PARTIAL HOSPITALIZATION RATES FOR FULL-DAY AND HALF-DAY PROGRAMS—Continued

[Fiscal year 2012]

United States Census Region	Full-day rate (6 hours or more)	Half-day rate (3–5 hours)
West North Central:		
(Minn., Iowa, Mo., N.D., S.D., Neb., Kan.)	302	225
South:		
South Atlantic (Del., Md., DC, Va., W.Va., N.C., S.C., Ga., Fla.)	323	244
East South Central:		
(Ky., Tenn., Ala., Miss.)	350	264
West South Central:		
(Ark., La., Texas, Okla.)	350	264
West:		
Mountain (Mon., Idaho, Wyo., Col., N.M., Ariz., Utah, Nev.)	353	267
Pacific (Wash., Ore., Calif., Alaska, Hawaii)	347	260
Puerto Rico	225	170

The above rates are effective for services rendered on or after October 1, 2011.

Dated: November 22, 2011.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer,

Department of Defense.

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DEPARTMENT OF DEFENSE

Office of the Secretary

TRICARE; Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Fiscal Year 2012 Diagnosis-Related Group (DRG) Updates

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

ACTION: Notice of DRG revised rates.

SUMMARY: This notice describes the changes made to the TRICARE DRG-based payment system in order to conform to changes made to the Medicare Prospective Payment System (PPS).

It also provides the updated fixed loss cost outlier threshold, cost-to-charge ratios and the data necessary to update the FY 2012 rates.

DATES: *Effective Dates:* The rates, weights and Medicare PPS changes which affect the TRICARE DRG-based payment system contained in this notice are effective for admissions occurring on or after October 1, 2011.

ADDRESSES: TRICARE Management Activity (TMA), Medical Benefits and Reimbursement Systems, 16401 East Centretech Parkway, Aurora, CO 80011–9066.

FOR FURTHER INFORMATION CONTACT: Mark A. Jacobs, Medical Benefits and Reimbursement Systems, TMA, telephone (303) 676–3802.

Questions regarding payment of specific claims under the TRICARE DRG-based payment system should be addressed to the appropriate contractor.

SUPPLEMENTARY INFORMATION: The final rule published on September 1, 1987 (52 FR 32992) set forth the basic procedures used under the CHAMPUS DRG-based payment system. This was subsequently amended by final rules published August 31, 1988 (53 FR 33461), October 21, 1988 (53 FR 41331), December 16, 1988 (53 FR 50515), May 30, 1990 (55 FR 21863), October 22, 1990 (55 FR 42560), and September 10, 1998 (63 FR 48439).

An explicit tenet of these final rules, and one based on the statute authorizing the use of DRGs by TRICARE, is that the TRICARE DRG-based payment system is modeled on the Medicare PPS, and that, whenever practicable, the TRICARE system will follow the same rules that apply to the Medicare PPS. The Centers for Medicare and Medicaid Services (CMS) publishes these changes annually in the **Federal Register** and discusses in detail the impact of the changes.

In addition, this notice updates the rates and weights in accordance with our previous final rules. The actual changes we are making, along with a description of their relationship to the Medicare PPS, are detailed below.

I. Medicare PPS Changes Which Affect the TRICARE DRG-Based Payment System

Following is a discussion of the changes CMS has made to the Medicare PPS that affect the TRICARE DRG-based payment system.

A. DRG Classifications

Under both the Medicare PPS and the TRICARE DRG-based payment system, cases are classified into the appropriate DRG by a Grouper program. The Grouper classifies each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). The Grouper used for the TRICARE DRG-based payment system is the same as the current Medicare Grouper with two modifications. The TRICARE system has replaced Medicare DRG 435 with two age-based DRGs (900 and 901), and has implemented thirty-four (34) neonatal DRGs in place of Medicare DRGs 385 through 390. For admissions occurring on or after October 1, 2001, DRG 435 has been replaced by DRG 523. The TRICARE system has replaced DRG 523 with the two age-based DRGs (900 and 901). For admissions occurring on or after October 1, 1995, the CHAMPUS grouper hierarchy logic was changed so the age split (age <29 days) and assignments to MDC 15 occur before assignment of the PreMDC DRGs. This resulted in all neonate tracheostomies and organ transplants to be grouped to MDC 15 and not to DRGs 480–483 or 495. For admissions occurring on or after October 1, 1998, the CHAMPUS grouper hierarchy logic was changed to move DRG 103 to the PreMDC DRGs and to assign patients to PreMDC DRGs 480, 103 and 495 before assignment to MDC 15 DRGs and the neonatal DRGs. For admissions occurring on or after October 1, 2001, DRGs 512 and 513 were added to the PreMDC DRGs, between DRGs 480 and 103 in the TRICARE grouper hierarchy logic. For admissions occurring on or after October 1, 2004, DRG 483 was deleted and replaced with DRGs 541 and 542, splitting the assignment of cases on the basis of the performance of a major operating room procedure. The description for DRG 480 was changed to ''Liver Transplant and/or Intestinal Transplant'', and the description for DRG 103 was changed to ''Heart/Heart

Lung Transplant or Implant of Heart Assist System''. For FY 2007, CMS implemented classification changes, including surgical hierarchy changes. The TRICARE Grouper incorporated all changes made to the Medicare Grouper, with the exception of the pre-surgical hierarchy changes, which will remain the same as FY 2006. For FY 2008, Medicare implemented the Medicare-Severity DRG (MS–DRG) based payment system. TRICARE, however, continued with the Centers for Medicare and Medicaid Services DRG-based (CMS–DRG) payment system for FY 2008. For FY 2009, the TRICARE/CHAMPUS DRG-based payment system was modeled on the MS–DRG system, with the following modifications.

The MS–DRG system consolidated the 43 pediatric CMS DRGs that were defined based on age less than or equal to 17 into the most clinically similar MS–DRGs. In the CMS Inpatient Prospective Payment System final rule for MS–DRGs, CMS stated for the Medicare population these pediatric CMS DRGs contained a very low volume of patients. At the same time, Medicare encouraged private insurers and other non-Medicare payers to make refinements to MS–DRGs to better suit the needs of the patients they serve. Consequently, TRICARE finds it appropriate to retain the pediatric CMS–DRGs for our population. TRICARE is also retaining the TRICARE-specific DRGs for neonates and substance use.

TRICARE retained the MS–DRG numbering system for FY09 and those TRICARE-specific DRGs were assigned available, blank DRG numbers unused in the MS–DRG system. We refer the reader to *http://www.tricare.mil/drgrates* for a complete crosswalk containing the TRICARE DRG numbers for FY09.

For FY09, TRICARE used the MS–DRG v26.0 pre-MDC hierarchy, with the exception that MDC 15 is applied after DRG 011–012 and before MDC 24.

For FY 10, there were no additional or deleted DRGs.

For FY 11, DRG 009 was deleted; DRGs 014 and 015 were added.

For FY 12, the added DRGs and deleted DRGs are the same as those included in CMS' final rule published on August 18, 2011 (76 FR 51476–51846). That is, DRG 015 is deleted; DRGs 016 and 017 are being added.

B. Wage Index and Medicare Geographic Classification Review Board Guidelines

TRICARE will continue to use the same wage index amounts used for the Medicare PPS. TRICARE will also duplicate all changes with regard to the wage index for specific hospitals that are re-designated by the Medicare Geographic Classification Review Board. In addition, TRICARE will continue to utilize the out commuting wage index adjustment.

C. Revision of the Labor-Related Share of the Wage Index

TRICARE is adopting CMS' percentage of labor related share of the standardized amount. For wage index values greater than 1.0, the labor related portion of the Adjusted Standardized Amount (ASA) shall equal 68.8 percent. For wage index values less than or equal to 1.0 the labor related portion of the ASA shall continue to equal 62 percent.

D. Hospital Market Basket

TRICARE will update the adjusted standardized amounts according to the final updated hospital market basket used for the Medicare PPS for all hospitals subject to the TRICARE DRG-based payment system according to CMS's August 18, 2011, final rule. For FY 2012, the market basket is 3.0%. Medicare applied reductions to the market basket in FY 2012, with an adjustment of 1.0 percentage point for economy-wide productivity and less 0.1 percentage point for hospitals in all areas. However, these reductions do not apply to TRICARE.

E. Outlier Payments

Since TRICARE does not include capital payments in our DRG-based payments (TRICARE reimburses hospitals for their capital costs as reported annually to the contractor on a pass through basis), we will use the fixed loss cost outlier threshold calculated by CMS for paying cost outliers in the absence of capital prospective payments. For FY 2012, the TRICARE fixed loss cost outlier threshold is based on the sum of the applicable DRG-based payment rate plus any amounts payable for Indirect Medical Education (IDME) plus a fixed dollar amount. Thus, for FY 2012, in order for a case to qualify for cost outlier payments, the costs must exceed the TRICARE DRG base payment rate (wage adjusted) for the DRG plus the IDME payment plus $21,482 (wage adjusted). The marginal cost factor for cost outliers continues to be 80 percent.

F. National Operating Standard Cost as a Share of Total Costs

The FY 2012 TRICARE National Operating Standard Cost as a Share of Total Costs (NOSCASTC) used in calculating the cost outlier threshold is 0.919. TRICARE uses the same methodology as CMS for calculating the NOSCASTC; however, the variables are different because TRICARE uses national cost to charge ratios while CMS uses hospital specific cost to charge ratios.

G. Indirect Medical Education (IDME) Adjustment

Passage of the MMA of 2003 modified the formula multipliers to be used in the calculation of the indirect medical education IDME adjustment factor. Since the IDME formula used by TRICARE does not include disproportionate share hospitals (DSHs), the variables in the formula are different than Medicare's, however; the percentage reductions that will be applied to Medicare's formula will also be applied to the TRICARE IDME formula. The multiplier for the IDME adjustment factor for TRICARE for FY 2012 is 1.02.

H. Expansion of the Post Acute Care Transfer Policy

For FY 2012 TRICARE is adopting CMS' expanded post acute care transfer policy according to CMS' final rule published August 18, 2011.

I. Cost to Charge Ratio

While CMS uses hospital-specific cost to charge ratios, TRICARE uses a national cost to charge ratio. For FY 2012, the cost-to-charge ratio used for the TRICARE DRG-based payment system for acute care hospitals and neonates will be 0.3460. This shall be used to calculate the adjusted standardized amounts and to calculate cost outlier payments, except for children's hospitals. For children's hospital cost outliers, the cost-to-charge ratio used is 0.3757.

J. Updated Rates and Weights

The updated rates and weights are accessible through the Internet at *http://www.tricare.osd.mil* under the sequential headings TRICARE Provider Information, Rates and Reimbursements, and DRG Information. Table 1 provides the ASA rates and Table 2 provides the DRG weights to be used under the TRICARE DRG-based payment system during FY 2012. The implementing regulations for the TRICARE/CHAMPUS DRG-based payment system are in 32 CFR part 199.

Dated: November 22, 2011.

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Alternate OSD Federal Register Liaison Officer, Department of Defense.

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