts would be set at 130 percent of the Medicare APC level for clinic visits and 150 percent for ER APCs. In the fourth year, the APC visit amounts would be set at 115 percent of the Medicare APC level for clinic visits and 130 per cent for ER APCs. In the fifth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

For non-network hospitals, under the TTPAs, the APC payment level for the five clinic and ER visit APCs would be set at 140 percent of the Medicare APC level in the first year of OPPS implementation. In the second year, the APC payment levels would be set at 125 percent of the Medicare APC level for clinic and ER visits. In the third year, the APC visit amounts would be set at 110 percent of the Medicare APC level for clinic and ER visits. In the fourth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

An additional temporary military contingency payment adjustment (TMCPA) will also be available at the discretion of the Director, TMA, or a designee, at any time after implementation to adopt, modify and/or extend temporary adjustments to OPPS payments for TRICARE network hospitals deemed essential for military readiness and deployment in time of contingency operations. Any TMCPAs to OPPS payments shall be made only on the basis of a determination that it is impracticable to support military readiness or contingency operations by making OPPS payments in accordance with the same reimbursement rules implemented by Medicare. The criteria for adopting, modifying, and/or extending deviations and/or adjustments to OPPS payments shall be issued through CHAMPUS policies, instructions, procedures and guidelines as deemed appropriate by the Director, TMA, or a designee. TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that the procedures cannot be obtained timely enough from a network hospital. For such case-by-case extensions, ''Temporary'' might be less than three

years at the discretion of the TMA Director, or designee.

* * * * *

(d) * * *

(1) *In general.* CHAMPUS pays institutional facility costs for ambulatory surgery on the basis of prospectively determined amounts, as provided in this paragraph, with the exception of ambulatory surgery procedures performed in hospital outpatient departments, which are to be reimbursed in accordance with the provisions of paragraph (a)(5)(ii) of this section. This payment method is similar to that used by the Medicare program for ambulatory surgery. This paragraph applies to payment for freestanding ambulatory surgical centers. It does not apply to professional services. A list of ambulatory surgery procedures subject to the payment method set forth in the paragraph shall be published periodically by the Director, TRICARE Management Activity (TMA). Payment to freestanding ambulatory surgery centers is limited to these procedures.

* * * * *

Dated: December 5, 2008.

Patricia Toppings,

OSD Federal Register, Liaison Officer, Department of Defense.

[FR Doc. E8–29251 Filed 12–5–08; 4:15 pm]

BILLING CODE 5001–06–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[USCG–2008–1124]

Drawbridge Operation Regulation; Long Island, New York Inland Waterway From East Rockaway Inlet to Shinnecock Canal, Hempstead, NY, Maintenance

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, First Coast Guard District, has issued a temporary deviation from the regulation governing the operation of the Wantagh State Parkway Bridge across Sloop Channel at mile 15.4, at Jones Beach, New York. Under this temporary deviation the bridge may operate on a limited operating schedule for four months to facilitate the completion of bridge construction.

DATES: This deviation is effective from December 1, 2008 through April 1, 2009.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket USCG–2008–1124 and are available online at *www.regulations.gov.* They are also available for inspection or copying two locations: The Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays, and the First Coast Guard District, Bridge Branch Office, 408 Atlantic Avenue, Boston, Massachusetts 02110, between 7 a.m. and 3 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Judy Leung-Yee, Project Officer, First Coast Guard District, at (212) 668–7165.

SUPPLEMENTARY INFORMATION: The Wantagh State Parkway Bridge has a vertical clearance in the closed position of 16 feet at mean high water. The existing drawbridge operation regulations are listed at 33 CFR 117.5.

The New York State Department of Transportation requested a temporary deviation to facilitate the completion of bridge construction and to accommodate holiday work schedule.

The waterway has seasonal recreational vessels and fishing vessels of various sizes.

We contacted the New York Marine Trades Association and Station Jones Beach. No objection to the proposed temporary deviation schedule was received.

Under this temporary deviation, in effect from December 1, 2008 through April 1, 2009, the Wantagh State Parkway Bridge at mile 15.4, across Sloop Channel, shall operate as follows:

From Monday through Friday the bridge shall open on signal at 6:30 a.m. and 4 p.m. after at least a 30-minute advance notice is given. From 4 p.m. to 6:30 a.m. the bridge shall open on signal after at least a two-hour advance notice is given.

From Friday, 4 p.m. through Monday, 6:30 a.m. the bridge shall open on signal after at least a two-hour advance notice is given.

At all other times including 24, 25, 31 December 2008 and 1 January 2009, the bridge need not open for marine traffic.

Advance notice may be given by calling (631) 383–6598.

In accordance with 33 CFR 117.35(e), the bridge must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: December 1, 2008.

Gary Kassof,

Bridge Program Manager, First Coast Guard District.

[FR Doc. E8–29237 Filed 12–9–08; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF THE INTERIOR

National Park Service

36 CFR Part 2

Fish and Wildlife Service

50 CFR Part 27

RIN 1024–AD70

General Regulations for Areas Administered by the National Park Service and the Fish and Wildlife Service

AGENCIES: Fish and Wildlife Service and National Park Service, Interior.

ACTION: Final rule.

SUMMARY: This final rulemaking amends regulations codified in 36 CFR part 2 and 50 CFR part 27, which pertain to the possession and transportation of firearms in national park areas and national wildlife refuges. The final rule updates these regulations to reflect state laws authorizing the possession of concealed firearms, while leaving unchanged the existing regulatory provisions that ensure visitor safety and resource protection such as the prohibitions on poaching and limitations on hunting and target practice.

DATES: This rule becomes effective on January 9, 2009.

FOR FURTHER INFORMATION CONTACT: Lyle Laverty, 202–208–4416.

SUPPLEMENTARY INFORMATION:

I. Background

America's parks and wildlife refuges are an important part of our shared national heritage, and a source of inspiration and enjoyment for visitors from around the world. For nearly 100 years, Congress has vested the Secretary of the Interior with the responsibility for managing these lands and resources in a manner that ensures their preservation and seeks to provide for the safety of visitors and employees. In administering these lands, Congress has enacted various statutes authorizing the Secretary to work closely with respective State and local governments in the management of these areas. In the following decades, the Department has worked closely with its State, local